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S.F. No. 1458 - Health and Human Services Budget Establishment and Provisions Modifications - the Division Report

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Article 1 – Children and Family Services

Sections 1 to 3 modify the Child Care Assistance Program (CCAP). The sections are effective January 1, 2016.

Sections 1 and 2 (119B.07, 119B.10, subd. 1) modify the calculation of authorized CCAP hours for students and employed persons, respectively. Under certain circumstances, the participant's activity schedule does not need to be verified.

Section 3 (119B.11, subd. 2a) simplifies the recovery of CCAP overpayments.

Section 4 (119B.125, subd. 7) establishes overpayment claim procedures with regard to failure to comply with child care attendance record requirements.

Section 5 and 6 (245C.03, subd. 10 and 245C.10, subd. 11) amend the background study chapter of law to require background studies for providers of group residential housing (GRH) and supplementary services, and allows the commissioner to recover $20 per study.

Section 7 (256.01, subd. 12a) establishes the Department of Human Services child fatality and

near fatality review team, to assess the child protection services process, conduct on-site reviews, and identify necessary program improvements.

Section 8 (256.01, subd. 14c) allows the commissioner to authorize grants to tribal child welfare agencies and urban Indian organizations for early intervention support and services to prevent child maltreatment for at-risk American Indian families.

Section 9 (256.017, subd. 1) adds GRH to the Department of Human Services (DHS) compliance system, which permits the commissioner to supervise the administration of public assistance programs.

Sections 10 and 11 (256.741, subd. 1 and 256.741, subd 2.) remove MinnesotaCare from the definition of public assistance for purposes of a child support referral to the county, and the assignment of child support rights to the state. These modifications are to conform to the Affordable Care Act, consistent with changes to chapter 518A.

Section 12 (256E.345) establishes the Healthy Eating, Here at Home grant program to provide incentives to low-income Minnesotans to use Supplemental Nutrition Assistance Program (SNAP) benefits for purchases at Minnesota farmers' markets. This section also adds a subdivision requiring the commissioner to submit a waiver request to the federal government to allow SNAP participants to use the vouchers for healthy produce at grocery stores.

Section 13 (256E.35, subd. 2) modifies the family assets for independence in Minnesota (FAIM) program by adding a definition for financial coach, and alphabetizing definitions in this section.

Section 14 (256E.35, subd. 4a) modifies the FAIM program, by specifying the duties of a financial coach.

Section 15 (256I.03, subd. 3) amends the definition of GRH to strike obsolete language, and updates references to the staffing and background study requirements.

Section 16 (256I.03, subd. 7) modifies the definition of "countable income" to clarify what is counted as income under the GRH program.

Section 17 (256I.03, subd. 9) defines the term "direct contact."

Section 18 (256I.03, subd. 10) defines the term "habitability inspection."

Section 19 (256I.03, subd. 11) defines the term "long-term homelessness."

Section 20 (256I.03, subd. 12) defines the term "professional statement of need."

Section 21 (256I.03, subd. 13) defines the term "prospective budgeting."

Section 22 (256I.03, subd. 14) defines the term "qualified professional."

Section 23 (256I.03, subd. 15) defines the term "supportive housing."

Section 24 (256I.04, subd. 1) clarifies eligibility for the GRH program.

Subdivision 1a provides that the county cannot approve a payment in excess of the MSA equivalent payment unless the individual has a professional certification, as defined in this chapter. Also, in order to be eligible for supplementary service payments, providers must enroll in the provider enrollment system, which is part of the MMIS system.

Subdivision 2a exempts supportive housing establishments from the licensure requirements and imposes staffing qualifications on GRH providers.

Subdivision 2b clarifies that agreements between agencies and providers must be in writing, and specifies the minimum requirements that the provider must verify in the agreement. Agreements may be terminated with or without cause by the commissioner, agency, or provider with two calendar months prior notice.

Subdivision 2c imposes background study requirements**.**

Subdivision 2d provides that the GRH or supplementary services must be provided to the satisfaction of the commissioner, and the commissioner has the right to suspend or terminate the agreement immediately if the health or welfare of the recipients is endangered, or when the commissioner has reasonable cause to believe that the provider has breached a material term of the agreement.

Subdivision 2e clarifies staffing and background study requirements when there are multiple licenses.

Subdivision 2f specifies the minimum requirements for licensed or registered settings, which include food preparation, housekeeping, and maintenance of the building.

Subdivision 2g is existing language that was moved from a previous subdivision**.**

Section 25 (256I.05, subd. 1c) changes the term "county" to "agency."

Section 26 (256I.05, subd. 1g) allows an agency to negotiate a supplemental services rate for individuals who have experienced long-term homelessness and who live in a supportive housing establishment.

Section 27 (256I.06, subd. 2) strikes references to countable income**.**

Section 28 (256I.06, subd. 6) requires recipients to report changes in income every six months, instead of every month under current law.

Section 29 (256I.06, subd. 7) makes technical conforming changes.

Section 30 (256I.06, subd. 8) provides that for an individual with earned income, prospective budgeting must be used to determine the individual's payment for the following six-month period. An increase in income must not affect eligibility until the month following the reporting month. A decrease in income is effective the first day of the month after the decrease.

Section 31 (256J.24, subd. 5) modifies the Minnesota Family Investment Plan transitional standard, by increasing the MFIP cash grant by $100 per month.

Section 32 (256J.24, subd. 5a) adds language requiring that the food portion of the MFIP transitional standard comply with federal waivers.

Section 33 (256K.45, Subd. 1a) amends the Homeless Youth Act by modifying the definition of the terms “homeless youth” and "youth at risk of homelessness" by changing eligibility from youth 21 years of age or younger, to youth 24 years of age or younger. This is consistent with the federal Runaway and Homeless Youth Act.

Section 34 (256K.45, subd. 6) adds language requiring the commissioner to provide outreach, technical assistance, and program development to increase capacity to better meet the needs of homeless youth statewide.

Section 35 (256M.41) establishes the child protection grant allocation to address county staffing.

Section 36 (256M.42) establishes the child protection grant allocation for county services.

Section 37 to 41 amend the Northstar Care for Children chapter of law.

Sections 37, 38, and 40 (256N.22, subds. 9 and 10, 256N.25, subd. 1) modify language to comply with the federal requirement related successor guardians for children in a custody arrangement with a relative.

Section 39 (256N.24, subd. 4) amends the provision related to extraordinary levels of care for children who have significant physical or mental health care needs, to include “foster care residence setting” to the settings that are eligible for difficulty of care supplemental rate payments.

Section 41 (256N.27, subd. 2) strikes language giving the commissioner authority to transfer funds into the Northstar Care for Children account if a deficit occurs.

Sections 42 to 46 (257.0755, subds. 1 and 2, 257.0761, subd. 1, 257.0766, subd. 1, 257.0769, subd. 1) modify the ombudsperson for families by eliminating the community-specific boards, establishing the Office of the Ombudsperson under DHS, and requiring that the ombudsperson for each community be appoint by the Governor.

Section 47 (257.75, subd. 3) amends the law governing the effect of a recognition of parentage. New language refers to awards of temporary custody or parenting time. **Section 518.131**, which applies to marriage dissolutions, would apply to awards of temporary or permanent custody or parenting time based on a recognition of parentage.

Sections 48 (257.75, subd. 5) modifies recognition of parentage form requirements. The limitations of the recognition for purposes of exercising and enforcing custody or parenting time must be clear and understandable. Notification requirements with respect to the effect of a recognition on custody and parenting time are expanded, along with support obligations and other expenses for which the parent may be liable.

Section 49 (259A.75) modifies the reimbursement of tribal contracted adoption placement. This section reallocates funds for tribal customary adoptions, and requires the commissioner to enter into grant contracts with Minnesota tribal social services agencies to provide child-specific recruitment and adoption placement services for Indian children.

Sections 50 to 63 amend the child protection chapter of law. The modifications in these sections are to conform to federal law. Generally, the changes expand the definition of relative and add language related to successor custodians, modify provisions so that youth in foster care can be more involved in their permanency planning, and specify requirements for missing and sex trafficked foster care youth.

Section 50 (260C.007, subd. 27) amends the definition of the term "relative."

Section 51 (260C.007, subd. 32) amends the definition of the term "sibling."

Section 52 (260C.203) modifies independent living plans so youth in foster care may start the plan at age 14 instead of age 16, updates a cross-reference, and requires the responsible agency to help the child obtain a tribal enrollment identification card prior to leaving foster care.

Section 53 (260C.212, subd. 1) allows a child in foster care who is 14 years old or older to include two additional individuals on the team preparing the child's out-of-home placement plan, adds language to reinforce transfer of custody to a relative, if possible, and requires that the independent living plan include objectives that allow for regular opportunities to engage in age appropriate activities typical for the child's age group.

Section 54 (260C.212, subd. 13) is a new subdivision related to protecting missing and runaway children and youth at risk of sex trafficking. Imposes duties on the local social services agency to report and locate a missing child, determine the primary factors that contributed to the child running away, what the child experienced while absent from foster care, and appropriate services for the child.

Section 55 (260C.212, subd. 14) is a new subdivision requiring that child-placing agencies support a foster child's emotional and developmental growth by permitting the child to participate in age and developmentally appropriate extracurricular activities.

Section 56 (260C.221) expands who is included in a relative search when a child is placed out of the home.

Sections 57 to 59 (260C.331, subd. 1, 260C.451, subds. 2 and 6) update cross-references.

Section 60 (260C.515, subd. 5) modifies the provision relating to ordering the child into permanent custody of the responsible social services agency. Under current law, the court may order a child age 12 or older into long-term foster care. This section changes the age to 16, and requires that the child be asked about his or her desired permanency outcome.

Section 61 (260C.521, subd. 1) requires that the child be asked about his or her desired permanency outcome as part of the agency's reasonable efforts to finalize a permanent plan for the child.

Section 62 (260C.521, subd. 2) allows an order for permanent legal and physical custody to be modified to name a successor guardian as the custodian if the original relative is incapacitate or dies.

Section 63 (260C.607, subd. 4) makes changes consistent with section 260C.203, changing the age of the child from 16 to 14.

Section 64 (290.0671, subd. 6) strikes language allowing the transfer of TANF funds to the commissioner of revenue for the Minnesota working family credit.

Sections 65 to 82 amend the Child Support chapter of law. Many of the amendments to this chapter are to conform to the Affordable Care Act, allowing the modification of a child support order for medical support.

Section 65 (518A.26, subd. 14) amends the definition of "obligor" for purposes of establishing child support obligations by striking a presumption that a person who has primary physical custody of the child is not an obligor.

Section 66 (518A.32, subd. 2) modifies one of the methods for determining potential income. The amount of income a parent could earn working full-time at 150 percent of the current federal or state minimum wage is changed to working 30 hours per week at 100 percent.

Section 67 (518A.39, subd. 1) allows a child support order to be modified for medical support.

Section 68 (518A.39, subd. 8) is a new subdivision allowing for a medical support-only modification of a support order.

Section 69 (518A.41, subd. 1) modifies the definition of "public coverage," with regard to health care benefits.

Section 70 (518A.41, subd. 3) amends the statute in which the court determines if a parent has appropriate health coverage for the child. This section adds language providing that health plans meeting the definition of minimum essential coverage under the ACA meet the definition of comprehensive medical coverage.

Section 71 (518A.41, subd. 4) modifies what a court may order related to a parent's contribution for health care coverage in a child support case, if neither parent has appropriate health care coverage.

Section 72 (518A.41, subd. 14) requires the public authority to assist with modifying a medical support order.

Section 73 (518A.41, subd. 15) amends the remedies available for the enforcement of a child support order. New language provides that failure to provide court-ordered coverage or provide medical support is a basis for a modification, unless it meets a presumption.

Section 74 (518A.43, subd. 1a) authorizes a court to elect not to order a party who has between 10 and 45 percent parenting time to pay basic support if there is such a significant disparity of income between the parties that an order directing payment would be detrimental to the joint

child.

Section 75 (518A.46, subd. 3) strikes reference to MinnesotaCare as a public assistance program.

Section 76 (518A.46, subd. 3a) specifies the contents of pleadings for medical support modifications.

Section 77 (518A.51) discontinues the $25 application fee for child support IV-D services. Federal conformity part of this section strikes reference to MinnesotaCare.

Section 78 (518A.53, subd. 1) modifies the definition of "arrears."

Sections 79 and 80 (518A.53, subds. 4 and 10) provides that child support arrears will be paid back in an amount equal to 20 percent of the child support amount, unless the court has ordered a specific monthly payback amount. **Section 73** also strikes the reference to the $25 application fee.

Section 81 (518A.60) is a technical modification to conform to changes made in **section 74**.

Section 82 (518A.685) contains new provisions governing reporting to consumer reporting agencies when an obligor is in arrears.

Section 83 (518C.802,) amends the Uniform Interstate Family Support Act (UIFSA), to comply to the federal law Preventing Sex Trafficking and Strengthening Families Act.

Section 84 (626.556, subd. 1) modifies the maltreatment of minors public policy statement, by providing that the health and safety of the children must be of paramount concern, and intervention and prevention must address immediate concerns for child safety.

Section 85 (626.556, subd. 2) amends the definition of the following terms: "family assessment," "investigation," "substantial child endangerment," "physical abuse," and "report."

Section 86 (626.556, subd. 3) amends the headnote to reflect the content of the subdivision, strikes language that is moved to **626.556, subd. 7 and 10**, and adds a paragraph referencing the moved language regarding mandatory notification between law enforcement and local welfare agency.

Section 87 (626.556, subd. 6a) updates a cross-reference.

Section 88 (626.556, subd. 7) requires the local welfare agency to determine if a report is screened in or out, and allows the agency to consider, when relevant, all previous history, including screened out reports. It also includes language providing for certain information regarding the disposition of reports to be given to reporters, which is moved from current law in **626.556, subd. 3**.

Section 89 (626.556, subd. 7a) requires child protection workers to follow the guidance provided in the child maltreatment screening guidelines when screening reports, and implement updated procedures and protocols. Any modifications to the screening guidelines by the county

agency must be preapproved by the Commissioner of Human Services.

Section 90 (626.556, subd. 10) moves existing language from **626.556, subd. 3** to this subdivision, requiring law enforcement and local welfare agencies to immediately notify each other orally and in writing upon receipt of a report. The law enforcement and local welfare agencies are required to designate a person responsible for ensuring that the notification duties under this section are carried out.

Section 91 (626.556, subd. 10e) strikes language that allowed counties to modify definitions or criteria under this section.

Section 92 (626.556, subd. 10j) requires the release of relevant private data to a mandated reporter who made the report and has an ongoing responsibility for the child, unless the agency determines that providing the data would not be in the best interests of the child. The agency may not provide the data to other mandated reporters. The reporter who receives private data under this subdivision must treat the data according to that classification.

Section 93 (626.556, subd. 10m) requires the local welfare agency to consult with the county attorney to determine the appropriateness of filing a CHIPS petition if the family does not accept or comply with a plan for child protective services, voluntary services may not provide sufficient protection for the child, or the family is not cooperating with an investigation. The agency must consult with the tribal authority if the agency is an Indian tribe social service agency.

Section 94 (626.556, subd. 11c) requires all reports under this paragraph, which includes reports that were not accepted for assessment or investigation, family assessment cases, and investigation cases that did not result in a finding of maltreatment, to be maintained by the local welfare agency for five years. This section also requires the county agency to document the reason as to why a report was not accepted for assessment or investigation.

Section 95 (626.556, subd. 16) requires the commissioner to develop a plan to perform quality assurance reviews of county screening practices and decisions, and provide oversight and guidance to counties to ensure the consistent application of screening guidelines, thorough and appropriate screening decisions, and correct documentation and maintenance of reports. The commissioner must also produce an annual report of summary results of reviews, which must be provided to the chairs and ranking minority members of appropriate legislative committees.

Sections 96 to 111 (Laws 2014, chapter 189, sections 5, 10, 11, 16, 17, 18, 19, 23, 24, 27,28, 29, 31, 43, 50, 51) amend UIFSA to comply to federal law.

Section 112 (Laws 2014, chapter 189, section 73) makes the UIFSA changes effective July 1, 2015.

Section 113 requires the commissioner, in coordination with stakeholders and advocates, to build on group residential housing (GRH) reforms made this session, and propose modifications that will result in a more cost-effective GRH program, and report to the legislative committees having jurisdiction over GRH issues by December 15, 2015. The working group shall examine the feasibility of restructuring service rates, develop a plan to fund only those services that are not funded by other programs based on individual need, and explore and recommend appropriate and effective assessment tools.

Section 114 requires the commissioner of human services to review the child support parenting expense adjustment, and identify and recommend changes. This section authorizes the commissioner to retain the services of an economist to help create an equitable parenting expense adjustment formula.

Section 115 requires the commissioner to update the child maltreatment screening guidelines by August 1, 2015, to require agencies to consider prior reports that were not accepted for assessment or investigation when screening a new report. Requires the commissioner to work with a diverse group of community representatives who are experts on limiting cultural and ethnic bias. This section also requires the commissioner to publish and distribute the updated guidelines by September 30, 2015, and ensure that agency staff have received training on updated guidelines. Agency staff must implement the guidelines by October 1, 2015.

Section 116 requires the commissioner to establish requirements for competency-based initial training, support, and continuing education for child protection supervisors. The training must advance continuous emphasis and improvement that integrates the client's traditions, customs, values, and faith into service delivery.

Section 117 requires the commissioner to recommend an updated equitable distribution formula beginning in fiscal year 2018 for the child protection funding under **256M.41 and 256M.42**, taking into consideration relief to counties and tribes for child welfare and foster care costs, and report to the legislature by December 15, 2016.

Section 118 relates to the transfer from the Office of Ombudspersons for Families to DHS by stating that Minnesota Statutes, section 15.039, applies to this transfer.

Section 119 is a revisor instructions, requiring the revisor to alphabetize the definitions in section 626.556, subdivision 2.

Section 120 repeals the TANF appropriation for working family tax credit.

Article 2 – Chemical and Mental Health Services

Section 1 (13.46, subd. 2) amends the welfare data statute to specifically authorize sharing of data with personnel of the welfare system for purposes of coordinating services for an individual or family. In addition, data can be shared with a health care provider, to the extent necessary to coordinate services, and a health record may be disclosed only with consent.

Section 2 (13.46, subd. 7) amends the welfare data provision governing mental health data to authorize disclosure to personnel of the welfare system working in the same program or providing services to the same individual or family, and to a health care provider, to the extent necessary to coordinate services, provided that a health record may be disclosed only with consent.

Section 3 (144.293, subd. 6) amends the health records statute so that a consent to the release of health records to the welfare system (as provided for under **sections 1 and 2**) would not expire after one year.

Section 4 (245.4661, subd. 5) corrects a reference to intensive residential treatment service

(IRTS)

Section 5 strikes language that allows the transfer of funds from a state-operated services account for mental health specialty treatment services. (Related to **section 14**)

Section 6 (245.4661, subd. 9) lists the services and programs for which the adult mental health grants may fund.

Section 7 (245.4661, subd. 10) requires the commissioner to report biennially on the use of the adult mental health grant funds, specifically the amount of funding to mental health initiatives, the programs and services that were funded, and outcome data related to those services and programs.

Sections 8 and 10 (245.467, subd. 6, 245.4876, subd. 7) make conforming changes in the human services chapter with regard to the modification to access to mental health data under section 2.

Section 9 (245.469, subd. 3) expands mental health crisis services to include oversight and training of mobile crisis service providers, specialty consultation for persons with traumatic brain injury or an intellectual disability who are experiencing a mental health crisis, a single statewide crisis phone number, and the expansion of mobile crisis teams statewide.

Section 11 (245.4889, subd. 1) lists the services and programs for which children's mental health grants may fund.

Section 12 (245.4889, subd. 3) requires the commissioner to report on the use of the children's mental health grants biennially, specifically the amount of grants awarded, the programs and services funded, and outcome data related to the funded services and programs.

Section 13 (245.735, subd. 1) requires the Commissioner of Human services to develop and execute projects to reform the mental health system by participating in the federal Excellence in Mental Health demonstration project.

> **Subdivision 2** requires the commissioner to submit a proposal to the federal Department of Health and Human Services for the demonstration project.
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> **Subdivision 3** gives the commissioner rulemaking authority to establish standards for reform projects under subdivision 4.
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> **Subdivision 4** requires the commissioner to establish standards for state certification of certified community behavioral health clinics, and specifies what the certification standards must include. The commissioner is also required to establish standards and methodologies for a prospective payment system for MA payments for mental health services delivered in the clinics.
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> **Subdivision 5** requires the commissioner to consult with mental health providers, and others in developing the projects under subdivision 4.
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> **Subdivision 6** requires the commissioner and the state chief information officer to

provider information systems support to the projects as necessary to comply with federal requirements and deadlines.

Section 14 (246.18, subd. 8) strikes language that allows the transfer of funds from a state-operated services account for mental health specialty treatment services. (Related to **section 5**)

Section 15 (253B.18, subd. 4c) requires the civil commitment special review board to review each denied petition for a reduction in custody for barriers and obstacles preventing a patient from progressing in treatment, and provide to the commissioner an annual summation of the barriers to treatment progress, and recommendations to achieve the common goal of making progress in treatment.

Section 16 (253B.18, subd. 5) requires the head of the treatment facility to schedule a hearing before the special review board for any patient who has not appeared before the board in the previous three years, and schedule a hearing at least every three years, thereafter.

Sections 17 and 18 (254B.05, subd. 5, 254B.12, subd. 2) allow the commissioner to establish a rate for high-intensity residential treatment services that provide 30 hours of clinical services each week for clients who have been committed to the commissioner who present complex and difficult care needs, and are a potential threat to the community.

Section 19 (256B.0615, subd. 3) corrects a reference to intensive residential treatment services (IRTS)

Section 20 (256B.0622, subd. 1) updates the name of the services to "assertive community treatment" (ACT) and "intensive residential treatment services" (IRTS).

Section 21 (256B.0622, subd. 2) strikes an old reference, adds a definition for ACT, and strikes outdated language.

Section 22 (256B.0622, subd. 3) modifies eligibility for ACT and IRTS by changing the reference to "two or more" inpatient hospitalizations in the past year, to "recurring or prolonged" inpatient hospitalizations in the past year.

Section 23 (256B.0622, subd. 4) updates references to ACT and IRTS.

Section 24 (256B.0622, subd. 5) amends the standards for ACT and IRTS providers by modifying when the functional assessment must be updated, and when the individual treatment plan must be completed and refined.

Section 25, 26, 27, and 28 (256B.0622, subds. 7, 8, 9, and 10) update references to ACT and IRTS, make changes to align with state plan, allow physician services to be delivered by telemedicine, strike obsolete references related to county rate setting due to the implementation of the statewide rate methodology, and add rate language for new programs.

Section 29 (256B.0622, subd. 11) allows the commissioner to disburse grants directly to providers ACT and IRTS to maintain access to these services.

Section 30 (256B.0624, subd. 7) clarifies staffing requirements for adult crisis stabilization

services.

Section 31 (256B.0625, subd. 45a) adds psychiatric residential treatment facility services for persons under 21 years of age to the services eligible for medical assistance coverage. The commissioner is required to develop admissions and discharge procedures and establish rates consistent with the guidelines from Centers for Medicare and Medicaid Services (CMS). The commissioner is required to enroll 150 certified psychiatric residential treatment facility services beds at up to six sites. The commissioner shall select the providers though a request for proposals (RFP) process. This section is effective July 1, 2017, or upon federal approval, whichever is later.

Section 32 (256B.0625, subd. 48) amends the medical assistance benefit chapter of law, specifically the benefit that allows psychiatric consultation to primary care practitioners, to include medical assistance reimbursement for consultation done by licensed independent clinical social workers and licensed marriage and family therapists.

Section 33 (256B.7631) increases by two percent the chemical dependency provider rate for services listed under section 254B.05, subdivision 5.

Section 34 requires the commissioner of human services, in consultation with stakeholders, to develop service standards and a payment methodology for Clubhouse program mental health services to be covered under medical assistance, and seek federal approval. Upon federal approval, the commissioner shall seek and obtain legislative approval allowing MA coverage for Clubhouse services.

Section 35 requires the commissioner to report to legislative committees on the progress of the Excellence in Mental Health demonstration project under section 245.735, and include any recommendations for legislative changes necessary to implement the reform projects.

Section 36 requires the commissioner to conduct a comprehensive analysis of the current rate-setting methodology for community-based mental health services for adults and children. The report must include alternative payment structures, and recommendations for establishing pay-for-performance measures for providers delivering services consistent with evidence-based practices. The commissioner shall consult with stakeholders and experts in Medicaid financing. The report is due January 1, 2017.

Section 37 requires the commissioner to report on the fiscal impact, including estimated savings, resulting from the modifications to the data practices act permitting the sharing of public data to coordinate care. The report is due January 1, 2017.

Section 38 provides that in order to receive the funds appropriated for the planning and development of a comprehensive mental health program in Beltrami county, Beltrami county must submit to the commissioner a formal commitment and plan to fund, operate, and sustain the program and services after the onetime state grant is expended. The planning and development of the program by the county must include an integrated case model for mental health and substance use disorder treatment for individuals who are under arrest, under a civil commitment transport hold, or in immediate need of mental health crisis services. The commissioner of human services, in consultation with Beltrami County, shall report on the status of the planning and development of the mental health program by November 1, 2017.

Article 3 – Withdrawal Management

Article 3 establishes a new model for detoxification programs, called Withdrawal Management. The article establishes the comprehensive program in a new chapter of law, Minnesota Statutes, chapter 245G, and the commissioner is required to develop a payment methodology for services provided under this chapter, and seek federal approval for the rate methodology, and obtain legislative approval before implementing the program.

Article 4 – Direct Care and Treatment

Section 1 (43A.241) requires the state to pay the employer contribution for health and dental benefits under the State Employee Group Insurance Program (SEGIP) for employees assaulted by a client or patient at the Minnesota sex offender program or a state-operated forensic services program, who are permanently physically disabled as a direct result of the assault.

Section 2 (246.54, subd. 1) modifies the county portion of the cost of care for the Anoka Metro Regional Treatment Center (AMRTC). Currently, the county pays zero percent of the cost of care for the first 30 days; 20 percent for days 31 to 60; and 75 percent for over 60 days. The proposal changes the cost of care to 20 percent for 31 days or more, provided the stay at the AMRTC is determined to be clinically appropriate for the client; and 100 percent for each day the facility determines that it is clinically appropriate to discharge the client.

Section 3 (246B.01, subd. 2b) expands the definition of "cost of care" to include Minnesota Sex Offender program aftercare services and supervision.

Section 4 (246B.033) is a new section of law requiring biennial evaluations of civilly committed sex offenders.

> **Subdivision 1** requires the executive director of MSOP to ensure that each civilly committed sex offender is evaluated not less than once every two years.
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> **Subdivision 2** requires that a copy of the report be provided to the civilly committed sex offender and the civilly committed sex offender's attorney, with a blank petition for a reduction in custody and instructions on completing and filing the petition.
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> **Subdivision 3** suspends the duty to evaluate the civilly committed sex offender if the individual is in a correctional facility.
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> **Subdivision 4** clarifies that this section does not impair or restrict the civilly committed sex offender's right to petition for a reduction in custody.

This section is effective July 1, 2015. The executive director is not required to begin the evaluations until January 4, 2016.

Section 5 (246B.10) requires the counties to pay either ten percent or 25 percent of the cost of care for civilly committed sex offenders who are discharged or provisionally discharged from MSOP.

Article 5 – Simplification of Public Assistance Programs

Article 5 contains language implementing the second phase of the administrative simplification of public assistance programs. Last session, Minnesota Statutes, chapter 256P was established, which made uniform the treatment of income, assets, and household composition for MFIP, GA, MSA, and GRH. This bill builds on chapter 256P by making uniform income calculations, reporting of income and changes to income, and correcting overpayments and underpayments, and incorporating child care assistance into chapter 256P, where applicable.

Sections 1 to 21 (119B.011, subd. 15, 119B.025, subd. 1, 119B.035, subd. 4, 119B.09, subd. 4, 256D.01, subd. 1a, 256D.02, subds. 1a and 1b, 256D.02, subd. 8, 256D.06, subd. 1, 256D.405, subd. 3, 256I.03, subds. 1b and 7, 256I.04, subd. 1, 256I.06, subd. 6, 256J.08, subds. 26 and 86, 256J.30, subds. 1 and 9, 256J.35, 256J.40, 256J.95, subd. 19) amend the child care assistance, general assistance, group residential housing programs, and MFIP to define terms, incorporate references to chapter 256P, and to make conforming changes.

Sections 22 to 33 amend chapter 256P.

Section 22 (256P.001) modifies the applicability of chapter 256P to include child care assistance programs.

Section 23 (256P.01, subd. 2a) defines the term "assistance unit."

Section 24 (256P.01, subd. 3) modifies the definition of "earned income."

Section 25 (256P.01, subd. 8) defines the term "unearned income."

Sections 26, 27, 28 and 30 (256P.02, subd. 1a, 256P.03, subd. 1, 256P.04, subd. 1, 256P.05, subd. 1) exempt child care programs from several requirements in 256P that were passed last year because the child care programs contain specific policies that are unique to that program, which include different documentation requirements related to authorized hours of care and authorized activities, and the use co-pays instead of income disregards. Child care programs must, however, comply with the new requirements related to the calculation of income and reporting requirements in **section 32**.

Section 29 (256P.04, subd. 4) requires certain nonrecurring income to be verified.

Section 31 (256P.06) adds a new section of law specifying the calculation of income, and what is included in determining the income of an assistance unit.

Section 32 (256P.07) adds a new section of law related to reporting income and reporting changes in income. This section requires that changes in income listed in this section must be reported within a specific period of time.

Section 33 (256P.08) adds a new section of law specifying the procedure for the correction of overpayments and underpayments, and specifies procedures for general assistance, Minnesota supplemental aid programs, and MFIP overpayments.

Section 34 repeals redundant language in law and rule.

Section 35 makes this article effective August 1, 2016.

Article 6 – Continuing Care

Section 1 (13.461, subd. 32) places notice in Minnesota Statutes, chapter 13, Minnesota Government Data Practices Act, that section 256Q.05, subdivision 8, classifies data as other than public, places restrictions on access to government data, or involves data sharing.

Section 2 (144.057, subd. 1) requires DHS, when conducting background studies of non-Minnesota residents who provide direct-care services in nursing homes, home care agencies, or boarding care homes, to (1) check for substantiated findings of maltreatment in the individual's state of residence when that information is available, and (2) check the national Crime Information Center database.

Section 3 (245C.08, subd. 1) provides a cross-reference to section144.057, subdivision 1, which requires DHS to review information from the national Crime Information System when conducting background studies of any non-Minnesota resident who performs direct-care services in a nursing home, home care agency, or boarding care home.

Section 4 (245C.12) requires DHS, when it contracts with Tribes to conduct background studies for staff working in Tribal nursing homes, to obtain data from the National Criminal Records Repository.

Section 5 (256.478) repeals the authority of the Commissioner of Human Services to transfer funds between the MA account and the home and community-based services transitions grant account.

Section 6 (256.975, subd. 8) establishes through the Senior LinkAge Line a long-term care call center.

Section 7 (256B.056, subd. 5c) modifies medical assistance eligibility requirements for persons who are over age 64, who are blind, or who have a disability by increasing the excess income standard (aka the spenddown limit) from 75 percent to 85 percent of the federal poverty guidelines on January 1, 2017, and from 85 percent to 95 percent of the federal poverty guidelines on January 1, 2019.

Section 8 (256B.057, subd. 9) reverses a premium increase that was implemented October 1, 2015, by reducing the amount of the minimum premium that enrollees in the MA-EPD program must pay from $65 to $35 and reduces the additional premium amount that enrollees who receive unearned income must pay from 5 percent of the unearned income to one-half of one percent of the unearned income.

Section 9 (256B.059, subd. 5) removes language that prohibits under any circumstances a married couple from converting assets to income in order to avoid being subject to the asset limit for the purposes of determining an institutionalized spouse's eligibility for long-term care under medical assistance.

Section 10 (256B.0916, subdivision 2) adds language clarifying that the commissioner must manage developmental disability (DD) waiver allocations in a manner that will maximize the

use of all available waiver funding.

Section 11 (256B.0916, subdivision 11) modifies the existing provisions governing the consequences for lead agencies if they overspend their DD waiver allocation. Under the proposed language, if a lead agency over spends its allocation for DD waiver services, it must submit a corrective action plan for approval. The lead agency will have 2 years to successfully implement the plan. The commissioner must recoup spending in excess of the allocation made to the agency, but only if the statewide appropriation dedicated to home and community-based services (HCBS) waivers is overspent.

Section 12 (256B.0916, subdivision 12) introduces new language to control underspending of DD waiver funds. A lead agency that underspends it allocation while maintaining a waiting list for waiver services must submit a corrective action plan for approval. If a lead agency fails to submit a corrective action plan, the commissioner is required to make sure that the lead agency's allocation is used to provide appropriate services to all waiver participants in the county or tribe.

Section 13 (256B.441, subdivision 65) This section establishes a method for providing a onetime rate increase to nursing facilities and encumbers 100 percent of the additional revenue for the purpose of increasing wages.

Section 14 (256B.49, subdivision 26) applies to over-authorizations under the community alternatives for disabled individuals (CADI), community alternative care (CAC), and brain injury (BI) waivers provisions similar to the overspending provisions for the DD waiver under section 256B.0916, subdivision 11.

Section 15 (256B.49, subdivision 27) applies to underauthorizations under the CADI, CAC and BI waivers provisions similar to the underspending provisions for the DD waiver under section 256B.0916, subdivision 12.

Section 16 (Section 256B.4913, subdivision 4a) creates a rate adjustment moratorium during the 12-month period following the end of the banding period, thereby extending the banding period an additional year.

Section 17 (Section 256B.4913, subdivision 5) increases the training of and resources available to county personnel responsible for administering the rate setting framework so that the framework is properly implemented.

Section 18 (Section 256B.4914, subdivision 2) modifies the definition of individual staffing.

Section 19 (Section 256B.4914, subdivision 8) makes a technical change to a program name.

Section 20 (Section 256B.4914, subdivision 10) expands the range of providers the costs of whom the commissioner must research and analyze. This section also requires the commissioner to develop and implement a methodology to determine appropriate shared staffing levels. Also, this section requires that individual staffing be used when shared staffing is insufficient to meet the needs of certain individuals living in shared residential settings.

Section 21 (Section 256B.4914, subdivision 14) makes extensive revisions to the procedures

and policies governing the approval of alternative payment plans for individuals with exceptional needs.

Section 22 (Section 256B.4914, subdivision 15) strikes language that provided for an alternative policy with respect to overspending during the first two years of implementation of the new rate-setting framework. The new language inserts cross-references to the overspending provisions in sections 256B.0916 and 246B.49.

Sections 23 to 30 are the ABLE Act.

Sections 23 to 25 (256Q.01-256Q.03) establish the Minnesota ABLE plan, states its purpose, provides a citation for chapter 256Q, and provides definitions, many of which are defined by cross-reference to federal law.

Section 26 (256Q.04) requires the Minnesota ABLE plan to meet the federally mandated requirements for a qualifying ABLE program. These requirements are that the plan only be available to state residents, that no participant in the plan be the beneficiary of more than one account, that the plan maintain a separate account for each beneficiary, that the state limit the number of opportunities for an account owner to direct investments, and that the state prohibit the use of account balances as security for a loan.

Section 27 (256Q.05) directs the Commissioner of Human Services in the administration of the ABLE plan by requiring the commissioner to ensure the plan conforms with federal law; requiring the commissioner to consult with the State Board of Investment and the Commissioner of the Office of Higher Education while establishing plan administration and entering into contracts; permitting the commissioner to enter into contracts with third parties to carry out some or all of the administrative duties and investment management; authorizing the commissioner to impose fees on account owners to cover administrative costs; requiring the commissioner to perform federally mandated reporting; and specifying the conditions under which the commissioner may share private and nonpublic data.

Section 28 (256Q.06) Subd. 1 allows anyone to make a cash contribution to any account, but that contribution becomes the property to the account beneficiary, and the contributor acquires no interest in the account.

> **Subd. 2** states that the annual contribution limit for each account from all sources is equal to the gift tax limit for that taxable year. This section also states that the total account balance cannot exceed the maximum account balance limit under the Minnesota college savings plan.
>
> **Subd. 3** specifies that only the account owner may request distributions or change the designated beneficiary of an account.
>
> **Subd. 4** states that any amendments to chapter 256Q automatically amends ABLE plan participation agreements.
>
> **Subd. 5** specifies that each beneficiary of an ABLE account is to have a separate account, and that plan assets are not subject to claims by creditors of the state, are not part of the general fund, and are not subject to appropriation be the state.

Section 29 (256Q.07) requires the State Board of Investment to invest the money in the accounts in the plan in approved ways or to contract with a third party to do so. The board may charge account owners a fee to recover the costs related to investment management.

Section 30 (256Q.08) specifies to whom and how distributions for qualifying disability expenses can be made. Section 9 also permits nonqualified distributions, but the earnings portions of such distributions are subject to applicable taxes and a ten percent penalty. Finally, section 9 permits the state, upon the death of an account's designated beneficiary, to make a claim against the account to recover costs for medical care provided to the account's beneficiary.

Section 31 (282.241, subd. 1) clarifies that if after a parcel of land has been forfeited for taxes it is repurchased by certain individuals associated with the original owner, all MA liens will remain in place.

Section 32 (514.73, subd.1) clarifies that the state may transfer its interest in any medical assistance lien.

> **Subd. 2** allows the state, as a holder of an MA lien, to transfer to a third party its redemption right, which is the right of a creditor to gain possession of a property after foreclosure by paying a price the creditor negotiates with the bank.
>
> **Subd. 3** allows DHS to disclose its financial interest in any MA liens when it transfers that interest or transfers its redemption rights.

Section 33 (514.981, subd. 2) allows DHS, for the purposes of filing an MA lien notice, to presume that MA recipients will not return home if they have resided in a long-term care facility for six months or longer.

Section 34 (580.032, subd. 1) allows a recorded MA lien to constitute a request for notice of a mortgage foreclosure, provided the lien includes a legal description of the real property and the department's mailing address.

Section 35 (Individual Providers of Direct Support Services) ratifies the personal care attendants' contract between SEIU Healthcare Minnesota and the state of Minnesota.

Section 36 (Rate Increase for Self-Directed Workforce Negotiations) increases the reimbursement rate by 1.53 percent on July 1, 2015, and by an additional 0.2 percent on July 1, 2016, for direct support services provided through a covered program if the legislature ratifies the contract negotiated between the state and SEIU Healthcare Minnesota. Covered programs include PCA Choice, Consumer-Directed Community Supports, home and community-based waivered services, alternative care, consumer support grant, and Community First Services and Supports.

Section 37 (Development of Long-Term Care; Life Stage Planning Insurance Product) requires the Commissioner of Human Services to work with stakeholders and other state agencies to research, develop, and investigate the marketability of a new long-term care insurance product.

Section 38 (Home and Community-Based Services Incentive Pool) grants authority to DHS to create a home and community-based services incentive pool to allow DHS to contract with providers and provide incentive payments to those providers to meet outcomes to be determined by DHS.

Section 39 (Direction to Commissioner; Report Required) requires the commissioner to submit two annual reports on the implementation of the reforms to the over and underspending provisions under the HCBS waivers.

Section 40 (Direction to the Commissioner; Day Training and Habilitation) requires the commissioner to calculate the transportation portion of the payment rate for day training and habilitation programs using the rates found in section 256B.4914, subdivision 7, clauses (16) and (17).

Article 7 – Health Department

Section 1 (13.3806, subd. 4) makes a conforming change to the vital statistics provision in chapter 13 to reference Minnesota Statutes, section 144.215, subdivision 4a

Section 2 (15.445) creates a new unified licensing structure for retail food handlers and food and beverage services establishments regulated by the Department of Health and Department of Agriculture.

Section 3 (16A.724, subd. 2) strikes the transfer from the health care access fund to the medical education and research costs fund that currently occurs if resources in the health care access fund exceed expenditures.

Sections 4 to 7 modify health information exchange oversight.

Section 4 (62J.498) updates definitions and specifies that portions of the application for certification classified as public data shall be made available to the public for at least ten days while an application is under consideration and upon the request of the commissioner. At the request of the commissioner, the applicant must participate in a public hearing by presenting an overview of the application and responding to questions from the public.

Section 5 (62J.4981) modifies the certificate of authority requirements for health data intermediaries and health information organizations.

Section 6 (62J.4982, subd. 4) strikes obsolete language.

Section 7 (62J.4982, subd. 5) modifies the fee structure for health information exchange service providers.

Section 8 (62J.692, subd. 4) strikes the $1,000,000 from the health care access fund for grants to family medicine residency programs.

Section 9 (62U.04, subd. 11) permits the Commissioner of Health to compile public use files of summary data or tables from the all-payer claims data submitted under section 62U.04 (encounter data and pricing data) that (1) are available to the public by March 1, 2016, at no or

at a minimal cost and available by web-based electronic data download by June 30, 2019; (2) do not identify individual patients, providers, or payers; (3) are updated by the commissioner at least annually with the most current data available; (4) contain clear and conspicuous explanations of the characteristics of the data; and (5) not lead to the collection of additional data elements beyond what is authorized as of June 30, 2015. This section also requires the commissioner to consult with the all-payer claims database work group when creating these public use summary files.

Sections 10 to 13 (144.1501) expand the health professional education loan forgiveness program to include advanced dental therapists, dental therapists, mental health professionals, and public health nurses.

Section 14 (144.1911) establishes the international medical graduates assistance program

Subd. 1 establishes the international medical graduate assistance program.

Subd. 2 defines the following terms: board; commissioner; immigrant international medical graduate; international medical graduate; Minnesota immigrant international medical graduate; rural community; and underserved community.

Subd. 3 requires the Commissioner of Health to administer the program. In administering the program, the commissioner shall (1) provide overall coordination for the planning, development, and implementation of a system for integrating qualified immigrant international medical graduates into the Minnesota health care delivery system; (2) develop and maintain a voluntary roster of immigrant international medical graduates interested in entering the Minnesota health work force; (3) work with graduate clinical medical training programs to address barriers faced by immigrant international medical graduates in securing residency positions in Minnesota; (4) develop a standardized assessment of the clinical readiness of eligible immigrant international medical graduates to serve in a residency program; (5) explore and facilitate more streamlined pathways for immigrant international medical graduates to serve in nonphysician professions; and (6) study changes necessary in health professional licensure and regulation to ensure full utilization of immigrant international medical graduates in the Minnesota health care delivery system and report recommendations to the legislature by January 15, 2017.

Subd. 4. requires the commissioner to award grants to eligible nonprofit organizations to provide career guidance and support services to immigrant international medical graduates seeking to enter Minnesota's work force.

Subd. 5. requires the commissioner to award grants to support clinical preparation for Minnesota international medical graduates needing additional clinical preparation or experience to qualify for residency.

Subd. 6. requires the commissioner to award grants to support primary care residency positions designated for Minnesota immigrant physicians who are willing to serve in rural or underserved areas of the state. The commissioner shall also establish a revolving international medical graduate residency account and require a participating resident to enter into an agreement to provide primary care for at least five years in a rural or underserved area after graduating from the residency program and to make payments to

the revolving account.

Subd. 7 specifies that a hospital may establish residency programs for foreign trained physicians to become candidates for licensure to practice medicine.

Subd. 8 specifies that this section does not alter the authority of the Board of Medical Practice to regulate the practice or the licensing of the practice of medicine.

Subd. 9 requires the commissioner to administer the program in consultation with a number of stakeholders.

Subd. 10 requires the commissioner to submit an annual report to the legislature on integration of international medical graduates into the Minnesota health care delivery system beginning January 15, 2016.

Section 15 (144.215, subd. 4a) classifies parent information used to register a birth as private data on individuals, but permits that that information may be disclosed to a school or local, state, tribal, or federal government entity as necessary for the entity to perform its duties.

Section 16 (144.225, subd. 4) makes a conforming change to the vital records disclosure statute to ensure that the parent information restricted under section 144.215, subdivision 4a, is still available for medical research.

Sections 17 to 20 (144.291, subd. 2; 144.293, subd. 8; 144.298, subd. 3) add a definition and references to a patient information service within the Health Records Act.

Section 21 (144.3831, subd. 1) increases the public water services annual connection fee from $6.36 to $8.28 for every service connection effective January 1, 2016.

Section 22 (144.3875) requires the commissioner to implement a statewide initiative to increase awareness among communities of color and recent immigrants on the importance of early preventive dental intervention for infants and toddlers before and after primary teeth appear. Requires the commissioner to develop educational materials and information for expectant and new parents within targeted communities on the importance of early dental care to prevent early cavities and to develop a distribution plan for these materials.

Section 23 (144.4961) establishes the Minnesota Radon Licensing Act.

Subd. 1 permits this section to be cited as the Minnesota Radon Licensing Act.

Subd. 2 defines terms.

Subd. 3 authorizes the Commissioner of Health to adopt rules relating to licensure and enforcement of laws and rules relating to indoor radon in dwellings and other buildings, with the exception of newly constructed homes.

Subd. 4 requires all radon mitigation systems installed in Minnesota on or after October 1, 2017, to have a radon mitigation system tag provided by the commissioner. The tag must be attached by a radon mitigation professional and must be in a visible location.

Subd. 5 requires that every person, firm, or corporation that sells or performs a service for compensation to detect the presence of radon in the indoor atmosphere, performs laboratory analysis, or performs a service to mitigate radon in the indoor atmosphere be licensed on an annual basis. Specifies that this does not apply to retail stores that only sell or distribute radon sampling and are not engaged in the manufacture of radon sampling devices.

Subd. 6 specifies that radon systems installed in newly constructed homes prior to the issuance of a certificate of occupancy are exempt from this section.

Subd. 7 requires that applications for licensure, system tags, and other reporting requirements be submitted on forms prescribed by the commissioner.

Subd. 8 establishes radon license fees.

Subd. 9 states that the commissioner shall enforce this section under Minnesota Statutes, sections 144.989 to 144.993.

Section 24 (144.566) requires hospitals to take various steps to prevent violence against health care workers.

Subd. 1 provides definitions of act of violence; commissioner; health care workers; hospital; incidence response; interfere; preparedness; and retaliate.

Subd. 2, paragraph (a), requires hospitals to design, implement, and review annually preparedness and incident response action plans.

Paragraph (b) requires hospitals to designate a committee to develop the plans and aid in the implementation of the plans.

Paragraph (c) specifies elements of required staff training.

Paragraph (d) specifies required elements of annual plan reviews.

Paragraph (e) requires hospitals to share information with local law enforcement.

Paragraph (f) prohibits hospitals from interfering with a health care worker's ability to report violence.

Paragraph (g) permits the commissioner to impose a fine of $250 on hospitals that fail to comply with the requirements of this subdivision.

Sections 25 to 29 (144.9501) make changes to the definitions for lead sampling technician and renovation, and adds definitions for "certified renovation firm," and "lead renovator."

Section 30 (144.9505) modifies the credentialing requirements for lead firms and professionals. Requires renovation firms to be licensed by the commissioner. Requires a person that employs an individual to perform regulated lead work outside the person's property to obtain certification as a certified lead firm or a certified renovation firm. Clarifies that an

individual who performs lead hazard reduction, lead hazard screens, lead inspections, lead risk assessment, lead project designer services, lead sampling technician services, swab team services, and activities performed to comply with lead orders must be employed by a certified lead firm. Specifies that the fees are annual fees. Specifies that a person who employs individuals to perform renovation activities outside the person's property must obtain certification as a renovation firm. Requires a person who provides training to lead workers, supervisors, inspectors, assessors, project designers, technicians, and lead renovators to obtain a permit from the commissioner.

Section 31 (144.9508) specifies that the commissioner's authority to adopt rules consistent with the Toxic Substance Control Act do not expire.

Section 32 (144.999) establishes the parameters in which epinephrine auto-injectors may be obtained and used by authorized entities.

Subd. 1. defines terms: administer; authorized entity; commissioner; epinephrine auto-injector; provider.

Subd. 2. permits the commissioner to identify additional categories of entities or organizations to be authorized entities.

Subd. 3 permits an authorized entity to obtain and possess epinephrine auto-injectors to provide or administer to individuals if an owner, manager, employee, or agent of the authorized entity believes in good faith that the individual is experiencing anaphylaxis, regardless of whether the individual has a prescription for an epinephrine auto-injector. Permits an authorized entity to obtain epinephrine auto-injectors from pharmacy wholesalers if the authorized entity presents the pharmacy or manufacturer with a valid certificate of training. Requires an authorized entity to store the epinephrine auto-injectors in a location readily accessible in an emergency and in accordance with the manufacturer's instructions and any additional requirements established by the commissioner.

Subd. 4 permits any owner, manager, employee, or agent of an authorized entity who has completed the training program to either provide an epinephrine auto-injector to an individual, or the individual's parent, legal guardian or caretaker, or administer an epinephrine auto-injector to the individual if the employee or agent believes in good faith the individual is experiencing anaphylaxis, regardless of whether the individual has a prescription for an epinephrine auto-injector or has previously been diagnosed with an allergy. Specifies that an authorized entity is not required to maintain a stock of epinephrine auto-injectors.

Subd. 5 requires an individual to successfully complete every two years a anaphylaxis training program before the individual can provide or administer an epinephrine auto-injector as permitted under subdivision 4. Requires the individual or entity conducting the training to issue a certificate to each person who completes the training program. Specifies that the certificate is valid for two years.

Subd. 6 specifies that an act or omission taken by an authorized entity that obtains, an employee or agent who provides or uses, a pharmacy or manufacturer that dispenses, or an individual or entity that conducts trainings for epinephrine auto- injectors pursuant to

this section, is considered “emergency care, advice, or assistance" under the Good Samaritan law.

Section 33 (144A.70, subd. 6) expands the list of temporary employees placed by supplemental nursing services agencies to include any licensed health professional.

Section 34 (144A.70, subd. 7) requires annual unannounced inspections of supplemental nursing services agencies to ensure compliance with the sections of statute regulating supplemental nursing services agencies.

Section 35 (144A.71, subd. 1) requires supplemental nursing agencies to register annually with DHS and requires DHS to deposit registration fees in the special revenue fund.

Subd. 2 requires registration applications to include a policy for making a supplemental nursing services agency’s records immediately available at all times to DHS and increases an annual registration fee from $891 to $2,035. If the agency fails to provide all the required parts of the registration application, DHS must refuse to issue the registration, subject to an appeals process.

Section 36 (144A.72, subd. 1) adds a requirement that supplemental nursing services agencies retain for five years all records pertaining to their registration, including those records related to an agency’s insurance and bonding and its employees’ education, training, and licensing. Agencies must make these documents immediately available to DHS. Subdivision 1 also adds a requirement that in order to retain their registration, agencies provide services to a health care facility during the year prior to the date of their registration renewal.

Subd. 2 removes the requirement that an agency must engage in a pattern of failure to comply with the provision of the section before it is subject to revocation or nonrenewal of its registration; a single instance of failure to comply is sufficient.

Subd. 4 requires a hearing involving an administrative law judge prior to the revocation or rejection of an agency’s registration or renewal of registration.

Section 37 (144A.73) requires the Office of Health Facility Complaints to investigate complaints against supplemental nursing services agencies.

Section 38 (144D.01) adds the definition of “direct-care staff” to the housing with services chapter.

Section 39 (144D.066, sub. 1) requires DHS to enforce dementia care training among the staff of housing with services establishments, including direct-care staff, supervisors of direct-care staff, maintenance staff, housekeeping staff, food service staff, and housing managers.

Subd. 2 permits DHS to impose fines for failure to comply with required dementia care training, but the fines are subject to an appeals process; requires that employees be permitted to complete the training as part of their duties; does not allow payment of a fine to substitute for completion of the required training; permits the revocation or nonrenewal of registration for continued noncompliance with the requirement to receive the required training; and requires DHS to make public a list of all housing with services

establishments that have complied with the training requirements.

Subd. 3 requires DHS, in lieu of imposing fines between January 1, 2016, and December 31, 2016, to offer technical assistance to help providers come into compliance with the dementia care training requirements.

Section 40 (144E.50) transfers administration of the emergency medical services fund from the Emergency Medical Services Regulatory Board to the Commissioner of Health. The money from the fund will no longer be evenly distributed by the board to the eight designated regional emergency medical services boards, but evenly distributed by the commissioner to eight successful grant applicants, one per region. The eight regions are defined. Each grantee will oversee its regional emergency medical services programs and determine how the funds granted it are utilized within the purpose of the grant, except that no funds can be used to directly subsidize any ambulance service. Because the funds will no longer be distributed to the regional boards, the regional board audit requirements are eliminated.

Section 41 (144F.01, subdivision 5) eliminates reference to the regional emergency medical services boards in connection to regional emergency medical services programs that may be funded with revenue raised by levies in emergency medical services special taxing districts.

Section 42 (145.928, subd. 15) requires the commissioner when considering grant applications for health disparities grants to give equal weight to a promising strategy as given to a research or evidence-based strategy.

Section 43 (145A.131, subd. 1) provides an increase in the local public health grant for community health boards that are all or a portion is located outside of the counties of Anoka, Chisago, Carver, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright equal to ten percent of the grant award to the community health board. The amount distributed shall be adjusted each year based on available funding and the number of eligible community health boards.

Sections 44 to 49 modify the mortuary science chapter.

Section 44 (149A.20, subd. 5) specifies that if a passing score is not attained on the state examination, the individual must wait two weeks before retaking the examination.

Section 45 (149A.20, subd. 6) requires that an internship shall at a minimum be 2,080 hours completed within a three-year period, and that the commissioner may waive up to 520 hours upon the satisfactory completion of a clinical or practicum in mortuary science through a program approved by the commissioner. Requires an intern to complete 25 case reports in the areas of embalming arrangements and services. Requires case reports be completed by the intern and filed with the commissioner before completion of the internship.

Section 46 (149A.20, subd. 11) requires 18 continuing education hours for license renewal to practice mortuary science. Specifies the areas that these hours must cover.

Section 47 (149A.65) increases mortuary science fees.

Section 48 (149A.92, subd. 1) eliminates a grandfather clause for minimum standards for

preparation and embalming rooms that had not been used for the preparation or embalming of a dead human body in the 12 months prior to July 1, 1997.

Section 49 (149A.97, subd. 7) requires funeral providers reporting preneed trust accounts to complete an independent audit by an independent third-party auditing firm every other year, and report the findings to the commissioner by March 31 of that calendar year. This is in addition to the annual report that is required to be submitted.

Section 50 (157.16) modifies the food and beverage services establishment fees to coordinate with the unified licensure structure established under section 15.445.

Section 51 (169.686, subdivision 3) changes the recipient of a portion of the funds collected as fines for violations of the state's seat belt laws from the regional emergency medical services boards to the commissioner of health for the grants specified in section 144E.50.

Section 52 requires the commissioner of health, in collaboration with the commissioners of human services and public safety and the Council on Asian-Pacific Minnesotans, to create a working group to address violence against Asian women and children and report back to the legislature with recommendations by February 15, 2017.

Section 53 (Revisor's Instruction) is an instruction to the revisor to move Minnesota Statutes, section 144E.50 "Emergency Medical Services Fund," from chapter 144E "Emergency Medical Services Regulatory Board" to chapter 144 "Department of Health."

Section 54 (Repealer) repeals section 144E.52 (Funding for emergency medical services regions).

Article 8 – Health Care Delivery

Sections 1 to 3 create the Minnesota Telemedicine Act.

Section 1 (62A.67) permits these sections to be cited as the "Minnesota Telemedicine Act."

Section 2 (62A.671) defines the following terms: distant site; health care provider; health carrier; health plan; licensed health care provider; originating site; store-and-forward technology; and telemedicine.

Section 3 (62A.672) requires the coverage of telemedicine services.

> **Subdivision 1** requires a health plan issued or renewed on or after January 1, 2017, to cover telemedicine benefits in the same manner as any other benefit covered under the health plan.
>
> **Subdivision 2** prohibits a health carrier from denying coverage of a service solely because the service was delivered via telemedicine and was not provided through in-person contact between the licensed health care provider and patient.
>
> **Subdivision 3** requires the health carrier to reimburse the distant site provider for services delivered via telemedicine on the same basis and at the same rate as would apply

to the services, consultation, or contacts if provided in person. Permits the health carrier to require a deductible, co-payment, or coinsurance for services provided by telemedicine so long as the deductible, co-payment, or coinsurance does not exceed the deductible, co-payment, or coinsurance applicable if the service is provided through in-person contact.

Subdivision 4 requires a health carrier to make a facility fee payment to the originating site health care provider for the delivery of telemedicine to the enrollee. The facility fee payment to the originating site provider is in addition to the reimbursement to the distant site provider. This payment is not subject to any patient coinsurance, deductible, or co-payment obligation.

Sections 4 to 7, amend the electronic prescription drug program.

Section 4 (62J.497, subd. 1) adds a definition of utilization review organization.

Section 5 (62J.497, subd. 3) requires group purchasers and utilization review organizations to develop processes to ensure notifications to prescribers upon a denial of a claim for a prescribed drug that is not covered or is not included in the group purchaser's formulary. Requires the process to provide a list of covered drugs from the same class or classes as the drug originally prescribed.

Section 6 (62J.497, subd. 4) requires providers, group purchasers, prescribers, dispensers, and utilization review organizations that use paper forms for prescription drugs prior authorization, or for medical exception requests, to only use the uniform formulary exception form.

Section 7 (62J.497, subd. 5) requires testing of electronic drug prior authorization transmission to begin no later than October 1, 2015.

Sections 8 through 28 amend chapter 62M, utilization review.

Section 8 (62M.01, subd. 2) clarifies that chapter 62M does not apply to the medical assistance fee-for-service program unless otherwise required.

Section 9 (62M.02, subd. 10a) adds a definition for "drug."

Section 10 (62M.02, subd. 11a) adds a definition for "formulary."

Section 11 (62M.02, subd. 12) modifies the definition of health benefit plan to include a health plan that provides coverage of prescription drugs.

Section 12 (62M.02, subd. 14) modifies the definition of "outpatient services" to include prescription drugs.

Section 13 (62M.02, subd. 14b) adds a definition for "prescription."

Section 14 (62M.02, subd. 14c) adds a definition for "prescription drug order."

Section 15 (62M.02, subd. 15) modifies the definition of "prior authorization" to include

preadmission review, pretreatment review, pharmaceutical utilization management procedures, utilization, and case management and any utilization review organization's requirement that an enrollee or provider notify the utilization review organization prior to providing a service.

Section 16 (62M.01, subd. 17) modifies the definition of "provider" to include a licensed pharmacist.

Section 17 (62M.01, subd. 18a) adds a definition for "quantity limit."

Section 18 (62M.01, subd. 19a) adds a definition for "step therapy."

Section 19 (62M.05, subd. 3a) modifies the time in which an initial determination on requests for utilization review must be communicated to the provider and enrollee from ten business days to five business days of the request.

Section 20 (62M.05, subd. 3b) modifies the time in which notification of an expedited initial determination to either certify or not to certify must be provided to the provider and enrollee from no later than 72 hours to no later than 36 hours from the initial request.

Section 21 (62M.05, subd. 4) requires a utilization review organization to have written procedures to address processes by which the utilization review organization must track and manage review requests and documentation submitted by providers and enrollees. Specifies that if a utilization review organization fails to meet specified timelines, or fails to notify a provider that information needed to conduct the review is incomplete, or fails to properly maintain submitted records for which the provider or enrollee has documentation of submission, the service will be deemed approved.

Section 22 (62M.06, subd. 2) modifies the time in which a utilization review organization must notify the enrollee and attending health care professional of its determination on the expedited appeal from no later than 72 hours to no later than 36 hours after receiving the expedited appeal.

Section 23 (62M.06, subd. 3) modifies the time in which a utilization review organization must notify the enrollee, attending health care professional, and claims administrator of its determination on a standard appeal from 30 days to 15 days upon receipt of the notice to appeal. If the utilization review organization cannot make a determination within 15 days due to circumstances outside the control of the review organization, the review organization may take up to ten additional days to notify the enrollee, attending health care professional, and claims administrator of its determination. If it takes any additional days beyond the initial 15-day period to make its determination, it must inform the enrollee, attending health care professional, and claims administrator in advance of the extension and reasons for it.

Section 24 (62M.07), Paragraph (d), specifies that any authorization for a prescription drug must remain valid for the duration of an enrollee's benefit year or enrollment year so long as the drug continues to be prescribed to the patient, the drug remains safe, has not been withdrawn from use by the FDA or the manufacturer, no evidence of an enrollee's abuse or misuse of the medication, and no drug warnings or recommended changes in drug usage has occurred.

Paragraph (e) prohibits a utilization review organization, health Plan Company, or

claims administrator from imposing step therapy requirements for enrollees currently on a prescription drug for six specified classes.

Section 25 (62M.09, subd. 3) requires all physicians conducting the review in connection with any policy issued by a health plan company, regardless of size to be licensed in Minnesota.

Section 26 (62M.10, subd. 7) requires a utilization review organization to provide upon request to an enrollee, provider, and the commissioner of commerce, the written clinical criteria used to determine medical necessity, appropriateness, and efficacy of a procedure or service. Permits this requirement to be met by posting the written clinical criteria on the utilization review organization's public Web site or by electronic distribution to the enrollee or provider.

Section 27 (62M.11) permits a provider to file a complaint regarding compliance with the requirements of this chapter or regarding a determination not to certify directly to the commissioner responsible for regulating the utilization review organization.

Section 28 (62M.17) requires utilization review organizations to annually report to the Commissioner of Health specified information regarding medical exception requests and for other prescription drug prior authorization requests.

Section 29 (62Q.83) permits enrollees of a health plan company (HPC) or pharmacy benefit manager to choose where they obtain their pharmacy services.

Subd. 1 prohibits a HPC or PBM from limiting or restricting an enrollee's ability to select a pharmacy or pharmacist of the enrollee's choice if the pharmacy or pharmacist is licensed in the state and the pharmacy or pharmacist has agreed to the terms of the HPC or PBM provider contract. Specifies that this subdivision does not apply to an enrollee in the Minnesota restricted recipient program.

Subd. 2 prohibits a HPC or PBM from denying a pharmacy or pharmacist the right to participate in its pharmacy network contracts if the pharmacy or pharmacist has a valid license in their state and agrees to accept the terms and conditions offered by the HPC or PBM and meets all state and federal laws and regulations.

Subd. 3 prohibits a HPC or PBM from imposing a cost-sharing requirement or other fee on an enrollee for selecting a pharmacy or pharmacist or impose conditions that limit or restrict an enrollee's choice unless the same cost-sharing, fees, limits, or conditions are imposed on an enrollee's selection of any pharmacy within the provider network contracts.

Subd. 4 defines pharmacy and pharmacy benefit manager.

Section 30 (62Q.84) requires a HPC or PBM to provide payment for any health care service that is a covered benefit and provided by a licensed pharmacist if the service performed is within the scope of practice of the licensed pharmacist and the service would be covered if the service was performed by a physician, advanced practice registered nurse or physician assistant.

Section 31 (62Q.85) creates prescription drug benefit transparency and management requirements.

Subd. 1 defines the following terms: drug; formulary; health plan company; and prescription.

Subd. 2 requires a health plan company that cover prescription drugs and uses a formulary to make its formulary and related benefit information available by electronic means and, upon request, in writing at least 30 days prior to annual renewal dates.

Subd. 3. Paragraph (a), specifies that once a formulary has been established a health plan company, may at any time during an enrollee's contract year, expand its formulary by adding drugs to the formulary; reduce the copayments or coinsurance; or move a drug to a benefit category that reduces the enrollee's cost.

Paragraph (b) states that a health plan company may remove a brand name drug from its formulary or place a brand name drug in a benefit category that increases an enrollee's cost only if an A-rated generic or multisource brand name equivalent is added to the formulary at a lower cost to the enrollee and upon 60 notice to prescribers, pharmacists, and affected enrollees.

Paragraph (c) prohibits a health plan company from removing drugs from its formulary or moving drugs to a benefit category that increases an enrollee's cost during the enrollee's contract year. This prohibition does not apply if the change is associated with the drug being deemed unsafe by the FDA or it has been withdrawn by the FDA or the manufacturer, or an independent source has issued drug specific warnings or recommended changes in drug usage.

Paragraph (d) prohibits managed care plans and county-based purchasing plans from removing drugs from its formulary or moving a drug to a benefit category that increases an enrollee's cost more than annually unless an A-rated generic or multisource brand name equivalent is added to formulary.

Subd. 4. Paragraph (a) requires a health plan company to establish and maintain a transition process to prevent gaps in prescription drug coverage for enrollees with ongoing prescription drug needs who are affected by changes in formulary drug availability.

Paragraph (b) requires the process to provide coverage for at least 60 days.

Paragraph (c) requires that any cost-sharing applied be based on the defined prescription drug benefit terms and must be consistent with any cost-sharing that would be charged for no formulary drugs approved under a medication exceptions process.

Paragraph (d) requires the health plan company to ensure that written notice is provided to each affected enrollee and prescriber within three business days after adjudication of the transition coverage.

Subd. 5. Paragraph (a) requires each health plan company to establish and maintain a medical exceptions process that allows enrollees, providers, and an authorized representative to request and obtain coverage approval in certain situations.

Paragraph (b) requires the exception to remain valid for the duration of an enrollee's contract term provided that the medication continues to be prescribed of the same condition, and the medication has not been withdrawn by the manufacturer or the FDA.

Paragraph (c) requires the medical exceptions process to comply with the requirements under chapter 62M (utilization review).

Subd. 6 requires the Commissioner of Health to convene an advisory group to provide guidance in monitoring changes and trends in prescription drug coverage and formulary design. Requires the commissioner to submit a report to the legislature on a biennial basis beginning January 15, 2017, describing trends in prescription drug coverage, formulary design, medication exception requests, and benefit designs. Requires health plan companies to cooperate in providing information necessary for the advisory group to carry out its responsibilities.

Section 32 (62U.02, subd. 1) requires the commissioner to stratify five quality measures the Commissioner of Health is required to develop to assess the quality of health care services offered by health care providers that are to be used for the quality incentive payment system by race, ethnicity, preferred language, and country of origin effective July 1, 2016. Permits the commissioner to require that other socio-demographics that are correlated with health disparities and have an impact on performance, quality, and cost indicators be considered after voluntary pilot projects are completed. Requires the commissioner to consult with the communities impacted by health disparities through culturally appropriate community engagement principles and methods. Specifies that the commissioner does not have the authority to collect or analyze patient-level or patient-specific data of the patient's characteristics.

Section 33 (62U.02, subd. 2) requires that the quality incentive payment system developed by the commissioner under this section adjust for variations in patient population to reduce incentives for providers to avoid patients with risk factors related to race, ethnicity, language, country of origin, and socio-demographic factors.

Section 34 (62U.02, subd. 3) requires that the risk adjustment system that the commissioner is developing under this section take into account patient characteristics that are correlated with health disparities and have an impact on performance, cost, and quality measures. Permits the risk adjustment method to be based on reporting based on an actual to expected comparison that reflects the characteristics of the patient population served by the clinic or hospital.

Section 35 (62U.02, subd. 4) specifies that if the commissioner contracts with a private entity to complete the requirements of this section that the entity has a governance that includes representatives of providers serving high concentration of patients and communities impacted by health disparities, and consumers who represent groups who experience health disparities.

Section 36 (144E.001, subd. 5h) adds a definition of community medical response emergency medical technician (CEMT) to the Emergency Medical Services Regulatory Board chapter of law.

Section 37 (144E.275, subd. 1) expands the definition of medical response unit to permit medical response units to provide CEMT services.

Section 38 (144.275, subd. 7) Paragraph (a) specifies the prerequisites for an individual to be certified by the board as a community medical response emergency medical technician.

Paragraph (b) requires a CEMT to practice under the supervision of the medical director of the CEMT's medical response unit.

Paragraphs (c) and (d) specify the services a CEMT is permitted to provide.

Paragraph (e) clarifies that CEMTs are not exempt from any of the regulatory requirements for EMTs or AEMTs.

Paragraph (f) further limits CEMT services by prohibiting most home care services.

Section 39 (151.58, subd. 2) modifies the definition of a health care facility for purposes of the use of automated drug distribution systems to include a boarding care home that provides centralized storage of medications.

Section 40 (151.58, subd. 5) creates an exemption from the requirement that a pharmacist employed by and working at the managing pharmacy certify that accuracy of the filling of the cassettes, canisters, or other containers that contain drugs that are loaded into an automated drug distribution system if the filled cassette, canister, or other container has been provided by a repackage registered by the FDA and licensed by the Board of Pharmacy as a manufacturer.

Section 41 (256B.0625, subdivision 3b) specifies that medical assistance cover services and consultations delivered via telemedicine as defined under section 62A.71, subdivision 9 (real-time two-way, interactive audio and visual communications and through technologies consisting of telephones, patient monitoring devises or other electronic means) in the same manner as if the service or consultation was delivered in person. Requires medical assistance to provide a facility fee payment to the originating site provider. Requires the commissioner to make a facility fee payment to the originating site health care provider in an amount equivalent to the originated site fee paid by Medicare. No fee shall be paid to a health care provider that is being paid under a cost-based methodology or the fee has already been paid by Medicare for a dually eligible enrollee.

Section 42 (256B.0625, subd. 13) modifies the reimbursement for over-the-counter medications under medical assistance by specifying that the payment is the lowest of: (1) the number of dosage units in the manufacturer's original package; (2) the number of dosage units required to complete the patient's course of therapy; or (3) if applicable, the number of dosage units dispensed for a system using retrospective billing as permitted under section 256B.0625, subd. 13e, paragraph (b).

Section 43 (256B.0625, subd. 13e, paragraph (a)) clarifies that the pharmacy dispensing fee for over-the-counter drugs shall be $365, except that the fee shall be $1.31 for retrospectively billing pharmacies when billing for quantities less than the number of units contained in the manufacturer's original package.

Paragraph (b) authorizes pharmacies dispensing prescriptions to residents of long-term care facilities using an automated drug distribution system or a packaging system that meet the rules governing the return of unused drugs to the pharmacy for reuse to use retrospective billing for prescription drugs dispensed to long-term care facility residents.

The pharmacy must submit a claim only for the quantity of medication used by the recipient during the defined billing period and the pharmacy must use a billing period not less than one calendar month or 30 days.

Paragraph (c) specifies that a pharmacy that is using a packaging system is required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse unless the pharmacy is using a retrospective rebilling.

Section 44 (256B.072) requires that the measures used in the performance reporting system established by the Commissioner of Human Services for health care providers who provide services to public program recipients must be stratified by race, ethnicity, preferred language, and country of origin and risk-adjusted as specified in section 62U.02, subdivision 3, paragraph (b).

Section 45 (256B.69, subd. 6) specifies that managed care plans and county-based purchasing plans must comply with chapter 62M and section 62Q.85, for purposes of delivering services under the prepaid medical assistance program.

Section 46 sets deadlines for the first appointments and the first meeting of the Prescription Drug Advisory Council.

Section 47 (Proposal for Child Protection Focused CEMT Model) requires the commissioner to develop a proposal for a pilot program to coordinate services between child protective services and CEMTs.

Section 48 (CEMT Technical Services Covered under Medical Assistance) requires that by January 15, 2016, the Commissioner of Human Services, in consultation with specified stakeholders, recommend to the legislature which CEMT services are to be covered under medical assistance and what the payment rates for those services are to be.

Section 49 (Evaluation of CEMT Services) In the event that legislation is enacted to cover CEMT services, under medical assistance, this section requires the Commissioner of Human Services to provide a report to the legislature on the cost, quality, and coordination of CEMT services. **Section 50** is a Revisor's instruction to comply with the changes in chapter 62M.

Article 9 – Health Licensing Board

Sections 1, 2, and 3 (148.57, subd. 1, subd. 2; 148.59) modify fees established under the Board of Optometry.

Section 4 (148E.075) creates the following alternative licenses: temporary leave license; emeritus inactive license; and an emeritus active license.

Subd. 1 establishes a temporary leave license and removes reference to inactive status.

Subd. 1a establishes an emeritus inactive license.

Subd. 1b establishes an emeritus active license.

Subd. 2 permits a licensee to apply for temporary leave license, emeritus inactive license, or emeritus active license at any time when currently licensed or as an alternative to applying for a renewal of a license.

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

Subds. 4, 5, 6 and 7 are stricken.

Subd. 8 authorizes the board to resolve any pending complaints against a licensee before approving an application for an alternative license. Permits the board to take disciplinary action against a licensee with an alternative license.

Section 5 (148E.080, subd.1) changes a cross-reference.

Section 6 (148E.080, subd. 2) changes a cross-reference.

Section 7 (148E.180, subd. 2) creates an emeritus inactive license fee and an emeritus active license.

Section 8 (148E.180, subd. 5) establishes a license late fee.

Sections 9 to 14 (150A.091, subds. 4, 5, 11, 17, 18; 150A.31) modify fees established by the Board of Dentistry.

Sections 15 to 18 (151.065, subds. 1, 2, 3, and 4) modify fees established by the Board of Pharmacy.

Section 19 repeals 148E.060, subd. 12 (temporary license, ineligibility) and 148E.075, subdivisions 4, 5, 6, and 7 (inactive, temporary leaves, emeritus license).

Article 10 – Health Care

Section 1 (16A.724, subd. 2) makes MinnesotaCare a forecasted program.

Section 2 (62A.045) requires a health insurer to process a claim from a state agency for covered expenses paid under state medical programs within 90 business days. Authorizes the state agency to grant the health insurer an additional 30 business days to process the claim if the request is submitted within 30 business days after the insurer received the claim.

Section 3 (174.29, subd. 1) Effective July 1, 2016, adds certain nonemergency medical transportation services to the definition of special transportation services.

Section 4 (174.30, subd. 3) Effective July 1, 2016, requires the Commissioner of Transportation to inspect the safety features required in vehicles designated as protected transport under section 256B.0625, subdivision 17.

Section 5 (174.30, subd. 4, paragraph (e)) Beginning July 1, 2016, requires certain nonemergency medical transportation providers and special transportation service providers to pay a $45 annual fee to obtain a decal signifying possession of a certificate of compliance with the operating standards for special transportation services, and exempts ambulance services from this fee. The revenue from the fee is appropriated to the Commissioner of Transportation to pay for the inspection program.

> **Paragraph (g)** permits nonemergency medical transportation providers to use the phrase "nonemergency medical transportation" in their name, advertisements or information describing their service, thereby exempting nonemergency medical transportation providers from a Minnesota Rule that prohibits special transportation service providers from using in their name, advertisements, or information describing their service, any words that offer, suggest, or imply they provide ambulance service.

Section 6 (174.30, subd. 4b) permits the Commissioner of Transportation to issue a variance from the operating standards for special transportation services to nonemergency medical transportation providers who were not subject to the operating standards prior to July 1, 2014. Providers may apply for a variance if they will not be able to meet the operating standards within six months following the enactment of this subdivision. No variance may exceed 60 days, unless extended by the commissioner.

Section 7 (174.30, subd. 10) Paragraphs (a) and (b) require a provider of special transportation services (STS) to initiate background studies on its employees using the online NETStudy system operated by the Commissioner of Human Services.

> **Paragraph (c)** prohibits an STS provider from allowing an employee to provide services unless the employee passes a background study.
>
> **Paragraph (d)** permits a local or contracting agency to initiate background studies of volunteer drivers who provide nonemergency medical transportation services.

Section 8 (245C.03, subd. 10) requires DHS to conduct background studies for providers of special transportation services who initiate the studies of their employees, as they are required to do under Minnesota Statutes, section 174.30, subdivision 10.

Section 9 (245C.10, subd. 11) imposes on special transportation providers a fee of no more than $20 per background study. Appropriates the fee to the commissioner to conduct the background studies.

Section 10 (256.015, subd. 7) requires an employer or third-party payer to provide DHS, within 60 days of a request, the following information as part of the data file: name, date of birth, Social Security number, if number is collected and stored in a system routinely used for producing data, employer name, policy identification number, group identification number, and plan or coverage type.

Section 11 (256.969, subd. 1) eliminates the requirement that MMB submit budget change requests for annual adjustments to hospital payment rates.

Section 12 (256.969, subd 2b) Paragraph (d) extends the percent banding that expires June 30, 2016, until the next rebasing, but only for hospitals paid on a diagnosis-related group

(DRG) methodology.

Paragraph (e) extends until the next rebasing the additional adjustments to the rebased hospital payment rates that were set to expire on June 30, 2016.

Paragraph (i) grants DHS the authority to determine a new methodology for determining a cost-based final payment rate for critical access hospitals.

Section 13 (256.969, subd. 3a) specifies that beginning July 1, 2015, individual hospital payment rate adjustments for long-term care hospitals and rehabilitation hospitals must be incorporated into the payment rate and not applied to each claim.

Section 14 256.969, subd. 3c) specifies that beginning July 1, 2015, any hospital payment rate reductions for inpatient services at long-term care hospitals and rehabilitation hospitals must be incorporated into the payment rate and not applied to each claim.

Section 15 (256.969, subd. 9) grants DHS the authority to determine a new methodology for determining the disproportionate share hospital payment rate.

Section 16 (256B.06, subd. 6) requires the commissioner to award grants to nonprofit programs that provide legal services based on indigency to provide legal services to individuals with emergency medical conditions or chronic health conditions who are not currently eligible for medical assistance due to their legal status, but may meet eligibility requirements with legal assistance.

Section 17 (256B.0625, subd. 9) modifies the adult dental services covered under medical assistance by covering a full-mouth series of x-rays or panoramic x-rays; covering nonsurgical treatment for periodontal disease limited to once a year; and covering a comprehensive oral exam and full-mouth series of x-rays as part of outpatient dental surgery.

Section 18 (256B.0625, subd. 9b) authorizes a dentist who is not a medical assistance provider, and who is either a faculty or adjunct member at the University of Minnesota Dental School or a dental resident to be enrolled as a medical assistance provider for purposes of providing dental services at the University of Minnesota Dental School clinic if the provider submits an agreement form to the commissioner.

Section 19 (256B.0625, subd. 9c) specifies that the following prior authorizations (PA) for dental services shall apply: (1) a PA must remain valid for at least 12 months; (2) a new PA is not required if a PA for the service has already been provided within the previous 12 months for the same enrollee if the enrollee changes health plans within the 12-month period; and (3) a managed care plan or county-based purchasing plan shall not require a PA that is more restrictive than the PA requirements in place in the fee-for-service system.

Section 20 (256B.0625, subd. 9d) requires the commissioner to designate a uniform application form to be used in the credentialing of all dental providers serving persons enrolled in medical assistance and MinnesotaCare.

Section 21 (256B.0625, subd. 13h) expands medication therapy services covered by MA to recipients taking prescriptions to treat or prevent one or more chronic medical conditions. Also

permits medication therapy management services to be delivered into patient's residence via secure interactive video if the services are performed electronically during a covered home visit by an enrolled provider. States that reimbursement shall be at the same rate and same condition as would otherwise apply and the pharmacist providing the services must be located within an ambulatory setting that meets specified requirements.

Section 22 (256B.0625, subd. 14) specifies that medical assistance covers as a part of screening services oral health screenings that are performed by a dental hygienist, dental therapist, or advanced dental therapist in a collaborative practice to determine an enrollee's need to be seen by a dentist for diagnosis, assessment, or referral for treatment. The oral screenings are limited to once a year and the provider performing the screening must have an agreement in place that refers to those needing follow-up care to a licensed dentist.

Section 23 (256B.0625, subd. 17) creates **effective July 1, 2016,** a new rate structure for nonemergency medical transportation and thereby implements the new modes of transportation placed in statute in 2014, implementation of which was contingent on a new rate structure.

Paragraph (f) eliminates the rate structure for special transportation services provided to eligible persons who need a wheelchair accessible van; and reorganizes the paragraph.

Old paragraph (g) eliminates redundant language contained in paragraph h.

New paragraph (g) permits acquaintances of a client to receive client reimbursement for providing qualifying transportation to the client and moves language concerning protected transport to clause (6).

Paragraph (i) clarifies that local agencies will assume responsibility for administering the nonemergency medical transportation program only after the commissioner has developed, made available, and funded the single administrative structure and delivery system described under section 256B.0625, subdivision 18e, but limits counties' financial obligations.

Paragraph (l) creates a new rate structure for nonemergency medical transportation based on a client's assessed mode of transportation.

Paragraph (m) provides adjustments to the base rate for services provided in super rural areas and to the mileage rates for services provided in rural and super rural areas.

Paragraph (n) makes technical and conforming changes.

Old paragraph (o) strikes a rate decrease for nonemergency medical transportation.

Section 24 (256B.0625, subd. 17a) strikes a rate decrease for ambulance services effective July 1, 2016.

Section 25 (256B.0625, subd. 18a) strikes language concerning direct mileage reimbursement that is replaced by the client reimbursement language in section 256B.0625, subdivision 17, paragraph (l), effective July 1, 2016.

Section 26 (256B.0625, subd. 18e) requires the Commissioner of Human Services to coordinate with the Commissioner of Transportation in developing the single administrative structure and delivery system for nonemergency medical transportation.

Section 27 (256B0625, subd. 31) permits the commissioner to set reimbursement rates for specialized categories of medical supplies at a level below the Medicare payment rate.

Section 28 (256B.0625, subd. 57) excludes payments to federally qualified health centers and rural health centers from the Medicare cost-sharing payment limitation.

Section 29 (256B.0625, subd. 58) specifies that payment for providing an EPSDT screening shall not include charges for health care services and products that are available to the provider at no cost.

Section 30 (256B.0631) makes changes to the MA co-payments to conform to changes in federal regulations.

> **Subd. 1** modifies the family deductible amount to keep the deductible at $2.75 per month per family and permits it to be adjusted annually by the percentage in the medical care component of the CPI-U. Also specifies that family deductible does not apply to premiums charged to individuals enrolled in MA-EPD.
>
> **Subd. 2** exempts from co-payments and deductibles: American Indians who are enrolled in a federally recognized tribe; individuals eligible for MA through the breast and cervical cancer control program; and preventive health services recommended by the U.S. Preventive Services Task Force.
>
> **Subd. 3** caps cost-sharing for all MA recipients at five percent of the family's income.

Section 31 (256B.0638) creates the opioid prescribing improvement program.

> **Subd. 1** requires the Commissioners of Human Services, in conjunction with the Commissioner of Health, to establish a statewide opioid prescribing program to reduce opioid dependency and substance use due to the prescribing of opioid analgesics by health care providers.
>
> **Subd. 2** defines terms.
>
> **Subd. 3** requires the Commissioner of Human Services, in consultation with the Commissioner of Health, to establish an opioid prescribing work group.
>
> **Subd. 4** requires the work group to recommend to the commissioners the components of the statewide opioid prescribing improvement program, including criteria for opioid prescribing protocols; developing sentinel measures; educational resources for opioid prescribers about pain management and the use of opioids to treat pain; opioid quality improvement standard thresholds and opioid disenrollment standards for opioid prescribers and provider groups; and other program issues as determined by the commissioners.

Subd. 5. Paragraph (a) requires the Commissioner of Human Services to implement the program and to annually collect and report to opioid prescriber's data showing the sentinel measures of their opioid prescribing patterns compared to their anonymized peers.

Paragraph (b) requires the commissioner to notify the prescriber and all provider groups with which the prescriber is employed or affiliated when the prescriber's prescribing pattern exceeds the opioid quality improvement standards thresholds. If notified by the commissioner, the prescriber is required to submit to the commissioner a quality improvement plan for review and approval.

Paragraph (c) specifies that if after one year the prescriber's prescribing practices are not consistent with community standards, the commissioner may take certain steps.

Paragraph (d) requires the commissioner to disenroll from the Minnesota health care programs all prescribers and provider groups whose prescribing practices fall within the applicable opioid disenrollment standards.

Subd. 6 classifies the reports and data identifying an opioid prescriber as private data on individuals until the prescriber is subject to disenrollment as a MA provider, then permits the commissioner to share with all the provider groups with which the prescriber is employed or affiliated a report identifying the prescriber. Specifies that data and reports identifying a provider group are nonpublic data until the provider group is subject to disenrollment. At that time the data and reports are public, except that any identifying information of enrollees must be redacted by the commissioner.

Subd. 7 requires the commissioner to annually report to the legislature on the status of the implementation of the program, including data on utilization of opioids in the Minnesota health care programs.

Section 32 (256B.0757) expands the certification of health homes to include behavioral health homes.

Subd. 1 requires the commissioner to establish behavioral health homes to serve individuals with serious mental illness. Requires the services provided by these behavioral health homes to focus on both behavioral and physical health.

Subd. 2 expands who is eligible for health home services to include individuals who have been diagnosed with a mental illness.

Subd. 4 specifies that health home services are voluntary and that an eligible individual may choose any designated provider. Defines a designated provider as a clinical practice or clinical group practice, rural clinic, community health center, community mental health center, or another entity that is determined by the commissioner to be qualified to be a health home.

Subd. 5 clarifies that the commissioner shall make payments to each designated provider for the provision of health home services.

Subd. 6 changes terminology to refer to designated providers.

Subd. 8 requires health homes to meet process, outcome, and quality standards developed and specified by the commissioner. Requires the commissioner to collect data from health homes to monitor compliance with certification standards. Permits the commissioner to contract with a private entity to evaluate patient and family experiences, health care utilization, and costs. Requires the commissioners to utilize findings from the utilization of health homes to determine populations to serve under subsequent health home models for individuals with chronic conditions.

Section 33 (256B.0758) permits the commissioner to establish a health care delivery pilot program to test integrated health care delivery networks created by or including North Memorial Health Care.

Section 34 (256B.69, subd. 5a) requires managed care and county-based purchasing plans to maintain current and fully executed agreements for all subcontractors, including bargaining groups for administrative services that are expensed to the state's public health care programs. Subcontractor agreements over $200,000 in annual payments must be in a form of a written instrument or electronic document and must contain specific elements and must clearly indicate how they relate to state public health care programs. Provides the commissioner, upon request, with access to all subcontractor documentation under this paragraph.

Section 35 (256B.69, subd. 5i) Paragraph (a) specifies that administrative costs paid to managed care plans or county-based purchasing plans must not exceed 6.6 percent of total payments to all managed care and county-based purchasing plans in aggregate across all state public health care programs based on payments to be made at the beginning of each calendar year. Authorizes the commissioner to eliminate or reduce administrative requirements to meet the administrative cost limit. Excludes state or federal taxes, surcharges, or assessments.

Paragraph (b) specifies the expenses that are not allowable administrative expenses for rate-setting purposes.

Paragraph (c) requires administrative expenses to be reported using the formats designated by the commissioner as part of the rate setting process and specifies the categories to be included.

Paragraph (d) requires the commissioner to reduce administrative expenses paid to managed care plans and county-based purchasing plans by half a percentage point for contracts beginning January 1, 2016. This paragraph sunsets for contracts ending December 31, 2019.

Section 36 (256B.69, subd. 9c) requires managed care plans and county-based purchasing plans to certify to the commissioner, for purposes of financial reporting, that costs reported for state public health care programs, including only services covered under the state plan and waivers and related allowable expenses; and the dollar value of unallowable and nonstate plan services that have been excluded.

Section 37 (256B.69, subd. 9d) modifies the current financial audits to require managed care plans and county-based purchasing plans to submit to and cooperate with the independent third-party financial audits by the legislative auditor. Authorizes the commissioner to conduct ad hoc

audits of the state public health care programs administrative and medical expenses of managed care plans and county-based purchasing plans.

Section 38 (256B.69, subd. 9e) requires the legislative auditor to contract with vendors to conduct independent third-party financial audits of the information required to be provided by managed care plans and county-based purchasing plans.

Section 39 (256B.695) establishes dental services utilization measures.

Subd. 1 requires the commissioner to evaluate access to dental services for children and adults in medical assistance and MinnesotaCare using the following:

1. the percentage of enrollees that have access to nonspecialty dental services within a 60-minute or 60-mile radius of the enrollee's residence;
2. the percentage of adult enrollees continuously enrolled for 6 months in a calendar year receiving an oral evaluation within the year; and
3. the percentage of children under the age of 21 continuously enrolled for at least 90 days in a calendar year receiving an oral evaluation and sealants, and follow-up care after an evaluation.

Subd. 2 Requires the commissioner to establish a baseline measurement using calendar year 2014 as the base year.

Subd. 3 requires the commissioner to calculate the measures described under subdivision 1 using fiscal year 2016 and compare these measures with the baseline measures calculated under subdivision 2 and submit the results to the legislature. If each measure has not increased by at least 20 percent, the dental competitive bidding system shall be implemented by the commissioner if the legislature ratifies its implementation after receipt of the calculations.

Subd. 4 requires the commissioner to contract through a competitive bidding process to an entity or entities to directly administer the delivery of dental services to all state public health care program enrollees effective for dental service provided on or after January 1, 2019.

Section 40 (256B.75) specifies that beginning July 1, 2015, payments to critical access hospitals for outpatient, emergency, and ambulatory surgery hospital facility fee services will be final payments and will not be settled to actual costs.

Section 41 (256B.76, subd. 2) increases payment rates for dental services provided on or after July 1, 2015, to the percentage of 2012 fee-for-service submitted charge that results in a 24 percent increase in the aggregate payment from the rates in effect on June 30, 2015. This increase shall be reflected in the payment rates for managed care plans and county-based purchasing plans effective January 1, 2016.

Section 42 (256B.76 subd. 4) modifies the critical access dental program requiring the commissioner to administer an incentive program that makes payments to dental clinics that meet the following criteria:

1. nonspecialty dental clinics that meet or exceed the annual median ratio of restorative to preventive dental services calculated based on the median ratio of all nonspecialty dental clinics serving public health care program enrollees; and

2. specialty dental clinics that provide services to a fee-for-service or managed care enrollee during the prior year and met or exceeded the annual median for dental providers for that dental specialty serving public health care program enrollees.

Eighty percent of the total payments for this program shall be paid out to nonspecialty dental clinics and 20 percent to specialty dental clinics. The payments made in fiscal year 2016 shall not exceed the total amount paid under the critical access dental program in fiscal year 2015. For fiscal year 2017 and each fiscal year thereafter, the total payments shall be adjusted annually based on the value of the dental services component of the medical services expenditure category of the CPI-U. Payments shall be made no later than April 1 of the year following the fiscal year for which payments are owed.

Section 43 (256B.76, subd. 7) provides for a payment rate increase of one percent for primary care services billed by certain physicians, advanced registered nurse practitioners, and physician assistants.

Section 44 (256B.7625) specifies a minimum payment rate of $140 per visit for public health nurse home visits administered by home visiting programs that meet certain evidence-based models and are identified by the Commissioner of Health as eligible to be implemented under the maternal, infant, and early childhood home visiting program, effective July 1, 2016.

Section 45 (256B.767) specifies that the payment rates for durable medical equipment, prosthetics, orthotics, or supplies on or after July 1, 2015, are not limited to the rates established under Medicare's competitive bidding program.

Section 46 (256B.79) establishes integrated care for high-risk pregnant women.

Subd. 1 defines terms.

Subd. 2 requires the commissioner to implement a pilot program to improve birth outcomes and strengthen early parental resilience for pregnant women who are receiving MA, are at a significantly elevated risk for adverse outcomes of pregnancy, and are in targeted populations.

Subd. 3 requires the commissioner to award grants to qualifying applicants to support interdisciplinary, integrated perinatal care. Requires the grants to be distributed through a request for proposals (RFP) process to a designated lead agency within an entity that has been determined to be a qualified integrated perinatal care collaborative or an entity in the process of meeting the qualifications to become a collaborative.

Subd. 4 specifies that to be eligible for a grant, an entity must show that the entity meets or is in the process of meeting the qualifications established by the commissioner to be a qualified perinatal care collaborative. Specifies the policies, services, and partnerships that an entity must have in place to meet the qualifications to be a collaborative.

Subd. 5 requires a collaborative receiving a grant to develop means to identify and report gaps in the communication, administrative support, and direct care that must be remedied for the collaborative to provide integrated care and enhanced services to targeted populations.

Subd. 6 requires the commissioner to report to the legislature on the status and progress of the pilot program by January 31, 2019.

Subd. 7 specifies that this section expires June 30, 2019.

Sections 47 to 60 make changes to the MinnesotaCare program to comply with federal requirements.

Section 47 (256L.01, subd.3a) defines family in the MinnesotaCare program to comply with federal requirements for the basic health plan (BHP).

Section 48 (256L.01, subd. 5) clarifies the definition of income to mean a household's projected annual income for the applicable year.

Section 49 (256L.03, subd. 5) updates the family deductible cost-sharing requirement by specifying that the family deductible is equal to $2.75 per month per family, and that it will be annually adjusted by the increase in the medical care component of the CPI-U. Also specifies that cost-sharing requirements do not apply to American Indians. The section also gives the commissioner authority to increase co-payments to reduce the actuarial value of the MinnesotaCare benefits to 94 percent.

Section 50 (256L.04, subd. 1a) specifies that a Social Security number is required when applying for MinnesotaCare if required under federal regulations.

Section 51 (256L.04, subd. 1c) clarifies eligibility requirements for MinnesotaCare.

Section 52 (256L.04, subd. 7b) requires the commissioner to adjust the income limits annually on January 1 as provided in federal regulations.

Section 53 (256L.05, subd. 2a) specifies that the commissioner must determine eligibility for each applicable period of eligibility, and if the individual is required to pay a premium, that coverage is only available in each month for which a premium has been paid.

Section 54 (256L.05, subd. 3) clarifies that coverage for American Indians begins the first day of the month following the month in which eligibility is approved.

Section 55 (256L.05, subd. 3a) clarifies that eligibility must be redetermined on an annual basis and that the period of eligibility is the entire calendar year following the year in which eligibility is redetermined. Specifies that beginning in calendar year 2015, eligibility redeterminations shall occur during open enrollment periods for qualified health plans.

Section 56 (256L.05, subd. 4) requires the commissioner to determine an applicant's eligibility for MinnesotaCare no more than 45 days from the date the application was received by the department.

Section 57 (256L.06, subd. 3) specifies that disenrollment for nonpayment of the premium is effective for the calendar month following the months the premium was due, and if disenrolled, an individual may not reenroll prior to the first day of the month following payment of an amount equal to two months' premiums.

Section 58 (256L.11, subd. 7a) specifies that the payment rate for dental services provided on or after January 1, 2016, shall be the rate in effect on December 31, 2015.

Section 59 (256L.121, subd. 1) clarifies a cross-reference.

Section 60 (256L.15, subd. 2) modifies the MinnesotaCare premiums to comply with federal regulations. Specifies that individuals with household incomes below 35 percent of federal poverty guidelines are not required to pay premiums.

Section 61 (297A.70, subd. 7) makes a conforming change to a cross-reference.

Section 62 strikes the current limits on administrative costs paid to managed care plans and county-based purchasing plans.

Section 63 (Laws 2014, Chapter 312, Article 45, subdivision 2) modifies the expiration date of variances from the operating standards for special transportation service issued by the Commissioner of Human Services to new nonemergency medical transportation providers.

Section 64 (Advisory Group on Administrative Efficiency and Regulatory Simplification) requires the Commissioner of Health to convene an advisory group on maximizing administrative efficiency and regulatory simplification in state public health care programs.

Section 65 (**Statewide Opioid Prescribing Improvement Program)** requires the Commissioner of Human Services to report to the legislature by December 1, 2015, any recommendations made by the opioid prescribing work group and steps taken to implement the opioid prescribing improvement program.

Section 66 (Task Force on Health Care Financing) requires the Governor to convene a task force on health care financing to advise the Governor and legislature on strategies that will increase access to and improve the quality of health care for Minnesotans.

Section 67 (Health Disparities Payment Enhancement) requires the Commissioner of Human Services to develop a methodology to pay a higher payment rate for providers and services that takes into account the higher cost, complexity, and resources needed to serve patients and populations who experience the greatest health disparities. The commissioner must submit a report to the legislature by December 15, 2015, that includes recommendations and a proposed methodology for providing a health disparities payment adjustment.

Section 68 (Repealer) repeals the following:

(a) Minnesota Statutes, sections 256.969, subd. 30 (payment for births); and 256B.69, subd. 32 (initiatives to reduce incidence of low birth weight), effective July 1, 2015.

(b) Minnesota Statutes, sections 256L.02, subd. 3 (financial management for

MinnesotaCare); and 256L.05, subd. 1b (MinnesotaCare enrollment by counties), 1c (open enrollment and streamlined application), 3c (retroactive coverage), and 5 (availability of private insurance), effective the day following final enactment.

(c) Minnesota Statutes, section 256L.11, subd. 7 (MinnesotaCare critical access dental payments), effective July 1, 2015.

(d) Repeals rules requiring providers of special transportation services to conduct driver and criminal record checks

Article 11 – MNsure

Section 1 (15.01) designates the Department of MNsure as a department of the state government.

Section 2 (15A.0815, subd. 2) adds the Commissioner of MNsure to the list of positions in which the salary for the position cannot exceed 133 per cent of the governor's salary.

Section 3 (62A.02, subd. 2) requires health plans offered outside of MNsure and qualified health plans offered through MNsure must receive rate approval from the Commissioner of Commerce no later than 30 days prior to the beginning of the annual open enrollment period for MNsure and final and approved rates must be released to the public at a uniform time no later than 30 days prior to the beginning of the open enrollment period.

Section 4 (62V.02, subd. 2) removes the definition of "board" and changes it to "commissioner" to refer to the Commissioner of MNsure.

Section 5 (62V.02, subd. 2a) adds a definition for consumer assistance partner.

Section 6 (62V.02, subd. 11) changes reference to "board" to "commissioner" in the definition of "qualified health plan."

Section 7 (62V.03) specifies that MNsure is a department of the state government. This section also specifies that MNsure will be subject to audits by the legislative auditor like any other state agency. This section also removes the following references to specific laws that were applicable to the MNsure board: 10A.07 (conflicts of interest); 10A.09 (statements of economic interest); 10A.071 (gifts by lobbyists prohibited). It should be noted that these sections would continue to apply to the commissioner, deputy commissioner, and all assistant commissioners of the Department of MNsure as they apply to all other state agencies. This section also strikes the reference to the open meeting law in chapter 13D (this chapter would apply to MNsure as it currently does for state agencies and departments.) This section also removes the current exemptions to certain sections of chapter 16E (Office of MN.IT Services), requiring the Department of MNsure to comply with all applicable sections of chapter 16E.

Section 8 (62V.041) requires the establishment of an executive steering committee to establish an overall governance structure of the shared eligibility system and to be responsible for the overall governance of the system. The commissioner shall be made up of two members appointed by the Commissioner of Human Services, two members appointed by the Commissioner of MNsure, two members appointed by MN.IT, and one member representing

the counties appointed by the Commissioner of Human Services.

Section 9 (62V.042) requires the commissioner to continue to maintain advisory committees to provide stakeholders the opportunity to advise the commissioner regarding the operation of MNsure. Requires the commissioner to establish an advisory committee to advise the commissioner on the MNsure enrollment process. Clarifies that the advisory committees are subject to the Open Meeting Law and must meet at least on a quarterly basis. This section also changes a number of references from the "board" to the "commissioner."

Section 10 (62V.05) contains the responsibilities and powers of MNsure and makes the following changes:

> **Subdivision 1** changes references from the "board" to the "commissioner." This subdivision also strikes the reference to a separate compensation plan for MNsure's director and managerial staff and the power to establish a budget to MNsure.
>
> **Subdivision 3** strikes obsolete language and changes references. Requires the Commissioners of MNsure and Human Services to establish an insurance producer incentive program to compensate insurance producers for application enrollment assistance for public health care programs.
>
> **Subdivision 4** strikes obsolete language and changes references. It also adds language specifying that entities that are eligible to be navigators may serve as in-person assisters.
>
> **Subdivision 5** strikes obsolete language, changes references, and updates several date references.
>
> **Subdivision 6** changes references. This subdivision also provides details for an appeals process for appellants aggrieved by orders of MNsure.
>
> **Subdivision 7** changes references. This subdivision also strikes the requirement that MNsure establish and maintain an agreement with the Office of MN.IT Services for information technology (IT) services.
>
> **Subdivision 8** changes references and strikes the "super" expedited rulemaking authority the MNsure board had until January 1, 2015. The commissioner will still have the option to use expedited rulemaking process under section 14.389.
>
> **Subdivision 10** changes references and strikes the language that states that MNsure can provide insurance to its employees. (MNsure employees would be state employees.)
>
> **Subdivision 11** prohibits MNsure from certifying, selecting, or offering products and policies of coverage other than qualified health plans or dental plans. This prohibition expires July 1, 2018.

Section 11 (62V.06) changes references and strikes obsolete language.

Section 12 (62V.07) specifies that all funds received by Mnsure shall be deposited in the state government special revenue fund instead of the special revenue fund and strikes the language

appropriating funds in the MNsure account to MNsure for the operations of MNsure. (The result of these changes is that the budget for MNsure would follow the same procedure that is followed by every other state agency, and would require funds for the operation of MNsure be appropriated by the legislature.)

Section 13 (62V.08) changes references.

Section 14 (245.10, subd. 12) requires the commissioner to recover the cost of the background studies on consumer assistance partners through a fee of no more than $20 per study. Appropriates the fee to the commissioner to conduct the background studies.

Section 15 (256.962, subd. 5) specifies that community assistance partners and insurance producers shall be paid an application assistance bonus of $70 for each applicant the partner or producer assists in successfully enrolling in medical assistance or MinnesotaCare. To be eligible for this bonus, an insurance producer must have completed a certification training program administered by the Commissioner of MNsure.

Section 16 (256.692, subd. 9) requires all consumer assistance partners to undergo a background study under chapter 245C.

Section 17 requires the Commissioner of Commerce, in consultation with the Commissioner of MNsure, to develop a proposal to allow small employers the ability to receive the small business health care tax credit when the small employer pays the premiums on behalf of employees enrolled in either a qualified health plan or small group health plan offered outside of MNsure.

Section 18 specifies the transition plan to a new state agency and specifies that section 15.039 applies.

Section 19 repeals sections 62V.04 (governance); 62V.09 (expiration and sunset exclusion); and 62V.11 (Legislative Oversight Committee).