

A bill for an act

relating to human services; making technical changes; chemical and mental health; continuing care; health care; extending certain alternative care pilot projects; amending Minnesota Statutes 2006, sections 245.4874; 252.32, subdivision 3; 253B.185, subdivision 2; 254A.03, subdivision 3; 254A.16, subdivision 2; 254B.02, subdivisions 1, 5; 254B.03, subdivisions 1, 3; 254B.06, subdivision 3; 256.476, subdivisions 1, 2, 3, 4, 5, 10; 256.974; 256.9744, subdivision 1; 256B.0625, subdivisions 13c, 23; 256B.0911, subdivision 4c; 256B.0913, subdivisions 4, 5, 5a, 8, 9, 10, 11, 12, 13, 14; 256B.0919, subdivision 3; 256B.0943, subdivisions 6, 9, 11, 12; 256B.431, subdivisions 1, 3f, 17e; 256D.03, subdivision 4; 256E.35, subdivision 2; 256L.03, subdivision 5; 256L.04, subdivisions 1, 12; Laws 2000, chapter 340, section 19; Laws 2005, chapter 98, article 3, section 25; repealing Minnesota Statutes 2006, sections 252.21; 252.22; 252.23; 252.24; 252.25; 252.261; 252.275, subdivision 5; 254A.02, subdivisions 7, 9, 12, 14, 15, 16; 254A.085; 254A.086; 254A.12; 254A.14; 254A.15; 254A.16, subdivision 5; 254A.175; 254A.18; 256B.0913, subdivisions 5b, 5c, 5d, 5e, 5f, 5g, 5h; 256J.561, subdivision 1; 256J.62, subdivision 9; 256J.65; Minnesota Rules, part 9503.0035, subpart 2.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

ARTICLE 1

CHEMICAL AND MENTAL HEALTH

Section 1. Minnesota Statutes 2006, section 245.4874, is amended to read:

245.4874 DUTIES OF COUNTY BOARD.

(a) The county board must:

(1) develop a system of affordable and locally available children's mental health services according to sections 245.487 to 245.4887;

(2) establish a mechanism providing for interagency coordination as specified in section 245.4875, subdivision 6;

(3) consider the assessment of unmet needs in the county as reported by the local children's mental health advisory council under section 245.4875, subdivision 5, paragraph (b), clause (3). The county shall provide, upon request of the local children's mental health advisory council, readily available data to assist in the determination of unmet needs;

(4) assure that parents and providers in the county receive information about how to gain access to services provided according to sections 245.487 to 245.4887;

(5) coordinate the delivery of children's mental health services with services provided by social services, education, corrections, health, and vocational agencies to improve the availability of mental health services to children and the cost-effectiveness of their delivery;

(6) assure that mental health services delivered according to sections 245.487 to 245.4887 are delivered expeditiously and are appropriate to the child's diagnostic assessment and individual treatment plan;

(7) provide the community with information about predictors and symptoms of emotional disturbances and how to access children's mental health services according to sections 245.4877 and 245.4878;

(8) provide for case management services to each child with severe emotional disturbance according to sections 245.486; 245.4871, subdivisions 3 and 4; and 245.4881, subdivisions 1, 3, and 5;

(9) provide for screening of each child under section 245.4885 upon admission to a residential treatment facility, acute care hospital inpatient treatment, or informal admission to a regional treatment center;

(10) prudently administer grants and purchase-of-service contracts that the county board determines are necessary to fulfill its responsibilities under sections 245.487 to 245.4887;

(11) assure that mental health professionals, mental health practitioners, and case managers employed by or under contract to the county to provide mental health services are qualified under section 245.4871;

(12) assure that children's mental health services are coordinated with adult mental health services specified in sections 245.461 to 245.486 so that a continuum of mental health services is available to serve persons with mental illness, regardless of the person's age;

(13) assure that culturally informed mental health consultants are used as necessary to assist the county board in assessing and providing appropriate treatment for children of cultural or racial minority heritage; and

(14) consistent with section 245.486, arrange for or provide a children's mental health screening to a child receiving child protective services or a child in out-of-home placement, a child for whom parental rights have been terminated, a child found to be delinquent, and a child found to have committed a juvenile petty offense for the third or subsequent time, unless a screening or diagnostic assessment has been performed within the previous 180 days, or the child is currently under the care of a mental health professional. The court or county agency must notify a parent or guardian whose parental rights have not been terminated of the potential mental health screening and the option to prevent the screening by notifying the court or county agency in writing. The screening shall be conducted with a screening instrument approved by the commissioner of human services according to criteria that are updated and issued annually to ensure that approved screening instruments are valid and useful for child welfare and juvenile justice populations, and shall be conducted by a mental health practitioner as defined in section 245.4871, subdivision 26, or a probation officer or local social services agency staff person who is trained in the use of the screening instrument. Training in the use of the instrument shall include training in the administration of the instrument, the interpretation of its validity given the child's current circumstances, the state and federal data practices laws and confidentiality standards, the parental consent requirement, and providing respect for families and cultural values. If the screen indicates a need for assessment, the child's family, or if the family lacks mental health insurance, the local social services agency, in consultation with the child's family, shall have conducted a diagnostic assessment, including a functional assessment, as defined in section 245.4871. The administration of the screening shall safeguard the privacy of children receiving the screening and their families and shall comply with the Minnesota Government Data Practices Act, chapter 13, and the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Screening results shall be considered private data and the commissioner shall not collect individual screening results.

(b) When the county board refers clients to providers of children's therapeutic services and supports under section 256B.0943, the county board must clearly identify the desired services components not covered under section 256B.0943 and identify the reimbursement source for those requested services, the method of payment, and the payment rate to the provider.

Sec. 2. Minnesota Statutes 2006, section 252.32, subdivision 3, is amended to read:

Subd. 3. **Amount of support grant; use.** Support grant amounts shall be determined by the county social service agency. Services and items purchased with a support grant must:

(1) be over and above the normal costs of caring for the dependent if the dependent did not have a disability;

(2) be directly attributable to the dependent's disabling condition; and

(3) enable the family to delay or prevent the out-of-home placement of the dependent.

The design and delivery of services and items purchased under this section must ~~suit the dependent's chronological age~~ and be provided in the least restrictive environment possible, consistent with the needs identified in the individual service plan.

Items and services purchased with support grants must be those for which there are no other public or private funds available to the family. Fees assessed to parents for health or human services that are funded by federal, state, or county dollars are not reimbursable through this program.

In approving or denying applications, the county shall consider the following factors:

(1) the extent and areas of the functional limitations of the disabled child;

(2) the degree of need in the home environment for additional support; and

(3) the potential effectiveness of the grant to maintain and support the person in the family environment.

The maximum monthly grant amount shall be \$250 per eligible dependent, or \$3,000 per eligible dependent per state fiscal year, within the limits of available funds.

The county social service agency may consider the dependent's supplemental security income in determining the amount of the support grant.

Any adjustments to their monthly grant amount must be based on the needs of the family and funding availability.

Sec. 3. Minnesota Statutes 2006, section 253B.185, subdivision 2, is amended to read:

Subd. 2. **Transfer to correctional facility.** (a) If a person has been committed under this section and later is committed to the custody of the commissioner of corrections for any reason, including but not limited to, being sentenced for a crime or revocation of the person's supervised release or conditional release under section 244.05, ~~609.108, subdivision 6,~~ or 609.109, subdivision 7, the person shall be transferred to a facility designated by the commissioner of corrections without regard to the procedures provided in section 253B.18.

(b) If a person is committed under this section after a commitment to the commissioner of corrections, the person shall first serve the sentence in a facility

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designated by the commissioner of corrections. After the person has served the sentence, the person shall be transferred to a treatment program designated by the commissioner of human services.

Sec. 4. Minnesota Statutes 2006, section 254A.03, subdivision 3, is amended to read:

Subd. 3. **Rules for chemical dependency care.** The commissioner of human services shall establish by rule criteria to be used in determining the appropriate level of chemical dependency care, ~~whether outpatient, inpatient or short-term treatment programs,~~ for each recipient of public assistance seeking treatment for alcohol or other drug dependency and abuse problems. ~~The criteria shall address, at least, the family relationship, past treatment history, medical or physical problems, arrest record, and employment situation.~~

Sec. 5. Minnesota Statutes 2006, section 254A.16, subdivision 2, is amended to read:

Subd. 2. **Program and service guidelines.** (a) The commissioner shall provide program and service guidelines and technical assistance to the county boards in carrying out services authorized under ~~sections~~ section 254A.08, ~~254A.12, 254A.14, and their responsibilities under chapter 256E.~~

(b) The commissioner shall recommend to the governor means of improving the efficiency and effectiveness of comprehensive program services in the state and maximizing the use of nongovernmental funds for providing comprehensive programs.

Sec. 6. Minnesota Statutes 2006, section 254B.02, subdivision 1, is amended to read:

Subdivision 1. **Chemical dependency treatment allocation.** The chemical dependency funds appropriated for allocation shall be placed in a special revenue account. The commissioner shall annually transfer funds from the chemical dependency fund to pay for operation of the drug and alcohol abuse normative evaluation system and to pay for all costs incurred by adding two positions for licensing of chemical dependency treatment and rehabilitation programs located in hospitals for which funds are not otherwise appropriated. ~~For each year of the biennium ending June 30, 1999, the commissioner shall allocate funds to the American Indian chemical dependency tribal account for treatment of American Indians by eligible vendors under section 254B.05, equal to the amount allocated in fiscal year 1997. Six percent of the remaining money must be reserved for tribal allocation under section 254B.09, subdivisions 4 and 5.~~ The commissioner shall annually divide the money available in the chemical dependency fund that is not held in reserve by counties from a previous allocation, or allocated to the American Indian

chemical dependency tribal account. Six percent of the remaining money must be reserved for the nonreservation American Indian chemical dependency allocation for treatment of American Indians by eligible vendors under section 254B.05, subdivision 1. The remainder of the money must be allocated among the counties according to the following formula, using state demographer data and other data sources determined by the commissioner:

(a) For purposes of this formula, American Indians and children under age 14 are subtracted from the population of each county to determine the restricted population.

(b) The amount of chemical dependency fund expenditures for entitled persons for services not covered by prepaid plans governed by section 256B.69 in the previous year is divided by the amount of chemical dependency fund expenditures for entitled persons for all services to determine the proportion of exempt service expenditures for each county.

(c) The prepaid plan months of eligibility is multiplied by the proportion of exempt service expenditures to determine the adjusted prepaid plan months of eligibility for each county.

(d) The adjusted prepaid plan months of eligibility is added to the number of restricted population fee for service months of eligibility for the Minnesota family investment program, general assistance, and medical assistance and divided by the county restricted population to determine county per capita months of covered service eligibility.

(e) The number of adjusted prepaid plan months of eligibility for the state is added to the number of fee for service months of eligibility for the Minnesota family investment program, general assistance, and medical assistance for the state restricted population and divided by the state restricted population to determine state per capita months of covered service eligibility.

(f) The county per capita months of covered service eligibility is divided by the state per capita months of covered service eligibility to determine the county welfare caseload factor.

(g) The median married couple income for the most recent three-year period available for the state is divided by the median married couple income for the same period for each county to determine the income factor for each county.

(h) The county restricted population is multiplied by the sum of the county welfare caseload factor and the county income factor to determine the adjusted population.

(i) \$15,000 shall be allocated to each county.

(j) The remaining funds shall be allocated proportional to the county adjusted population.

7.1 Sec. 7. Minnesota Statutes 2006, section 254B.02, subdivision 5, is amended to read:

7.2 Subd. 5. **Administrative adjustment.** The commissioner may make payments to
7.3 local agencies from money allocated under this section to support administrative activities
7.4 under sections 254B.03 and 254B.04. The administrative payment must not exceed
7.5 five percent of the first \$50,000, four percent of the next \$50,000, and three percent of
7.6 the remaining payments for services from the allocation. ~~Twenty-five percent of the~~
7.7 ~~administrative allowance shall be advanced at the beginning of each quarter, based on~~
7.8 ~~the payments for services made in the most recent quarter for which data is available.~~
7.9 ~~Adjustment of any overestimate or underestimate based on actual expenditures shall be~~
7.10 ~~made by the state agency by adjusting the administrative allowance for any succeeding~~
7.11 ~~quarter.~~

7.12 Sec. 8. Minnesota Statutes 2006, section 254B.03, subdivision 1, is amended to read:

7.13 Subdivision 1. **Local agency duties.** (a) Every local agency shall provide chemical
7.14 dependency services to persons residing within its jurisdiction who meet criteria
7.15 established by the commissioner for placement in a chemical dependency residential or
7.16 nonresidential treatment service. Chemical dependency money must be administered
7.17 by the local agencies according to law and rules adopted by the commissioner under
7.18 sections 14.001 to 14.69.

7.19 (b) In order to contain costs, the county board shall, with the approval of the
7.20 commissioner of human services, select eligible vendors of chemical dependency services
7.21 who can provide economical and appropriate treatment. Unless the local agency is a social
7.22 services department directly administered by a county or human services board, the local
7.23 agency shall not be an eligible vendor under section 254B.05. The commissioner may
7.24 approve proposals from county boards to provide services in an economical manner or to
7.25 control utilization, with safeguards to ensure that necessary services are provided. If a
7.26 county implements a demonstration or experimental medical services funding plan, the
7.27 commissioner shall transfer the money as appropriate. If a county selects a vendor located
7.28 in another state, the county shall ensure that the vendor is in compliance with the rules
7.29 governing licensure of programs located in the state.

7.30 ~~(c) The calendar year 2002 rate for vendors may not increase more than three~~
7.31 ~~percent above the rate approved in effect on January 1, 2001. The calendar year 2003~~
7.32 ~~rate for vendors may not increase more than three percent above the rate in effect on~~
7.33 ~~January 1, 2002. The calendar years 2004 and 2005 rates may not exceed the rate in~~
7.34 ~~effect on January 1, 2003.~~

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~~(d)~~ (c) A culturally specific vendor that provides assessments under a variance under Minnesota Rules, part 9530.6610, shall be allowed to provide assessment services to persons not covered by the variance.

Sec. 9. Minnesota Statutes 2006, section 254B.03, subdivision 3, is amended to read:

Subd. 3. **Local agencies to pay state for county share.** ~~Local agencies shall submit invoices to the state on forms supplied by the commissioner and according to procedures established by the commissioner. Local agencies shall pay the state for the county share of the invoiced services authorized by the local agency. Payments shall be made at the beginning of each month for services provided in the previous month. The commissioner shall bill the county monthly for services, based on the most recent month for which expenditure information is available. Adjustment of any overestimate or underestimate based on actual expenditures shall be made by the state agency by adjusting the estimate for any succeeding month.~~

Sec. 10. Minnesota Statutes 2006, section 254B.06, subdivision 3, is amended to read:

Subd. 3. **Payment; denial.** The commissioner shall pay eligible vendors for placements made by local agencies under section 254B.03, subdivision 1, and placements by tribal designated agencies according to section 254B.09. The commissioner may reduce or deny payment of the state share when services are not provided according to the placement criteria established by the commissioner. The commissioner may pay for all or a portion of improper county chemical dependency placements and bill the county for the entire payment made when the placement did not comply with criteria established by the commissioner. The commissioner may make payments to vendors and charge the county 100 percent of the payments if documentation of a county approved placement is received more than 30 working days, exclusive of weekends and holidays, after the date services began; ~~or if the county approved invoice is received by the commissioner more than 120 days after the last date of service provided.~~ The commissioner shall not pay vendors until private insurance company claims have been settled.

Sec. 11. Minnesota Statutes 2006, section 256B.0943, subdivision 6, is amended to read:

Subd. 6. **Provider entity clinical infrastructure requirements.** (a) To be an eligible provider entity under this section, a provider entity must have a clinical infrastructure that utilizes diagnostic assessment, an individualized treatment plan, service delivery, and individual treatment plan review that are culturally competent,

child-centered, and family-driven to achieve maximum benefit for the client. The provider entity must review and update the clinical policies and procedures every three years and must distribute the policies and procedures to staff initially and upon each subsequent update.

(b) The clinical infrastructure written policies and procedures must include policies and procedures for:

(1) providing or obtaining a client's diagnostic assessment that identifies acute and chronic clinical disorders, co-occurring medical conditions, sources of psychological and environmental problems, and a functional assessment. The functional assessment must clearly summarize the client's individual strengths and needs;

(2) developing an individual treatment plan that is:

(i) based on the information in the client's diagnostic assessment;

(ii) developed no later than the end of the first psychotherapy session after the completion of the client's diagnostic assessment by the mental health professional who provides the client's psychotherapy;

(iii) developed through a child-centered, family-driven planning process that identifies service needs and individualized, planned, and culturally appropriate interventions that contain specific treatment goals and objectives for the client and the client's family or foster family;

(iv) reviewed at least once every 90 days and revised, if necessary; and

(v) signed by the client or, if appropriate, by the client's parent or other person authorized by statute to consent to mental health services for the client;

(3) developing an individual behavior plan that documents services to be provided by the mental health behavioral aide. The individual behavior plan must include:

(i) detailed instructions on the service to be provided;

(ii) time allocated to each service;

(iii) methods of documenting the child's behavior;

(iv) methods of monitoring the child's progress in reaching objectives; and

(v) goals to increase or decrease targeted behavior as identified in the individual treatment plan;

(4) clinical supervision of the mental health practitioner and mental health behavioral aide. A mental health professional must document the clinical supervision the professional provides by cosigning individual treatment plans and making entries in the client's record on supervisory activities. Clinical supervision does not include the authority to make or terminate court-ordered placements of the child. A clinical supervisor must be available for urgent consultation as required by the individual client's needs or the situation. Clinical

10.1 supervision may occur individually or in a small group to discuss treatment and review
10.2 progress toward goals. The focus of clinical supervision must be the client's treatment
10.3 needs and progress and the mental health practitioner's or behavioral aide's ability to
10.4 provide services;

10.5 (4a) CTSS certified provider entities providing day treatment programs must meet
10.6 the conditions in items (i) to (iii):

10.7 (i) the ~~provider~~ supervisor must be present and available on the premises more
10.8 than 50 percent of the time in a five-working-day period during which the supervisee is
10.9 providing a mental health service;

10.10 (ii) the diagnosis and the client's individual treatment plan or a change in the
10.11 diagnosis or individual treatment plan must be made by or reviewed, approved, and signed
10.12 by the ~~provider~~ supervisor; and

10.13 (iii) every 30 days, the supervisor must review and sign the record of the client's care
10.14 for all activities in the preceding 30-day period;

10.15 (4b) for all other services provided under CTSS, clinical supervision standards
10.16 provided in items (i) to (iii) must be used:

10.17 (i) medical assistance shall reimburse a mental health practitioner who maintains a
10.18 consulting relationship with a mental health professional who accepts full professional
10.19 responsibility and is present on site for at least one observation during the first 12 hours
10.20 in which the mental health practitioner provides the individual, family, or group skills
10.21 training to the child or the child's family;

10.22 (ii) thereafter, the mental health professional is required to be present on site for
10.23 observation as clinically appropriate when the mental health practitioner is providing
10.24 individual, family, or group skills training to the child or the child's family; and

10.25 (iii) the observation must be a minimum of one clinical unit. The on-site presence of
10.26 the mental health professional must be documented in the child's record and signed by the
10.27 mental health professional who accepts full professional responsibility;

10.28 (5) providing direction to a mental health behavioral aide. For entities that employ
10.29 mental health behavioral aides, the clinical supervisor must be employed by the provider
10.30 entity or other certified children's therapeutic supports and services provider entity to
10.31 ensure necessary and appropriate oversight for the client's treatment and continuity
10.32 of care. The mental health professional or mental health practitioner giving direction
10.33 must begin with the goals on the individualized treatment plan, and instruct the mental
10.34 health behavioral aide on how to construct therapeutic activities and interventions that
10.35 will lead to goal attainment. The professional or practitioner giving direction must also
10.36 instruct the mental health behavioral aide about the client's diagnosis, functional status,

11.1 and other characteristics that are likely to affect service delivery. Direction must also
11.2 include determining that the mental health behavioral aide has the skills to interact with
11.3 the client and the client's family in ways that convey personal and cultural respect and
11.4 that the aide actively solicits information relevant to treatment from the family. The aide
11.5 must be able to clearly explain the activities the aide is doing with the client and the
11.6 activities' relationship to treatment goals. Direction is more didactic than is supervision
11.7 and requires the professional or practitioner providing it to continuously evaluate the
11.8 mental health behavioral aide's ability to carry out the activities of the individualized
11.9 treatment plan and the individualized behavior plan. When providing direction, the
11.10 professional or practitioner must:

11.11 (i) review progress notes prepared by the mental health behavioral aide for accuracy
11.12 and consistency with diagnostic assessment, treatment plan, and behavior goals and the
11.13 professional or practitioner must approve and sign the progress notes;

11.14 (ii) identify changes in treatment strategies, revise the individual behavior plan,
11.15 and communicate treatment instructions and methodologies as appropriate to ensure
11.16 that treatment is implemented correctly;

11.17 (iii) demonstrate family-friendly behaviors that support healthy collaboration among
11.18 the child, the child's family, and providers as treatment is planned and implemented;

11.19 (iv) ensure that the mental health behavioral aide is able to effectively communicate
11.20 with the child, the child's family, and the provider; and

11.21 (v) record the results of any evaluation and corrective actions taken to modify the
11.22 work of the mental health behavioral aide;

11.23 (6) providing service delivery that implements the individual treatment plan and
11.24 meets the requirements under subdivision 9; and

11.25 (7) individual treatment plan review. The review must determine the extent to which
11.26 the services have met the goals and objectives in the previous treatment plan. The review
11.27 must assess the client's progress and ensure that services and treatment goals continue to
11.28 be necessary and appropriate to the client and the client's family or foster family. Revision
11.29 of the individual treatment plan does not require a new diagnostic assessment unless the
11.30 client's mental health status has changed markedly. The updated treatment plan must be
11.31 signed by the client, if appropriate, and by the client's parent or other person authorized by
11.32 statute to give consent to the mental health services for the child.

11.33 Sec. 12. Minnesota Statutes 2006, section 256B.0943, subdivision 9, is amended to
11.34 read:

Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a certified provider entity must ensure that:

(1) each individual provider's caseload size permits the provider to deliver services to both clients with severe, complex needs and clients with less intensive needs. The provider's caseload size should reasonably enable the provider to play an active role in service planning, monitoring, and delivering services to meet the client's and client's family's needs, as specified in each client's individual treatment plan;

(2) site-based programs, including day treatment and preschool programs, provide staffing and facilities to ensure the client's health, safety, and protection of rights, and that the programs are able to implement each client's individual treatment plan;

(3) a day treatment program is provided to a group of clients by a multidisciplinary team under the clinical supervision of a mental health professional. The day treatment program must be provided in and by: (i) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55; (ii) a community mental health center under section 245.62; and (iii) an entity that is under contract with the county board to operate a program that meets the requirements of sections 245.4712, subdivision 2, and 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment program must stabilize the client's mental health status while developing and improving the client's independent living and socialization skills. The goal of the day treatment program must be to reduce or relieve the effects of mental illness and provide training to enable the client to live in the community. The program must be available at least one day a week for a ~~minimum~~ three-hour time block. The three-hour time block must include at least one hour, but no more than two hours, of individual or group psychotherapy. The remainder of the three-hour time block may include recreation therapy, socialization therapy, or independent living skills therapy, but only if the therapies are included in the client's individual treatment plan. Day treatment programs are not part of inpatient or residential treatment services; and

(4) a preschool program is a structured treatment program offered to a child who is at least 33 months old, but who has not yet reached the first day of kindergarten, by a preschool multidisciplinary team in a day program licensed under Minnesota Rules, parts 9503.0005 to 9503.0175. The program must be available at least one day a week for a minimum two-hour time block. The structured treatment program may include individual or group psychotherapy and recreation therapy, socialization therapy, or independent living skills therapy, if included in the client's individual treatment plan.

13.1 (b) A provider entity must deliver the service components of children's therapeutic
13.2 services and supports in compliance with the following requirements:

13.3 (1) individual, family, and group psychotherapy must be delivered as specified in
13.4 Minnesota Rules, part 9505.0323;

13.5 (2) individual, family, or group skills training must be provided by a mental health
13.6 professional or a mental health practitioner who has a consulting relationship with a
13.7 mental health professional who accepts full professional responsibility for the training;

13.8 (3) crisis assistance must be time-limited and designed to resolve or stabilize crisis
13.9 through arrangements for direct intervention and support services to the child and the
13.10 child's family. Crisis assistance must utilize resources designed to address abrupt or
13.11 substantial changes in the functioning of the child or the child's family as evidenced by
13.12 a sudden change in behavior with negative consequences for well being, a loss of usual
13.13 coping mechanisms, or the presentation of danger to self or others;

13.14 (4) medically necessary services that are provided by a mental health behavioral
13.15 aide must be designed to improve the functioning of the child and support the family in
13.16 activities of daily and community living. A mental health behavioral aide must document
13.17 the delivery of services in written progress notes. The mental health behavioral aide
13.18 must implement goals in the treatment plan for the child's emotional disturbance that
13.19 allow the child to acquire developmentally and therapeutically appropriate daily living
13.20 skills, social skills, and leisure and recreational skills through targeted activities. These
13.21 activities may include:

13.22 (i) assisting a child as needed with skills development in dressing, eating, and
13.23 toileting;

13.24 (ii) assisting, monitoring, and guiding the child to complete tasks, including
13.25 facilitating the child's participation in medical appointments;

13.26 (iii) observing the child and intervening to redirect the child's inappropriate behavior;

13.27 (iv) assisting the child in using age-appropriate self-management skills as related
13.28 to the child's emotional disorder or mental illness, including problem solving, decision
13.29 making, communication, conflict resolution, anger management, social skills, and
13.30 recreational skills;

13.31 (v) implementing deescalation techniques as recommended by the mental health
13.32 professional;

13.33 (vi) implementing any other mental health service that the mental health professional
13.34 has approved as being within the scope of the behavioral aide's duties; or

14.1 (vii) assisting the parents to develop and use parenting skills that help the child
14.2 achieve the goals outlined in the child's individual treatment plan or individual behavioral
14.3 plan. Parenting skills must be directed exclusively to the child's treatment; and

14.4 (5) direction of a mental health behavioral aide must include the following:

14.5 (i) a total of one hour of on-site observation by a mental health professional during
14.6 the first 12 hours of service provided to a child;

14.7 (ii) ongoing on-site observation by a mental health professional or mental health
14.8 practitioner for at least a total of one hour during every 40 hours of service provided
14.9 to a child; and

14.10 (iii) immediate accessibility of the mental health professional or mental health
14.11 practitioner to the mental health behavioral aide during service provision.

14.12 Sec. 13. Minnesota Statutes 2006, section 256B.0943, subdivision 11, is amended to
14.13 read:

14.14 Subd. 11. **Documentation and billing.** (a) A provider entity must document the
14.15 services it provides under this section. The provider entity must ensure that the entity's
14.16 documentation standards meet the requirements of federal and state laws. Services billed
14.17 under this section that are not documented according to this subdivision shall be subject to
14.18 monetary recovery by the commissioner. The provider entity may not bill for anything
14.19 other than direct service time.

14.20 (b) An individual mental health provider must promptly document the following
14.21 in a client's record after providing services to the client:

14.22 (1) each occurrence of the client's mental health service, including the date, type,
14.23 length, and scope of the service;

14.24 (2) the name of the person who gave the service;

14.25 (3) contact made with other persons interested in the client, including representatives
14.26 of the courts, corrections systems, or schools. The provider must document the name
14.27 and date of each contact;

14.28 (4) any contact made with the client's other mental health providers, case manager,
14.29 family members, primary caregiver, legal representative, or the reason the provider did
14.30 not contact the client's family members, primary caregiver, or legal representative, if
14.31 applicable; and

14.32 (5) required clinical supervision, as appropriate.

14.33 Sec. 14. Minnesota Statutes 2006, section 256B.0943, subdivision 12, is amended to
14.34 read:

Subd. 12. **Excluded services.** The following services are not eligible for medical assistance payment as children's therapeutic services and supports:

(1) service components of children's therapeutic services and supports simultaneously provided by more than one provider entity unless prior authorization is obtained;

(2) children's therapeutic services and supports provided in violation of medical assistance policy in Minnesota Rules, part 9505.0220;

(3) mental health behavioral aide services provided by a personal care assistant who is not qualified as a mental health behavioral aide and employed by a certified children's therapeutic services and supports provider entity;

(4) service components of CTSS that are the responsibility of a residential or program license holder, including foster care providers under the terms of a service agreement or administrative rules governing licensure; ~~and~~

(5) adjunctive activities that may be offered by a provider entity but are not otherwise covered by medical assistance, including:

(i) a service that is primarily recreation oriented or that is provided in a setting that is not medically supervised. This includes sports activities, exercise groups, activities such as craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours;

(ii) a social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the client's emotional disturbance;

(iii) consultation with other providers or service agency staff about the care or progress of a client;

(iv) prevention or education programs provided to the community; and

(v) treatment for clients with primary diagnoses of alcohol or other drug abuse; and

(6) activities that are not direct service time.

ARTICLE 2 CONTINUING CARE

Section 1. Minnesota Statutes 2006, section 256.476, subdivision 1, is amended to read:

Subdivision 1. **Purpose and goals.** The commissioner of human services shall establish a consumer support grant program for individuals with functional limitations and their families who wish to purchase and secure their own supports. ~~The commissioner and local agencies shall jointly develop an implementation plan which must include a way to resolve the issues related to county liability.~~ The program shall:

(1) make support grants available to individuals or families as an effective alternative to the ~~developmental disability~~ family support program, personal care attendant services, home health aide services, and private duty nursing services;

(2) provide consumers more control, flexibility, and responsibility over their services and supports;

(3) promote local program management and decision making; and

(4) encourage the use of informal and typical community supports.

Sec. 2. Minnesota Statutes 2006, section 256.476, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them:

(a) "County board" means the county board of commissioners for the county of financial responsibility as defined in section 256G.02, subdivision 4, or its designated representative. When a human services board has been established under sections 402.01 to 402.10, it shall be considered the county board for the purposes of this section.

(b) "Family" means the person's birth parents, adoptive parents or stepparents, siblings or stepsiblings, children or stepchildren, grandparents, grandchildren, niece, nephew, aunt, uncle, or spouse. For the purposes of this section, a family member is at least 18 years of age.

(c) "Functional limitations" means the long-term inability to perform an activity or task in one or more areas of major life activity, including self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living. For the purpose of this section, the inability to perform an activity or task results from a mental, emotional, psychological, sensory, or physical disability, condition, or illness.

(d) "Informed choice" means a voluntary decision made by the person ~~or~~, the person's legal representative, or other authorized representative after becoming familiarized with the alternatives to:

(1) select a preferred alternative from a number of feasible alternatives;

(2) select an alternative which may be developed in the future; and

(3) refuse any or all alternatives.

(e) "Local agency" means the local agency authorized by the county board or, for counties not participating in the consumer grant program by July 1, 2002, the commissioner, to carry out the provisions of this section.

(f) "Person" or "persons" means a person or persons meeting the eligibility criteria in subdivision 3.

(g) "Authorized representative" means an individual designated by the person or their legal representative to act on their behalf. This individual may be a family member, guardian, representative payee, or other individual designated by the person or their legal representative, if any, to assist in purchasing and arranging for supports. For the purposes of this section, an authorized representative is at least 18 years of age.

(h) "Screening" means the screening of a person's service needs under sections 256B.0911 and 256B.092.

(i) "Supports" means services, care, aids, environmental modifications, or assistance purchased by the person ~~or the person's family~~, the person's legal representative, or other authorized representative. Examples of supports include respite care, assistance with daily living, and assistive technology. For the purpose of this section, notwithstanding the provisions of section 144A.43, supports purchased under the consumer support program are not considered home care services.

(j) "Program of origination" means the program the individual transferred from when approved for the consumer support grant program.

Sec. 3. Minnesota Statutes 2006, section 256.476, subdivision 3, is amended to read:

Subd. 3. **Eligibility to apply for grants.** (a) A person is eligible to apply for a consumer support grant if the person meets all of the following criteria:

(1) the person is eligible for and has been approved to receive services under medical assistance as determined under sections 256B.055 and 256B.056 or the person has been approved to receive a grant under the ~~developmental disability~~ family support program under section 252.32;

(2) the person is able to direct and purchase the person's own care and supports, or the person has a family member, legal representative, or other authorized representative who can purchase and arrange supports on the person's behalf;

(3) the person has functional limitations, requires ongoing supports to live in the community, and is at risk of or would continue institutionalization without such supports; and

(4) the person will live in a home. For the purpose of this section, "home" means the person's own home or home of a person's family member. These homes are natural home settings and are not licensed by the Department of Health or Human Services.

(b) Persons may not concurrently receive a consumer support grant if they are:

(1) receiving personal care attendant and home health aide services, or private duty nursing under section 256B.0625; a ~~developmental disability~~ family support grant; or alternative care services under section 256B.0913; or

18.1 (2) residing in an institutional or congregate care setting.

18.2 (c) A person or person's family receiving a consumer support grant shall not be
18.3 charged a fee or premium by a local agency for participating in the program.

18.4 (d) Individuals receiving home and community-based waivers under United States
18.5 Code, title 42, section 1396h(c), are not eligible for the consumer support grant, except
18.6 for individuals receiving consumer support grants before July 1, 2003, as long as other
18.7 eligibility criteria are met.

18.8 (e) The commissioner shall establish a budgeted appropriation each fiscal year
18.9 for the consumer support grant program. The number of individuals participating in
18.10 the program will be adjusted so the total amount allocated to counties does not exceed
18.11 the amount of the budgeted appropriation. The budgeted appropriation will be adjusted
18.12 annually to accommodate changes in demand for the consumer support grants.

18.13 Sec. 4. Minnesota Statutes 2006, section 256.476, subdivision 4, is amended to read:

18.14 Subd. 4. **Support grants; criteria and limitations.** (a) A county board may
18.15 choose to participate in the consumer support grant program. If a county has not chosen
18.16 to participate by July 1, 2002, the commissioner shall contract with another county or
18.17 other entity to provide access to residents of the nonparticipating county who choose
18.18 the consumer support grant option. The commissioner shall notify the county board
18.19 in a county that has declined to participate of the commissioner's intent to enter into
18.20 a contract with another county or other entity at least 30 days in advance of entering
18.21 into the contract. The local agency shall establish written procedures and criteria to
18.22 determine the amount and use of support grants. These procedures must include, at least,
18.23 the availability of respite care, assistance with daily living, and adaptive aids. The local
18.24 agency may establish monthly or annual maximum amounts for grants and procedures
18.25 where exceptional resources may be required to meet the health and safety needs of the
18.26 person on a time-limited basis, however, the total amount awarded to each individual may
18.27 not exceed the limits established in subdivision 11.

18.28 (b) Support grants to a person ~~or a person's family~~, a person's legal representative,
18.29 or other authorized representative will be provided through a monthly subsidy payment
18.30 and be in the form of cash, voucher, or direct county payment to vendor. Support grant
18.31 amounts must be determined by the local agency. Each service and item purchased with a
18.32 support grant must meet all of the following criteria:

18.33 (1) it must be over and above the normal cost of caring for the person if the person
18.34 did not have functional limitations;

18.35 (2) it must be directly attributable to the person's functional limitations;

(3) it must enable the person ~~or the person's family~~, a person's legal representative, or other authorized representative to delay or prevent out-of-home placement of the person; and

(4) it must be consistent with the needs identified in the service agreement, when applicable.

(c) Items and services purchased with support grants must be those for which there are no other public or private funds available to the person ~~or the person's family~~, a person's legal representative, or other authorized representative. Fees assessed to the person or the person's family for health and human services are not reimbursable through the grant.

(d) In approving or denying applications, the local agency shall consider the following factors:

(1) the extent and areas of the person's functional limitations;

(2) the degree of need in the home environment for additional support; and

(3) the potential effectiveness of the grant to maintain and support the person in the family environment or the person's own home.

(e) At the time of application to the program or screening for other services, the person ~~or the person's family~~, a person's legal representative, or other authorized representative shall be provided sufficient information to ensure an informed choice of alternatives by the person, the person's legal representative, or other authorized representative, if any, ~~or the person's family~~. The application shall be made to the local agency and shall specify the needs of the person and family, the form and amount of grant requested, the items and services to be reimbursed, and evidence of eligibility for medical assistance.

(f) Upon approval of an application by the local agency and agreement on a support plan for the person or person's family, the local agency shall make grants to the person or the person's family. The grant shall be in an amount for the direct costs of the services or supports outlined in the service agreement.

(g) Reimbursable costs shall not include costs for resources already available, such as special education classes, day training and habilitation, case management, other services to which the person is entitled, medical costs covered by insurance or other health programs, or other resources usually available at no cost to the person or the person's family.

(h) The state of Minnesota, the county boards participating in the consumer support grant program, or the agencies acting on behalf of the county boards in the implementation and administration of the consumer support grant program shall not be liable for damages, injuries, or liabilities sustained through the purchase of support by the individual, the individual's family, or the authorized representative under this section

with funds received through the consumer support grant program. Liabilities include but are not limited to: workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA). For purposes of this section, participating county boards and agencies acting on behalf of county boards are exempt from the provisions of section 268.04.

Sec. 5. Minnesota Statutes 2006, section 256.476, subdivision 5, is amended to read:

Subd. 5. **Reimbursement, allocations, and reporting.** (a) For the purpose of transferring persons to the consumer support grant program from the ~~developmental disability~~ family support program and personal care assistant services, home health aide services, or private duty nursing services, the amount of funds transferred by the commissioner between the ~~developmental disability~~ family support program account, the medical assistance account, or the consumer support grant account shall be based on each county's participation in transferring persons to the consumer support grant program from those programs and services.

(b) At the beginning of each fiscal year, county allocations for consumer support grants shall be based on:

(1) the number of persons to whom the county board expects to provide consumer supports grants;

(2) their eligibility for current program and services;

(3) the amount of nonfederal dollars allowed under subdivision 11; and

(4) projected dates when persons will start receiving grants. County allocations shall be adjusted periodically by the commissioner based on the actual transfer of persons or service openings, and the nonfederal dollars associated with those persons or service openings, to the consumer support grant program.

(c) The amount of funds transferred by the commissioner from the medical assistance account for an individual may be changed if it is determined by the county or its agent that the individual's need for support has changed.

(d) The authority to utilize funds transferred to the consumer support grant account for the purposes of implementing and administering the consumer support grant program will not be limited or constrained by the spending authority provided to the program of origination.

(e) The commissioner may use up to five percent of each county's allocation, as adjusted, for payments for administrative expenses, to be paid as a proportionate addition to reported direct service expenditures.

21.1 (f) The county allocation for each individual or individual's family cannot exceed
21.2 the amount allowed under subdivision 11.

21.3 (g) The commissioner may recover, suspend, or withhold payments if the county
21.4 board, local agency, or grantee does not comply with the requirements of this section.

21.5 (h) Grant funds unexpended by consumers shall return to the state once a year. The
21.6 annual return of unexpended grant funds shall occur in the quarter following the end of
21.7 the state fiscal year.

21.8 Sec. 6. Minnesota Statutes 2006, section 256.476, subdivision 10, is amended to read:

21.9 Subd. 10. **Consumer responsibilities.** Persons receiving grants under this section
21.10 shall:

21.11 (1) spend the grant money in a manner consistent with their agreement with the
21.12 local agency;

21.13 (2) notify the local agency of any necessary changes in the grant or the items on
21.14 which it is spent;

21.15 (3) notify the local agency of any decision made by the person, ~~the~~ a person's legal
21.16 representative, ~~or the person's family~~ or other authorized representative that would change
21.17 their eligibility for consumer support grants;

21.18 (4) arrange and pay for supports; and

21.19 (5) inform the local agency of areas where they have experienced difficulty securing
21.20 or maintaining supports.

21.21 Sec. 7. Minnesota Statutes 2006, section 256.974, is amended to read:

21.22 **256.974 OFFICE OF OMBUDSMAN FOR ~~OLDER MINNESOTANS~~**
21.23 **LONG-TERM CARE; LOCAL PROGRAMS.**

21.24 The ombudsman for ~~older Minnesotans~~ long-term care serves in the classified service
21.25 under section 256.01, subdivision 7, in an office within the Minnesota Board on Aging that
21.26 incorporates the long-term care ombudsman program required by the Older Americans
21.27 Act, ~~Public Law 100-75 as amended~~, United States Code, title 42, section 3027(a)(12)
21.28 (9) and 3058g (a), and established within the Minnesota Board on Aging. The Minnesota
21.29 Board on Aging may make grants to and designate local programs for the provision of
21.30 ombudsman services to clients in county or multicounty areas. The local program may not
21.31 be an agency engaged in the provision of nursing home care, hospital care, or home care
21.32 services either directly or by contract, or have the responsibility for planning, coordinating,
21.33 funding, or administering nursing home care, hospital care, or home care services.

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22.1 Sec. 8. Minnesota Statutes 2006, section 256.9744, subdivision 1, is amended to read:

22.2 Subdivision 1. **Classification.** Except as provided in this section, data maintained
22.3 by the office under sections 256.974 to 256.9744 are private data on individuals or
22.4 nonpublic data as defined in section 13.02, subdivision 9 or 12, and must be maintained
22.5 in accordance with the requirements of ~~Public Law 100-75~~ the Older Americans Act, as
22.6 amended, United States Code, title 42, section ~~3027(a)(12)(D)~~ 3058g(d).

22.7 Sec. 9. Minnesota Statutes 2006, section 256B.0625, subdivision 23, is amended to
22.8 read:

22.9 Subd. 23. **Day treatment services.** Medical assistance covers day treatment
22.10 services as specified in sections 245.462, subdivision 8, and 245.4871, subdivision 10, that
22.11 are provided under contract with the county board. Notwithstanding Minnesota Rules,
22.12 part 9505.0323, subpart 15, the commissioner may set authorization thresholds for day
22.13 treatment for adults according to section 256B.0625, subdivision 25. Notwithstanding
22.14 Minnesota Rules, part 9505.0323, subpart 15, effective July 1, 2004, medical assistance
22.15 covers day treatment services for children as specified under section 256B.0943.

22.16 Sec. 10. Minnesota Statutes 2006, section 256B.0911, subdivision 4c, is amended to
22.17 read:

22.18 Subd. 4c. **Screening requirements.** (a) A person may be screened for nursing
22.19 facility admission by telephone or in a face-to-face screening interview. Consultation team
22.20 members shall identify each individual's needs using the following categories:

22.21 (1) the person needs no face-to-face screening interview to determine the need
22.22 for nursing facility level of care based on information obtained from other health care
22.23 professionals;

22.24 (2) the person needs an immediate face-to-face screening interview to determine the
22.25 need for nursing facility level of care and complete activities required under subdivision
22.26 4a; or

22.27 (3) the person may be exempt from screening requirements as outlined in subdivision
22.28 4b, but will need transitional assistance after admission or in-person follow-along after
22.29 a return home.

22.30 (b) Persons admitted on a nonemergency basis to a Medicaid-certified nursing
22.31 facility must be screened prior to admission.

22.32 ~~(c) The long-term care consultation team shall recommend a case mix classification~~
22.33 ~~for persons admitted to a certified nursing facility when sufficient information is received~~
22.34 ~~to make that classification. The nursing facility is authorized to conduct all case mix~~

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~~assessments for persons who have been screened prior to admission for whom the county did not recommend a case mix classification. The nursing facility is authorized to conduct all case mix assessments for persons admitted to the facility prior to a preadmission screening. The county retains the responsibility of distributing appropriate case mix forms to the nursing facility.~~

~~(d)~~ (c) The county screening or intake activity must include processes to identify persons who may require transition assistance as described in subdivision 3b.

Sec. 11. Minnesota Statutes 2006, section 256B.0913, subdivision 4, is amended to read:

Subd. 4. Eligibility for funding for services for nonmedical assistance recipients.

(a) Funding for services under the alternative care program is available to persons who meet the following criteria:

(1) the person has been determined by a community assessment under section 256B.0911 to be a person who would require the level of care provided in a nursing facility, but for the provision of services under the alternative care program;

(2) the person is age 65 or older;

(3) the person would be eligible for medical assistance within 135 days of admission to a nursing facility;

(4) the person is not ineligible for the medical assistance program due to an asset transfer penalty;

(5) the person needs long-term care services that are not funded through other state or federal funding;

(6) the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the monthly limit described under section 256B.0915, subdivision 3a. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased under this section exceed the difference between the client's monthly service limit defined under section 256B.0915, subdivision 3, and the alternative care program monthly service limit defined in this paragraph. If ~~medical~~ care-related supplies and equipment or environmental modifications and adaptations are or will be purchased for an alternative care services recipient, the costs may be prorated on a monthly basis for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's other alternative care services exceeds the monthly limit established in this paragraph, the annual cost of the alternative care services shall be determined. In this

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24.1 event, the annual cost of alternative care services shall not exceed 12 times the monthly
24.2 limit described in this paragraph; and

24.3 (7) the person is making timely payments of the assessed monthly fee.

24.4 A person is ineligible if payment of the fee is over 60 days past due, unless the person
24.5 agrees to:

24.6 (i) the appointment of a representative payee;

24.7 (ii) automatic payment from a financial account;

24.8 (iii) the establishment of greater family involvement in the financial management of
24.9 payments; or

24.10 (iv) another method acceptable to the ~~county~~ lead agency to ensure prompt fee
24.11 payments.

24.12 The ~~county shall~~ lead agency may extend the client's eligibility as necessary while
24.13 making arrangements to facilitate payment of past-due amounts and future premium
24.14 payments. Following disenrollment due to nonpayment of a monthly fee, eligibility shall
24.15 not be reinstated for a period of 30 days.

24.16 (b) Alternative care funding under this subdivision is not available for a person
24.17 who is a medical assistance recipient or who would be eligible for medical assistance
24.18 without a spenddown or waiver obligation. A person whose initial application for medical
24.19 assistance and the elderly waiver program is being processed may be served under the
24.20 alternative care program for a period up to 60 days. If the individual is found to be eligible
24.21 for medical assistance, medical assistance must be billed for services payable under the
24.22 federally approved elderly waiver plan and delivered from the date the individual was
24.23 found eligible for the federally approved elderly waiver plan. Notwithstanding this
24.24 provision, alternative care funds may not be used to pay for any service the cost of which:
24.25 (i) is payable by medical assistance; (ii) is used by a recipient to meet a waiver obligation;
24.26 or (iii) is used to pay a medical assistance income spenddown for a person who is eligible
24.27 to participate in the federally approved elderly waiver program under the special income
24.28 standard provision.

24.29 (c) Alternative care funding is not available for a person who resides in a licensed
24.30 nursing home, certified boarding care home, hospital, or intermediate care facility, except
24.31 for case management services which are provided in support of the discharge planning
24.32 process for a nursing home resident or certified boarding care home resident to assist with
24.33 a relocation process to a community-based setting.

24.34 (d) Alternative care funding is not available for a person whose income is greater
24.35 than the maintenance needs allowance under section 256B.0915, subdivision 1d, but is
24.36 equal to or less than 120 percent of the federal poverty guideline effective July 1 in the

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25.1 fiscal year for which alternative care eligibility is determined, who would be eligible for
25.2 the elderly waiver with a waiver obligation.

25.3 Sec. 12. Minnesota Statutes 2006, section 256B.0913, subdivision 5, is amended to
25.4 read:

25.5 Subd. 5. **Services covered under alternative care.** Alternative care funding may
25.6 be used for payment of costs of:

- 25.7 (1) adult day care;
- 25.8 (2) home health aide;
- 25.9 (3) homemaker services;
- 25.10 (4) personal care;
- 25.11 (5) case management;
- 25.12 (6) respite care;
- 25.13 (7) care-related supplies and equipment;
- 25.14 (8) meals delivered to the home;
- 25.15 (9) nonmedical transportation;
- 25.16 (10) nursing services;
- 25.17 (11) chore services;
- 25.18 (12) companion services;
- 25.19 (13) nutrition services;
- 25.20 (14) training for direct informal caregivers;
- 25.21 (15) telehome care to provide services in their own homes in conjunction with
25.22 in-home visits;
- 25.23 (16) ~~discretionary services, for which counties may make payment from their~~
25.24 ~~alternative care program allocation or services not otherwise defined in this section~~
25.25 ~~or section 256B.0625, following approval by the commissioner~~ consumer-directed
25.26 community services under the alternative care programs which are available statewide and
25.27 limited to the average monthly expenditures representative of all alternative care program
25.28 participants for the same case mix resident class assigned in the most recent fiscal year for
25.29 which complete expenditure data is available;
- 25.30 (17) environmental modifications and adaptations; and
- 25.31 (18) ~~direct cash payments for which counties may make payment from their~~
25.32 ~~alternative care program allocation to clients for the purpose of purchasing services,~~
25.33 ~~following approval by the commissioner, and subject to the provisions of subdivision 5h,~~
25.34 ~~until approval and implementation of consumer-directed services through the federally~~
25.35 ~~approved elderly waiver plan. Upon implementation, consumer-directed services under~~

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~~the alternative care program are available statewide and limited to the average monthly expenditures representative of all alternative care program participants for the same case mix resident class assigned in the most recent fiscal year for which complete expenditure data is available~~ discretionary services, for which lead agencies may make payment from their alternative care program allocation for services not otherwise defined in this section or section 256B.0625, following approval by the commissioner.

~~Total annual payments for discretionary services and direct cash payments, until the federally approved consumer-directed service option is implemented statewide, for all clients within a county may served by a lead agency must not exceed 25 percent of that county's lead agency's annual alternative care program base allocation. Thereafter, discretionary services are limited to 25 percent of the county's annual alternative care program base allocation.~~

Sec. 13. Minnesota Statutes 2006, section 256B.0913, subdivision 5a, is amended to read:

Subd. 5a. **Services; service definitions; service standards.** (a) Unless specified in statute, the services, service definitions, and standards for alternative care services shall be the same as the services, service definitions, and standards specified in the federally approved elderly waiver plan, except for transitional support services, assisted living services, adult foster care services, and residential care services.

(b) The ~~county~~ lead agency must ensure that the funds are not used to supplant services available through other public assistance or services programs. For a provider of supplies and equipment when the monthly cost of the supplies and equipment is less than \$250, persons or agencies must be employed by or under a contract with the ~~county~~ lead agency or the public health nursing agency of the local board of health in order to receive funding under the alternative care program. Supplies and equipment may be purchased from a vendor not certified to participate in the Medicaid program if the cost for the item is less than that of a Medicaid vendor.

(c) Personal care services must meet the service standards defined in the federally approved elderly waiver plan, except that a ~~county~~ lead agency may contract with a client's relative who meets the relative hardship waiver requirements or a relative who meets the criteria and is also the responsible party under an individual service plan that ensures the client's health and safety and supervision of the personal care services by a qualified professional as defined in section 256B.0625, subdivision 19c. Relative hardship is established by the ~~county~~ lead agency when the client's care causes a relative caregiver to do any of the following: resign from a paying job, reduce work hours resulting in lost

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27.1 wages, obtain a leave of absence resulting in lost wages, incur substantial client-related
27.2 expenses, provide services to address authorized, unstaffed direct care time, or meet
27.3 special needs of the client unmet in the formal service plan.

27.4 Sec. 14. Minnesota Statutes 2006, section 256B.0913, subdivision 8, is amended to
27.5 read:

27.6 Subd. 8. **Requirements for individual care plan.** (a) The case manager shall
27.7 implement the plan of care for each alternative care client and ensure that a client's
27.8 service needs and eligibility are reassessed at least every 12 months. The plan shall
27.9 include any services prescribed by the individual's attending physician as necessary to
27.10 allow the individual to remain in a community setting. In developing the individual's care
27.11 plan, the case manager should include the use of volunteers from families and neighbors,
27.12 religious organizations, social clubs, and civic and service organizations to support the
27.13 formal home care services. The ~~county~~ lead agency shall be held harmless for damages or
27.14 injuries sustained through the use of volunteers under this subdivision including workers'
27.15 compensation liability. The ~~county of service~~ case manager shall provide documentation
27.16 in each individual's plan of care and, if requested, to the commissioner that the most
27.17 cost-effective alternatives available have been offered to the individual and that the
27.18 individual was free to choose among available qualified providers, both public and private,
27.19 including qualified case management or service coordination providers other than those
27.20 employed by any county; however, the county or tribe maintains responsibility for prior
27.21 authorizing services in accordance with statutory and administrative requirements. The
27.22 case manager must give the individual a ten-day written notice of any denial, termination,
27.23 or reduction of alternative care services.

27.24 (b) The county of service or tribe must provide access to and arrange for case
27.25 management services, including assuring implementation of the plan. "County of service"
27.26 has the meaning given it in Minnesota Rules, part 9505.0015, subpart 11. The county of
27.27 service must notify the county of financial responsibility of the approved care plan and
27.28 the amount of encumbered funds.

27.29 Sec. 15. Minnesota Statutes 2006, section 256B.0913, subdivision 9, is amended to
27.30 read:

27.31 Subd. 9. **Contracting provisions for providers.** Alternative care funds paid to
27.32 service providers are subject to audit by the commissioner for fiscal and utilization control.

27.33 The lead agency must select providers for contracts or agreements using the
27.34 following criteria and other criteria established by the ~~county~~ lead agency:

- (1) the need for the particular services offered by the provider;
- (2) the population to be served, including the number of clients, the length of time services will be provided, and the medical condition of clients;
- (3) the geographic area to be served;
- (4) quality assurance methods, including appropriate licensure, certification, or standards, and supervision of employees when needed;
- (5) rates for each service and unit of service exclusive of county lead agency administrative costs;
- (6) evaluation of services previously delivered by the provider; and
- (7) contract or agreement conditions, including billing requirements, cancellation, and indemnification.

The county lead agency must evaluate its own agency services under the criteria established for other providers.

Sec. 16. Minnesota Statutes 2006, section 256B.0913, subdivision 10, is amended to read:

Subd. 10. **Allocation formula.** (a) ~~The alternative care appropriation for fiscal years 1992 and beyond shall cover only alternative care eligible clients.~~ By July 1 of each year, the commissioner shall allocate to county agencies the state funds available for alternative care for persons eligible under subdivision 2.

(b) The adjusted base for each county lead agency is the county's lead agency's current fiscal year base allocation plus any targeted funds approved during the current fiscal year. Calculations for paragraphs (c) and (d) are to be made as follows: for each county lead agency, the determination of alternative care program expenditures shall be based on payments for services rendered from April 1 through March 31 in the base year, to the extent that claims have been submitted and paid by June 1 of that year.

(c) If the alternative care program expenditures as defined in paragraph (b) are 95 percent or more of the county's lead agency's adjusted base allocation, the allocation for the next fiscal year is 100 percent of the adjusted base, plus inflation to the extent that inflation is included in the state budget.

(d) If the alternative care program expenditures as defined in paragraph (b) are less than 95 percent of the county's lead agency's adjusted base allocation, the allocation for the next fiscal year is the adjusted base allocation less the amount of unspent funds below the 95 percent level.

(e) If the annual legislative appropriation for the alternative care program is inadequate to fund the combined county lead agency allocations for a biennium, the

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29.1 commissioner shall distribute to each ~~county~~ lead agency the entire annual appropriation
29.2 as that ~~county's~~ lead agency's percentage of the computed base as calculated in paragraphs
29.3 (c) and (d).

29.4 (f) On agreement between the commissioner and the lead agency, the commissioner
29.5 may have discretion to reallocate alternative care base allocations distributed to lead
29.6 agencies in which the base amount exceeds program expenditures.

29.7 Sec. 17. Minnesota Statutes 2006, section 256B.0913, subdivision 11, is amended to
29.8 read:

29.9 Subd. 11. **Targeted funding.** (a) The purpose of targeted funding is to make
29.10 additional money available to ~~counties~~ lead agencies with the greatest need. Targeted
29.11 funds are not intended to be distributed equitably among all ~~counties~~ lead agencies, but
29.12 rather, allocated to those with long-term care strategies that meet state goals.

29.13 (b) The funds available for targeted funding shall be the total appropriation for each
29.14 fiscal year minus ~~county~~ lead agency allocations determined under subdivision 10 as
29.15 adjusted for any inflation increases provided in appropriations for the biennium.

29.16 (c) The commissioner shall allocate targeted funds to ~~counties~~ lead agencies that
29.17 demonstrate to the satisfaction of the commissioner that they have developed feasible
29.18 plans to increase alternative care spending. In making targeted funding allocations, the
29.19 commissioner shall use the following priorities:

29.20 (1) ~~counties~~ lead agencies that received a lower allocation in fiscal year 1991 than in
29.21 fiscal year 1990. Counties remain in this priority until they have been restored to their
29.22 fiscal year 1990 level plus inflation;

29.23 (2) ~~counties~~ lead agencies that sustain a base allocation reduction for failure to spend
29.24 95 percent of the allocation if they demonstrate that the base reduction should be restored;

29.25 (3) ~~counties~~ lead agencies that propose projects to divert community residents from
29.26 nursing home placement or convert nursing home residents to community living; and

29.27 (4) ~~counties~~ lead agencies that can otherwise justify program growth by
29.28 demonstrating the existence of waiting lists, demographically justified needs, or other
29.29 unmet needs.

29.30 (d) ~~Counties~~ Lead agencies that would receive targeted funds according to
29.31 paragraph (c) must demonstrate to the commissioner's satisfaction that the funds
29.32 would be appropriately spent by showing how the funds would be used to further the
29.33 state's alternative care goals as described in subdivision 1, and that the county has the
29.34 administrative and service delivery capability to use them.

(e) The commissioner shall ~~request applications~~ make applications available for targeted funds by November 1 of each year. The ~~counties~~ lead agencies selected for targeted funds shall be notified of the amount of their additional funding. Targeted funds allocated to a ~~county~~ lead agency in one year shall be treated as part of the ~~county's~~ lead agency's base allocation for that year in determining allocations for subsequent years. No reallocations between ~~counties~~ lead agencies shall be made.

Sec. 18. Minnesota Statutes 2006, section 256B.0913, subdivision 12, is amended to read:

Subd. 12. **Client fees.** (a) A fee is required for all alternative care eligible clients to help pay for the cost of participating in the program. The amount of the fee for the alternative care client shall be determined as follows:

(1) when the alternative care client's income less recurring and predictable medical expenses is less than 100 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the fee is being computed, and total assets are less than \$10,000, the fee is zero;

(2) when the alternative care client's income less recurring and predictable medical expenses is equal to or greater than 100 percent but less than 150 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the fee is being computed, and total assets are less than \$10,000, the fee is five percent of the cost of alternative care services;

(3) when the alternative care client's income less recurring and predictable medical expenses is equal to or greater than 150 percent but less than 200 percent of the federal poverty guidelines effective on July 1 of the state fiscal year in which the fee is being computed and assets are less than \$10,000, the fee is 15 percent of the cost of alternative care services;

(4) when the alternative care client's income less recurring and predictable medical expenses is equal to or greater than 200 percent of the federal poverty guidelines effective on July 1 of the state fiscal year in which the fee is being computed and assets are less than \$10,000, the fee is 30 percent of the cost of alternative care services; and

(5) when the alternative care client's assets are equal to or greater than \$10,000, the fee is 30 percent of the cost of alternative care services.

For married persons, total assets are defined as the total marital assets less the estimated community spouse asset allowance, under section 256B.059, if applicable. For married persons, total income is defined as the client's income less the monthly spousal allotment, under section 256B.058.

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31.1 All alternative care services shall be included in the estimated costs for the purpose
31.2 of determining the fee.

31.3 Fees are due and payable each month alternative care services are received unless the
31.4 actual cost of the services is less than the fee, in which case the fee is the lesser amount.

31.5 (b) The fee shall be waived by the commissioner when:

31.6 (1) a person ~~who~~ is residing in a nursing facility ~~is receiving case management only;~~

31.7 (2) a married couple is requesting an asset assessment under the spousal
31.8 impoverishment provisions;

31.9 (3) a person is found eligible for alternative care, but is not yet receiving alternative
31.10 care services including case management services; or

31.11 (4) a person has chosen to participate in a consumer-directed service plan for which
31.12 the cost is no greater than the total cost of the person's alternative care service plan less
31.13 the monthly fee amount that would otherwise be assessed.

31.14 (c) ~~The county agency must record in the state's receivable system the client's~~
31.15 ~~assessed fee amount or the reason the fee has been waived. The commissioner will bill~~
31.16 ~~and collect the fee from the client. Money collected must be deposited in the general fund~~
31.17 ~~and is appropriated to the commissioner for the alternative care program. The client must~~
31.18 ~~supply the county lead agency with the client's Social Security number at the time of~~
31.19 ~~application. The county lead agency shall supply the commissioner with the client's Social~~
31.20 ~~Security number and other information the commissioner requires to collect the fee from~~
31.21 ~~the client. The commissioner shall collect unpaid fees using the Revenue Recapture Act in~~
31.22 ~~chapter 270A and other methods available to the commissioner. The commissioner may~~
31.23 ~~require counties lead agencies to inform clients of the collection procedures that may be~~
31.24 ~~used by the state if a fee is not paid. This paragraph does not apply to alternative care~~
31.25 ~~pilot projects authorized in Laws 1993, First Special Session chapter 1, article 5, section~~
31.26 ~~133, if a county operating under the pilot project reports the following dollar amounts~~
31.27 ~~to the commissioner quarterly:~~

31.28 (1) total fees billed to clients;

31.29 (2) total collections of fees billed; and

31.30 (3) balance of fees owed by clients.

31.31 If a county lead agency does not adhere to these reporting requirements, the commissioner
31.32 may terminate the billing, collecting, and remitting portions of the pilot project and require
31.33 the county lead agency involved to operate under the procedures set forth in this paragraph.

31.34 Sec. 19. Minnesota Statutes 2006, section 256B.0913, subdivision 13, is amended to
31.35 read:

32.1 Subd. 13. **County Lead agency biennial plan.** The ~~county~~ county lead agency biennial
32.2 plan for long-term care consultation services under section 256B.0911, the alternative
32.3 care program under this section, and waivers for the elderly under section 256B.0915,
32.4 shall be submitted by the lead agency as the home and community-based services quality
32.5 assurance plan on a form provided by the commissioner.

32.6 Sec. 20. Minnesota Statutes 2006, section 256B.0913, subdivision 14, is amended to
32.7 read:

32.8 Subd. 14. **Provider requirements, payment, and rate adjustments.** (a) Unless
32.9 otherwise specified in statute, providers must be enrolled as Minnesota health care
32.10 program providers and abide by the requirements for provider participation according to
32.11 Minnesota Rules, part 9505.0195.

32.12 (b) Payment for provided alternative care services as approved by the client's
32.13 case manager shall occur through the invoice processing procedures of the department's
32.14 Medicaid Management Information System (MMIS). To receive payment, the ~~county~~ county lead
32.15 agency or vendor must submit invoices within 12 months following the date of service.
32.16 The ~~county~~ county lead agency and its vendors under contract shall not be reimbursed for services
32.17 which exceed the county allocation.

32.18 (c) The ~~county~~ county lead agency shall negotiate individual rates with vendors and may
32.19 authorize service payment for actual costs up to the county's current approved rate.
32.20 Notwithstanding any other rule or statutory provision to the contrary, the commissioner
32.21 shall not be authorized to increase rates by an annual inflation factor, unless so authorized
32.22 by the legislature. To improve access to community services and eliminate payment
32.23 disparities between the alternative care program and the elderly waiver program, the
32.24 commissioner shall establish statewide maximum service rate limits and eliminate
32.25 county-specific service rate limits.

32.26 (1) Effective July 1, 2001, for service rate limits, except those in subdivision 5,
32.27 paragraphs (d) and (i), the rate limit for each service shall be the greater of the alternative
32.28 care statewide maximum rate or the elderly waiver statewide maximum rate.

32.29 (2) ~~Counties~~ County lead agencies may negotiate individual service rates with vendors for
32.30 actual costs up to the statewide maximum service rate limit.

32.31 Sec. 21. Minnesota Statutes 2006, section 256B.0919, subdivision 3, is amended to
32.32 read:

32.33 Subd. 3. **County certification of persons providing adult foster care to related**
32.34 **persons.** A person exempt from licensure under section 245A.03, subdivision 2, who

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provides adult foster care to a related individual age 65 and older, and who meets the requirements in Minnesota Rules, parts 9555.5105 to 9555.6265, may be certified by the county to provide adult foster care. A person certified by the county to provide adult foster care may be reimbursed for services provided and eligible for funding under ~~sections 256B.0913 and~~ section 256B.0915, if the relative would suffer a financial hardship as a result of providing care. For purposes of this subdivision, financial hardship refers to a situation in which a relative incurs a substantial reduction in income as a result of resigning from a full-time job or taking a leave of absence without pay from a full-time job to care for the client.

Sec. 22. Minnesota Statutes 2006, section 256B.431, subdivision 1, is amended to read:

Subdivision 1. **In general.** The commissioner shall determine prospective payment rates for resident care costs. For rates established on or after July 1, 1985, the commissioner shall develop procedures for determining operating cost payment rates that take into account the mix of resident needs, geographic location, and other factors as determined by the commissioner. The commissioner shall consider whether the fact that a facility is attached to a hospital or has an average length of stay of 180 days or less should be taken into account in determining rates. The commissioner shall consider the use of the standard metropolitan statistical areas when developing groups by geographic location. The commissioner shall provide notice to each nursing facility on or before ~~May 1~~ August 15 of the rates effective for the following rate year except that if legislation is pending on ~~May 1~~ August 15 that may affect rates for nursing facilities, the commissioner shall set the rates after the legislation is enacted and provide notice to each facility as soon as possible.

Compensation for top management personnel shall continue to be categorized as a general and administrative cost and is subject to any limits imposed on that cost category.

Sec. 23. Minnesota Statutes 2006, section 256B.431, subdivision 3f, is amended to read:

Subd. 3f. **Property costs after July 1, 1988.** (a) **Investment per bed limit.** For the rate year beginning July 1, 1988, the replacement-cost-new per bed limit must be \$32,571 per licensed bed in multiple bedrooms and \$48,857 per licensed bed in a single bedroom. For the rate year beginning July 1, 1989, the replacement-cost-new per bed limit for a single bedroom must be \$49,907 adjusted according to Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1). Beginning January 1, 1990, the replacement-cost-new per bed limits must be adjusted annually as specified in Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1). Beginning January 1, 1991, the replacement-cost-new per

bed limits will be adjusted annually as specified in Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1), except that the index utilized will be the Bureau of ~~the Census: Composite fixed-weighted price index as published in the C30 Report, Value of New Construction Put in Place~~ Economic Analysis: Price Indexes for Private Fixed Investments in Structures; Special Care.

(b) **Rental factor.** For the rate year beginning July 1, 1988, the commissioner shall increase the rental factor as established in Minnesota Rules, part 9549.0060, subpart 8, item A, by 6.2 percent rounded to the nearest 100th percent for the purpose of reimbursing nursing facilities for soft costs and entrepreneurial profits not included in the cost valuation services used by the state's contracted appraisers. For rate years beginning on or after July 1, 1989, the rental factor is the amount determined under this paragraph for the rate year beginning July 1, 1988.

(c) **Occupancy factor.** For rate years beginning on or after July 1, 1988, in order to determine property-related payment rates under Minnesota Rules, part 9549.0060, for all nursing facilities except those whose average length of stay in a skilled level of care within a nursing facility is 180 days or less, the commissioner shall use 95 percent of capacity days. For a nursing facility whose average length of stay in a skilled level of care within a nursing facility is 180 days or less, the commissioner shall use the greater of resident days or 80 percent of capacity days but in no event shall the divisor exceed 95 percent of capacity days.

(d) **Equipment allowance.** For rate years beginning on July 1, 1988, and July 1, 1989, the commissioner shall add ten cents per resident per day to each nursing facility's property-related payment rate. The ten-cent property-related payment rate increase is not cumulative from rate year to rate year. For the rate year beginning July 1, 1990, the commissioner shall increase each nursing facility's equipment allowance as established in Minnesota Rules, part 9549.0060, subpart 10, by ten cents per resident per day. For rate years beginning on or after July 1, 1991, the adjusted equipment allowance must be adjusted annually for inflation as in Minnesota Rules, part 9549.0060, subpart 10, item E. For the rate period beginning October 1, 1992, the equipment allowance for each nursing facility shall be increased by 28 percent. For rate years beginning after June 30, 1993, the allowance must be adjusted annually for inflation.

(e) **Post chapter 199 related-organization debts and interest expense.** For rate years beginning on or after July 1, 1990, Minnesota Rules, part 9549.0060, subpart 5, item E, shall not apply to outstanding related organization debt incurred prior to May 23, 1983, provided that the debt was an allowable debt under Minnesota Rules, parts 9510.0010 to 9510.0480, the debt is subject to repayment through annual principal payments, and

the nursing facility demonstrates to the commissioner's satisfaction that the interest rate on the debt was less than market interest rates for similar arm's-length transactions at the time the debt was incurred. If the debt was incurred due to a sale between family members, the nursing facility must also demonstrate that the seller no longer participates in the management or operation of the nursing facility. Debts meeting the conditions of this paragraph are subject to all other provisions of Minnesota Rules, parts 9549.0010 to 9549.0080.

(f) Building capital allowance for nursing facilities with operating leases. For rate years beginning on or after July 1, 1990, a nursing facility with operating lease costs incurred for the nursing facility's buildings shall receive its building capital allowance computed in accordance with Minnesota Rules, part 9549.0060, subpart 8. If an operating lease provides that the lessee's rent is adjusted to recognize improvements made by the lessor and related debt, the costs for capital improvements and related debt shall be allowed in the computation of the lessee's building capital allowance, provided that reimbursement for these costs under an operating lease shall not exceed the rate otherwise paid.

Sec. 24. Minnesota Statutes 2006, section 256B.431, subdivision 17e, is amended to read:

Subd. 17e. **Replacement-costs-new per bed limit effective July 1, 2001.** Notwithstanding Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), for a total replacement, as defined in ~~paragraph (f)~~ subdivision 17d, authorized under section 144A.071 or 144A.073 after July 1, 1999, or any building project that is a relocation, renovation, upgrading, or conversion completed on or after July 1, 2001, the replacement-costs-new per bed limit shall be \$74,280 per licensed bed in multiple-bed rooms, \$92,850 per licensed bed in semiprivate rooms with a fixed partition separating the resident beds, and \$111,420 per licensed bed in single rooms. Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), does not apply. These amounts must be adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1, 2000.

Sec. 25. Laws 2000, chapter 340, section 19, is amended to read:

Sec. 19. ALTERNATIVE CARE PILOT PROJECTS.

(a) Expenditures for housing with services and adult foster care shall be excluded when determining average monthly expenditures per client for alternative care pilot projects authorized in Laws 1993, First Special Session chapter 1, article 5, section 133.

(b) Alternative care pilot projects shall not expire on June 30, 2001, but shall continue until June 30, ~~2005~~ 2007.

EFFECTIVE DATE. This section is effective retroactively from June 29, 2005, for activities related to discontinuing pilot projects under this section.

ARTICLE 3
HEALTH CARE

Section 1. Minnesota Statutes 2006, section 256B.0625, subdivision 13c, is amended to read:

Subd. 13c. **Formulary committee.** The commissioner, after receiving recommendations from professional medical associations and professional pharmacy associations, and consumer groups shall designate a Formulary Committee to carry out duties as described in subdivisions 13 to 13g. The Formulary Committee shall be comprised of four licensed physicians actively engaged in the practice of medicine in Minnesota one of whom must be actively engaged in the treatment of persons with mental illness; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota; and one consumer representative; the remainder to be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. Members of the Formulary Committee shall not be employed by the Department of Human Services, but the committee shall be staffed by an employee of the department who shall serve as an ex officio, nonvoting member of the ~~board~~ committee. The department's medical director shall also serve as an ex officio, nonvoting member for the committee. Committee members shall serve three-year terms and may be reappointed by the commissioner. The Formulary Committee shall meet at least quarterly. The commissioner may require more frequent Formulary Committee meetings as needed. An honorarium of \$100 per meeting and reimbursement for mileage shall be paid to each committee member in attendance.

Sec. 2. Minnesota Statutes 2006, section 256D.03, subdivision 4, is amended to read:

Subd. 4. **General assistance medical care; services.** (a)(i) For a person who is eligible under subdivision 3, paragraph (a), clause (2), item (i), general assistance medical care covers, except as provided in paragraph (c):

- (1) inpatient hospital services;
- (2) outpatient hospital services;
- (3) services provided by Medicare certified rehabilitation agencies;
- (4) prescription drugs and other products recommended through the process established in section 256B.0625, subdivision 13;

- 37.1 (5) equipment necessary to administer insulin and diagnostic supplies and equipment
37.2 for diabetics to monitor blood sugar level;
- 37.3 (6) eyeglasses and eye examinations provided by a physician or optometrist;
- 37.4 (7) hearing aids;
- 37.5 (8) prosthetic devices;
- 37.6 (9) laboratory and X-ray services;
- 37.7 (10) physician's services;
- 37.8 (11) medical transportation except special transportation;
- 37.9 (12) chiropractic services as covered under the medical assistance program;
- 37.10 (13) podiatric services;
- 37.11 (14) dental services as covered under the medical assistance program;
- 37.12 (15) outpatient services provided by a mental health center or clinic that is under
37.13 contract with the county board and is established under section 245.62;
- 37.14 (16) day treatment services for mental illness provided under contract with the
37.15 county board;
- 37.16 (17) prescribed medications for persons who have been diagnosed as mentally ill as
37.17 necessary to prevent more restrictive institutionalization;
- 37.18 (18) psychological services, medical supplies and equipment, and Medicare
37.19 premiums, coinsurance and deductible payments;
- 37.20 (19) medical equipment not specifically listed in this paragraph when the use of
37.21 the equipment will prevent the need for costlier services that are reimbursable under
37.22 this subdivision;
- 37.23 (20) services performed by a certified pediatric nurse practitioner, a certified family
37.24 nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological
37.25 nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse
37.26 practitioner in independent practice, if (1) the service is otherwise covered under this
37.27 chapter as a physician service, (2) the service provided on an inpatient basis is not included
37.28 as part of the cost for inpatient services included in the operating payment rate, and (3) the
37.29 service is within the scope of practice of the nurse practitioner's license as a registered
37.30 nurse, as defined in section 148.171;
- 37.31 (21) services of a certified public health nurse or a registered nurse practicing in
37.32 a public health nursing clinic that is a department of, or that operates under the direct
37.33 authority of, a unit of government, if the service is within the scope of practice of the
37.34 public health nurse's license as a registered nurse, as defined in section 148.171;
- 37.35 (22) telemedicine consultations, to the extent they are covered under section
37.36 256B.0625, subdivision 3b; and

(23) mental health telemedicine and psychiatric consultation as covered under section 256B.0625, subdivisions 46 and 48.

(ii) Effective October 1, 2003, for a person who is eligible under subdivision 3, paragraph (a), clause (2), item (ii), general assistance medical care coverage is limited to inpatient hospital services, including physician services provided during the inpatient hospital stay. A \$1,000 deductible is required for each inpatient hospitalization.

(b) Effective August 1, 2005, sex reassignment surgery is not covered under this subdivision.

(c) In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall where possible contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for prepaid health plans, competitive bidding programs, block grants, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. Before implementing prepaid programs in counties with a county operated or affiliated public teaching hospital or a hospital or clinic operated by the University of Minnesota, the commissioner shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the opportunity to participate in the program in a manner that reflects the risk of adverse selection and the nature of the patients served by the hospital, provided the terms of participation in the program are competitive with the terms of other participants considering the nature of the population served. Payment for services provided pursuant to this subdivision shall be as provided to medical assistance vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For payments made during fiscal year 1990 and later years, the commissioner shall consult with an independent actuary in establishing prepayment rates, but shall retain final control over the rate methodology.

(d) Effective January 1, 2008, drug coverage under general assistance medical care is limited to prescription drugs that:

(i) are covered under the medical assistance program as described in section 256B.0625, subdivisions 13 and 13d; and

(ii) are provided by manufacturers that have fully executed general assistance medical care rebate agreements with the commissioner and comply with the agreements.
Prescription drug coverage under general assistance medical care must conform to coverage under the medical assistance program according to section 256B.0625, subdivisions 13 to 13g.

39.1 ~~(d)~~ (e) Recipients eligible under subdivision 3, paragraph (a), shall pay the following
39.2 co-payments for services provided on or after October 1, 2003:

39.3 (1) \$25 for eyeglasses;

39.4 (2) \$25 for nonemergency visits to a hospital-based emergency room;

39.5 (3) \$3 per brand-name drug prescription and \$1 per generic drug prescription,
39.6 subject to a \$12 per month maximum for prescription drug co-payments. No co-payments
39.7 shall apply to antipsychotic drugs when used for the treatment of mental illness; and

39.8 (4) 50 percent coinsurance on restorative dental services.

39.9 ~~(e)~~ (f) Co-payments shall be limited to one per day per provider for nonpreventive
39.10 visits, eyeglasses, and nonemergency visits to a hospital-based emergency room.

39.11 Recipients of general assistance medical care are responsible for all co-payments in this
39.12 subdivision. The general assistance medical care reimbursement to the provider shall be
39.13 reduced by the amount of the co-payment, except that reimbursement for prescription
39.14 drugs shall not be reduced once a recipient has reached the \$12 per month maximum for
39.15 prescription drug co-payments. The provider collects the co-payment from the recipient.
39.16 Providers may not deny services to recipients who are unable to pay the co-payment,
39.17 except as provided in paragraph (f).

39.18 ~~(f)~~ (g) If it is the routine business practice of a provider to refuse service to an
39.19 individual with uncollected debt, the provider may include uncollected co-payments
39.20 under this section. A provider must give advance notice to a recipient with uncollected
39.21 debt before services can be denied.

39.22 ~~(g)~~ (h) Any county may, from its own resources, provide medical payments for
39.23 which state payments are not made.

39.24 ~~(h)~~ (i) Chemical dependency services that are reimbursed under chapter 254B must
39.25 not be reimbursed under general assistance medical care.

39.26 ~~(i)~~ (j) The maximum payment for new vendors enrolled in the general assistance
39.27 medical care program after the base year shall be determined from the average usual and
39.28 customary charge of the same vendor type enrolled in the base year.

39.29 ~~(j)~~ (k) The conditions of payment for services under this subdivision are the same
39.30 as the conditions specified in rules adopted under chapter 256B governing the medical
39.31 assistance program, unless otherwise provided by statute or rule.

39.32 ~~(k)~~ (l) Inpatient and outpatient payments shall be reduced by five percent, effective
39.33 July 1, 2003. This reduction is in addition to the five percent reduction effective July 1,
39.34 2003, and incorporated by reference in paragraph (i).

39.35 ~~(l)~~ (m) Payments for all other health services except inpatient, outpatient, and
39.36 pharmacy services shall be reduced by five percent, effective July 1, 2003.

40.1 ~~(m)~~ (n) Payments to managed care plans shall be reduced by five percent for services
40.2 provided on or after October 1, 2003.

40.3 ~~(n)~~ (o) A hospital receiving a reduced payment as a result of this section may apply
40.4 the unpaid balance toward satisfaction of the hospital's bad debts.

40.5 ~~(o)~~ (p) Fee-for-service payments for nonpreventive visits shall be reduced by \$3
40.6 for services provided on or after January 1, 2006. For purposes of this subdivision, a
40.7 visit means an episode of service which is required because of a recipient's symptoms,
40.8 diagnosis, or established illness, and which is delivered in an ambulatory setting by
40.9 a physician or physician ancillary, chiropractor, podiatrist, advance practice nurse,
40.10 audiologist, optician, or optometrist.

40.11 ~~(p)~~ (q) Payments to managed care plans shall not be increased as a result of the
40.12 removal of the \$3 nonpreventive visit co-payment effective January 1, 2006.

40.13 Sec. 3. Minnesota Statutes 2006, section 256E.35, subdivision 2, is amended to read:

40.14 Subd. 2. **Definitions.** (a) The definitions in this subdivision apply to this section.

40.15 (b) "Family asset account" means a savings account opened by a household
40.16 participating in the Minnesota family assets for independence initiative.

40.17 (c) "Fiduciary organization" means:

40.18 (1) a community action agency that has obtained recognition under section ~~268.53~~
40.19 256E.31;

40.20 (2) a federal community development credit union serving the seven-county
40.21 metropolitan area; or

40.22 (3) a women-oriented economic development agency serving the seven-county
40.23 metropolitan area.

40.24 (d) "Financial institution" means a bank, bank and trust, savings bank, savings
40.25 association, or credit union, the deposits of which are insured by the Federal Deposit
40.26 Insurance Corporation or the National Credit Union Administration.

40.27 (e) "Permissible use" means:

40.28 (1) postsecondary educational expenses at an accredited public postsecondary
40.29 institution including books, supplies, and equipment required for courses of instruction;

40.30 (2) acquisition costs of acquiring, constructing, or reconstructing a residence,
40.31 including any usual or reasonable settlement, financing, or other closing costs;

40.32 (3) business capitalization expenses for expenditures on capital, plant, equipment,
40.33 working capital, and inventory expenses of a legitimate business pursuant to a business
40.34 plan approved by the fiduciary organization; and

41.1 (4) acquisition costs of a principal residence within the meaning of section 1034 of
41.2 the Internal Revenue Code of 1986 which do not exceed 100 percent of the average area
41.3 purchase price applicable to the residence determined according to section 143(e)(2) and
41.4 (3) of the Internal Revenue Code of 1986.

41.5 (f) "Household" means all individuals who share use of a dwelling unit as primary
41.6 quarters for living and eating separate from other individuals.

41.7 Sec. 4. Minnesota Statutes 2006, section 256L.03, subdivision 5, is amended to read:

41.8 Subd. 5. **Co-payments and coinsurance.** (a) Except as provided in paragraphs (b)
41.9 and (c), the MinnesotaCare benefit plan shall include the following co-payments and
41.10 coinsurance requirements for all enrollees:

41.11 (1) ten percent of the paid charges for inpatient hospital services for adult enrollees,
41.12 subject to an annual inpatient out-of-pocket maximum of \$1,000 per individual and
41.13 \$3,000 per family;

41.14 (2) \$3 per prescription for adult enrollees;

41.15 (3) \$25 for eyeglasses for adult enrollees;

41.16 (4) \$3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an
41.17 episode of service which is required because of a recipient's symptoms, diagnosis, or
41.18 established illness, and which is delivered in an ambulatory setting by a physician or
41.19 physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,
41.20 audiologist, optician, or optometrist; and

41.21 (5) \$6 for nonemergency visits to a hospital-based emergency room.

41.22 (b) Paragraph (a), clause (1), does not apply to parents and relative caretakers of
41.23 children under the age of 21 in households with family income equal to or less than 175
41.24 percent of the federal poverty guidelines. Paragraph (a), clause (1), does not apply to
41.25 parents and relative caretakers of children under the age of 21 in households with family
41.26 income greater than 175 percent of the federal poverty guidelines for inpatient hospital
41.27 admissions occurring on or after January 1, 2001.

41.28 (c) Paragraph (a), ~~clauses (1) to (4), do~~ does not apply to pregnant women and
41.29 children under the age of 21.

41.30 (d) Adult enrollees with family gross income that exceeds 175 percent of the
41.31 federal poverty guidelines and who are not pregnant shall be financially responsible for
41.32 the coinsurance amount, if applicable, and amounts which exceed the \$10,000 inpatient
41.33 hospital benefit limit.

41.34 (e) When a MinnesotaCare enrollee becomes a member of a prepaid health plan,
41.35 or changes from one prepaid health plan to another during a calendar year, any charges

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42.1 submitted towards the \$10,000 annual inpatient benefit limit, and any out-of-pocket
42.2 expenses incurred by the enrollee for inpatient services, that were submitted or incurred
42.3 prior to enrollment, or prior to the change in health plans, shall be disregarded.

42.4 Sec. 5. Minnesota Statutes 2006, section 256L.04, subdivision 1, is amended to read:

42.5 Subdivision 1. **Families with children.** (a) Families with children with family
42.6 income equal to or less than 275 percent of the federal poverty guidelines for the
42.7 applicable family size shall be eligible for MinnesotaCare according to this section. All
42.8 other provisions of sections 256L.01 to 256L.18, including the insurance-related barriers
42.9 to enrollment under section 256L.07, shall apply unless otherwise specified.

42.10 (b) Parents who enroll in the MinnesotaCare program must also enroll their children,
42.11 if the children are eligible. Children may be enrolled separately without enrollment by
42.12 parents. However, if one parent in the household enrolls, both parents must enroll, unless
42.13 other insurance is available. If one child from a family is enrolled, all children must
42.14 be enrolled, unless other insurance is available. If one spouse in a household enrolls,
42.15 the other spouse in the household must also enroll, unless other insurance is available.
42.16 Families cannot choose to enroll only certain uninsured members.

42.17 (c) Beginning October 1, 2003, the dependent sibling definition no longer applies
42.18 to the MinnesotaCare program. These persons are no longer counted in the parental
42.19 household and may apply as a separate household.

42.20 (d) Beginning July 1, 2003, or upon federal approval, whichever is later, parents
42.21 are not eligible for MinnesotaCare if their gross income exceeds ~~\$50,000~~ \$25,000 for the
42.22 six-month period of eligibility.

42.23 Sec. 6. Minnesota Statutes 2006, section 256L.04, subdivision 12, is amended to read:

42.24 Subd. 12. **Persons in detention.** Beginning January 1, 1999, an applicant residing
42.25 in a correctional or detention facility is not eligible for MinnesotaCare. An enrollee
42.26 residing in a correctional or detention facility is not eligible at renewal of eligibility under
42.27 section 256L.05, subdivision ~~3b~~ 3a.

42.28 **ARTICLE 4**

42.29 **MISCELLANEOUS**

42.30 Section 1. Laws 2005, chapter 98, article 3, section 25, is amended to read:

42.31 Sec. 25. **REPEALER.**

42.32 Minnesota Statutes 2004, sections 245.713, ~~subdivisions 2 and~~ subdivision 4;
42.33 245.716; and 626.5551, subdivision 4, are repealed.

43.1 **EFFECTIVE DATE.** This section is effective retroactively from August 1, 2005.

43.2 Sec. 2. **REVISOR'S INSTRUCTION.**

43.3 The revisor of statutes shall change the terms in column A to the terms in column B
43.4 wherever they appear in Minnesota Statutes,

43.5	<u>Column A</u>	<u>Column B</u>
43.6	<u>"Office of Ombudsman</u>	<u>"Office of Ombudsman</u>
43.7	<u>for Older Minnesotans"</u>	<u>for Long-Term Care"</u>
43.8	<u>and "Office of the</u>	
43.9	<u>Ombudsman for Older</u>	
43.10	<u>Minnesotans"</u>	
43.11	<u>"ombudsman for older</u>	<u>"ombudsman for</u>
43.12	<u>Minnesotans"</u>	<u>long-term care"</u>

43.13 Sec. 3. **MINNESOTA RULES.**

43.14 The Department of Administration shall publish adopted rules in the State Register
43.15 making the terminology changes specified in section 2 in Minnesota Rules. Upon
43.16 publication in the State Register, the terminology changes for Minnesota Rules are
43.17 adopted without further administrative action.

43.18 Sec. 4. **REPEALER.**

43.19 (a) Minnesota Statutes 2006, sections 252.21; 252.22; 252.23; 252.24; 252.25;
43.20 252.261; 252.275, subdivision 5; 254A.02, subdivisions 7, 9, 12, 14, 15, and 16;
43.21 254A.085; 254A.086; 254A.12; 254A.14; 254A.15; 254A.16, subdivision 5; 254A.175;
43.22 254A.18; 256B.0913, subdivisions 5b, 5c, 5d, 5e, 5f, 5g, and 5h; 256J.561, subdivision 1;
43.23 256J.62, subdivision 9; and 256J.65, are repealed.
43.24 (b) Minnesota Rules, part 9503.0035, subpart 2, is repealed.