HOUSE RESEARCH
Bill Summary

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Article 1: Children and Family Services

Overview

This article makes changes to the child care assistance programs, MFIP, GA, emergency assistance, MSA, GRH, and creates a new adult assistance program.

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.

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, subdivision 1b. Requires legal nonlicensed child care providers to complete CPR training.

6 **Subsidy restrictions.** Amends § 119B.13, subd. 1. Reduces child care assistance provider rates by five percent. 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 this section effective September 3, 2012, except the amendments to paragraph (e) are effective April 16, 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 July 1, 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 card. Requires cash benefits for GA, MSA, and MFIP to be issued on a separate EBT card with the head of household's name printed on the card. Requires the card to include a statement that it is unlawful to use the card to purchase tobacco or alcoholic beverages. 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. EBT use restricted to Minnesota vendors. Prohibits EBT debit cardholders from using the EBT debit card at vendors located outside of Minnesota. Specifies that this subdivision does not apply to the food portion.

Subd. 3. Prohibited purchases. Prohibits EBT cardholder's from using the card to purchase tobacco products or alcoholic beverages.

Makes subdivisions 1 and 2 effective June 1, 2012.

10 **Resident; GAMC.** Amends § 256D.02, subdivision 12a. Continues the 30-day residency requirement for general assistance medical care and strikes existing language in this subdivision related to general assistance. Makes this section effective October 1, 2012.

11 **Eligibility.** Amends § 256D.05, subd. 1. Modifies eligibility for the general assistance program by removing several categories of eligibility. Makes this section effective May 1, 2012.

12 **Emergency need.** Amends § 256D.06, subd. 2. Modifies eligibility criteria for emergency assistance. Makes this section effective November 1, 2011.

13 **Special needs.** Amends § 256D.44, subdivision 5. Amends the Minnesota supplemental aid program by eliminating allowances for special needs and special diets. Makes this section effective August 1, 2011.

14 **Eligibility.** Amends § 256D.46, subd. 1. Modifies eligibility of SSI and MSA recipients for emergency assistance. Makes this section effective November 1, 2011.

15 **Payment methods.** Amends § 256D.47. Amends the Minnesota supplemental aid program by striking a cross-reference to special needs and special diets. Makes this section effective August 1, 2011.

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

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

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

19 **Individual eligibility requirements.** Amends § 256I.04, subd. 1. Modifies individual eligibility requirements for the GRH program effective October 1, 2012.

20 **Group residential housing agreements.** Amends § 256I.04, subd. 2b. Prohibits counties from entering into agreements with GRH providers that do not include a residency requirement of at least 20 hours per month of volunteer or paid work. Makes this section effective May 1, 2012.

21 **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.

22 **60-day residency requirement.** Amends § 256J.12, subdivision 1a. Imposes a 60-day residency requirement on the Minnesota Family Investment program. Current law imposes a 30-day residency requirement. Current law is stricken that allows the residency requirement to be waived for unusual hardship, as defined in this section.

23 **Exceptions.** Amends § 256J.12, subdivision 2. Imposes a 60-day residency requirement on the Minnesota Family Investment program. Current law imposes a 30-day residency requirement. Current law is stricken that allows the residency requirement to be waived for unusual hardship, as defined in this section.

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

25 **Treatment of supplemental security income.** Amends § 256J.37, subdivision 3c. Modifies the MFIP program by reducing the MFIP grant by $50 per SSI recipient who resides in the household. Makes this section effective May 1, 2012.

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

27 **Approval of postsecondary education or training.** Amends § 256J.53, subd. 2. Requires participants to be working in unsubsidized employment at least 10 hours per week in order for postsecondary education or training to be an approved activity in an MFIP employment plan. Specifies this requirement does not apply for intensive education or training programs lasting 12 weeks or less when full-time attendance is required.

28 **Adult assistance grant program.** Creates § 256N.10. Creates the adult assistance grant program, which is a capped allocation to counties to provide flexible adult assistance benefits. Makes this section effective October 1, 2012.

29 **Definitions.** Creates § 256N.20. Defines terms under the adult assistance grant program. Makes this section effective October 1, 2012.

30 **Residency.** Creates § 256N.22. Defines "residency" for purposes of the adult assistance program. Specifies documentation necessary to verify residency. Includes a severability clause if this section is enjoined from implementation. Makes this section effective October 1, 2012.

31 **Program evaluation.** Creates § 256N.25. Requires the commissioner to define outcomes and performance indicators and requires counties to report to the commissioner annually on outcomes, performance indicators, and how funds were spent on the target population of the adult assistance program. Requires the commissioner to prepare a report on the counties' progress in improving the outcomes of adults related to safety and well-being. Makes this section effective October 1, 2012.

32 **Funding.** Creates § 256N.30. Specifies how counties may use the adult assistance grant program funding and how the commissioner shall allocate funds to the counties. Makes this section effective October 1, 2012.

33 **Applicant requirements.** Creates § 256N.35. Specifies applicant requirements under the adult assistance grant program, including making an application for any federal maintenance benefits for which the person may be eligible. Makes this section effective October 1, 2012.

34 **Juvenile treatment screening team.** Amends § 260C.157, subd. 3. Adds that county juvenile treatment screening teams must conduct screenings within 15 days of a request for a screening. Adds

the child's parent, guardian, or permanent legal custodian as a member of the team.

35 **Child in voluntary foster care for treatment.** Amends § 260D.01. Adds a cross-reference to section 260C.157, so that children in voluntary foster care for treatment can be screened by the juvenile treatment screening team.

36 **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. Removes obsolete language.

37 **Fees for IV-D services.** Amends § 518A.51. Modifies how the nonfederal share of certain fees are distributed and limits how counties may use the funds.

38 **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.

39 **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.

40 **Streamlining CCSA reporting requirements.** Requires the commissioner of human services, in consultation with others, to develop a streamlined alternative to current reporting requirements under the CCSA service plan. Requires the commissioner to submit recommendations and draft legislation to the legislature by November 15, 2012.

41 **Revisor's instruction.** Instructs the Revisor to make conforming amendments and correct statutory cross-references as necessitated by the creation of Minnesota Statutes, chapter 256N, and related repealers.

42 **Repealer.** Paragraph (a) repeals Minn. Stat. § 256.9862, subd. 2 (EBT card transaction fee) effective February 1, 2012.

Paragraph (b) repeals Minn. Stat. §§ 256.979, subds. 5, 6, 7, and 10 (child support incentives); 256.9791 (medical support bonus incentives); 256D.01, subds. 1, 1a, 1b, 1e, and 2 (GA declaration of policy; citation); 256D.03, subds. 1, 2, and 2a (GA county administration, assistance standards, and county agency options); 256D.05, subds. 1, 2, 4, 5, 6, 7, and 8 (eligibility for GA); 256D.0513 (budgeting lump sums); 256D.06, subds. 1, 1b, 2, 5, 7, and 8 (amount of assistance); 256D.09, subds. 1, 2, 2a, 2b, 5, and 6 (payments; assessment; overpayment); 256D.10 (administrative hearing prior to adverse action); 256D.13 (mandamus to compel payment of GA); 256D. 15 (relative's responsibility); 256D.16 (GA to be allowed as a claim in court); 256D.35, subd. 8b (emergency); and 256D.46 (emergency MSA) effective October 1, 2012.

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

Paragraph (d) repeals Minn. 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 **Consistent administrative expenses and investment income reporting.** Amends § 62D.08, subd. 7. Requires that the definition of "administrative expenses" must be consistent with the definition provided by the National Association of Insurance Commissioners (NAIC).

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

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

4 **Exemption.** Amends § 62J.495 by adding subd. 7. Exempts certain small clinical practices from the current 2015 deadline for interoperable electronic health records. Provides that this exemption expires December 31, 2020.

5 **Medical education.** Amends § 62J.692. Provides that training sites with a grant level less than $1,000 are ineligible for funds. Reduces direct payments of MERC funds and makes technical changes.

Subd. 11. Distribution of funds. Proposes a new MERC distribution formula, subject to federal approval, which would include (1) a public program volume factor - similar to the existing formula; (2) 10 percent primary care bonus pool; (3) a cap for training sites eligible for grants greater than the 95th percentile and a minimum of $1,000; and (4) the remainder divided evenly to two grant programs.

6 **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.

7 **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.

8 **Statewide tobacco prevention grants.** Amends § 144.396, subd. 5. Permits the commissioner to award statewide tobacco prevention grants within available appropriations.

9 **Local tobacco prevention grants.** Amends § 144.396, subd. 6. Requires the commissioner to award local tobacco prevention grants within available appropriations.

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

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

12 **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.

13 **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.

14 **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.

15 **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.

16 **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.

Provides an immediate effective date.

17 **Human cloning prohibited.** Creates § 145.4221. Prohibits any person or entity, whether public or private, from performing or attempting to perform human cloning; participating in an attempt to perform human cloning; shipping, importing, or receiving for any purpose an embryo produced by human cloning or any product derived from such an embryo; or shipping or receiving, in whole or in part, any oocyte, embryo, fetus, or human somatic cell for the purpose of human cloning. A knowing or reckless violation of the prohibition is punishable as a misdemeanor. Defines "human cloning" and "somatic cell." Provides that nothing in the law restricts areas of scientific research, including stem cell research, not specifically prohibited by the provision. Includes a severability provision.

18 **Eligible organizations; purpose.** Amends § 145.925, subd. 1. Limits the family planning special project grants to available appropriations.

19 **Prohibition.** Amends § 145.925, subd. 2. Limits family planning grants such that the commissioner shall not make grants to eligible organizations that perform or make referrals for abortion services, and grantees shall not contract with such organizations using these grant funds.

20 **White Earth Band urban clinic.** Adds § 145.9271. Requires the White Earth Band of Ojibwe Indians to establish and operate one or more health clinics in Minneapolis or greater Minnesota to serve member of the White Earth tribe.

21 **Community mental health center grants.** Adds § 145.9272. Requires the commissioner of health to distribute grants to community mental health centers for providing services to low-income consumers and patients with mental illness. Provides a formula for determining the amount of the grant based on public program revenues.

Provides that this section is effective upon federal approval of the funding mechanism.

22 **Community grant program; immunization rates and infant mortality rates.** Amends § 145.928, subd. 7. Permits the commissioner to award health disparities grants to reduce immunization rates and infant mortality within the available appropriations.

23 **Community grant program; other health disparities.** Amends § 145.928, subd. 8. Permits the commissioner to award health disparities grants within the available appropriations.

24 **Community health centers development grants.** Amends § 145.987. Requires the commissioner of health to award grants to expand community health centers by establishing new centers in small or isolated rural areas, as described by the Rural Urban Commuting Area system. Specifies uses for these community health center development grants.

Provides that this section is effective upon federal approval of the funding mechanism.

25 **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.

26 **Limited food establishment.** Amends § 157.15 by adding subd. 21. 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.

27 **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.

28 **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. Makes a conforming change related to the proposed formula changes to MERC distribution.

29 **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.

30 **Study of for-profit health maintenance organizations.** Requires the commissioner of health to contract with an entity to study efficiency, cost, service quality and enrollee satisfaction data for for-profit health maintenance organizations (HMO) relative to the non-profit HMO's. Requires a report on the findings by January 15, 2012.

31 **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.

32 **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.

33 Repealer. (a) Repeals §§ 62J.17, subds. 1, 3, 5a, 6a, and 8 (provisions related to expenditure reporting); 62J.321, subd. 5a (prescription drug price disclosure data); 62J.381 (prescription drug price disclosure); 62J.41, subds. 1 and 2 (cost containment reporting); 144.1464 (summer health care interns) 144.149 (rural hospital planning and transition grant program); 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.

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 requirements: local zoning regulations, specified fire code, and age and capacity limitations and square footage determinations as required by the fire code. Requires the license holder to display the license issued by the commissioner which will contain the statement, "This special family child 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. Instructs the commissioner to conduct background studies for children's therapeutic services and supports providers.

3 **Children's therapeutic services and supports providers.** Amends § 245C.10, by adding subd. 8. Allows the commissioner to recover the cost of background studies for children's therapeutic services and supports providers. Permits no more than a $20 fee per study which is charged to the license holder. Currently background studies are completed through BCA, and a similar fee is assessed.

4 **Level of need determination.** Amends § 256B.04, subd. 14a. Limits charges and payments for level of need determinations for nonemergency medical transportation to $25. Exempts from level of need determinations special transportation services to persons who need a stretcher-accessible vehicle from an inpatient or outpatient hospital, if the services are ordered by specified health care professionals according to Medicare guidelines. Exempts level of need determinations for persons transported to a nursing facility.

5 **Transportation costs.** Amends § 256B.0625, subd. 17. Requires the most direct route for purposes of reimbursement to special transportation providers to be determined by commercially available mileage software.

6 **Background studies.** Amends § 256B.0943, by adding subd. 5a. Allows children's therapeutic services and supports providers to access the commissioner's NETStudy system.

7 **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 county or tribal agency 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 county or tribal agency'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.

Paragraph (n) provides that counties and tribes are entitle to 1/2 of the nonfederal share of collections for long term care spouses on medical assistance and 1/4 of the nonfederal share of collections for long term care spouses on alternative care.

Provides a July 1, 2012, effective date.

8 **Elevators; entrances sealed.** Amends § 326B.175. Modifies the requirement that elevators not meeting building code requirements be taken out of service until modifications to bring the device into compliance with code requirements are completed. New compliance timeline is established in section 326B.188.

9 **Compliance with elevator code changes.** Creates § 326B.188. Provides an alternative compliance timeline for elevators that have a current law compliance deadline of January 29, 2012, or later. Owners of elevators that were notified of compliance issues before the effective date of this section, must submit a compliance plan for their devices by December 30, 2011. Owners not notified before the effective date of this section must submit a compliance plan by December 30, 2011, or within 60 days of notification, whichever is later. Any plan submitted under this section has to result in code compliance by the later of January 29, 2012, or within three years after submission of the compliance plan.

10 **Nonemergency medical transportation single administrative structure proposal.** (a) Requires the commissioner of human services to develop a proposal to create a single administrative structure for providing nonemergency medical transportation services to MA fee-for-service recipients. Requires the proposal to consolidate access and special transportation services into one administrative structure, with the goal of standardizing eligibility determination processes, scheduling arrangements, billing procedures, data collection, and oversight mechanisms.

(b) Requires the commissioner, in developing the proposal, to:

(1) examine the current responsibilities of the counties and DHS and consider any cost-shifting if responsibilities are changed;

(2) identify key performance measures to assess the cost effectiveness of medical nonemergency transportation, including a process to collect, audit, and report data;

(3) develop a statewide complaint system for recipients;

(4) establish a standardized billing process;

(5) establish a process for public input;

(6) establish eligibility criteria, including the frequency of eligibility assessments and the length of the eligibility period;

(7) develop a reimbursement method to compensate volunteers for no-load miles; and

(8) establish criteria to maximize the use of public transportation.

(c) Requires the commissioner to consult with the nonemergency medical transportation advisory council when developing the proposal.

(d) Requires the commissioner to establish the nonemergency medical transportation advisory council, and specifies membership and governance.

(e) Requires the commissioner to submit the proposal and draft legislation to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance, by January 15, 2012.

Article 4: Health Licensing Fees

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 **Nurse licensure compact.** Adds § 148.2855. Establishes the nurse licensure compact, which includes ten articles specifying the enforcement of the compact.

9 **Application of nurse licensure compact to existing laws.** Adds § 148.2856. States that nurses practicing in Minnesota under the nurse licensure shall have the same obligations, privileges, and rights as if the nurse was licensed in Minnesota, and shall be required to comply with and follow all laws and rules as nurses licensed in Minnesota.

10 **Withdrawal from compact.** Adds § 148.2857. Allows the governor to withdraw the state from the nurse licensure compact.

11 **Miscellaneous provisions.** Adds § 148.2858. Authorizes the Board of Nursing to recover costs of investigation and disposition of cases resulting from any adverse action taken against a nurse practicing under the compact.

12 **Nurse licensure compact advisory committee.** Adds § 148.2859. Establishes the nurse licensure compact advisory committee.

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

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

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

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

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

18 **Annual license fees.** Amends § 150A.91, subd. 4. Clarifies annual license fee.

19 **Biennial license or permit fees.** Amends § 150A.91, subd. 5. Makes a conforming change.

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

21 **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.

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

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

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

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

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

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

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

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

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

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

32 **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.

33 **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.

34 **Effective date.** Makes the sections related to the nurse licensure compact effective July 1, 2012, or upon implementation of a coordinated licensure information system, whichever is later.

Article 5: Health Care

1 **Freedom of Choice in Health Care Act.** Creates § 1.06. Establishes the Freedom of Choice in Health Care Act.

Subd. 1. Citation. States that this section may be cited as the "Freedom of Choice in Health Care Act."

Subd. 2 Definitions. Defines the following terms: "health care service," "mode of securing," and "penalty."

Subd. 3. Statement of public policy. Paragraph (a), states as public policy that the power to require or regulate a person's choice of in the mode of securing health care services or to impose a penalty related to that choice is not found in the U.S. Constitution and that the state hereby exercises its sovereign power to declare the right of all persons residing in the state in choosing the mode of securing health care services.

Paragraph (b) declares that as a public policy of the state of Minnesota every resident is free to choose or decline to choose any mode of securing health care services without penalty or threat of penalty.

Paragraph (c) states that this public policy is not to be applied to impair any right of contract related to the provision of health care services to any person or group.

Subd. 4. Enforcement. States that no public official, employee, or agent of the state or any of its political subdivisions shall act to impose, collect, enforce, or effectuate any penalty that violates the public policy set forth in this section. This subdivision also requires the Attorney General to take any action as provided in this section or in Minnesota Statutes, section 8.31, to defend or prosecute the rights protected under this section.

2 **Investigate offenses against provisions of certain designated sections; assist in enforcement.** Amends § 8.31, subd. 1. Requires the Attorney General to seek injunctive and any other appropriate relief to preserve the rights and property of the residents of the state and to defend the state's officials, employees, and agents in the event that there is a law or regulation that violates the public policy as set forth in the Freedom of Choice in Health Care Act. This section also requires the Attorney General to seek injunctive and any other appropriate relief in the event that any law or regulation that violates the public policy of the Freedom of Choice in Health Care Act is enacted without adequate federal funding to the state to ensure affordable health care coverage is available to the residents of the state.

3 **Private remedies.** Amends § 8.31, subd. 3a. States that any person injured by a violation of the public policy in section 1.06 may bring a civil action and recover damages, cost and disbursements, and other equitable relief as determined by the court. This section also states that an action brought under this section for a violation of section 1.06 is in the public interest.

4 **Establishment.** Amends § 62E.08, subd. 1. Provides that the MCHA premium for the high-deductible, basic plan offered under section 62E.121 shall range from 101 to 125 percent of the weighted average of rates for comparable plans offered outside of MCHA.

5 **High-deductible, basic plan.** Adds § 62E.121.

Subd. 1. Required offering. Requires MCHA to offer a high deductible, basic plan that meets the requirements in this section. Specifies that the plan is a one-person plan and that dependents must be covered separately.

Subd. 2. Annual deductible; out-of-pocket maximum. (a) Requires the plan to provide in-network annual deductible options of $3,000, $6,000, $9,000, and $12,000, with an in-network out-of-pocket maximum that is $1,000 greater than the amount of the annual deductible.

(b) Provides an annual increase in the deductible, based on the change in the CPI.

Subd. 3. Office visits for nonpreventive care. Specifies different levels of copayments for the first three nonpreventive office visits, depending upon the deductible option chosen. Provides 80 percent coverage for subsequent visits, after the deductible is met.

Subd. 4. Preventive care. Provides 100 percent coverage for preventive care, with no cost-sharing.

Subd. 5. Prescription drugs. Requires a $10 copayment for preferred generic drugs, and requires enrollees to pay 100 percent of the plan's rate for preferred brand-name drugs.

Subd. 6. Convenience care center visits. Requires a $20 copayment for the first three convenience center visits, with 80 percent coverage for subsequent visits after the deductible is met.

Subd. 7. Urgent care center visits. Requires a $100 copayment for the first urgent care visit, and provides 80 percent coverage for subsequent visits after the deductible is met.

Subd. 8. Emergency room visits. Requires a $200 copayment for the first emergency room visit, and provides 80 percent coverage for subsequent visits after the deductible is met.

Subd. 9. Lab and x-ray; hospital services; ambulance; surgery. Provides that these services are covered at 80 percent after the deductible is met.

Subd. 10. Eyewear. Pays $50 per calendar year for eyewear.

Subd. 11. Maternity. Specifies that maternity, labor and delivery, and postpartum care are not covered. Provides 100 percent coverage for prenatal care with no deductible.

Subd. 12. Other eligible health care services. Provides 80 percent coverage for other eligible health care services after the deductible is met.

Subd. 13. Option to remove mental health and substance abuse coverage. Allows enrollees to remove mental health and substance abuse coverage and receive a reduced premium.

Subd. 14. Option to upgrade prescription drug coverage. Allows enrollees to upgrade prescription drug coverage in return for an increased premium.

Subd. 15. Out-of-network services. Provides that: the out-of-network deductible is twice the in-network annual deductible; there is no out-of-pocket maximum for out-of-network services; out-of-network benefits are covered at 60 percent after the deductible is met; and the lifetime maximum for out-of-network services is $1 million.

Subd. 16. Services not covered. Lists services not covered by the plan.

6 **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 limit, if they are eligible for the healthy Minnesota contribution program and have been denied private sector coverage.

7 **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.

8 **Transfers from the commissioner of human services.** Amends § 62J.692, subd. 7. Requires MERC funding to be distributed, upon federal approval, under a modified formula that will replace the general distribution formula in current law.

9 **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.

10 **Billing for procedures to correct medical errors is prohibited.** Adds § 62J.824. Prohibits a health care provider from billing and being reimbursed for any service provided to reverse, correct, or otherwise minimize the effects of an adverse health event for which the health care provider is responsible.

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

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

13 **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.

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

15 **Performance payments.** Amends § 256.01, subd. 2b. Strikes language requiring the commissioner to develop and implement a performance payment system for eligible medical groups and clinics serving state health care program enrollees with chronic diseases.

16 **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.

17 **Operating payment rates.** Amends § 256.969, subd. 2b. Delays hospital rebasing for the first six months of the rebased period beginning January 1, 2013.

18 **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.

19 **Asset limitations for individuals and families.** Amends § 256B.056, subd. 3. Strikes language stating that MA enrollees who are adults with no children have no asset limit (related to repeal of coverage for this group).

20 **Income.** Amends § 256b.056, subd. 4. Strikes language specifying the income limit for MA enrollees who are adults with no children (related to repeal of coverage for this group).

21 **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-funded medical assistance coverage for certain legal noncitizens.

22 **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 the program, if the commissioner determines that at least 90 percent of MA and MinnesotaCare births occur at hospitals that have approved policies.

23 **Physical therapy.** Amends § 256B.0625, subd. 8. Limits specialized maintenance therapy provided as a physical therapy service to recipients age 20 and under. Provides an effective date of July 1, 2011, for services provided through fee-for-service, and January 1, 2012, for services provided by a managed care or county-based purchasing plan.

24 **Occupational therapy.** Amends § 256B.0625, subd. 8a. Limits specialized maintenance therapy provided as an occupational therapy service to recipients age 20 and under. Provides an effective date of July 1, 2011, for services provided through fee-for-service, and January 1, 2012, for services provided by a managed care or county-based purchasing plan.

25 **Speech-language pathology and audiology services.** Amends § 256B.0625, subd. 8b. Limits specialized maintenance therapy provided as a speech-language pathology service to recipients age 20 and under. Provides an effective date of July 1, 2011, for services provided through fee-for-service, and January 1, 2012, for services provided by a managed care or county-based purchasing plan.

26 **Care management; rehabilitation services.** Amends § 256B.0625, subd. 8c. Requires a care management approach to authorize rehabilitation services beyond the thresholds for physical therapy, occupational therapy, and speech-language pathology and audiology services to be instituted in conjunction with onetime thresholds.

27 **Chiropractic services.** Amends § 256B.0625, subd. 8e. Increases from 12 to 24 the number of chiropractic visits allowed before prior authorization is required.

28 **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.

29 **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 four 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 (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 July 1, 2011, or upon federal approval.

30 **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

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

32 **Payment for ambulance services.** Amends § 256B.0625, subd. 17a. Effective July 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.

33 **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.

34 **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.

35 **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.)

36 **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.

37 **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 receiving care coordination from a health care home are not eligible for reimbursement. Sets requirements for in-reach service coordinators.

(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.

38 **Payment for Part B Medicare crossover claims.** Amends § 256B.0625, by adding subd. 57. Effective January 1, 2012, limits MA payment for an enrollee's Medicare Part B cost-sharing to an amount, when combined with Medicare payments, that does not exceed the MA rate.

39 **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).

40 **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.

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

- reinstates certain co-payments (these had been reduced or eliminated by the legislature)
- requires a family deductible
- establishes tiered copayments for nonpreventive visits

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

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

44 **Reimbursement under other state health care programs.** Amends § 256B.0644. Allows an entity that operates both a Medicare certified comprehensive outpatient rehabilitation facility and a facility licensed to provide residential programs and services for persons with physical disabilities to limit the eligibility of new state health care program patients for specific categories of rehabilitative services, if state health care program patients make up more than 30 percent of the provider's patient population.

45 **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.

46 **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.

47 **Managed care contracts.** Amends § 256B.69, subd. 5a. Effective January 1, 2012, requires the commissioner to include as a performance target a reduction in a plan's rate subsequent hospitalizations, within 30 days of a previous hospitalization, by 5 percent from the rate for the previous calendar year. Requires withholds to be returned between July 1 and July 31 of the following year, if the target reduction rate is achieved. Requires this performance withhold to continue until the plan's subsequent hospitalization rate is reduced by 25 percent.

48 **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 $2,012,000 for FY 2012 and $2,213,000 in FY 2013 and thereafter.

49 **Medicare special needs plans; medical assistance basic health care.** Amends § 256B.69, subd. 28. Requires the commissioner to enroll MA enrollees with disabilities in special needs basic 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.

50 **Provider payment rates.** Amends § 256B.69, by adding subd. 30. Requires managed care and county-based purchasing plans to implement progressive payment withhold methodologies, based upon a provider's risk adjusted total annual cost of care, relative to other providers of the same type. Requires each plan to establish the 70^{th} percentile as a benchmark percentile, and to return the full amount of the withhold to providers whose risk-adjusted total annual cost of care is at or below this percentile. For providers whose cost of care is above this percentile, requires plans to return only that portion of the withhold sufficient to bring a provider's payment rate to the average for providers whose cost of care is at the benchmark. Requires the commissioner to reduce capitation rates by 10 percent, for the contract year beginning January 1, 2012, and allows additional reductions in future years. Allows plans to reduce payments to providers, but prohibits reductions to lower cost providers and to children's hospitals. Requires plans to use the withhold methodology specified by this subdivision, unless the plan develops an alternative model consistent with the purposes of the subdivision.

51 **Health education.** Amends § 256B.69, by adding subd. 31. Directs the commissioner to require managed care and county-based purchasing plans to provide health education, wellness training, and information about the availability and benefits of preventive services to all MA and MinnesotaCare enrollees, beginning January 1, 2012.

52 **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. Prohibits the commissioner from adopting rules related to critical access dental providers.

53 **Complementary and alternative medicine demonstration project.** Adds § 256B.771. Requires the commissioner of human services, in consultation with the commissioner of health, to contract with a Minnesota-based academic and research institution specializing in complementary and alternative medicine 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 July 1, 2011, or upon federal approval, whichever is later.

54 **Minnesota CHOICE waiver application and process.** Adds § 256B.841.

Subd. 1. Intent. Provides an intent statement.

Subd. 2. Waiver application. Requires the commissioner to apply for a waiver and any necessary state plan amendments that provides program flexibility and under which Minnesota will operate its MA program. States that the waiver shall be known as the Minnesota Consumer Health Opportunities and Innovative Care Excellence (CHOICE) waiver. Requires the commissioner to provide the relevant legislative committees with the waiver application and related materials. If the waiver application is approved, requires the commissioner to notify legislative chairs, allow review by legislative committees, and not implement the waiver until ten legislative days have passed following notification.

Subd. 3. Rulemaking; legislative proposals. Upon acceptance of the waiver, requires the commissioner to adopt rules and to propose any legislative changes needed to implement the waiver.

Subd. 4. Joint commission on waiver implementation. Requires the governor to establish a joint commission on waiver implementation. Specifies membership and duties.

55 **Principles and goals for medical assistance reform.** Adds § 256B.842.

Subd. 1. Goals for reform. Requires the commissioner to ensure that the reformed MA program is a person-centered, financially sustainable, and cost-effective program.

Subd. 2. Reformed medical assistance criteria. Establishes criteria for the reformed program established through the CHOICE waiver.

Subd. 3. Annual report. Requires the commissioner to report annually to the governor and the legislature on the status of the administration and implementation of the waiver.

56 **CHOICE waiver application requirements.** Adds § 256B.843.

Subd. 1. Requirements for waiver request. Requires the commissioner to seek federal approval to enter into a five-year agreement with the federal government under section 1115a to waive specific provisions of Medicaid law, including but not limited to statewideness, comparability of services, and freedom of choice of providers. Also requires the commissioner to seek a waiver of Medicaid law provisions, in order to expand cost-sharing, establish health savings or power accounts, provide enrollees with a choice of appropriate private sector coverage, consolidate waivered services, and implement other specified initiatives.

Subd. 2. Agency coordination. Requires the commissioner to establish an intraagency assessment and coordination unit.

57 **General assistance medical care; eligibility.** Amends § 256D.03, subd. 3. Reinstates the modified GAMC program (which would delivery care through coordinated care delivery systems (CCDS)), effective October 1, 2011.

58 **Eligibility.** Amends § 256D.031, subd. 1. Sets the income limit for the reinstated GAMC program at 125 percent of FPG (the income limit for the previous GAMC program was 75% of FPG).

59 **Coordinated care delivery systems.** Amends § 256D.031, subd. 6. Makes changes to CCDS service delivery. Allows county-based purchasing plans to establish CCDSs. Requires hospitals and plans

operating a CCDS to give preference to health care homes when contracting with providers, and to contract with FQHCs and FQHC look-alikes, and essential community providers, that accept contract terms.

60 **Payments; rate setting for the coordinated care delivery system.** Amends § 256D.031, subd. 7. Reinstates CCDS payment language. Requires payments to hospitals and plans operating a CCDS to be based upon enrollment thresholds negotiated with the commissioner.

61 **Prescription drug pool.** Amends § 256D.031, subd. 9. Reinstates the GAMC prescription drug pool, effective October 1, 2011. Requires a CCDS to pay to the commissioner quarterly assessments equal to 20 percent of prescription drug costs for its enrollees.

62 **Assistance for veterans.** Amends § 256D.031, subd. 10. Makes a conforming change related to county-based purchasing plans being allowed to operated CCDSs.

63 **Gross individual or gross family income.** Amends § 256L.01, subd. 4a. Makes conforming changes to the reduction in the MinnesotaCare eligibility period from 12 to six months.

64 **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.

65 **Cost-sharing.** Amends § 256L.03, subd. 5. Requires MinnesotaCare enrollees to pay a family deductible. Effective January 1, 2012, establishes tiered copayments for nonpreventive visits.

66 **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 125 percent of FPG, with a monthly defined contribution to purchase a health plan.

(b) Requires the commissioner, beginning January 1, 2012, to provide MinnesotaCare enrollees who are parents, with gross family income equal to or greater than 133 percent of FPG, with a monthly defined contribution to purchase a health plan.

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

(d) 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.

(e) 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. (a) Allows enrollees to use up to the monthly defined contribution only 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 $105 for persons under age 19 to $360 for persons age 60 and over. The base contribution is multiplied by a percentage inversely related to income, ranging from 110 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 January 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 act to be paid from the health care access fund.

Subd. 7. Federal approval. Requires the commissioner to seek all federal approvals and waivers necessary to implement coverage under this section for MinnesotaCare enrollees who are parents with gross family incomes equal to or greater than 133 percent of FPG, while continuing to receive federal funds.

67 **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 an increase in the program income limit for parents, for which federal approval has not yet been obtained.

68 **Single adults and households with no children.** Amends § 256L.04, subd. 7. Eliminates MinnesotaCare eligibility for adults without children with incomes less than or equal to 125 percent of FPG, effective October 1, 2012.

69 **Citizenship requirements.** Amends § 256L.04, subd. 10. Eliminates MinnesotaCare coverage for certain legal noncitizens. Provides a January 1, 2012 effective date.

70 **Commissioner's duties.** Amends § 256L.05, subd. 2. Requires the commissioner to verify both earned and unearned income for MinnesotaCare applicants and enrollees, and verify eligibility for employer-subsidized insurance.

71 **Renewal of eligibility.** Amends § 256L.05, subd. 3a. Requires MinnesotaCare eligibility to be renewed every six months. (Under current law, eligibility must be renewed every 12 months.)

72 **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.

73 **General requirements.** Amends § 256L.07, subd. 1. Reinstates in law the $50,000 income limit for parents under MinnesotaCare (the increase to $57,500 has not yet been approved by the federal government). Also makes conforming changes related to the establishment of a six-month renewal period.

74 **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 July 1, 2011.

75 **Rate setting; performance withholds.** Amends § 256L.12, subd. 9. Effective January 1, 2012, requires the commissioner to include as a performance target under MinnesotaCare a reduction in a plan's rate of subsequent hospitalizations, within 30 days of a previous hospitalization, by 5 percent from the rate for the previous calendar year. Requires withholds to be returned between July 1 and July 31 of the following year, if the target reduction rate is achieved. Requires this performance withhold to continue until the plan's subsequent hospitalization rate is reduced by 25 percent.

76 **Payment options.** Amends § 256L.15, subd. 1a. Requires the commissioner to include information about MinnesotaCare premium payment options on each premium notice.

77 **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 December 15, 2011, a plan to provide care coordination to MA and MinnesotaCare enrollees who are children with high-cost mental conditions.

78 **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 January 1, 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.

79 **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.

80 **Benefit set options.** Requires the commissioner of human services to analyze and provide recommendations for state plan amendments that would provide different benefits for different demographic populations of MA enrollees, as permitted under federal law, in order make coverage more cost-effective for the needs of each group. Requires the commissioner to report recommendations to the chairs and ranking minority members of the senate and house health and human services committees, by January 15, 2012.

81 **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.

82 **Medicaid fraud prevention and detection.**

Subd. 1. Request for proposals. Requires the commissioner of human services, by October 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.

83 **Wound care treatment.** Requires the commissioner of human services, through the health services policy committee, to study new strategies for wound care treatment for MA and MinnesotaCare enrollees, and present recommendations to the legislature by December 15, 2011, on whether the new strategies should be covered under the state programs.

84 **Prohibition of state funds to implement certain federal health care reforms.** Prohibits state funds from being expended for planning or implementation related to the Affordable Care Act and related legislation, and prohibits implementation of the act until its constitutionality has been affirmed by the U.S. Supreme Court.

85 **Commissioner's actions; repeal of early MA expansion.** Effective October 1, 2011, requires the commissioner of human services to suspend implementation and administration of early MA expansion for adult without children, and to refer these individuals to the reinstated GAMC program.

86 **GAMC program; provisions revived.** Effective January 1, 2012, revives selected provisions of the modified GAMC program that had been repealed with implementation of early MA expansion.

87 **Repealer.**

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

(c) Repeals an exemption for certain children transitioned from MA from MinnesotaCare income limits (see § 256L.04, subd. 1) retroactively from January 1, 2009 (this provision has not yet been approved by the federal government).
(d) Repeals a provision allowing children with incomes over 275 percent of FPG to remain on the program (see § 256L.04, subd. 1b) retroactively from January 1, 2009 (this provision has not yet been approved by the federal government).
(e) Repeals a provision requiring a streamlined application and enrollment process for MA and MinnesotaCare enrollees (see § 256L.05, subd. 1c) retroactively from July 1, 2009 (this provision has not yet been approved by the federal government).
(f) Repeals a provision providing automatic MinnesotaCare eligibility for certain children from foster care and juvenile correctional facilities (see § 256L.07, subd. 8) retroactively from July 1, 2009 (this provision has not yet been approved by the federal government).
(g) Repeals a conforming change related to a provision allowing children with incomes over 275 percent of FPG to remain on MinnesotaCare, that is repealed elsewhere in this section (see § 256L.04, subd. 7a).
(h) Repeals language establishing the effective date of coverage for children from foster care and juvenile correctional facilities (see § 256L.05, subd. 3).
(i) Repeals a provision that provides continued eligibility under MinnesotaCare for children who fail to submit renewal information in a timely manner (see § 256L.05, subd 3a) retroactively from July 1, 2009 (this provision has not yet been approved by the federal government).
(j) Repeals language related to a provision allowing children with incomes over 275 percent of FPG to remain on MinnesotaCare, that is repealed elsewhere in this section (see § 256L.07, subd. 1; this provision has not yet been approved by the federal government).
(k) Repeals an exemption for low-income children from the MinnesotaCare employer-subsidized insurance insurance barrier (see § 256L.07, subd. 2; this provision has not yet been approved by the federal government).
(l) Repeals an exemption for low-income children from the MinnesotaCare four-month uninsured requirement (see § 256L.07, subd. 3; this provision has not yet been approved by the federal government).
(m) Repeals an exemption for low-income children from MinnesotaCare premiums (see § 256L.15, subd. 2; this provision has not yet been approved by the federal government).
(n) Repeals a provision exempting low-income children from MinnesotaCare premiums (see § 256L.15; this provision has not yet been approved by the federal government).
(o) Repeals a provision requiring the commissioner of human services to request approval from the federal government to eliminate the add-back of depreciation when determining income eligibility under MinnesotaCare for self-employed farmers (uncodified section; this request has not yet been approved by the federal government).
(p) Repeals § 256B.057, subdivision 2c (extended MA coverage for certain children; this provision has not yet been approved by the federal government).
(q) Repeals provisions providing MinnesotaCare enrollees with a renewal rolling month and a premium grace month (these provisions have not yet been approved by the federal government).

88 **Repealer.** Repeals the MA early expansion for adults without children with incomes not exceeding 75 percent of FPG (§ 256B.055, subd. 15), and a related county demonstration project (§ 256B.0756), effective October 1, 2011.

Article 6: Continuing Care

Overview

This article makes changes to long-term care consultation services, case management, assessments, home and community-based waiver services, alternative care, and nursing facilities.

1 **Performance-based organizations.** Creates § 15.996.

Subd. 1. Designation. Allows the governor to designate one or more programs within DHS and within up to two other executive branch state agencies whose missions involve people with disabilities as performance-based organizations. Sets out the goals of the performance-based organization designation. Allows agencies with this designation more flexibility in their operations in exchange for a greater level of accountability. Allows performance-based organization agreements to exempt agencies from procedural laws, rules, or policies that otherwise would govern the program, with any required legislative approval.

Subd. 2. Performance-based organization agreement. Requires designation of a performance-based organization to be implemented through an agreement. Specifies the entities that may be part of a performance-based organization agreement. Specifies the elements that must be included in the agreement.

Subd. 3. Duration; legislative approval; reporting. Allows performance-based organization agreements to be up to three years and to be renewed. Requires the legislature to approve a performance-based organization before a state agency may enter into an agreement.

2 **Contribution amount.** Amends § 252.27, subd. 2a. Makes TEFRA parental fee temporary increases made in 2010 permanent.

3 **Disability linkage line.** Amends § 256.01, subd. 24. Removes a cross-reference. Makes this section effective July 1, 2011.

4 **State medical review team.** Amends § 256.01, subd. 29. Removes a cross-reference. Makes this section effective July 1, 2011.

5 **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.

6 **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.

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

8 **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.

9 **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.

10 **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.

11 **Definitions.** Amends § 256B.0911, subd. 1a. Modifies the definition of "long-term care consultation services." Makes this section effective January 1, 2012.

12 **Assessment and support planning.** Amends § 256B.0911, subd. 3a. Modifies the timeline for the long-term care consultation team to visit a person requesting services. Allows a client's provider of services to submit a copy of the provider's nursing assessment or a written report of recommendations regarding the client's care needs at the time of a long-term care (LTC) assessment. The assessor must notify the provider of the nursing assessment or written report due date; the due date must be prior to the assessment date. For persons determined eligible for specified services, requires the community support plan to include the estimated annual and monthly average authorized budget amount for those services. Specifies what information must be included in the community support plan. Allows updated assessments to be completed by face-to-face visit, written communication, or telephone. Makes this section effective January 1, 2012.

13 **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.

14 **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.

15 **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.

16 **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.

17 **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.

18 **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.

19 **Statewide availability of self-directed support services.** Amends § 256B.0916, subd. 6a. Paragraph (a) makes technical changes.

Paragraph (b) makes technical changes and specifies that this paragraph is in effect until a waiver amendment is effective.

Paragraph (c) makes technical changes.

Makes this section effective July 1, 2011.

20 **Coordinated services and support plan.** Amends § 256B.092, subd. 1b. Requires each recipient of case management services and any legal representative to be provided a written copy of the coordinated services and support plan and specifies requirements of the plans. Makes this section effective January 1, 2013.

21 **Case management service monitoring, coordination, and evaluation duties.** Amends § 256B.092, subd. 1e. Requires the case management service provider to assure that individual provider plans are developed by the providers when a need for the plans is identified in the coordinated services and support plan. Specifies the requirements the provider plans must meet. Makes technical changes. Makes this section effective January 1, 2012.

22 **Conditions not requiring development of a coordinated services and support plan.** Amends § 256B.092, subd. 1g. Makes conforming changes related to the re-naming of the plan. Makes this section effective January 1, 2012.

23 **Authorization and termination of services.** Amends § 256B.092, subd. 3. Makes technical and conforming changes. Makes this section effective January 1, 2012.

24 **Additional certified assessor duties.** Amends § 256B.092, subd. 8. Makes technical and conforming changes related to changes in terminology. Requires the certified assessor to provide written notice of the annual and monthly amount authorized to be spent for services for the recipient. Makes this section effective January 1, 2012.

25 **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.

26 **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.

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

31 **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.

32 **Prohibited practices.** Amends § 256B.48, subd. 1. Modifies the nursing facility rate equalization provision to allow private pay rates to increase two percent per year beginning July 1, 2011. Modifies consumer protections.

33 **Case management.** Amends § 256B.49, subd. 13. Modifies how case management services are provided to recipients of the CAC, CADI, and TBI home- and community-based waivers. Aligns case management services for these recipients with case management services for recipients of the DD waiver. Makes this section effective January 1, 2012.

34 **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 this section effective January 1, 2012, except for paragraph (f), which is effective July 1, 2013.

35 **Coordinated services and support plan; comprehensive transitional service plan; maintenance service plan.** Amends § 256B.49, subd. 15. Aligns the coordinated services and support plan requirements for recipients of waivers under this section with the requirements for recipients of the

DD waiver. Specifies timelines and requirements in developing and implementing comprehensive transitional service plans and maintenance service plans. Makes this section effective January 1, 2012, except for paragraphs (b), (c), and (d), which are effective July 1, 2013.

36 **ICF/MR rate increase.** Amends § 256B.5012, by adding subd. 9. Requires the commissioner to increase the daily rate to $138.23 at a specified ICF/MR in Clearwater County. Makes this section effective July 1, 2011.

37 **ICF/MR 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.

38 **Excluded time.** Amends § 256G.02, subd. 6. Removes a reference to the PCA program from the definition of "excluded time" under the unitary residence and financial responsibility chapter. Makes this section effective July 1, 2011.

39 **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.

40 **Establishment of rates for shared home- and community-based waiver services.** Requires the commissioner to establish rates to be paid for in-home services and personal supports under all of the home- and community-based waiver programs by January 1, 2012, consistent with certain standards.

41 **Establishment of rate for case management services.** Requires the commissioner to establish the rate to be paid for case management services under the home- and community-based waiver programs for persons with disabilities by January 1, 2012, consistent with certain standards.

42 **Recommendations for further case management redesign.** Requires the commissioner to develop a legislative report with specific recommendations and language for proposed legislation to be effective July 1, 2012, for further case management redesign.

43 **My Life, My Choices Task Force.**

Subd. 1. Establishment. Establishes the My Life, My Choices Task Force to create a system of supports and services for people with disabilities governed by certain specified principles.

Subd. 2. Membership. Establishes the membership of the task force including members appointed by the governor and by the legislature. Specifies that nongovernmental members of the task force shall serve as staff for the task force.

Subd. 3. Duties. Establishes the duties of the task force including making recommendations and reporting to the legislature by November 15, 2011, on creating a system of supports and services for people with disabilities as governed by the principles established in subdivision 1.

Subd. 4. Expense reimbursement. Prohibits members of the task force from being reimbursed by the state for expenses related to the duties of the task force. Specifies that the task force shall be staffed by the nongovernmental members of the task force, and no state funding shall be appropriated for the task force.

Subd. 5. Expiration. Makes the task force expire on July 1, 2013.

Makes this section effective the day following final enactment.

44 **Direction to Ombudsman for Long-Term Care.** Requires the Office of Ombudsman for Long-Term Care to develop a work group to address issues about, but not limited to: housing with services fees, staffing, and quality assurance. Specifies the membership of the work group. Requires the Office of Ombudsman for Long-Term Care to present a report with recommendations related to housing with services fees, staffing, and quality assurance to the legislative committees with jurisdiction over health and human services policy and finance by January 15, 2012.

45 **Direction to counties.** Requires counties to inform individuals who have had a level of service reduction of their right to request an informal review conference with their case worker and any other relevant county staff.

46 **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.

Article 7: Redesigning Service Delivery

1 **Child welfare reform pilots.** Amends § 256.01, subd. 14. Limits child welfare pilot programs to available appropriations.

2 **American Indian child welfare projects.** Amends § 256.01, subd. 14b, by adding paragraph (i). Allows the commissioner and the White Earth Band to develop a plan for the tribe to provide child welfare services to tribal children who are residents of Hennepin County.

3 **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.

4 **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.

5 **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.

6 **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.

7 **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.

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

9 **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.

10 **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.

11 **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.

12 **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.

13 **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.

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

Subd. 1. Application of section. Provides that this section applies to the initial certification and decertification of exclusive representatives for service delivery authorities (SDA). Classifies employees of SDAs as public employees and SDAs as public employers.

Subd. 2. Existing majority. Requires certification of an employee organization for SDA employees as exclusive representative upon the filing of a petition demonstrating that the petition is the exclusive representative of the majority of the employees.

Subd. 3. No existing majority. Establishes the procedure for certification of an exclusive representative when fewer than a majority of employees are represented by an exclusive representative.

Subd. 4. Decertification. Provides that a petition for decertification cannot be considered until at least one year has passed since certification of the exclusive representative.

Subd. 5. Continuing contract. Paragraph (a) provides that when an SDA is created the terms and conditions of collective bargaining agreements remain in effect until a successor agreement becomes effective.

Paragraph (b) provides that any leave accumulated while the employee worked for the previously employing county continues to apply in the newly created SDA.

Paragraph (c) establishes the lay off procedures prior to the negotiation of a new collective bargaining agreement.

Subd. 6. Contract and representation responsibilities. Provides that the exclusive representatives remain responsible for administration of their contracts and other contractual responsibilities until a contract is agreed upon with the SDA.

15 **County Electronic Verification Procedures.** Requires the Commissioner of Human Services to define which public assistance program requirements may be electronically verified for purposes of eligibility, and also defines procedures for electronic verification, and report back to the Legislature by January 15, 2012.

16 **Alignment of verification and redetermination policies.** Requires the commissioner to develop recommendations to align eligibility verification procedures for all public assistance programs. 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 alignment of eligibility verifications.

17 **Alternative strategies for certain redeterminations.** Requires the commissioner to develop and implement by January 15, 2012, a simplified process to redetermine eligibility for recipient populations in the MA, MSA, food support, and GRH programs who are eligible based on disability, age, or chronic medical conditions, 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.

18 **Simplification of eligibility and enrollment process.** Requires the Commissioner of Human Services to issue an RFP for an integrated service delivery system for health care programs, food support, cash assistance, and child care. Lists the requirements for the system.

Requires the commissioner to consult with specific groups and entities in developing the framework.

Requires the commissioner to issue a plan and progress report to the legislature by October 31, 2011, and requires ongoing reports on the implementation to the legislature annually beginning May 15, 2012.

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

19 **American Indian child welfare, social, and human services project; White Earth Band of Ojibwe.** Amends § 256.01, by adding subd. 14c. Instructs the commissioner to transfer legal responsibility to the White Earth Band for the tribe to provide all human services and public assistance programs to tribal members and their families who reside on or off the reservation in Mahnomen County. Requires the commissioner to seek federal approval and waivers as needed to implement this project. Provides that when programs are transferred Mahnomen County is relieved of responsibility for providing services to tribal members and families who reside on or off the reservation. Requires Mahnomen County to transfer the proportion of property taxes allocated for funding of county social services to the tribe.

20 **Repealer.** Repeals §§ 402A.30 (Designation of Service Delivery Authority); and 402A.45 (Essential Services Outside Jurisdiction of Service Delivery Authority).

Repeals Minn. Rules, part 9500.1243, subp. 3 (recoupment of overpayments).

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 **Minnesota extended treatment options.** Amends § 252.025, subd. 7. Prohibits mid-contract layoffs from occurring as a result of restructuring this program, but permits layoffs as a result of low census or closure of the facility due to decreased census.

3 **Commitment; Red Lake Band of Chippewa Indians; White Earth Band of Ojibwe.** Amends § 253B.212. Makes technical changes. Adds subdivision 1a. Allows the commissioner to enter into agreements with the Indian Health Service for care and treatment of White Earth 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.

4 **Local agency duties.** Amends § 253B.03, subd. 1. Adds that the county requirement to provide chemical dependency treatment services is subject to the limitations imposed in section 254B.04, subd. 1.

5 **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.

6 **Eligibility.** Amends § 254B.04, subd. 1. Limits access to residential chemical dependency treatment services to no more than three spans of treatment for the same person in a four year period, and no more than four spans of treatment in a lifetime. Provides an exception that additional placements can be made when the person meets criteria established by the commissioner.

Provides that this section is effective for all admissions beginning on or after July 1, 2011.

7 **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.

8 **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.

9 **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.

10 **Payment rate.** 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.

11 **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.

12 **Integrated dual diagnosis treatment.** Instructs the commissioner to require assessors to screen individuals using an approved tool to determine whether individuals have co-occurring substance abuse and mental health disorders. Requires the commissioner to seek federal waivers as necessary, in order to provide IDDT.

13 **Regional treatment centers; employees; reports.** 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.

14 **Commissioner's criteria for residential criteria.** Instructs the commissioner to develop criteria to approve treatment for individuals who require residential chemical dependency treatment in excess of the number allowed in section 256B.04, subdivision 1. Requires criteria to be established by October 1, 2011.

15 **Repealer.** Repeals Laws 2009, chapter 79, art. 3, sec. 18, the Anoka-Metro Regional Treatment Center redesign.

Article 9: Human Services Forecast Adjustments

See spreadsheet for details.

Article 10: Health and Human Services Appropriations

See spreadsheet for details.