

A bill for an act

relating to human services; amending continuing care policy provisions; making changes to the telephone equipment program; making changes to disability services provisions; reforming comprehensive assessments and case management services; making changes to nursing facility provisions; making technical and conforming changes; providing for rulemaking authority; requiring reports; amending Minnesota Statutes 2010, sections 144A.071, subdivisions 3, 4a, 5a; 144A.073, subdivision 3c, by adding a subdivision; 144D.03, subdivision 2; 144D.04, subdivision 2; 237.50; 237.51; 237.52; 237.53; 237.54; 237.55; 237.56; 245A.03, subdivision 7; 245A.11, subdivision 8; 245B.02, subdivision 20; 245B.06, subdivision 7; 252.32, subdivision 1a; 252.40; 252.41, subdivisions 1, 3; 252.42; 252.43; 252.44; 252.45; 252.451, subdivisions 2, 5; 252.46, subdivision 1a; 252A.21, subdivision 2; 256.476, subdivision 11; 256B.0625, subdivision 19c; 256B.0659, subdivisions 1, 2, 3, 3a, 4, 9, 11, 13, 14, 19, 21, 30; 256B.0911, subdivisions 1, 1a, 2b, 2c, 3, 3a, 3b, 3c, 4a, 4c, 6; 256B.0913, subdivisions 7, 8; 256B.0915, subdivisions 1a, 1b, 3c, 6; 256B.0916, subdivision 7; 256B.092, subdivisions 1, 1a, 1b, 1e, 1g, 2, 3, 5, 7, 8, 8a, 9, 11; 256B.096, subdivision 5; 256B.19, subdivision 1e; 256B.431, subdivisions 2t, 26; 256B.438, subdivisions 1, 3, 4, by adding a subdivision; 256B.441, subdivision 55a, by adding a subdivision; 256B.49, subdivisions 13, 14, 15, 21; 256B.4912; 256B.501, subdivision 4b; 256B.5013, subdivision 1; 256B.5015, subdivision 1; 256B.765; 256G.02, subdivision 6; Laws 2009, chapter 79, article 8, section 81, as amended; proposing coding for new law in Minnesota Statutes, chapter 252; repealing Minnesota Statutes 2010, sections 144A.073, subdivisions 4, 5; 252.46, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 16, 17, 18, 19, 20, 21; 256.0112, subdivision 6; 256B.092, subdivision 8a; 256B.49, subdivision 16a; 256B.501, subdivision 8.

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

ARTICLE 1

TELEPHONE EQUIPMENT PROGRAM

Section 1. Minnesota Statutes 2010, section 237.50, is amended to read:

237.50 DEFINITIONS.

Subdivision 1. **Scope.** The terms used in sections 237.50 to 237.56 have the meanings given them in this section.

Subd. 3. **Communication ~~impaired~~ disability.** "Communication ~~impaired~~ disability" means certified as ~~deaf, severely hearing impaired, hard-of-hearing~~ having a hearing loss, speech ~~impaired, deaf and blind~~ disability, or ~~mobility impaired if the mobility impairment significantly impedes the ability~~ physical disability that makes it difficult or impossible to use ~~standard customer premises~~ telecommunications services and equipment.

~~Subd. 4. **Communication device.** "Communication device" means a device that when connected to a telephone enables a communication-impaired person to communicate with another person utilizing the telephone system. A "communication device" includes a ring signaler, an amplification device, a telephone device for the deaf, a Braille device for use with a telephone, and any other device the Department of Human Services deems necessary.~~

Subd. 4a. **Deaf.** "Deaf" means a hearing ~~impairment~~ loss of such severity that the individual must depend primarily upon visual communication such as writing, lip reading, ~~manual communication~~ sign language, and gestures.

~~Subd. 5. **Exchange.** "Exchange" means a unit area established and described by the tariff of a telephone company for the administration of telephone service in a specified geographical area, usually embracing a city, town, or village and its environs, and served by one or more central offices, together with associated facilities used in providing service within that area.~~

Subd. 6. **Fund.** "Fund" means the telecommunications access Minnesota fund established in section 237.52.

Subd. 6a. **Hard-of-hearing.** "Hard-of-hearing" means a hearing ~~impairment~~ loss resulting in a functional ~~loss~~ limitation, but not to the extent that the individual must depend primarily upon visual communication.

~~Subd. 7. **Interexchange service.** "Interexchange service" means telephone service between points in two or more exchanges.~~

~~Subd. 8. **Inter-LATA interexchange service.** "Inter-LATA interexchange service" means interexchange service originating and terminating in different LATAs.~~

~~Subd. 9. **Local access and transport area.** "Local access and transport area (LATA)" means a geographical area designated by the Modification of Final Judgment in U.S. v. Western Electric Co., Inc., 552 F. Supp. 131 (D.D.C. 1982), including modifications in effect on the effective date of sections 237.51 to 237.54.~~

~~Subd. 10. **Local exchange service.** "Local exchange service" means telephone service between points within an exchange.~~

Subd. 10a. **Telecommunications device.** "Telecommunications device" means a device that (1) allows a person with a communication disability to have access to telecommunications services as defined in subdivision 13, and (2) is specifically selected by the Department of Human Services for its capacity to allow persons with communication disabilities to use telecommunications services in a manner that is functionally equivalent to the ability of an individual who does not have a communication disability. A telecommunications device may include a ring signaler, an amplified telephone, a hands-free telephone, a text telephone, a captioned telephone, a wireless device, a device that produces Braille output for use with a telephone, and any other device the Department of Human Services deems appropriate.

Subd. 11. ~~**Telecommunication**~~ **Telecommunications Relay service Services.** "~~Telecommunication~~ Telecommunications Relay service Services" or "TRS" means ~~a central statewide service through which a communication-impaired person, using a communication device, may send and receive messages to and from a non-communication-impaired person whose telephone is not equipped with a communication device and through which a non-communication-impaired person may, by using voice communication, send and receive messages to and from a communication-impaired person~~ the telecommunications transmission services required under Federal Communications Commission (FCC) regulations at Code of Federal Regulations, title 47, sections 64.604 to 64.606. TRS allows an individual who has a communication disability to use telecommunications services in a manner that is functionally equivalent to the ability of an individual who does not have a communication disability.

Subd. 12. **Telecommunications.** "Telecommunications" means the transmission, between or among points specified by the user, of information of the user's choosing, without change in the form or content of the information as sent and received.

Subd. 13. **Telecommunications services.** "Telecommunications services" means the offering of telecommunications for fee directly to the public, or to such classes of users as to be effectively available to the public, regardless of the facilities used.

Sec. 2. Minnesota Statutes 2010, section 237.51, is amended to read:

**237.51 TELECOMMUNICATIONS ACCESS MINNESOTA PROGRAM
ADMINISTRATION.**

Subdivision 1. **Creation.** The commissioner of commerce shall:

(1) administer through interagency agreement with the commissioner of human services a program to distribute ~~communication~~ telecommunications devices to eligible ~~communication-impaired~~ persons who have communication disabilities; and

(2) contract with ~~a~~ one or more qualified ~~vendor~~ vendors that ~~serves~~ communication-impaired serve persons who have communication disabilities to ~~create and maintain a telecommunication~~ provide telecommunications relay ~~service~~ services.

For purposes of sections 237.51 to 237.56, the Department of Commerce and any organization with which it contracts pursuant to this section or section 237.54, subdivision 2, are not telephone companies or telecommunications carriers as defined in section 237.01.

Subd. 5. **Commissioner of commerce duties.** In addition to any duties specified elsewhere in sections 237.51 to 237.56, the commissioner of commerce shall:

(1) prepare the reports required by section 237.55;

(2) administer the fund created in section 237.52; and

(3) adopt rules under chapter 14 to implement the provisions of sections 237.50 to 237.56.

Subd. 5a. ~~Department~~ **Commissioner of human services duties.** (a) In addition to any duties specified elsewhere in sections 237.51 to 237.56, the commissioner of human services shall:

(1) define economic hardship, special needs, and household criteria so as to determine the priority of eligible applicants for initial distribution of devices and to determine circumstances necessitating provision of more than one ~~communication~~ telecommunications device per household;

(2) establish a method to verify eligibility requirements;

(3) establish specifications for ~~communication~~ telecommunications devices to be ~~purchased~~ provided under section 237.53, subdivision 3; ~~and~~

(4) inform the public and specifically ~~the community of communication-impaired~~ persons who have communication disabilities of the program; ~~and~~

(5) provide devices based on the assessed need of eligible applicants.

(b) The commissioner may establish an advisory board to advise the department in carrying out the duties specified in this section and to advise the commissioner of commerce in carrying out duties under section 237.54. If so established, the advisory board must include, at a minimum, the following ~~communication-impaired~~ persons:

(1) at least one member who is deaf;

(2) at least one member who ~~is~~ has a speech ~~impaired~~ disability;

(3) at least one member who ~~is mobility impaired~~ has a physical disability that makes it difficult or impossible for the person to access telecommunications services; and
(4) at least one member who is hard-of-hearing.

The membership terms, compensation, and removal of members and the filling of membership vacancies are governed by section 15.059. Advisory board meetings shall be held at the discretion of the commissioner.

Sec. 3. Minnesota Statutes 2010, section 237.52, is amended to read:

237.52 TELECOMMUNICATIONS ACCESS MINNESOTA FUND.

Subdivision 1. **Fund established.** A telecommunications access Minnesota fund is established as an account in the state treasury. Earnings, such as interest, dividends, and any other earnings arising from fund assets, must be credited to the fund.

Subd. 2. **Assessment.** (a) The commissioner of commerce, the commissioner of employment and economic development, and the commissioner of human services shall annually recommend to the Public Utilities Commission (PUC) an adequate and appropriate surcharge and budget to implement sections 237.50 to 237.56, 248.062, and 256C.30, respectively. The maximum annual budget for section 248.062 must not exceed \$100,000 and for section 256C.30 must not exceed \$300,000. The Public Utilities Commission shall review the budgets for reasonableness and may modify the budget to the extent it is unreasonable. The commission shall annually determine the funding mechanism to be used within 60 days of receipt of the recommendation of the departments and shall order the imposition of surcharges effective on the earliest practicable date. The commission shall establish a monthly charge no greater than 20 cents for each customer access line, including trunk equivalents as designated by the commission pursuant to section 403.11, subdivision 1.

(b) If the fund balance falls below a level capable of fully supporting all programs eligible under subdivision 5 and sections 248.062 and 256C.30, expenditures under sections 248.062 and 256C.30 shall be reduced on a pro rata basis and expenditures under sections 237.53 and 237.54 shall be fully funded. Expenditures under sections 248.062 and 256C.30 shall resume at fully funded levels when the commissioner of commerce determines there is a sufficient fund balance to fully fund those expenditures.

Subd. 3. **Collection.** Every ~~telephone company or communications carrier that provides service~~ provider of services capable of originating a ~~telecommunications relay~~ TRS call, including cellular communications and other nonwire access services, in this state shall collect the charges established by the commission under subdivision 2 and transfer amounts collected to the commissioner of public safety in the same manner as

provided in section 403.11, subdivision 1, paragraph (d). The commissioner of public safety must deposit the receipts in the fund established in subdivision 1.

Subd. 4. **Appropriation.** Money in the fund is appropriated to the commissioner of commerce to implement sections 237.51 to 237.56, to the commissioner of employment and economic development to implement section 248.062, and to the commissioner of human services to implement section 256C.30.

Subd. 5. **Expenditures.** (a) Money in the fund may only be used for:

(1) expenses of the Department of Commerce, including personnel cost, public relations, advisory board members' expenses, preparation of reports, and other reasonable expenses not to exceed ten percent of total program expenditures;

(2) reimbursing the commissioner of human services for purchases made or services provided pursuant to section 237.53;

(3) reimbursing telephone companies for purchases made or services provided under section 237.53, subdivision 5; and

(4) contracting for ~~establishment and operation of the telecommunication relay service~~ the provision of TRS required by section 237.54.

(b) All costs directly associated with the establishment of the program, the purchase and distribution of ~~communication~~ telecommunications devices, and the ~~establishment and operation of the telecommunication relay service~~ provision of TRS are either reimbursable or directly payable from the fund after authorization by the commissioner of commerce. The commissioner of commerce shall contract with ~~the message relay service operator~~ one or more TRS providers to indemnify the ~~local exchange carriers of the relay telecommunications service providers~~ for any fines imposed by the Federal Communications Commission related to the failure of the relay service to comply with federal service standards. Notwithstanding section 16A.41, the commissioner may advance money to the ~~contractor of the telecommunication relay service~~ TRS providers if the ~~contractor establishes~~ providers establish to the commissioner's satisfaction that the advance payment is necessary for the ~~operation~~ provision of the service. The advance payment may be used only for working capital reserve for the operation of the service. The advance payment must be offset or repaid by the end of the contract fiscal year together with interest accrued from the date of payment.

Sec. 4. Minnesota Statutes 2010, section 237.53, is amended to read:

237.53 ~~COMMUNICATION~~ TELECOMMUNICATIONS DEVICE.

Subdivision 1. **Application.** A person applying for a ~~communication~~ telecommunications device under this section must apply to the program administrator on a form prescribed by the Department of Human Services.

Subd. 2. **Eligibility.** To be eligible to obtain a ~~communication~~ telecommunications device under this section, a person must ~~be~~:

(1) ~~be~~ able to benefit from and use the equipment for its intended purpose;

(2) ~~have a communication impaired~~ disability;

(3) ~~be~~ a resident of the state;

(4) ~~be~~ a resident in a household that has a median income at or below the applicable median household income in the state, except a ~~deaf and blind~~ person who has both hearing and vision loss applying for a ~~telebraille unit~~ Braille device may reside in a household that has a median income no more than 150 percent of the applicable median household income in the state; and

(5) ~~be~~ a resident in a household that has ~~telephone~~ telecommunications service or that has made application for service and has been assigned a telephone number; or a resident in a residential care facility, such as a nursing home or group home where ~~telephone~~ telecommunications service is not included as part of overall service provision.

Subd. 3. **Distribution.** The commissioner of human services shall purchase and distribute a sufficient number of ~~communication~~ telecommunications devices so that each eligible household receives ~~an appropriate device~~ devices as determined under section 237.51, subdivision 5a. The commissioner of human services shall distribute the devices to eligible households ~~in each service area free of charge as determined under section 237.51, subdivision 5a~~.

Subd. 4. **Training; maintenance.** The commissioner of human services shall maintain the ~~communication~~ telecommunications devices until the warranty period expires, and provide training, without charge, to first-time users of the devices.

~~Subd. 5. **Wiring installation.** If a communication-impaired person is not served by telephone service and is subject to economic hardship as determined by the Department of Human Services, the telephone company providing local service shall at the direction of the administrator of the program install necessary outside wiring without charge to the household.~~

Subd. 6. **Ownership.** ~~All communication~~ Telecommunications devices purchased pursuant to subdivision 3 ~~will become~~ are the property of the state of Minnesota. Policies and procedures for the return of devices from individuals who withdraw from the program or whose eligibility status changes shall be determined by the commissioner of human services.

Subd. 7. **Standards.** The ~~communication~~ telecommunications devices distributed under this section must comply with the electronic industries ~~association~~ alliance standards and be approved by the Federal Communications Commission. The commissioner of human services must provide each eligible person a choice of several models of devices, the retail value of which may not exceed \$600 for a ~~communication device for the deaf~~ text telephone, and a retail value of \$7,000 for a ~~telebraille~~ Braille device, or an amount authorized by the Department of Human Services for a ~~telephone device for the deaf with auxiliary equipment~~ all other telecommunications devices and auxiliary equipment it deems cost-effective and appropriate to distribute according to sections 237.51 to 237.56.

Sec. 5. Minnesota Statutes 2010, section 237.54, is amended to read:

237.54 TELECOMMUNICATION TELECOMMUNICATIONS RELAY SERVICE SERVICES (TRS).

Subd. 2. **Operation.** (a) The commissioner of commerce shall contract with ~~a one or more qualified vendor~~ vendors for the ~~operation and maintenance of the telecommunication relay system~~ provision of Telecommunications Relay Services (TRS).

(b) The ~~telecommunication relay service provider~~ TRS providers shall operate the relay service within the state of Minnesota. The ~~operator of the system~~ TRS providers shall ~~keep all messages confidential, shall train personnel in the unique needs of communication-impaired people, and shall inform communication-impaired persons and the public of the availability and use of the system. Except in the case of a speech- or mobility-impaired person, the operator shall not relay a message unless it originates or terminates through a communication device for the deaf or a Braille device for use with a telephone~~ comply with all current and subsequent FCC regulations at Code of Federal Regulations, title 47, sections 64.601 to 64.606, and shall inform persons who have communication disabilities and the public of the availability and use of TRS.

Sec. 6. Minnesota Statutes 2010, section 237.55, is amended to read:

237.55 ANNUAL REPORT ON COMMUNICATION TELECOMMUNICATIONS ACCESS.

The commissioner of commerce must prepare a report for presentation to the Public Utilities Commission by January 31 of each year. Each report must review the accessibility of ~~the telephone system to communication-impaired persons, review the ability of non-communication-impaired persons to communicate with communication-impaired persons via the telephone system~~ telecommunications services to persons who have communication disabilities, describe services provided, account for ~~money received and~~

9.1 ~~disbursed annually~~ annual revenues and expenditures for each aspect of the ~~program~~ fund
9.2 to date, and include predicted program future operation.

9.3 Sec. 7. Minnesota Statutes 2010, section 237.56, is amended to read:

9.4 **237.56 ADEQUATE SERVICE ENFORCEMENT.**

9.5 The services required to be provided under sections 237.50 to 237.55 may be
9.6 enforced under section 237.081 upon a complaint of at least two ~~communication-impaired~~
9.7 persons within the service area of any one ~~telephone company~~ telecommunications
9.8 service provider, provided that if only one person within the service area of a company
9.9 is receiving service under sections 237.50 to 237.55, the ~~commission~~ Public Utilities
9.10 Commission may proceed upon a complaint from that person.

9.11 **ARTICLE 2**

9.12 **DISABILITY SERVICES**

9.13 Section 1. Minnesota Statutes 2010, section 245A.03, subdivision 7, is amended to
9.14 read:

9.15 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an
9.16 initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to
9.17 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to
9.18 9555.6265, under this chapter for a physical location that will not be the primary residence
9.19 of the license holder for the entire period of licensure. If a license is issued during this
9.20 moratorium, and the license holder changes the license holder's primary residence away
9.21 from the physical location of the foster care license, the commissioner shall revoke the
9.22 license according to section 245A.07. Exceptions to the moratorium include:

9.23 (1) foster care settings that are required to be registered under chapter 144D;

9.24 (2) foster care licenses replacing foster care licenses in existence on May 15, 2009,
9.25 and determined to be needed by the commissioner under paragraph (b);

9.26 (3) new foster care licenses determined to be needed by the commissioner under
9.27 paragraph (b) for the closure or downsizing of a nursing facility, ICF/MR, or regional
9.28 treatment center;

9.29 (4) new foster care licenses determined to be needed by the commissioner under
9.30 paragraph (b) for persons requiring hospital level care; or

9.31 (5) new foster care licenses determined to be needed by the commissioner for the
9.32 transition of people from personal care assistance to the home and community-based
9.33 services.

(b) The commissioner shall determine the need for newly licensed foster care homes as defined under this subdivision. As part of the determination, the commissioner shall consider the availability of foster care capacity in the area in which the licensee seeks to operate, and the recommendation of the local county board. The determination by the commissioner must be final. A determination of need is not required for a change in ownership at the same address.

~~(c) Residential settings that would otherwise be subject to the moratorium established in paragraph (a), that are in the process of receiving an adult or child foster care license as of July 1, 2009, shall be allowed to continue to complete the process of receiving an adult or child foster care license. For this paragraph, all of the following conditions must be met to be considered in the process of receiving an adult or child foster care license:~~

~~(1) participants have made decisions to move into the residential setting, including documentation in each participant's care plan;~~

~~(2) the provider has purchased housing or has made a financial investment in the property;~~

~~(3) the lead agency has approved the plans, including costs for the residential setting for each individual;~~

~~(4) the completion of the licensing process, including all necessary inspections, is the only remaining component prior to being able to provide services; and~~

~~(5) the needs of the individuals cannot be met within the existing capacity in that county.~~

~~To qualify for the process under this paragraph, the lead agency must submit documentation to the commissioner by August 1, 2009, that all of the above criteria are met.~~

~~(d)~~ (c) The commissioner shall study the effects of the license moratorium under this subdivision and shall report back to the legislature by January 15, 2011. This study shall include, but is not limited to the following:

(1) the overall capacity and utilization of foster care beds where the physical location is not the primary residence of the license holder prior to and after implementation of the moratorium;

(2) the overall capacity and utilization of foster care beds where the physical location is the primary residence of the license holder prior to and after implementation of the moratorium; and

(3) the number of licensed and occupied ICF/MR beds prior to and after implementation of the moratorium.

(d) At the time of application and reapplication for licensure, the applicant and the license holder that are subject to the moratorium or an exclusion established in paragraph (a) are required to inform the commissioner whether the physical location where the foster care will be provided is or will be the primary residence of the license holder for the entire period of licensure. If the primary residence of the applicant or license holder changes, the applicant or license holder must notify the commissioner immediately. The commissioner shall print on the foster care license certificate whether or not the physical location is the primary residence of the license holder.

(e) License holders of foster care homes identified under paragraph (e) that are not the primary residence of the license holder and that also provide services in the foster care home that are covered by a federally approved home and community-based services waiver, as authorized under section 256B.0915, 256B.092, or 256B.49 must inform the human services licensing division that the license holder provides or intends to provide these waiver-funded services. These license holders must be considered registered under section 256B.092, subdivision 11, paragraph (c), and this registration status must be identified on their license certificates.

Sec. 2. Minnesota Statutes 2010, section 245A.11, subdivision 8, is amended to read:

Subd. 8. **Community residential setting license.** (a) The commissioner shall establish provider standards for residential support services that integrate service standards and the residential setting under one license. The commissioner shall propose statutory language and an implementation plan for licensing requirements for residential support services to the legislature by January 15, ~~2011~~ 2012, as a component of the quality outcome standards recommendations required by Laws 2010, chapter 352, article 1, section 24.

(b) Providers licensed under chapter 245B, and providing, contracting, or arranging for services in settings licensed as adult foster care under Minnesota Rules, parts 9555.5105 to 9555.6265, or child foster care under Minnesota Rules, parts 2960.3000 to 2960.3340; and meeting the provisions of section 256B.092, subdivision 11, paragraph (b), must be required to obtain a community residential setting license.

Sec. 3. Minnesota Statutes 2010, section 252.32, subdivision 1a, is amended to read:

Subd. 1a. **Support grants.** (a) Provision of support grants must be limited to families who require support and whose dependents are under the age of 21 and who have been certified disabled under section 256B.055, subdivision 12, paragraphs (a), (b), (c), (d), and (e). Families who are receiving home and community-based waived services for persons with ~~developmental~~ disabilities authorized under section 256B.092 or

12.1 256B.49; personal care assistance under section 256B.0652; or a consumer support grant
12.2 under section 256.476 are not eligible for support grants.

12.3 Families whose annual adjusted gross income is \$60,000 or more are not eligible for
12.4 support grants except in cases where extreme hardship is demonstrated. Beginning in state
12.5 fiscal year 1994, the commissioner shall adjust the income ceiling annually to reflect the
12.6 projected change in the average value in the United States Department of Labor Bureau of
12.7 Labor Statistics Consumer Price Index (all urban) for that year.

12.8 (b) Support grants may be made available as monthly subsidy grants and lump-sum
12.9 grants.

12.10 (c) Support grants may be issued in the form of cash, voucher, and direct county
12.11 payment to a vendor.

12.12 (d) Applications for the support grant shall be made by the legal guardian to the
12.13 county social service agency. The application shall specify the needs of the families, the
12.14 form of the grant requested by the families, and the items and services to be reimbursed.

12.15 Sec. 4. **[252.34] REPORT BY COMMISSIONER.**

12.16 Beginning January 1, 2013, the commissioner shall provide a biennial report to the
12.17 chairs of the legislative committees with jurisdiction over health and human services
12.18 policy and funding. The report must provide a summary of overarching goals and priorities
12.19 for persons with disabilities, including the status of how each of the following programs
12.20 administered by the commissioner is supporting the overarching goals and priorities:

12.21 (1) home and community-based services waivers for persons with disabilities under
12.22 sections 256B.092 and 256B.49;

12.23 (2) home care services under section 256B.0652; and

12.24 (3) other relevant programs and services as determined by the commissioner.

12.25 Sec. 5. Minnesota Statutes 2010, section 252.40, is amended to read:

12.26 **252.40 SERVICE PRINCIPLES AND RATE-SETTING PROCEDURES.**

12.27 (a) Sections 252.40 to 252.46 apply to day training and habilitation services for
12.28 adults with developmental disabilities when the services are authorized to be funded by a
12.29 county and provided under a contract between a county board and a vendor as defined
12.30 in section 252.41. Nothing in sections 252.40 to 252.46 absolves intermediate care
12.31 facilities for persons with developmental disabilities of the responsibility for providing
12.32 active treatment and habilitation under federal regulations with which those facilities must
12.33 comply to be certified by the Minnesota Department of Health.

13.1 (b) This section expires January 1, 2013, or on the date the commissioner adopts
13.2 rules for the administration of home and community-based services waivers under section
13.3 256B.4912, subdivision 4, whichever is sooner.

13.4 Sec. 6. Minnesota Statutes 2010, section 252.41, subdivision 3, is amended to read:

13.5 Subd. 3. **Day training and habilitation services for adults with developmental**
13.6 **disabilities.** "Day training and habilitation services for adults with developmental
13.7 disabilities" means services that:

13.8 (1) include supervision, training, assistance, and supported employment,
13.9 work-related activities, or other community-integrated activities designed and
13.10 implemented in accordance with the individual service and individual habilitation plans
13.11 required under Minnesota Rules, parts 9525.0015 to 9525.0165, to help an adult reach
13.12 and maintain the highest possible level of independence, productivity, and integration
13.13 into the community; and

13.14 (2) are provided ~~under contract with the county where the services are delivered~~
13.15 by a vendor licensed under sections 245A.01 to 245A.16 and 252.28, subdivision 2, to
13.16 provide day training and habilitation services.

13.17 Day training and habilitation services reimbursable under this section do not include
13.18 special education and related services as defined in the Education of the Individuals with
13.19 Disabilities Act, United States Code, title 20, chapter 33, section 1401, clauses (6) and
13.20 (17), or vocational services funded under section 110 of the Rehabilitation Act of 1973,
13.21 United States Code, title 29, section 720, as amended.

13.22 **EFFECTIVE DATE.** This section is effective January 1, 2013, or on the date the
13.23 commissioner adopts rules for the administration of home and community-based services
13.24 waivers under section 256B.4912, subdivision 4, whichever is sooner.

13.25 Sec. 7. Minnesota Statutes 2010, section 252.42, is amended to read:

13.26 **252.42 SERVICE PRINCIPLES.**

13.27 The design and delivery of services eligible for reimbursement ~~under the rates~~
13.28 ~~established in section 252.46~~ should reflect the following principles:

13.29 (1) services must suit a person's chronological age and be provided in the least
13.30 restrictive environment possible, consistent with the needs identified in the person's
13.31 individual service and individual habilitation plans under Minnesota Rules, parts
13.32 9525.0015 to 9525.0165;

(2) a person with a developmental disability whose individual service and individual habilitation plans authorize employment or employment-related activities shall be given the opportunity to participate in employment and employment-related activities in which nondisabled persons participate;

(3) a person with a developmental disability participating in work shall be paid wages commensurate with the rate for comparable work and productivity except as regional centers are governed by section 246.151;

(4) a person with a developmental disability shall receive services which include services offered in settings used by the general public and designed to increase the person's active participation in ordinary community activities;

(5) a person with a developmental disability shall participate in the patterns, conditions, and rhythms of everyday living and working that are consistent with the norms of the mainstream of society.

EFFECTIVE DATE. This section is effective January 1, 2013, or on the date the commissioner adopts rules for the administration of home and community-based services waivers under section 256B.4912, subdivision 4, whichever is sooner.

Sec. 8. Minnesota Statutes 2010, section 252.43, is amended to read:

252.43 COMMISSIONER'S DUTIES.

The commissioner shall supervise county boards' provision of day training and habilitation services to adults with developmental disabilities. The commissioner shall:

(1) determine the need for day training and habilitation services under section 252.28;

(2) ~~approve~~ establish payment rates ~~established by a county under section 252.46, subdivision 1~~ under section 256B.4912;

(3) adopt rules for the administration and provision of day training and habilitation services under sections ~~252.40~~ 252.41 to 252.46 and sections 245A.01 to 245A.16 and 252.28, subdivision 2;

(4) enter into interagency agreements necessary to ensure effective coordination and provision of day training and habilitation services;

(5) monitor and evaluate the costs and effectiveness of day training and habilitation services; and

(6) provide information and technical help to county boards and vendors in their administration and provision of day training and habilitation services.

15.1 **EFFECTIVE DATE.** This section is effective January 1, 2013, or on the date the
15.2 commissioner adopts rules for the administration of home and community-based services
15.3 waivers under section 256B.4912, subdivision 4, whichever is sooner.

15.4 Sec. 9. Minnesota Statutes 2010, section 252.44, is amended to read:

15.5 **252.44 COUNTY BOARD RESPONSIBILITIES.**

15.6 ~~(a)~~ When the need for day training and habilitation services in a county has been
15.7 determined under section 252.28, the board of commissioners for that county shall:

15.8 (1) authorize the delivery of services according to the individual service and
15.9 habilitation plans required as part of the county's provision of case management services
15.10 under Minnesota Rules, parts 9525.0015 to 9525.0165. ~~For calendar years for which~~
15.11 ~~section 252.46, subdivisions 2 to 10, apply, the county board shall not authorize a change~~
15.12 ~~in service days from the number of days authorized for the previous calendar year unless~~
15.13 ~~there is documentation for the change in the individual service plan. An increase in service~~
15.14 ~~days must also be supported by documentation that the goals and objectives assigned to the~~
15.15 ~~vendor cannot be met more economically and effectively by other available community~~
15.16 ~~services and that without the additional days of service the individual service plan could~~
15.17 ~~not be implemented in a manner consistent with the service principles in section 252.42;~~

15.18 ~~(2) contract with licensed vendors, as specified in paragraph (b), under sections~~
15.19 ~~256E.12 and 256B.092 and rules adopted under those sections;~~

15.20 ~~(3)~~ (2) ensure that transportation is provided or arranged by the vendor in the most
15.21 efficient and reasonable way possible; and

15.22 ~~(4) set payment rates under section 252.46;~~

15.23 ~~(5)~~ (3) monitor and evaluate ~~the cost and effectiveness of that~~ the services; and
15.24 being paid for are being provided.

15.25 ~~(6) reimburse vendors for the provision of authorized services according to the rates,~~
15.26 ~~procedures, and regulations governing reimbursement.~~

15.27 ~~(b) With all vendors except regional centers, the contract must include the approved~~
15.28 ~~payment rates, the projected budget for the contract period, and any actual expenditures~~
15.29 ~~of previous and current contract periods. With all vendors, including regional centers,~~
15.30 ~~the contract must also include the amount, availability, and components of day training~~
15.31 ~~and habilitation services to be provided, the performance standards governing service~~
15.32 ~~provision and evaluation, and the time period in which the contract is effective.~~

EFFECTIVE DATE. This section is effective January 1, 2013, or on the date the commissioner adopts rules for the administration of home and community-based services waivers under section 256B.4912, subdivision 4, whichever is sooner.

Sec. 10. Minnesota Statutes 2010, section 252.45, is amended to read:

252.45 VENDOR'S DUTIES.

~~A vendor's responsibility~~ vendor enrolled through the process established by the commissioner is responsible under clauses (1), ~~(2), and (3)~~ to (4). This responsibility extends only to the provision of services that are reimbursable under state and federal law. A vendor ~~under contract with a county board to provide~~ providing day training and habilitation services shall:

(1) provide the amount and type of services authorized in the individual service plan under Minnesota Rules, parts 9525.0015 to 9525.0165;

(2) design the services to achieve the outcomes assigned to the vendor in the individual service plan;

(3) provide or arrange for transportation of persons receiving services to and from service sites; and

(4) enter into agreements with community-based intermediate care facilities for persons with developmental disabilities to ensure compliance with applicable federal regulations; ~~and~~

~~(5) comply with state and federal law.~~

EFFECTIVE DATE. This section is effective January 1, 2013, or on the date the commissioner adopts rules for the administration of home and community-based services waivers under section 256B.4912, subdivision 4, whichever is sooner.

Sec. 11. Minnesota Statutes 2010, section 252.451, subdivision 2, is amended to read:

Subd. 2. **Vendor participation and reimbursement.** Notwithstanding requirements in chapter 245A, and sections 252.28, ~~252.40~~ 252.41 to 252.46, and 256B.501, vendors of day training and habilitation services may enter into written agreements with qualified businesses to provide additional training and supervision needed by individuals to maintain their employment.

EFFECTIVE DATE. This section is effective January 1, 2013, or on the date the commissioner adopts rules for the administration of home and community-based services waivers under section 256B.4912, subdivision 4, whichever is sooner.

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Sec. 12. Minnesota Statutes 2010, section 252.451, subdivision 5, is amended to read:

Subd. 5. **Vendor payment.** (a) For purposes of this section, ~~the vendor shall bill and the commissioner shall reimburse the vendor for full-day or partial-day services to a client that would otherwise have been paid to the vendor for providing direct services, provided that both of the following criteria are met:~~

~~(1) the vendor provides services and payments to the qualified business that enable the business to perform support and supervision services for the client that the vendor would otherwise need to perform; and~~

~~(2) the client for whom a rate will be billed will receive full-day or partial-day services from the vendor and the rate to be paid the vendor will allow the client to work with this support and supervision at the qualified business instead of receiving these services from the vendor.~~ vendors of day training and habilitation services that enter into written agreements with qualified businesses shall reimburse the qualified business according to the terms of their written agreement as defined in section 252.45, subdivision 3, clause (5), items (i) and (ii).

(b) Medical assistance reimbursement of services provided to persons receiving day training and habilitation services under this section is subject to the limitations on reimbursement for vocational services under federal law and regulation.

EFFECTIVE DATE. This section is effective January 1, 2013, or on the date the commissioner adopts rules for the administration of home and community-based services waivers under section 256B.4912, subdivision 4, whichever is sooner.

Sec. 13. Minnesota Statutes 2010, section 252.46, subdivision 1a, is amended to read:

Subd. 1a. **Day training and habilitation rates.** The commissioner shall establish a statewide rate-setting methodology for all day training and habilitation services as defined in section 256B.4912. The rate-setting methodology must abide by the principles of transparency and equitability across the state. The methodology must involve a uniform process of structuring rates for each service and must promote quality and participant choice under section 256B.4912.

EFFECTIVE DATE. This section is effective January 1, 2013, or on the date the commissioner adopts rules for the administration of home and community-based services waivers under section 256B.4912, subdivision 4, whichever is sooner.

Sec. 14. Minnesota Statutes 2010, section 252A.21, subdivision 2, is amended to read:

Subd. 2. **Rules.** The commissioner shall adopt rules to implement this chapter. The rules must include standards for performance of guardianship or conservatorship duties including, but not limited to: twice a year visits with the ward; ~~quarterly reviews of records from day, residential, and support services;~~ a requirement that the duties of guardianship or conservatorship and case management not be performed by the same person; specific standards for action on "do not resuscitate" orders, sterilization requests, and the use of psychotropic medication and aversive procedures.

Sec. 15. Minnesota Statutes 2010, section 256.476, subdivision 11, is amended to read:

Subd. 11. **Consumer support grant program after July 1, 2001.** Effective July 1, 2001, the commissioner shall allocate consumer support grant resources to serve additional individuals based on a review of Medicaid authorization and payment information of persons eligible for a consumer support grant from the most recent fiscal year. The commissioner shall use the following methodology to calculate maximum allowable monthly consumer support grant levels:

(1) For individuals whose program of origination is medical assistance home care under sections 256B.0651 and 256B.0653 to 256B.0656, the maximum allowable monthly grant levels are calculated by:

(i) ~~determining 50 percent of the average~~ the service authorization for each individual based on the individual's home care rating assessment;

(ii) calculating the overall ratio of actual payments to service authorizations by program;

(iii) applying the overall ratio to ~~the average 50 percent of the~~ service authorization level of each home care rating; and

(iv) adjusting the result for any authorized rate ~~increases~~ changes provided by the legislature; ~~and~~

~~(v) adjusting the result for the average monthly utilization per recipient.~~

(2) The commissioner ~~may review and evaluate~~ shall ensure the methodology ~~to reflect changes in~~ is consistent with the home care programs.

Sec. 16. Minnesota Statutes 2010, section 256B.0625, subdivision 19c, is amended to read:

Subd. 19c. **Personal care.** Medical assistance covers personal care assistance services provided by an individual who is qualified to provide the services according to subdivision 19a and sections 256B.0651 to 256B.0656, provided in accordance with a plan, and supervised by a qualified professional.

19.1 "Qualified professional" means a mental health professional as defined in section
19.2 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6);
19.3 or a registered nurse as defined in sections 148.171 to 148.285, a licensed social worker
19.4 as defined in sections 148D.010 and 148D.055, or a qualified developmental disabilities
19.5 specialist under section 245B.07, subdivision 4. The qualified professional shall perform
19.6 the duties required in section 256B.0659.

19.7 Sec. 17. Minnesota Statutes 2010, section 256B.0659, subdivision 1, is amended to
19.8 read:

19.9 Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in
19.10 paragraphs (b) to (r) have the meanings given unless otherwise provided in text.

19.11 (b) "Activities of daily living" means grooming, dressing, bathing, transferring,
19.12 mobility, positioning, eating, and toileting.

19.13 (c) "Behavior," effective January 1, 2010, means a category to determine the home
19.14 care rating and is based on the criteria found in this section. "Level I behavior" means
19.15 physical aggression towards self, others, or destruction of property that requires the
19.16 immediate response of another person.

19.17 (d) "Complex health-related needs," effective January 1, 2010, means a category to
19.18 determine the home care rating and is based on the criteria found in this section.

19.19 (e) "Critical activities of daily living," effective January 1, 2010, means transferring,
19.20 mobility, eating, and toileting.

19.21 (f) "Dependency in activities of daily living" means a person requires assistance to
19.22 begin and complete one or more of the activities of daily living.

19.23 (g) "Extended personal care assistance service" means personal care assistance
19.24 services included in a service plan under one of the home and community-based services
19.25 waivers authorized under sections 256B.0915, 256B.092, subdivision 5, and 256B.49,
19.26 which exceed the amount, duration, and frequency of the state plan personal care
19.27 assistance services for participants who:

19.28 (1) need assistance provided periodically during a week, but less than daily will not
19.29 be able to remain in their homes without the assistance, and other replacement services
19.30 are more expensive or are not available when personal care assistance services are to
19.31 be ~~terminated~~ reduced; or

19.32 (2) need additional personal care assistance services beyond the amount authorized
19.33 by the state plan personal care assistance assessment in order to ensure that their safety,
19.34 health, and welfare are provided for in their homes.

(h) "Health-related procedures and tasks" means procedures and tasks that can be delegated or assigned by a licensed health care professional under state law to be performed by a personal care assistant.

(i) "Instrumental activities of daily living" means activities to include meal planning and preparation; basic assistance with paying bills; shopping for food, clothing, and other essential items; performing household tasks integral to the personal care assistance services; communication by telephone and other media; and traveling, including to medical appointments and to participate in the community.

(j) "Managing employee" has the same definition as Code of Federal Regulations, title 42, section 455.

(k) "Qualified professional" means a professional providing supervision of personal care assistance services and staff as defined in section 256B.0625, subdivision 19c.

(l) "Personal care assistance provider agency" means a medical assistance enrolled provider that provides or assists with providing personal care assistance services and includes a personal care assistance provider organization, personal care assistance choice agency, class A licensed nursing agency, and Medicare-certified home health agency.

(m) "Personal care assistant" or "PCA" means an individual employed by a personal care assistance agency who provides personal care assistance services.

(n) "Personal care assistance care plan" means a written description of personal care assistance services developed by the personal care assistance provider according to the service plan.

(o) "Responsible party" means an individual who is capable of providing the support necessary to assist the recipient to live in the community.

(p) "Self-administered medication" means medication taken orally, by injection or insertion, or applied topically without the need for assistance.

(q) "Service plan" means a written summary of the assessment and description of the services needed by the recipient.

(r) "Wages and benefits" means wages and salaries, the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, mileage reimbursement, health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and contributions to employee retirement accounts.

Sec. 18. Minnesota Statutes 2010, section 256B.0659, subdivision 3, is amended to read:

21.1 Subd. 3. **Noncovered personal care assistance services.** (a) Personal care
21.2 assistance services are not eligible for medical assistance payment under this section
21.3 when provided:

21.4 (1) by the recipient's spouse, parent of a recipient under the age of 18, paid legal
21.5 guardian, licensed foster provider, except as allowed under section 256B.0652, subdivision
21.6 10, or responsible party;

21.7 (2) ~~in lieu of other staffing options~~ order to meet staffing or license requirements in a
21.8 residential or child care setting;

21.9 (3) solely as a child care or babysitting service; or

21.10 (4) without authorization by the commissioner or the commissioner's designee.

21.11 (b) The following personal care services are not eligible for medical assistance
21.12 payment under this section when provided in residential settings:

21.13 (1) ~~effective January 1, 2010,~~ when the provider of home care services who is not
21.14 related by blood, marriage, or adoption owns or otherwise controls the living arrangement,
21.15 including licensed or unlicensed services; or

21.16 (2) when personal care assistance services are the responsibility of a residential or
21.17 program license holder under the terms of a service agreement and administrative rules.

21.18 (c) Other specific tasks not covered under paragraph (a) or (b) that are not eligible
21.19 for medical assistance reimbursement for personal care assistance services under this
21.20 section include:

21.21 (1) sterile procedures;

21.22 (2) injections of fluids and medications into veins, muscles, or skin;

21.23 (3) home maintenance or chore services;

21.24 (4) homemaker services not an integral part of assessed personal care assistance
21.25 services needed by a recipient;

21.26 (5) application of restraints or implementation of procedures under section 245.825;

21.27 (6) instrumental activities of daily living for children under the age of 18, except
21.28 when immediate attention is needed for health or hygiene reasons integral to the personal
21.29 care services and the need is listed in the service plan by the assessor; and

21.30 (7) assessments for personal care assistance services by personal care assistance
21.31 provider agencies or by independently enrolled registered nurses.

21.32 Sec. 19. Minnesota Statutes 2010, section 256B.0659, subdivision 9, is amended to
21.33 read:

22.1 Subd. 9. **Responsible party; generally.** (a) "Responsible party" means an
22.2 individual who is capable of providing the support necessary to assist the recipient to live
22.3 in the community.

22.4 (b) A responsible party must be 18 years of age, actively participate in planning and
22.5 directing of personal care assistance services, and attend all assessments for the recipient.

22.6 (c) A responsible party must not be the:

22.7 (1) personal care assistant;

22.8 (2) qualified professional;

22.9 (3) home care provider agency owner or ~~staff~~ manager; ~~or~~

22.10 (4) home care provider agency staff unless staff who are not listed in clauses (1) to
22.11 (3) are related to the recipient by blood, marriage, or adoption; or

22.12 ~~(3)~~ (5) county staff acting as part of employment.

22.13 (d) A licensed family foster parent who lives with the recipient may be the
22.14 responsible party as long as the family foster parent meets the other responsible party
22.15 requirements.

22.16 (e) A responsible party is required when:

22.17 (1) the person is a minor according to section 524.5-102, subdivision 10;

22.18 (2) the person is an incapacitated adult according to section 524.5-102, subdivision
22.19 6, resulting in a court-appointed guardian; or

22.20 (3) the assessment according to subdivision 3a determines that the recipient is in
22.21 need of a responsible party to direct the recipient's care.

22.22 (f) There may be two persons designated as the responsible party for reasons such
22.23 as divided households and court-ordered custodies. Each person named as responsible
22.24 party must meet the program criteria and responsibilities.

22.25 (g) The recipient or the recipient's legal representative shall appoint a responsible
22.26 party if necessary to direct and supervise the care provided to the recipient. The
22.27 responsible party must be identified at the time of assessment and listed on the recipient's
22.28 service agreement and personal care assistance care plan.

22.29 Sec. 20. Minnesota Statutes 2010, section 256B.0659, subdivision 11, is amended to
22.30 read:

22.31 Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant
22.32 must meet the following requirements:

22.33 (1) be at least 18 years of age with the exception of persons who are 16 or 17 years
22.34 of age with these additional requirements:

22.35 (i) supervision by a qualified professional every 60 days; and

- 23.1 (ii) employment by only one personal care assistance provider agency responsible
23.2 for compliance with current labor laws;
- 23.3 (2) be employed by a personal care assistance provider agency;
- 23.4 (3) enroll with the department as a personal care assistant after clearing a background
23.5 study. Except as provided in subdivision 11a, before a personal care assistant provides
23.6 services, the personal care assistance provider agency must initiate a background study on
23.7 the personal care assistant under chapter 245C, and the personal care assistance provider
23.8 agency must have received a notice from the commissioner that the personal care assistant
23.9 is:
- 23.10 (i) not disqualified under section 245C.14; or
- 23.11 (ii) is disqualified, but the personal care assistant has received a set aside of the
23.12 disqualification under section 245C.22;
- 23.13 (4) be able to effectively communicate with the recipient and personal care
23.14 assistance provider agency;
- 23.15 (5) be able to provide covered personal care assistance services according to the
23.16 recipient's personal care assistance care plan, respond appropriately to recipient needs,
23.17 and report changes in the recipient's condition to the supervising qualified professional
23.18 or physician;
- 23.19 (6) not be a consumer of personal care assistance services;
- 23.20 (7) maintain daily written records including, but not limited to, time sheets under
23.21 subdivision 12;
- 23.22 (8) effective January 1, 2010, complete standardized training as determined
23.23 by the commissioner before completing enrollment. The training must be available
23.24 in languages other than English and to those who need accommodations due to
23.25 disabilities. Personal care assistant training must include successful completion of the
23.26 following training components: basic first aid, vulnerable adult, child maltreatment,
23.27 OSHA universal precautions, basic roles and responsibilities of personal care assistants
23.28 including information about assistance with lifting and transfers for recipients, emergency
23.29 preparedness, orientation to positive behavioral practices, fraud issues, and completion of
23.30 time sheets. Upon completion of the training components, the personal care assistant must
23.31 demonstrate the competency to provide assistance to recipients;
- 23.32 (9) complete training and orientation on the needs of the recipient within the first
23.33 seven days after the services begin. This training shall occur where services are provided
23.34 with the recipient present; and
- 23.35 (10) be limited to providing and being paid for up to 275 hours per month, ~~except~~
23.36 ~~that this limit shall be 275 hours per month for the period July 1, 2009, through June 30,~~

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24.1 ~~2011~~, of personal care assistance services regardless of the number of recipients being
24.2 served or the number of personal care assistance provider agencies enrolled with. The
24.3 number of hours worked per day shall not be disallowed by the department unless in
24.4 violation of the law.

24.5 (b) A legal guardian may be a personal care assistant if the guardian is not being paid
24.6 for the guardian services and meets the criteria for personal care assistants in paragraph (a).

24.7 (c) ~~Effective January 1, 2010~~, Persons who do not qualify as a personal care
24.8 assistant include parents, legal guardians, and stepparents of minors; ~~spouses; paid legal~~
24.9 ~~guardians; of adults;~~ family foster care providers, except as otherwise allowed in section
24.10 256B.0625, subdivision 19a, ~~or~~, and staff of a residential setting.

24.11 Sec. 21. Minnesota Statutes 2010, section 256B.0659, subdivision 13, is amended to
24.12 read:

24.13 Subd. 13. **Qualified professional; qualifications.** (a) The qualified professional
24.14 must work for a personal care assistance provider agency and meet the definition under
24.15 section 256B.0625, subdivision 19c. Before a qualified professional provides services, the
24.16 personal care assistance provider agency must initiate a background study on the qualified
24.17 professional under chapter 245C, and the personal care assistance provider agency must
24.18 have received a notice from the commissioner that the qualified professional:

24.19 (1) is not disqualified under section 245C.14; or

24.20 (2) is disqualified, but the qualified professional has received a set aside of the
24.21 disqualification under section 245C.22.

24.22 (b) The qualified professional shall perform the duties of training, supervision, and
24.23 evaluation of the personal care assistance staff and evaluation of the effectiveness of
24.24 personal care assistance services. The qualified professional shall:

24.25 (1) develop and monitor with the recipient a personal care assistance care plan based
24.26 on the service plan and individualized needs of the recipient;

24.27 (2) develop and monitor with the recipient a monthly plan for the use of personal
24.28 care assistance services;

24.29 (3) review documentation of personal care assistance services provided;

24.30 (4) provide training and ensure competency for the personal care assistant in the
24.31 individual needs of the recipient; and

24.32 (5) document all training, communication, evaluations, and needed actions to
24.33 improve performance of the personal care assistants.

24.34 (c) Effective July 1, ~~2010~~ 2011, the qualified professional shall complete the provider
24.35 training with basic information about the personal care assistance program approved by

the commissioner. Newly hired qualified professionals must complete the training within six months of the date hired by a personal care assistance provider agency. Qualified professionals who have completed the required training as a worker from a personal care assistance provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the last three years. The required training ~~shall~~ must be available in languages other than English and to those who need accommodations due to disabilities, with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online, or by electronic remote connection, and. The required training must provide for competency testing to demonstrate an understanding of the content without attending in-person training. A qualified professional is allowed to be employed and is not subject to the training requirement until the training is offered online or through remote electronic connection. A qualified professional employed by a personal care assistance provider agency certified for participation in Medicare as a home health agency is exempt from the training required in this subdivision. When available, the qualified professional working for a Medicare-certified home health agency must successfully complete the competency test. The commissioner shall ensure there is a mechanism in place to verify the identity of persons completing the competency testing electronically.

Sec. 22. Minnesota Statutes 2010, section 256B.0659, subdivision 14, is amended to read:

Subd. 14. **Qualified professional; duties.** (a) Effective January 1, 2010, all personal care assistants must be supervised by a qualified professional.

(b) Through direct training, observation, return demonstrations, and consultation with the staff and the recipient, the qualified professional must ensure and document that the personal care assistant is:

- (1) capable of providing the required personal care assistance services;
- (2) knowledgeable about the plan of personal care assistance services before services are performed; and
- (3) able to identify conditions that should be immediately brought to the attention of the qualified professional.

(c) The qualified professional shall evaluate the personal care assistant within the first 14 days of starting to provide regularly scheduled services for a recipient except for the personal care assistance choice option under subdivision 19, paragraph (a), clause (4). For the initial evaluation, the qualified professional shall evaluate the personal care assistance

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26.1 services for a recipient through direct observation of a personal care assistant's work.
26.2 Subsequent visits to evaluate the personal care assistance services provided to a recipient
26.3 do not require direct observation of each personal care assistant's work and shall occur:
26.4 (1) at least every 90 days thereafter for the first year of a recipient's services;
26.5 (2) every 120 days after the first year of a recipient's service or whenever needed for
26.6 response to a recipient's request for increased supervision of the personal care assistance
26.7 staff; and
26.8 (3) after the first 180 days of a recipient's service, supervisory visits may alternate
26.9 between unscheduled phone or Internet technology and in-person visits, unless the
26.10 in-person visits are needed according to the care plan.
26.11 (d) Communication with the recipient is a part of the evaluation process of the
26.12 personal care assistance staff.
26.13 (e) At each supervisory visit, the qualified professional shall evaluate personal care
26.14 assistance services including the following information:
26.15 (1) satisfaction level of the recipient with personal care assistance services;
26.16 (2) review of the month-to-month plan for use of personal care assistance services;
26.17 (3) review of documentation of personal care assistance services provided;
26.18 (4) whether the personal care assistance services are meeting the goals of the service
26.19 as stated in the personal care assistance care plan and service plan;
26.20 (5) a written record of the results of the evaluation and actions taken to correct any
26.21 deficiencies in the work of a personal care assistant; and
26.22 (6) revision of the personal care assistance care plan as necessary in consultation
26.23 with the recipient or responsible party, to meet the needs of the recipient.
26.24 (f) The qualified professional shall complete the required documentation in the
26.25 agency recipient and employee files and the recipient's home, including the following
26.26 documentation:
26.27 (1) the personal care assistance care plan based on the service plan and individualized
26.28 needs of the recipient;
26.29 (2) a month-to-month plan for use of personal care assistance services;
26.30 (3) changes in need of the recipient requiring a change to the level of service and the
26.31 personal care assistance care plan;
26.32 (4) evaluation results of supervision visits and identified issues with personal care
26.33 assistance staff with actions taken;
26.34 (5) all communication with the recipient and personal care assistance staff; and
26.35 (6) hands-on training or individualized training for the care of the recipient.
26.36 (g) The documentation in paragraph (f) must be done on agency ~~forms~~ templates.

27.1 (h) The services that are not eligible for payment as qualified professional services
27.2 include:

27.3 (1) direct professional nursing tasks that could be assessed and authorized as skilled
27.4 nursing tasks;

27.5 ~~(2) supervision of personal care assistance completed by telephone;~~

27.6 ~~(3)~~ (2) agency administrative activities;

27.7 ~~(4)~~ (3) training other than the individualized training required to provide care for a
27.8 recipient; and

27.9 ~~(5)~~ (4) any other activity that is not described in this section.

27.10 Sec. 23. Minnesota Statutes 2010, section 256B.0659, subdivision 19, is amended to
27.11 read:

27.12 Subd. 19. **Personal care assistance choice option; qualifications; duties.** (a)

27.13 Under personal care assistance choice, the recipient or responsible party shall:

27.14 (1) recruit, hire, schedule, and terminate personal care assistants according to the
27.15 terms of the written agreement required under subdivision 20, paragraph (a);

27.16 (2) develop a personal care assistance care plan based on the assessed needs
27.17 and addressing the health and safety of the recipient with the assistance of a qualified
27.18 professional as needed;

27.19 (3) orient and train the personal care assistant with assistance as needed from the
27.20 qualified professional;

27.21 (4) effective January 1, 2010, supervise and evaluate the personal care assistant with
27.22 the qualified professional, who is required to visit the recipient at least every 180 days;

27.23 (5) monitor and verify in writing and report to the personal care assistance choice
27.24 agency the number of hours worked by the personal care assistant and the qualified
27.25 professional;

27.26 (6) engage in an annual face-to-face reassessment to determine continuing eligibility
27.27 and service authorization; and

27.28 (7) use the same personal care assistance choice provider agency if shared personal
27.29 assistance care is being used.

27.30 (b) The personal care assistance choice provider agency shall:

27.31 (1) meet all personal care assistance provider agency standards;

27.32 (2) enter into a written agreement with the recipient, responsible party, and personal
27.33 care assistants;

27.34 (3) not be related as a parent, child, sibling, or spouse to the recipient, ~~qualified~~
27.35 ~~professional~~, or the personal care assistant; and

(4) ensure arm's-length transactions without undue influence or coercion with the recipient and personal care assistant.

(c) The duties of the personal care assistance choice provider agency are to:

(1) be the employer of the personal care assistant and the qualified professional for employment law and related regulations including, but not limited to, purchasing and maintaining workers' compensation, unemployment insurance, surety and fidelity bonds, and liability insurance, and submit any or all necessary documentation including, but not limited to, workers' compensation and unemployment insurance;

(2) bill the medical assistance program for personal care assistance services and qualified professional services;

(3) request and complete background studies that comply with the requirements for personal care assistants and qualified professionals;

(4) pay the personal care assistant and qualified professional based on actual hours of services provided;

(5) withhold and pay all applicable federal and state taxes;

(6) verify and keep records of hours worked by the personal care assistant and qualified professional;

(7) make the arrangements and pay taxes and other benefits, if any, and comply with any legal requirements for a Minnesota employer;

(8) enroll in the medical assistance program as a personal care assistance choice agency; and

(9) enter into a written agreement as specified in subdivision 20 before services are provided.

Sec. 24. Minnesota Statutes 2010, section 256B.0659, subdivision 21, is amended to read:

Subd. 21. Requirements for initial enrollment of personal care assistance provider agencies. (a) All personal care assistance provider agencies must provide, at the time of enrollment as a personal care assistance provider agency in a format determined by the commissioner, information and documentation that includes, but is not limited to, the following:

(1) the personal care assistance provider agency's current contact information including address, telephone number, and e-mail address;

(2) proof of surety bond coverage in the amount of \$50,000 or ten percent of the provider's payments from Medicaid in the previous year, whichever is less;

(3) proof of fidelity bond coverage in the amount of \$20,000;

- 29.1 (4) proof of workers' compensation insurance coverage;
- 29.2 (5) proof of liability insurance;
- 29.3 (6) a description of the personal care assistance provider agency's organization
- 29.4 identifying the names of all owners, managing employees, staff, board of directors, and
- 29.5 the affiliations of the directors, owners, or staff to other service providers;
- 29.6 (7) a copy of the personal care assistance provider agency's written policies and
- 29.7 procedures including: hiring of employees; training requirements; service delivery;
- 29.8 and employee and consumer safety including process for notification and resolution
- 29.9 of consumer grievances, identification and prevention of communicable diseases, and
- 29.10 employee misconduct;
- 29.11 (8) copies of all other forms the personal care assistance provider agency uses in
- 29.12 the course of daily business including, but not limited to:
- 29.13 (i) a copy of the personal care assistance provider agency's time sheet if the time
- 29.14 sheet varies from the standard time sheet for personal care assistance services approved
- 29.15 by the commissioner, and a letter requesting approval of the personal care assistance
- 29.16 provider agency's nonstandard time sheet;
- 29.17 (ii) the personal care assistance provider agency's template for the personal care
- 29.18 assistance care plan; and
- 29.19 (iii) the personal care assistance provider agency's template for the written
- 29.20 agreement in subdivision 20 for recipients using the personal care assistance choice
- 29.21 option, if applicable;
- 29.22 (9) a list of all training and classes that the personal care assistance provider agency
- 29.23 requires of its staff providing personal care assistance services;
- 29.24 (10) documentation that the personal care assistance provider agency and staff have
- 29.25 successfully completed all the training required by this section;
- 29.26 (11) documentation of the agency's marketing practices;
- 29.27 (12) disclosure of ownership, leasing, or management of all residential properties
- 29.28 that is used or could be used for providing home care services;
- 29.29 (13) documentation that the agency will use the following percentages of revenue
- 29.30 generated from the medical assistance rate paid for personal care assistance services
- 29.31 for employee personal care assistant wages and benefits: 72.5 percent of revenue in the
- 29.32 personal care assistance choice option and 72.5 percent of revenue from other personal
- 29.33 care assistance providers; and
- 29.34 (14) effective May 15, 2010, documentation that the agency does not burden
- 29.35 recipients' free exercise of their right to choose service providers by requiring personal
- 29.36 care assistants to sign an agreement not to work with any particular personal care

30.1 assistance recipient or for another personal care assistance provider agency after leaving
30.2 the agency and that the agency is not taking action on any such agreements or requirements
30.3 regardless of the date signed.

30.4 (b) Personal care assistance provider agencies shall provide the information specified
30.5 in paragraph (a) to the commissioner at the time the personal care assistance provider
30.6 agency enrolls as a vendor or upon request from the commissioner. The commissioner
30.7 shall collect the information specified in paragraph (a) from all personal care assistance
30.8 providers beginning July 1, 2009.

30.9 (c) All personal care assistance provider agencies shall require all employees in
30.10 management and supervisory positions and owners of the agency who are active in the
30.11 day-to-day management and operations of the agency to complete mandatory training
30.12 as determined by the commissioner before enrollment of the agency as a provider.
30.13 Employees in management and supervisory positions and owners who are active in
30.14 the day-to-day operations of an agency who have completed the required training as
30.15 an employee with a personal care assistance provider agency do not need to repeat
30.16 the required training if they are hired by another agency, if they have completed the
30.17 training within the past three years. By September 1, 2010, the required training must be
30.18 ~~available in languages other than English and to those who need accommodations due~~
30.19 ~~to disabilities;~~ with meaningful access according to title VI of the Civil Rights Act and
30.20 federal regulations adopted under that law or any guidance from the United States Health
30.21 and Human Services Department. The required training must be available online; or by
30.22 electronic remote connection; and. The required training must provide for competency
30.23 testing. Personal care assistance provider agency billing staff shall complete training about
30.24 personal care assistance program financial management. This training is effective July 1,
30.25 2009. Any personal care assistance provider agency enrolled before that date shall, if it
30.26 has not already, complete the provider training within 18 months of July 1, 2009. Any new
30.27 owners or employees in management and supervisory positions involved in the day-to-day
30.28 operations are required to complete mandatory training as a requisite of working for the
30.29 agency. Personal care assistance provider agencies certified for participation in Medicare
30.30 as home health agencies are exempt from the training required in this subdivision. When
30.31 available, Medicare-certified home health agency owners, supervisors, or managers must
30.32 successfully complete the competency test.

30.33 Sec. 25. Minnesota Statutes 2010, section 256B.0659, subdivision 30, is amended to
30.34 read:

30.35 Subd. 30. **Notice of service changes to recipients.** The commissioner must provide:

(1) by October 31, 2009, information to recipients likely to be affected that (i) describes the changes to the personal care assistance program that may result in the loss of access to personal care assistance services, and (ii) includes resources to obtain further information;

(2) effective through January 1, 2012, notice of changes in medical assistance personal care assistance services to each affected recipient at least 30 days before the effective date of the change.

The notice shall include how to get further information on the changes, how to get help to obtain other services, a list of community resources, and appeal rights. Notwithstanding section 256.045, a recipient may request continued services pending appeal within the time period allowed to request an appeal; and

(3) a service agreement authorizing personal care assistance hours of service at the previously authorized level, throughout the appeal process period, when a recipient requests services pending an appeal.

Sec. 26. Minnesota Statutes 2010, section 256B.0916, subdivision 7, is amended to read:

Subd. 7. **Annual report by commissioner.** (a) Beginning November 1, 2001, and each November 1 thereafter, the commissioner shall issue an annual report on county and state use of available resources for the home and community-based waiver for persons with developmental disabilities. For each county or county partnership, the report shall include:

(1) the amount of funds allocated but not used;

(2) the county specific allowed reserve amount approved and used;

(3) the number, ages, and living situations of individuals screened and waiting for services;

(4) the urgency of need for services to begin within one, two, or more than two years for each individual;

(5) the services needed;

(6) the number of additional persons served by approval of increased capacity within existing allocations;

(7) results of action by the commissioner to streamline administrative requirements and improve county resource management; and

(8) additional action that would decrease the number of those eligible and waiting for waived services.

The commissioner shall specify intended outcomes for the program and the degree to which these specified outcomes are attained.

32.1 (b) This subdivision expires January 1, 2012.

32.2 Sec. 27. Minnesota Statutes 2010, section 256B.092, subdivision 1b, is amended to
32.3 read:

32.4 Subd. 1b. **Individual service plan.** The individual service plan must:

32.5 (1) include the results of the assessment information on the person's need for service,
32.6 including identification of service needs that will be or that are met by the person's
32.7 relatives, friends, and others, as well as community services used by the general public;

32.8 (2) identify the person's preferences for services as stated by the person, the person's
32.9 legal guardian or conservator, or the parent if the person is a minor;

32.10 (3) identify long- and short-range goals for the person;

32.11 (4) identify specific services and the amount and frequency of the services to be
32.12 provided to the person based on assessed needs, preferences, and available resources.

32.13 The individual service plan shall also specify other services the person needs that are
32.14 not available;

32.15 (5) identify the need for an individual program plan to be developed by the provider
32.16 according to the respective state and federal licensing and certification standards, and
32.17 additional assessments to be completed or arranged by the provider after service initiation;

32.18 (6) identify provider responsibilities to implement and make recommendations for
32.19 modification to the individual service plan;

32.20 (7) include notice of the right to request a conciliation conference or a hearing
32.21 under section 256.045;

32.22 (8) be agreed upon and signed by the person, the person's legal guardian
32.23 or conservator, or the parent if the person is a minor, and the authorized county
32.24 representative; ~~and~~

32.25 (9) be reviewed by a health professional if the person has overriding medical needs
32.26 that impact the delivery of services; and

32.27 (10) provide a notice at least annually of the amount of funds authorized for services.

32.28 Service planning formats developed for interagency planning such as transition,
32.29 vocational, and individual family service plans may be substituted for service planning
32.30 formats developed by county agencies.

32.31 Sec. 28. Minnesota Statutes 2010, section 256B.092, subdivision 11, is amended to
32.32 read:

32.33 Subd. 11. **Residential support services.** (a) Upon federal approval, there is
32.34 established a new service called residential support that is available on the community

alternative care, community alternatives for disabled individuals, developmental disabilities, and traumatic brain injury waivers. Existing waiver service descriptions must be modified to the extent necessary to ensure there is no duplication between other services. Residential support services must be provided by vendors licensed as a community residential setting as defined in section 245A.11, subdivision 8.

(b) Residential support services must meet the following criteria:

(1) providers of residential support services must own or control the residential site;

(2) the residential site must not be the primary residence of the license holder;

(3) the residential site must have a designated program supervisor responsible for program oversight, development, and implementation of policies and procedures;

(4) the provider of residential support services must provide supervision, training, and assistance as described in the person's community support plan; and

(5) the provider of residential support services must meet the requirements of licensure and additional requirements of the person's community support plan.

(c) Providers of residential support services that meet the definition in paragraph

(a) must be registered using a process determined by the commissioner beginning July

1, 2009. Providers licensed to provide child foster care under Minnesota Rules, parts

2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts

9555.5105 to 9555.6265, and that meet the requirements in section 245A.03, subdivision

7, paragraph (e), are considered registered under this section.

Sec. 29. Minnesota Statutes 2010, section 256B.096, subdivision 5, is amended to read:

Subd. 5. **Biennial report.** (a) The commissioner shall provide a biennial report to the chairs of the legislative committees with jurisdiction over health and human services policy and funding beginning January 15, 2009, on the development and activities of the quality management, assurance, and improvement system designed to meet the federal requirements under the home and community-based services waiver programs for persons with disabilities. By January 15, 2008, the commissioner shall provide a preliminary report on priorities for meeting the federal requirements, progress on development and field testing of the annual survey, appropriations necessary to implement an annual survey of service recipients once field testing is completed, recommendations for improvements in the incident reporting system, and a plan for incorporating quality assurance efforts under section 256B.095 and other regional efforts into the statewide system.

(b) This subdivision expires January 1, 2012.

Sec. 30. Minnesota Statutes 2010, section 256B.49, subdivision 15, is amended to read:

Subd. 15. **Individualized service plan.** (a) Each recipient of home and community-based waived services shall be provided a copy of the written service plan which:

(1) is developed and signed by the recipient within ten working days of the completion of the assessment;

(2) meets the assessed needs of the recipient;

(3) reasonably ensures the health and safety of the recipient;

(4) promotes independence;

(5) allows for services to be provided in the most integrated settings; ~~and~~

(6) provides for an informed choice, as defined in section 256B.77, subdivision 2, paragraph ~~(p)~~ (o), of service and support providers; and

(7) provides a notice at least annually of the amount of funds authorized for services.

(b) When a county is evaluating denials, reductions, or terminations of home and community-based services under section 256B.49 for an individual, the case manager shall offer to meet with the individual or the individual's guardian in order to discuss the prioritization of service needs within the individualized service plan. The reduction in the authorized services for an individual due to changes in funding for waived services may not exceed the amount needed to ensure medically necessary services to meet the individual's health, safety, and welfare.

Sec. 31. Minnesota Statutes 2010, section 256B.49, subdivision 21, is amended to read:

Subd. 21. **Report.** (a) The commissioner shall expand on the annual report required under section 256B.0916, subdivision 7, to include information on the county of residence and financial responsibility, age, and major diagnoses for persons eligible for the home and community-based waivers authorized under subdivision 11 who are:

(1) receiving those services;

(2) screened and waiting for waiver services; and

(3) residing in nursing facilities and are under age 65.

(b) This subdivision expires January 1, 2012.

Sec. 32. Minnesota Statutes 2010, section 256B.4912, is amended to read:

256B.4912 HOME AND COMMUNITY-BASED WAIVERS; PROVIDERS AND PAYMENT.

Subdivision 1. **Provider qualifications.** (a) For the home and community-based waivers providing services to seniors and individuals with disabilities, the commissioner shall establish:

(1) agreements with enrolled waiver service providers to ensure providers meet ~~qualifications defined in the waiver plans~~ Minnesota health care program requirements;

(2) regular reviews of provider qualifications, and including requests of proof of documentation; and

(3) processes to gather the necessary information to determine provider qualifications.

~~By July 2010, Beginning July 2011, staff that provide direct contact, as defined in section 245C.02, subdivision 11, that are employees of waiver service providers for services specified in the federally approved waiver plans must meet the requirements of chapter 245C prior to providing waiver services and as part of ongoing enrollment. Upon federal approval, this requirement must also apply to consumer-directed community supports.~~

(b) By January 1, 2013, or on the date the state adopts rules under subdivision 4, whichever is sooner, providers of waiver services must re-enroll with the state. County and tribal agency contracts existing prior to January 1, 2013, are not effective beginning January 1, 2013.

Subd. 1a. **Definitions.** For the purposes of this section, the following definitions apply.

(a) "Home and community-based service providers" means approved vendors who provide community services and long-term supports under medical assistance programs that include waiver programs as defined in sections 245B.092, 256B.0915, and 256B.49, and state plan home care services as defined in section 256B.0651.

(b) "Home and community-based service administrators" means counties and tribes that, individually or collaboratively, administer home and community-based waiver services delivery in a consistent manner under a state agency directive.

Subd. 2. Rate-setting methodologies. (a) The commissioner shall establish statewide rate-setting methodologies that meet federal waiver requirements for home and community-based waiver services for individuals with disabilities. The rate-setting methodologies must abide by the principles of transparency and equitability across the state. The methodologies must involve a uniform process of structuring rates for each service and must promote quality and participant choice.

(b) No later than January 1, 2012, the commissioner shall authorize the final determination of rates for waiver and day services. Rates must be determined utilizing individualized payment structures and methodologies established by the commissioner.

Subd. 3. Payment rate criteria. (a) The payment structures and methodologies under this section shall reflect the payment rate criteria in paragraphs (b) and (c).

(b) Payment rates must be based on reasonable costs that are ordinary, necessary, and related to delivery of authorized client services.

(c) The commissioner must not reimburse:

(1) unauthorized service delivery;

(2) services provided under a receipt of a special grant;

(3) services provided under contract to a local school district;

(4) extended employment services under Minnesota Rules, parts 3300.2005 to 3300.3100, or vocational rehabilitation services provided under the federal Rehabilitation Act, as amended, Title I, section 110, or Title VI-C, and not through use of medical assistance or county social service funds; or

(5) services provided to a client by a licensed medical, therapeutic, or rehabilitation practitioner or any other vendor of medical care which are billed separately on a fee-for-service basis.

Subd. 4. Rate exception process. The payment structures and methodologies under this section must include procedures to seek authorization from the commissioner for exceptions for very dependent persons with special needs to the rates in excess of the amounts as determined utilizing individualized payment structures and methodologies established by the commissioner under subdivision 2.

Subd. 5. Shared service limits. The commissioner retains authority to limit the number of people that share waiver and day services. Individualized payment structures and methodologies established by the commissioner under subdivision 2 must reflect the option to share services within the limits established by the commissioner.

Subd. 6. Home and community-based service administrator roles and responsibilities. The commissioner shall define roles and responsibilities of home and community-based service administrators to include:

(1) certification functions to include monitoring and review of waiver home and community-based service providers in compliance with federal requirements; and

(2) assessment of home and community-based waiver service capacity and development to address identified service gaps.

Subd. 7. Authority to enter into expedited rulemaking. The commissioner is authorized to adopt rules using the expedited rulemaking process as defined in section 14.389. Rules adopted under the expedited rulemaking process are in effect until operational structures under subdivisions 1 to 6 are developed, evaluated, and approved and rules are adopted through the rulemaking process in sections 14.131 to 14.28 and pursuant to the authority in sections 256B.04, subdivision 2, and 256B.092, subdivision 6.

Sec. 33. Minnesota Statutes 2010, section 256B.501, subdivision 4b, is amended to read:

Subd. 4b. **Waiver rates and group residential housing rates.** (a) The average daily reimbursement rates established by the commissioner for waived services shall be adjusted to include the additional costs of services eligible for waiver funding under title XIX of the Social Security Act and for which there is no group residential housing payment available as a result of the payment limitations set forth in section 256I.05, subdivision 10. The adjustment to the waiver rates shall be based on county reports of service costs that are no longer eligible for group residential housing payments. No adjustment shall be made for any amount of reported payments that prior to July 1, 1992, exceeded the group residential housing rate limits established in section 256I.05 and were reimbursed through county funds.

(b) This subdivision expires January 1, 2013, or on the date the commissioner adopts rules for the administration of home and community-based services waivers under section 256B.4912, subdivision 4, whichever is sooner.

Sec. 34. Laws 2009, chapter 79, article 8, section 81, as amended by Laws 2010, chapter 352, article 1, section 24, is amended to read:

Sec. 81. ESTABLISHING A SINGLE SET OF STANDARDS.

(a) The commissioner of human services shall consult with disability service providers, advocates, counties, and consumer families to develop a single set of standards, to be referred to as "quality outcome standards," governing services for people with disabilities receiving services under the home and community-based waiver services program, with the exception of customized living services because the service license is under the jurisdiction of the Department of Health, to replace all or portions of existing laws and rules including, but not limited to, data practices, licensure of facilities and providers, background studies, reporting of maltreatment of minors, reporting of maltreatment of vulnerable adults, and the psychotropic medication checklist. The standards must:

- (1) enable optimum consumer choice;
- (2) be consumer driven;
- (3) link services to individual needs and life goals;
- (4) be based on quality assurance and individual outcomes;
- (5) utilize the people closest to the recipient, who may include family, friends, and health and service providers, in conjunction with the recipient's risk management plan to

assist the recipient or the recipient's guardian in making decisions that meet the recipient's needs in a cost-effective manner and assure the recipient's health and safety;

(6) utilize person-centered planning; and

(7) maximize federal financial participation.

(b) The commissioner may consult with existing stakeholder groups convened under the commissioner's authority, including the home and community-based expert services panel established by the commissioner in 2008, to meet all or some of the requirements of this section.

(c) The commissioner shall provide the reports and plans required by this section to the legislative committees and budget divisions with jurisdiction over health and human services policy and finance by January 15, 2012.

Sec. 35. STREAMLINE CONSUMER-DIRECTED SERVICES.

The commissioner of human services shall prepare and provide recommendations for streamlining administrative oversight, financial management, and payment protocols for consumer-directed services administered through the commissioner, including consumer-directed community supports, under Minnesota Statutes, sections 256B.49, subdivision 16, and 256B.0916, subdivision 6a; consumer support grants, under Minnesota Statutes, section 256.476; family support grants, under Minnesota Statutes, section 252.32; and any other consumer directed service options identified by the commissioner. The commissioner shall report to the legislature by January 15, 2012, with recommendations prepared under this section.

Sec. 36. REPEALER.

Minnesota Statutes 2010, sections 252.46, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 16, 17, 18, 19, 20, and 21; 256.0112, subdivision 6; 256B.092, subdivision 8a; 256B.49, subdivision 16a; and 256B.501, subdivision 8, are repealed effective January 1, 2013, or on the date the commissioner adopts rules for the administration of home and community-based services waivers under section 256B.4912, subdivision 4, whichever is sooner.

ARTICLE 3

COMPREHENSIVE ASSESSMENT AND CASE MANAGEMENT REFORM

Section 1. Minnesota Statutes 2010, section 256B.0659, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in paragraphs (b) to (r) have the meanings given unless otherwise provided in text.

(b) "Activities of daily living" means grooming, dressing, bathing, transferring, mobility, positioning, eating, and toileting.

(c) "Level I behavior," ~~effective January 1, 2010,~~ means a category to determine the home care rating ~~and is based on the criteria found in this section. "Level I behavior" means and is defined as~~ physical aggression towards self, others, or destruction of property that requires the immediate response of another person and either:

(1) has occurred within 30 days prior to the assessment; or

(2) there is objective evidence that, without intervention, it would have occurred 30 days prior to the assessment. Objective evidence includes logs of intervention kept by the family or provider.

(d) "Complex health-related needs," effective January 1, 2010, means a category to determine the home care rating and is based on the criteria found in this section.

(e) "Critical activities of daily living," effective January 1, 2010, means transferring, mobility, eating, and toileting.

(f) "Dependency in activities of daily living" means a person requires physical assistance to begin and complete one or more of the activities of daily living- or constant oversight, cueing, and monitoring throughout the activity. Dependency does not mean oversight, cueing, monitoring, and redirection related to behaviors, as defined in subdivision 4, paragraph (d). The need must be present on a daily basis or on the days that the activity is performed. For the purposes of this section, a person is not considered dependent in an activity of daily living if the person needs assistance only to begin or set up the activity.

(g) "Extended personal care assistance service" means personal care assistance services included in a service plan under one of the home and community-based services waivers authorized under sections 256B.0915, 256B.092, subdivision 5, and 256B.49, which exceed the amount, duration, and frequency of the state plan personal care assistance services for participants who:

(1) need assistance provided periodically during a week, but less than daily will not be able to remain in their homes without the assistance, and other replacement services are more expensive or are not available when personal care assistance services are to be terminated; or

(2) need additional personal care assistance services beyond the amount authorized by the state plan personal care assistance assessment in order to ensure that their safety, health, and welfare are provided for in their homes.

(h) "Health-related procedures and tasks" means procedures and tasks that can be delegated or assigned by a licensed health care professional under state law to be performed by a personal care assistant.

(i) "Instrumental activities of daily living" means activities to include meal planning and preparation; basic assistance with paying bills; shopping for food, clothing, and other essential items; performing household tasks integral to the personal care assistance services; communication by telephone and other media; and traveling, including to medical appointments and to participate in the community.

(j) "Managing employee" has the same definition as Code of Federal Regulations, title 42, section 455.

(k) "Qualified professional" means a professional providing supervision of personal care assistance services and staff as defined in section 256B.0625, subdivision 19c.

(l) "Personal care assistance provider agency" means a medical assistance enrolled provider that provides or assists with providing personal care assistance services and includes a personal care assistance provider organization, personal care assistance choice agency, class A licensed nursing agency, and Medicare-certified home health agency.

(m) "Personal care assistant" or "PCA" means an individual employed by a personal care assistance agency who provides personal care assistance services.

(n) "Personal care assistance care plan" means a written description of personal care assistance services developed by the personal care assistance provider according to the service plan.

(o) "Responsible party" means an individual who is capable of providing the support necessary to assist the recipient to live in the community.

(p) "Self-administered medication" means medication taken orally, by injection or insertion, or applied topically without the need for assistance.

(q) "Service plan" means a written summary of the assessment and description of the services needed by the recipient.

(r) "Wages and benefits" means wages and salaries, the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, mileage reimbursement, health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and contributions to employee retirement accounts.

Sec. 2. Minnesota Statutes 2010, section 256B.0659, subdivision 2, is amended to read:

41.1 Subd. 2. **Personal care assistance services; covered services.** (a) The personal
41.2 care assistance services eligible for payment include services and supports furnished
41.3 to an individual, as needed, to assist in:

41.4 (1) activities of daily living;
41.5 (2) health-related procedures and tasks;
41.6 (3) observation and redirection of behaviors; and
41.7 (4) instrumental activities of daily living.

41.8 (b) Activities of daily living include the following covered services:

41.9 (1) dressing, including assistance with choosing, application, and changing of
41.10 clothing and application of special appliances, wraps, or clothing;

41.11 (2) grooming, including assistance with basic hair care, washing hands, oral care,
41.12 shaving, applying cosmetics and deodorant, feminine hygiene, and care of eyeglasses and
41.13 hearing aids. Nail care is included, except for recipients who are diabetic or have poor
41.14 circulation;

41.15 (3) bathing, ~~including~~ assistance with basic personal hygiene, and inspection of the
41.16 skin and skin care;

41.17 (4) eating, ~~including and~~ assistance with ~~hand washing and~~ application of orthotics
41.18 required for eating, ~~transfers~~, and feeding;

41.19 (5) transfers, including hands-on assistance with transferring the recipient from one
41.20 seating or reclining area to another, and transfers for activities of daily living;

41.21 (6) mobility, including hands-on assistance with ~~ambulation~~ locomotion, ~~including~~
41.22 or with the use of a wheelchair or other device inside or outside of the home. Mobility
41.23 does not include providing transportation for a recipient or redirection and monitoring;

41.24 (7) positioning, ~~including~~ defined as hands-on assistance with positioning or turning
41.25 a recipient for necessary care and comfort; and

41.26 (8) toileting, including assistance with helping recipient with bowel or bladder
41.27 elimination and care ~~including transfers, mobility, positioning, feminine hygiene~~, use of
41.28 toileting equipment or supplies, cleansing the perineal area, ~~inspection of the skin~~, and
41.29 adjusting clothing.

41.30 (c) Health-related procedures and tasks include the following covered services:

41.31 (1) range of motion and passive exercise to maintain a recipient's strength and
41.32 muscle functioning;

41.33 (2) assistance with self-administered medication as defined by this section, ~~including~~.
41.34 The personal care assistant must not determine the medication dose or time for the
41.35 medication. Assistance with medications includes reminders to take medication, bringing

medication to the recipient, and assistance with opening medication under the direction of the recipient or responsible party, including medications given through a nebulizer;

(3) interventions for seizure disorders, including monitoring and observation; and

(4) other activities considered within the scope of the personal care service and meeting the definition of health-related procedures and tasks under this section.

(d) A personal care assistant may provide health-related procedures and tasks associated with the complex health-related needs of a recipient if the procedures and tasks meet the definition of health-related procedures and tasks under this section and the personal care assistant is trained by a qualified professional and demonstrates competency to safely complete the procedures and tasks. Delegation of health-related procedures and tasks and all training must be documented in the personal care assistance care plan and the recipient's and personal care assistant's files.

(e) Effective January 1, 2010, for a personal care assistant to provide the health-related procedures and tasks of tracheostomy suctioning and services to recipients on ventilator support there must be:

(1) delegation and training by a registered nurse, certified or licensed respiratory therapist, or a physician;

(2) utilization of clean rather than sterile procedure;

(3) specialized training about the health-related procedures and tasks and equipment, including ventilator operation and maintenance;

(4) individualized training regarding the needs of the recipient; and

(5) supervision by a qualified professional who is a registered nurse.

(f) Effective January 1, 2010, a personal care assistant may observe and redirect the recipient for episodes where there is a need for redirection due to behaviors. Training of the personal care assistant must occur based on the needs of the recipient, the personal care assistance care plan, and any other support services provided.

(g) Instrumental activities of daily living under subdivision 1, paragraph (i).

Sec. 3. Minnesota Statutes 2010, section 256B.0659, subdivision 3a, is amended to read:

Subd. 3a. **Assessment; defined.** This subdivision is effective until January 1, 2012, or until a new form and process have been developed by the commissioner, whichever is later. "Assessment" means a review and evaluation of a recipient's need for ~~home~~ personal care assistance services conducted in person. Assessments for personal care assistance services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county except when a long-term care

consultation is being conducted for the purposes of determining a person's eligibility for home and community-based waiver services according to section 256B.0911 and the support plan may include personal care assistance services. An in-person assessment must include: documentation of health status, determination of need, evaluation of service effectiveness, identification of appropriate services, service plan development or modification, coordination of services, referrals and follow-up to appropriate payers and community resources, completion of required reports, recommendation of service authorization, and consumer education. Once the need for personal care assistance services is determined under this section or sections 256B.0651, 256B.0653, 256B.0654, and 256B.0656, the county public health nurse or certified public health nurse under contract with the county is responsible for communicating this recommendation to the commissioner and the recipient. An in-person assessment must occur at least annually or when there is a significant change in the recipient's condition or when there is a change in the need for personal care assistance services. A service update may substitute for the annual face-to-face assessment when there is not a significant change in recipient condition or a change in the need for personal care assistance service. A service update may be completed by telephone, used when there is no need for an increase in personal care assistance services, and used for two consecutive assessments if followed by a face-to-face assessment. A service update must be completed on a form approved by the commissioner. A service update or review for temporary increase includes a review of initial baseline data, evaluation of service effectiveness, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and on going consumer education. Assessments or reassessments must be completed on forms provided by the commissioner within ~~30~~ 20 days of a request for home care services by a recipient or responsible party ~~or personal care provider agency.~~

Sec. 4. Minnesota Statutes 2010, section 256B.0659, subdivision 4, is amended to read:

Subd. 4. **Assessment for personal care assistance services; limitations.** (a) An assessment as defined in subdivision 3a must be completed for personal care assistance services.

(b) The following limitations apply to the assessment:

(1) a person must be assessed as dependent in an activity of daily living ~~based on the person's daily need or need on the days during the week the activity is completed for:~~

~~(i) cuing and constant supervision to complete the task; or~~

44.1 ~~(ii) hands-on assistance to complete the task; and~~ if the need for assistance meets
44.2 the definition of dependency defined in subdivision 1, paragraph (e), except as noted in
44.3 subdivision 2; and

44.4 (2) a child may not be found to be dependent in an activity of daily living if because
44.5 of the child's age an adult would either perform the activity for the child or assist the child
44.6 with the activity. Assistance needed is the assistance appropriate for a typical child of
44.7 the same age.

44.8 (c) Assessment for complex health-related needs must meet the criteria in this
44.9 paragraph. During the assessment process, a recipient qualifies as having complex
44.10 health-related needs if the recipient has one or more of the interventions that are ordered by
44.11 a physician, specified in a personal care assistance care plan, and found in the following:

44.12 (1) tube feedings requiring:

44.13 (i) a gastrojejunostomy tube; or

44.14 (ii) continuous tube feeding lasting longer than 12 hours per day;

44.15 (2) wounds described as:

44.16 (i) stage III or stage IV;

44.17 (ii) multiple wounds;

44.18 (iii) requiring sterile or clean dressing changes or a wound vac; or

44.19 (iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require
44.20 specialized care;

44.21 (3) parenteral therapy described as:

44.22 (i) IV therapy more than two times per week lasting longer than four hours for
44.23 each treatment; or

44.24 (ii) total parenteral nutrition (TPN) daily;

44.25 (4) respiratory interventions₂ including:

44.26 (i) oxygen required more than eight hours per day;

44.27 (ii) respiratory vest more than one time per day;

44.28 (iii) bronchial drainage treatments more than two times per day;

44.29 (iv) sterile or clean suctioning more than six times per day;

44.30 (v) dependence on another to apply respiratory ventilation augmentation devices
44.31 such as BiPAP and CPAP; and

44.32 (vi) ventilator dependence under section 256B.0652;

44.33 (5) insertion and maintenance of catheter₂ including:

44.34 (i) sterile catheter changes more than one time per month;

44.35 (ii) clean intermittent catheterization, and including self-catheterization more than
44.36 six times per day; or

- 45.1 (iii) bladder irrigations;
- 45.2 (6) bowel program more than two times per week requiring more than 30 minutes to
- 45.3 perform each time;
- 45.4 (7) neurological intervention, including:
- 45.5 (i) seizures more than two times per week affecting daily functioning and requiring
- 45.6 significant physical assistance to maintain safety; or
- 45.7 (ii) swallowing disorders diagnosed by a physician and requiring specialized
- 45.8 assistance from another on a daily basis; and
- 45.9 (8) other congenital or acquired diseases creating a need for significantly increased
- 45.10 direct hands-on assistance and interventions in six to eight activities of daily living.
- 45.11 (d) An assessment of behaviors must meet the criteria in this paragraph. A recipient
- 45.12 qualifies as having a need for assistance due to behaviors if the recipient's behavior requires
- 45.13 assistance at least four times per week and shows one or more of the following behaviors:
- 45.14 (1) physical aggression towards self or others, or destruction of property that requires
- 45.15 the immediate response of another person;
- 45.16 (2) increased vulnerability due to cognitive deficits or socially inappropriate
- 45.17 behavior; or
- 45.18 (3) increased need for assistance for recipients who are verbally aggressive and or
- 45.19 resistive to care such that the time needed to perform activities of daily living is increased.

45.20 Sec. 5. Minnesota Statutes 2010, section 256B.0911, subdivision 1, is amended to read:

45.21 Subdivision 1. **Purpose and goal.** (a) The purpose of long-term care consultation

45.22 services is to assist persons with long-term or chronic care needs in making ~~long-term~~ care

45.23 decisions and selecting support and service options that meet their needs and reflect their

45.24 preferences. The availability of, and access to, information and other types of assistance,

45.25 including assessment and support planning, is also intended to prevent or delay ~~certified~~

45.26 ~~nursing facility~~ institutional placements and to provide access to transition assistance

45.27 after admission. Further, the goal of these services is to contain costs associated with

45.28 unnecessary ~~certified nursing facility~~ institutional admissions. Long-term consultation

45.29 services must be available to any person regardless of public program eligibility. The

45.30 commissioner of human services shall seek to maximize use of available federal and state

45.31 funds and establish the broadest program possible within the funding available.

45.32 (b) These services must be coordinated with long-term care options counseling

45.33 provided under section 256.975, subdivision 7, and section 256.01, subdivision 24, ~~for~~

45.34 ~~telephone assistance and follow up and to offer a variety of cost-effective alternatives~~

45.35 ~~to persons with disabilities and elderly persons.~~ The ~~county or tribal~~ lead agency or

46.1 ~~managed care plan~~ providing long-term care consultation services shall encourage the use
46.2 of volunteers from families, religious organizations, social clubs, and similar civic and
46.3 service organizations to provide community-based services.

46.4 Sec. 6. Minnesota Statutes 2010, section 256B.0911, subdivision 1a, is amended to
46.5 read:

46.6 Subd. 1a. **Definitions.** For purposes of this section, the following definitions apply:

46.7 (a) "Long-term care consultation services" means:

46.8 (1) intake for and access to assistance in identifying services needed to maintain an
46.9 individual in the most inclusive environment;

46.10 (2) providing recommendations on for and referrals to cost-effective community
46.11 services that are available to the individual;

46.12 (3) development of an individual's person-centered community support plan;

46.13 (4) providing information regarding eligibility for Minnesota health care programs;

46.14 (5) face-to-face long-term care consultation assessments, which may be completed
46.15 in a hospital, nursing facility, intermediate care facility for persons with developmental
46.16 disabilities (ICF/DDs), regional treatment centers, or the person's current or planned
46.17 residence;

46.18 (6) federally mandated preadmission screening to determine the need for an
46.19 institutional level of care activities described under subdivision subdivisions 4a and 4b;

46.20 (7) determination of home and community-based waiver and other service eligibility
46.21 as required under sections 256B.0913, 256B.0915, 256B.092, and 256B.49, including
46.22 level of care determination for individuals who need an institutional level of care as
46.23 defined under section 144.0724, subdivision 11, or 256B.092, service eligibility including
46.24 state plan home care services identified in sections 256B.0625, subdivisions 6, 7, and 19,
46.25 paragraphs (a) and (c), and 256B.0657, based on assessment and community support
46.26 plan development with, appropriate referrals to obtain necessary diagnostic information,
46.27 and including the option an eligibility determination for consumer-directed community
46.28 supports;

46.29 (8) service eligibility determination for state plan home care services identified in:

46.30 (i) section 256B.0625, subdivisions 7, 19a, and 19c;

46.31 (ii) section 256B.0657; or

46.32 (iii) consumer support grants under section 256.476;

46.33 (9) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024,

46.34 determination of eligibility for case management services available under sections

47.1 256B.0621, subdivision 2, paragraph (4), and 256B.0924 and Minnesota Rules, part
47.2 9525.0016, and also includes obtaining necessary diagnostic information;

47.3 (10) determination of eligibility for family support grants under section 252.32 and
47.4 semi-independent living services under section 252.275 and day training and habilitation
47.5 services under section 256B.092;

47.6 ~~(8)~~ (11) providing recommendations for nursing facility institutional placement
47.7 when there are no cost-effective community services available; and

47.8 ~~(9)~~ (12) providing access to assistance to transition people back to community
47.9 settings after facility institutional admission.

47.10 (b) "Long-term care options counseling" means the services provided by the linkage
47.11 lines as mandated by sections 256.01 and 256.975, subdivision 7, and also includes
47.12 telephone assistance and follow up once a long-term care consultation assessment has
47.13 been completed.

47.14 (c) "Minnesota health care programs" means the medical assistance program under
47.15 chapter 256B and the alternative care program under section 256B.0913.

47.16 (d) "Lead agencies" means counties or a collaboration of counties, tribes, and health
47.17 plans administering long-term care consultation assessment and support planning services.

47.18 Sec. 7. Minnesota Statutes 2010, section 256B.0911, subdivision 2b, is amended to
47.19 read:

47.20 Subd. 2b. **Certified assessors.** (a) Beginning January 1, ~~2011~~ 2012, each lead
47.21 agency shall use certified assessors who have completed training and the certification
47.22 processes determined by the commissioner in subdivision 2c. Certified assessors shall
47.23 demonstrate best practices in assessment and support planning including person-centered
47.24 planning principals and have a common set of skills that must ensure consistency and
47.25 equitable access to services statewide. ~~Assessors must be part of a multidisciplinary team~~
47.26 ~~of professionals that includes public health nurses, social workers, and other professionals~~
47.27 ~~as defined in paragraph (b). For persons with complex health care needs, a public health~~
47.28 ~~nurse or registered nurse from a multidisciplinary team must be consulted.~~ A lead agency
47.29 may choose, according to departmental policies, to contract with a qualified, certified
47.30 assessor to conduct assessments and reassessments on behalf of the lead agency.

47.31 (b) Certified assessors are persons with a minimum of a bachelor's degree in social
47.32 work, nursing with a public health nursing certificate, or other closely related field with at
47.33 least one year of home and community-based experience or a two-year registered nursing
47.34 degree with at least three years of home and community-based experience that have

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48.1 received training and certification specific to assessment and consultation for long-term
48.2 care services in the state.

48.3 Sec. 8. Minnesota Statutes 2010, section 256B.0911, subdivision 2c, is amended to
48.4 read:

48.5 Subd. 2c. **Assessor training and certification.** The commissioner shall develop a
48.6 curriculum and an assessor certification process ~~to begin no later than January 1, 2010.~~ All
48.7 existing lead agency staff designated to provide the services defined in subdivision 1a must
48.8 be certified by ~~December 30, 2010~~ January 1, 2012. Each lead agency is required to ensure
48.9 that they have sufficient numbers of certified assessors to provide long-term consultation
48.10 assessment and support planning within the timelines and parameters of the service ~~by~~
48.11 ~~January 1, 2011.~~ Certified assessors are required to be recertified every three years.

48.12 Sec. 9. Minnesota Statutes 2010, section 256B.0911, subdivision 3, is amended to read:

48.13 Subd. 3. **Long-term care consultation team.** (a) Until January 1, 2011, a long-term
48.14 care consultation team shall be established by the county board of commissioners. Each
48.15 local consultation team shall consist of at least one social worker and at least one public
48.16 health nurse from their respective county agencies. The board may designate public
48.17 health or social services as the lead agency for long-term care consultation services. If a
48.18 county does not have a public health nurse available, it may request approval from the
48.19 commissioner to assign a county registered nurse with at least one year experience in
48.20 home care to participate on the team. Two or more counties may collaborate to establish
48.21 a joint local consultation team or teams.

48.22 (b) Certified assessors must be part of a multidisciplinary team of professionals
48.23 that includes public health nurses, social workers, and other professionals as defined in
48.24 subdivision 2b, paragraph (b). The team is responsible for providing long-term care
48.25 consultation services to all persons located in the county who request the services,
48.26 regardless of eligibility for Minnesota health care programs.

48.27 (c) The commissioner shall allow arrangements and make recommendations that
48.28 encourage counties and tribes to collaborate to establish joint local long-term care
48.29 consultation teams to ensure that long-term care consultations are done within the
48.30 timelines and parameters of the service. This includes integrated service models as
48.31 required in subdivision 1, paragraph (b).

48.32 Sec. 10. Minnesota Statutes 2010, section 256B.0911, subdivision 3a, is amended to
48.33 read:

Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services planning, or other assistance intended to support community-based living, including persons who need assessment in order to determine waiver or alternative care program eligibility, must be visited by a long-term care consultation team within ~~15~~ 20 calendar days after the date on which an assessment was requested or recommended. After January 1, ~~2011~~ 2012, ~~these requirements~~ this requirement also ~~apply~~ applies to assessment of persons requesting personal care assistance services, and private duty nursing, and home health agency services, on timelines established in subdivision 5. Face-to-face assessments must be conducted according to paragraphs (b) to (i).

(b) The county may utilize a team of either the social worker or public health nurse, or both. After January 1, ~~2011~~ 2012, lead agencies shall use certified assessors to conduct the ~~assessment in a face-to-face interview~~ assessments. The consultation team members must confer regarding the most appropriate care for each individual screened or assessed. For persons with complex health care needs, a public health or registered nurse from the team must be consulted.

(c) The assessment must be comprehensive and include a person-centered assessment of the health, psychological, functional, environmental, and social needs of referred individuals and provide information necessary to develop a community support plan that meets the consumers needs, using an assessment form provided by the commissioner.

(d) The assessment must be conducted in a face-to-face interview with the person being assessed and the person's legal representative, ~~as required by legally executed documents~~, and other individuals as requested by the person, who can provide information on the needs, strengths, and preferences of the person necessary to develop a community support plan that ensures the person's health and safety, but who is not a provider of service or has any financial interest in the provision of services.

~~(e) The person, or the person's legal representative, must be provided with written recommendations for community-based services, including consumer-directed options, or institutional care that include documentation that the most cost-effective alternatives available were offered to the individual. For purposes of this requirement, "cost-effective alternatives" means community services and living arrangements that cost the same as or less than institutional care.~~

~~(f)~~ (e) If the person chooses to use community-based services, the person or the person's legal representative must be provided with a written community support plan within 40 calendar days of the assessment visit, regardless of whether the individual is eligible for Minnesota health care programs. The written community support plan must include:

(1) a summary of assessed needs as defined in paragraphs (c) and (d);

(2) the individual's options and choices to meet identified needs, including all available options for case management services and providers;

(3) identification of health and safety risks and how those risks will be addressed, including personal risk management strategies;

(4) referral information; and

(5) informal caregiver supports, if applicable.

For persons determined eligible for services defined under subdivision 1a, paragraph (a), clauses (7) to (10), the community support plan must also include the estimated annual and monthly budget amount for those services. In addition, for persons determined eligible for state plan home care under subdivision 1a, paragraph (a), clause (8), the person or person's representative must also receive a copy of the home care service plan developed by the certified assessor.

(f) A person may request assistance in identifying community supports without participating in a complete assessment. Upon a request for assistance identifying community support, the person must be transferred or referred to ~~the~~ long-term care options counseling services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for telephone assistance and follow up.

(g) The person has the right to make the final decision between institutional placement and community placement after the recommendations have been provided, except as provided in subdivision 4a, paragraph (c).

(h) The ~~team~~ lead agency must give the person receiving assessment or support planning, or the person's legal representative, materials, and forms supplied by the commissioner containing the following information:

(1) written recommendations for community-based services and consumer-directed options;

(2) documentation that the most cost-effective alternatives available were offered to the individual. For purposes of this clause, "cost-effective" means community services and living arrangements that cost the same as or less than institutional care;

(3) the need for and purpose of preadmission screening if the person selects nursing facility placement;

~~(2)~~ (4) the role of the long-term care consultation assessment and support planning in ~~waiver and alternative care program~~ eligibility determination for waiver and alternative care programs, and state plan home care and case management services as defined in subdivision 1a, paragraph (a), clauses (7) to (10);

~~(3)~~ (5) information about Minnesota health care programs;

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51.1 ~~(4)~~ (6) the person's freedom to accept or reject the recommendations of the team;
51.2 ~~(5)~~ (7) the person's right to confidentiality under the Minnesota Government Data
51.3 Practices Act, chapter 13;

51.4 ~~(6)~~ (8) the ~~long-term care consultant's~~ certified assessor's decision regarding the
51.5 person's need for institutional level of care as determined under criteria established
51.6 in section 144.0724, subdivision 11, or 256B.092 and the certified assessor's decision
51.7 regarding eligibility for all services and programs as defined in subdivision 1a, paragraph
51.8 (a), clauses (7) to (10); and

51.9 ~~(7)~~ (9) the person's right to appeal any certified assessor's decision regarding
51.10 eligibility for all services and programs as defined in subdivision 1a, paragraph (a),
51.11 clauses (7) to (10), and incorporating the decision regarding the need for nursing facility
51.12 institutional level of care or the county's lead agency's final decisions regarding public
51.13 programs eligibility according to section 256.045, subdivision 3.

51.14 (i) Face-to-face assessment completed as part of eligibility determination for
51.15 the alternative care, elderly waiver, community alternatives for disabled individuals,
51.16 community alternative care, and traumatic brain injury waiver programs under sections
51.17 256B.0913, 256B.0915, ~~256B.0917~~, and 256B.49 is valid to establish service eligibility
51.18 for no more than 60 calendar days after the date of assessment. The effective eligibility
51.19 start date for these programs can never be prior to the date of assessment. If an assessment
51.20 was completed more than 60 days before the effective waiver or alternative care program
51.21 eligibility start date, assessment and support plan information must be updated in a
51.22 face-to-face visit and documented in the department's Medicaid Management Information
51.23 System (MMIS). The effective date of program eligibility in this case cannot be prior to
51.24 the date the updated assessment is completed.

51.25 Sec. 11. Minnesota Statutes 2010, section 256B.0911, subdivision 3b, is amended to
51.26 read:

51.27 Subd. 3b. **Transition assistance.** (a) ~~A long-term care consultation team~~ Lead
51.28 agency certified assessors shall provide assistance to persons residing in a nursing
51.29 facility, hospital, regional treatment center, or intermediate care facility for persons with
51.30 developmental disabilities who request or are referred for assistance. Transition assistance
51.31 must include assessment, community support plan development, referrals to long-term
51.32 care options counseling under section ~~256B.975~~ 256.975, subdivision ~~10~~ 7, for community
51.33 support plan implementation and to Minnesota health care programs, including home and
51.34 community-based waiver services and consumer-directed options through the waivers,
51.35 and referrals to programs that provide assistance with housing. Transition assistance

must also include information about the Centers for Independent Living ~~and the Senior LinkAge Line~~, Disability Linkage Line, and about other organizations that can provide assistance with relocation efforts, and information about contacting these organizations to obtain their assistance and support.

(b) The ~~county lead agency~~ shall ~~develop transition processes with institutional social workers and discharge planners to~~ ensure that:

(1) referrals for in-person assessments are taken from long-term care options counselors as provided for in section 256.975, subdivision 7, paragraph (b), clause (11);

(2) ~~persons admitted to facilities~~ assessed in institutions receive information about transition assistance that is available;

~~(2)~~ (3) the assessment is completed for persons within ~~ten working~~ 20 calendar days of the date of request or recommendation for assessment; ~~and~~

~~(3)~~ (4) there is a plan for transition and follow-up for the individual's return to the community. ~~The plan must require, including notification of other local agencies when a person who may require assistance is screened by one county for admission to a facility from agencies located in another county; and~~

(5) relocation targeted case management as defined in section 256B.0621, subdivision 2, clause (4), is authorized for an eligible medical assistance recipient.

~~(c) If a person who is eligible for a Minnesota health care program is admitted to a nursing facility, the nursing facility must include a consultation team member or the case manager in the discharge planning process.~~

Sec. 12. Minnesota Statutes 2010, section 256B.0911, subdivision 3c, is amended to read:

Subd. 3c. **Transition to housing with services.** (a) Housing with services establishments offering or providing assisted living under chapter 144G shall inform all prospective residents of the availability of and contact information for transitional consultation services under this subdivision prior to executing a lease or contract with the prospective resident. The purpose of transitional long-term care consultation is to support persons with current or anticipated long-term care needs in making informed choices among options that include the most cost-effective and least restrictive settings, and to delay spenddown to eligibility for publicly funded programs by connecting people to alternative services in their homes before transition to housing with services. Regardless of the consultation, prospective residents maintain the right to choose housing with services or assisted living if that option is their preference.

(b) Transitional consultation services are provided as determined by the commissioner of human services in partnership with ~~county~~ long-term care consultation units, and the Area Agencies on Aging, and are a combination of telephone-based and in-person assistance provided under models developed by the commissioner. The consultation shall be performed in a manner that provides objective and complete information. Transitional consultation must be provided within five working days of the request of the prospective resident as follows:

(1) the consultation must be provided by a qualified professional as determined by the commissioner;

(2) the consultation must include a review of the prospective resident's reasons for considering assisted living, the prospective resident's personal goals, a discussion of the prospective resident's immediate and projected long-term care needs, and alternative community services or assisted living settings that may meet the prospective resident's needs; and

(3) the prospective resident shall be informed of the availability of long-term care consultation services described in subdivision 3a that are available at no charge to the prospective resident to assist the prospective resident in assessment and planning to meet the prospective resident's long-term care needs. The Senior LinkAge Line and long-term care consultation team shall give the highest priority to referrals of individuals who are at highest risk of nursing facility placement or as needed for determining eligibility.

Sec. 13. Minnesota Statutes 2010, section 256B.0911, subdivision 4a, is amended to read:

Subd. 4a. **Preadmission screening activities related to nursing facility admissions.** (a) All applicants to Medicaid certified nursing facilities, including certified boarding care facilities, must be screened prior to admission regardless of income, assets, or funding sources for nursing facility care, except as described in subdivision 4b. The purpose of the screening is to determine the need for nursing facility level of care as described in paragraph (d) and to complete activities required under federal law related to mental illness and developmental disability as outlined in paragraph (b).

(b) A person who has a diagnosis or possible diagnosis of mental illness or developmental disability must receive a preadmission screening before admission regardless of the exemptions outlined in subdivision 4b, paragraph (b), to identify the need for further evaluation and specialized services, unless the admission prior to screening is authorized by the local mental health authority or the local developmental disabilities case manager, or unless authorized by the county agency according to Public Law 101-508.

54.1 The following criteria apply to the preadmission screening:

54.2 (1) the ~~county~~ lead agency must use forms and criteria developed by the
54.3 commissioner to identify persons who require referral for further evaluation and
54.4 determination of the need for specialized services; and

54.5 (2) the evaluation and determination of the need for specialized services must be
54.6 done by:

54.7 (i) a qualified independent mental health professional, for persons with a primary or
54.8 secondary diagnosis of a serious mental illness; or

54.9 (ii) a qualified developmental disability professional, for persons with a primary or
54.10 secondary diagnosis of developmental disability. For purposes of this requirement, a
54.11 qualified developmental disability professional must meet the standards for a qualified
54.12 developmental disability professional under Code of Federal Regulations, title 42, section
54.13 483.430.

54.14 (c) The local county mental health authority or the state developmental disability
54.15 authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a
54.16 nursing facility if the individual does not meet the nursing facility level of care criteria or
54.17 needs specialized services as defined in Public Law Numbers 100-203 and 101-508. For
54.18 purposes of this section, "specialized services" for a person with developmental disability
54.19 means active treatment as that term is defined under Code of Federal Regulations, title
54.20 42, section 483.440 (a)(1).

54.21 (d) The determination of the need for nursing facility level of care must be made
54.22 according to criteria established in section 144.0724, subdivision 11, and 256B.092,
54.23 using forms developed by the commissioner. In assessing a person's needs, consultation
54.24 team members shall have a physician available for consultation and shall consider the
54.25 assessment of the individual's attending physician, if any. The individual's physician must
54.26 be included if the physician chooses to participate. Other personnel may be included on
54.27 the team as deemed appropriate by the ~~county~~ lead agency.

54.28 Sec. 14. Minnesota Statutes 2010, section 256B.0911, subdivision 4c, is amended to
54.29 read:

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

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

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

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

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

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

Sec. 15. Minnesota Statutes 2010, section 256B.0911, subdivision 6, is amended to read:

Subd. 6. Payment for long-term care consultation services. (a) The total payment for each county must be paid monthly by certified nursing facilities in the county. The monthly amount to be paid by each nursing facility for each fiscal year must be determined by dividing the county's annual allocation for long-term care consultation services by 12 to determine the monthly payment and allocating the monthly payment to each nursing facility based on the number of licensed beds in the nursing facility. Payments to counties in which there is no certified nursing facility must be made by increasing the payment rate of the two facilities located nearest to the county seat.

(b) The commissioner shall include the total annual payment determined under paragraph (a) for each nursing facility reimbursed under section 256B.431 ~~or~~ 256B.434₂ or 256B.441, according to section 256B.431, subdivision 2b, paragraph (g).

(c) In the event of the layaway, delicensure and decertification, or removal from layaway of 25 percent or more of the beds in a facility, the commissioner may adjust the per diem payment amount in paragraph (b) and may adjust the monthly payment amount in paragraph (a). The effective date of an adjustment made under this paragraph shall be on or after the first day of the month following the effective date of the layaway, delicensure and decertification, or removal from layaway.

(d) Payments for long-term care consultation services are available to the county or counties to cover staff salaries and expenses to provide the services described in subdivision 1a. The county shall employ, or contract with other agencies to employ, within

the limits of available funding, sufficient personnel to provide long-term care consultation services while meeting the state's long-term care outcomes and objectives as defined in ~~section 256B.0917~~, subdivision 1. The county shall be accountable for meeting local objectives as approved by the commissioner in the biennial home and community-based services quality assurance plan on a form provided by the commissioner.

(e) Notwithstanding section 256B.0641, overpayments attributable to payment of the screening costs under the medical assistance program may not be recovered from a facility.

(f) The commissioner of human services shall amend the Minnesota medical assistance plan to include reimbursement for the local consultation teams.

(g) Until the alternative payment methodology in paragraph (h) is implemented, the county may bill, as case management services, assessments, support planning, and follow-along provided to persons determined to be eligible for case management under Minnesota health care programs. No individual or family member shall be charged for an initial assessment or initial support plan development provided under subdivision 3a or 3b.

(h) The commissioner shall develop an alternative payment methodology for long-term care consultation services that includes the funding available under this subdivision, and sections 256B.092 and 256B.0659. In developing the new payment methodology, the commissioner shall consider the maximization of other funding sources, including federal funding, for this all long-term care consultation and preadmission screening activity.

Sec. 16. Minnesota Statutes 2010, section 256B.0913, subdivision 7, is amended to read:

Subd. 7. **Case management.** (a) The provision of case management under the alternative care program is governed by requirements in section 256B.0915, subdivisions 1a and 1b.

(b) The case manager must not approve alternative care funding for a client in any setting in which the case manager cannot reasonably ensure the client's health and safety.

(c) The case manager is responsible for the cost-effectiveness of the alternative care individual ~~care~~ coordinated services and support plan and must not approve any ~~care~~ plan in which the cost of services funded by alternative care and client contributions exceeds the limit specified in section 256B.0915, subdivision 3, paragraph (b).

(d) Case manager responsibilities include those in section 256B.0915, subdivision 1a, paragraph (g).

Sec. 17. Minnesota Statutes 2010, section 256B.0913, subdivision 8, is amended to read:

Subd. 8. **Requirements for individual ~~care~~ coordinated services and support plan.** (a) The case manager shall implement the coordinated services and support plan ~~of care~~ for each alternative care client and ensure that a client's service needs and eligibility are reassessed at least every 12 months. The coordinated services and support plan must meet the requirements in section 256B.0915, subdivision 6. The plan shall include any services prescribed by the individual's attending physician as necessary to allow the individual to remain in a community setting. In developing the individual's care plan, the case manager should include the use of volunteers from families and neighbors, religious organizations, social clubs, and civic and service organizations to support the formal home care services. The lead agency shall be held harmless for damages or injuries sustained through the use of volunteers under this subdivision including workers' compensation liability. The case manager shall provide documentation in each individual's plan ~~of care~~ and, if requested, to the commissioner that the most cost-effective alternatives available have been offered to the individual and that the individual was free to choose among available qualified providers, both public and private, including qualified case management or service coordination providers other than those employed by any county; however, the county or tribe maintains responsibility for prior authorizing services in accordance with statutory and administrative requirements. The case manager must give the individual a ten-day written notice of any denial, termination, or reduction of alternative care services.

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

Sec. 18. Minnesota Statutes 2010, section 256B.0915, subdivision 1a, is amended to read:

Subd. 1a. **Elderly waiver case management services.** (a) Elderly case management services under the home and community-based services waiver for elderly individuals are available from providers meeting qualification requirements and the standards specified in subdivision 1b. Eligible recipients may choose any qualified provider of elderly case management services.

(b) Case management services assist individuals who receive waiver services in gaining access to needed waiver and other state plan services; and assist individuals in

appeals under section 256.045, as well as needed medical, social, educational, and other services regardless of the funding source for the services to which access is gained. Case managers shall collaborate with consumers, families, legal representatives, and relevant medical experts and service providers in the development and periodic review of the coordinated services and support plan.

(c) A case aide shall provide assistance to the case manager in carrying out administrative activities of the case management function. The case aide may not assume responsibilities that require professional judgment including assessments, reassessments, and care plan development. The case manager is responsible for providing oversight of the case aide.

(d) Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care. Case managers shall initiate ~~and oversee~~ the process of ~~assessment and~~ reassessment of the individual's ~~care~~ coordinated services and support plan as defined in subdivision 6 and review ~~the plan of care~~ at intervals specified in the federally approved waiver plan.

(e) The county of service or tribe must provide access to and arrange for case management services. County of service has the meaning given it in Minnesota Rules, part 9505.0015, subpart 11.

(f) Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in subdivision 1b. Case management services must not be provided to a recipient by a private agency that has a financial interest in the provision of any other services included in the recipient's coordinated service and support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision 1a, paragraph (d).

(g) Case management service activities provided to or arranged for a person include:
(1) development of the coordinated services and support plan under subdivision 6;
(2) informing the individual or the individual's legal guardian or conservator of service options, and options for case management services and providers;

(3) consulting with relevant medical experts or service providers;

(4) assisting the person in the identification of potential providers;

(5) assisting the person to access services;

(6) coordination of services; and

(7) evaluation and monitoring of the services identified in the plan, including at least one annual face-to-face visit by the case manager with each person.

Sec. 19. Minnesota Statutes 2010, section 256B.0915, subdivision 1b, is amended to read:

Subd. 1b. **Provider qualifications and standards.** The commissioner must enroll qualified providers of elderly case management services under the home and community-based waiver for the elderly under section 1915(c) of the Social Security Act. The enrollment process shall ensure the provider's ability to meet the qualification requirements and standards in this subdivision and other federal and state requirements of this service. An elderly case management provider is an enrolled medical assistance provider who is determined by the commissioner to have all of the following characteristics:

(1) the demonstrated capacity and experience to provide the components of case management to coordinate and link community resources needed by the eligible population;

(2) administrative capacity and experience in serving the target population for whom it will provide services and in ensuring quality of services under state and federal requirements;

(3) a financial management system that provides accurate documentation of services and costs under state and federal requirements;

(4) the capacity to document and maintain individual case records under state and federal requirements; and

(5) the lead agency may allow a case manager employed by the lead agency to delegate certain aspects of the case management activity to another individual employed by the lead agency provided there is oversight of the individual by the case manager. The case manager may not delegate those aspects which require professional judgment including assessments, reassessments, and ~~care~~ coordinated services and support plan development. Lead agencies include counties, health plans, and federally recognized tribes who authorize services under this section.

Sec. 20. Minnesota Statutes 2010, section 256B.0915, subdivision 3c, is amended to read:

Subd. 3c. **Service approval and contracting provisions.** (a) Medical assistance funding for skilled nursing services, private duty nursing, home health aide, and personal care services for waiver recipients must be approved by the case manager and included in the ~~individual care~~ coordinated services and support plan.

(b) A lead agency is not required to contract with a provider of supplies and equipment if the monthly cost of the supplies and equipment is less than \$250.

Sec. 21. Minnesota Statutes 2010, section 256B.0915, subdivision 6, is amended to read:

Subd. 6. **Implementation of ~~care~~ coordinated services and support plan.** (a) Each elderly waiver client shall be provided a copy of a written ~~care~~ coordinated services and support plan that meets the requirements outlined in section 256B.0913, subdivision 8. ~~The care plan must be implemented by the county of service when it is different than the county of financial responsibility. The county of service administering waived services must notify the county of financial responsibility of the approved care plan. that:~~

(1) is developed and signed by the recipient within ten working days after the case manager receives the community support plan from the certified assessor;

(2) includes the results of the assessment information on the person's need for service and identification of service needs that will be or that are met by the person's relatives, friends, and others, as well as community services used by the general public;

(3) reasonably ensures the health and safety of the recipient;

(4) identifies the person's preferences for services as stated by the person or the person's legal guardian or conservator;

(5) reflects the person's informed choice between institutional and community-based services, as well as choice of services, supports, and providers, including available case manager providers;

(6) identifies long and short-range goals for the person;

(7) identifies specific services and the amount, frequency, duration, and cost of the services to be provided to the person based on assessed needs, preferences, and available resources; and

(8) includes information about the right to appeal decisions under section 256.045;

(b) In developing the coordinated services and support plan, the case manager should also include the use of volunteers, religious organizations, social clubs, and civic and service organizations to support the individual in the community. The lead agency must be held harmless for damages or injuries sustained through the use of volunteers and agencies under this paragraph, including workers' compensation liability.

Sec. 22. Minnesota Statutes 2010, section 256B.092, subdivision 1, is amended to read:

Subdivision 1. **County of financial responsibility; duties.** Before any services shall be rendered to persons with developmental disabilities who are in need of social service and medical assistance, the county of financial responsibility shall conduct or arrange for a diagnostic evaluation in order to determine whether the person has or may have a developmental disability or has or may have a related condition. If the county

of financial responsibility determines that the person has a developmental disability, the county shall inform the person of case management services available under this section. Except as provided in subdivision 1g or 4b, if a person is diagnosed as having a developmental disability, the county of financial responsibility shall conduct or arrange for a needs assessment by a certified assessor, and develop or arrange for an individual service a community support plan according to section 256B.0911, provide or arrange for ongoing case management services at the level identified in the individual service plan, provide or arrange for case management administration, and authorize services identified in the person's individual service coordinated services and support plan developed according to subdivision 1b. Diagnostic information, obtained by other providers or agencies, may be used by the county agency in determining eligibility for case management. Nothing in this section shall be construed as requiring: (1) assessment in areas agreed to as unnecessary by ~~the case manager~~ a certified assessor and the person, or the person's legal guardian or conservator, or the parent if the person is a minor, or (2) assessments in areas where there has been a functional assessment completed in the previous 12 months for which the ~~case manager~~ certified assessor and the person or person's guardian or conservator, or the parent if the person is a minor, agree that further assessment is not necessary. For persons under state guardianship, the ~~case manager~~ certified assessor shall seek authorization from the public guardianship office for waiving any assessment requirements. Assessments related to health, safety, and protection of the person for the purpose of identifying service type, amount, and frequency or assessments required to authorize services may not be waived. To the extent possible, for wards of the commissioner the county shall consider the opinions of the parent of the person with a developmental disability when developing the person's ~~individual service~~ community support plan and coordinated services and support plan.

Sec. 23. Minnesota Statutes 2010, section 256B.092, subdivision 1a, is amended to read:

Subd. 1a. **Case management ~~administration and services~~.** (a) ~~The administrative functions of case management provided to or arranged for a person include:~~ Each recipient of a home and community-based waiver shall be provided case management services by qualified vendors as described in the federally approved waiver application.

~~(1) review of eligibility for services;~~

~~(2) screening;~~

~~(3) intake;~~

~~(4) diagnosis;~~

~~(5) the review and authorization of services based upon an individualized service plan, and~~

~~(6) responding to requests for conciliation conferences and appeals according to section 256.045 made by the person, the person's legal guardian or conservator, or the parent if the person is a minor.~~

(b) Case management service activities provided to or arranged for a person include:

(1) development of the ~~individual service~~ coordinated services and support plan under subdivision 1b;

(2) informing the individual or the individual's legal guardian or conservator, or parent if the person is a minor, of service options;

(3) consulting with relevant medical experts or service providers;

(4) assisting the person in the identification of potential providers;

(5) assisting the person to access services and assisting in appeals under section 256.045;

(6) coordination of services, if coordination is not provided by another service provider;

(7) evaluation and monitoring of the services identified in the coordinated services and support plan, which must incorporate at least one annual face-to-face visit by the case manager with each person; and

~~(8) annual reviews of service plans and services provided~~ review and provide the lead agency with recommendations for service authorization based upon the individual's needs identified in the coordinated services and support plan.

(c) Case management ~~administration and~~ service activities that are provided to the person with a developmental disability shall be provided directly by county agencies or under contract. Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in the approved federal waiver plans. Case management services must not be provided to a recipient by a private agency that has a financial interest in the provision of any other services included in the recipient's coordinated services and support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision 1a, paragraph (d).

(d) Case managers are responsible for ~~the administrative duties and~~ service provisions listed in paragraphs (a) and (b). Case managers shall collaborate with consumers, families, legal representatives, and relevant medical experts and service providers in the development and annual review of the ~~individualized service~~ coordinated services and support plan and habilitation ~~plans~~ plan.

63.1 (e) The Department of Human Services shall offer ongoing education in case
63.2 management to case managers. Case managers shall receive no less than ten hours of case
63.3 management education and disability-related training each year.

63.4 (f) For persons eligible for home and community-based waiver services under this
63.5 section, case management service must be provided and paid for under the terms of the
63.6 approved federal waiver plans and must not be billed as targeted case management.

63.7 Sec. 24. Minnesota Statutes 2010, section 256B.092, subdivision 1b, is amended to
63.8 read:

63.9 Subd. 1b. ~~Individual~~ **Coordinated service and support plan.** ~~The individual~~
63.10 ~~service plan must~~ (a) Each recipient of home and community-based waived services
63.11 shall be provided a copy of the written coordinated service and support plan which:

63.12 (1) is developed and signed by the recipient within ten working days after the case
63.13 manager receives the community support plan from the certified assessor;

63.14 ~~(1) include~~ (2) includes the results of the assessment information on the person's
63.15 need for service, including identification of service needs that will be or that are met
63.16 by the person's relatives, friends, and others, as well as community services used by
63.17 the general public;

63.18 (3) reasonably ensures the health and safety of the recipient;

63.19 ~~(2) identify~~ (4) identifies the person's preferences for services as stated by the person,
63.20 the person's legal guardian or conservator, or the parent if the person is a minor;

63.21 (5) provides for an informed choice, as defined in section 256B.77, subdivision 2,
63.22 paragraph (o), of service and support providers, and identifies all available options for
63.23 case management services and providers;

63.24 ~~(3) identify~~ (6) identifies long- and short-range goals for the person;

63.25 ~~(4) identify~~ (7) identifies specific services and the amount and frequency of the
63.26 services to be provided to the person based on assessed needs, preferences, and available
63.27 resources. ~~The individual service~~ coordinated service and support plan shall also specify
63.28 other services the person needs that are not available;

63.29 ~~(5) identify~~ (8) identifies the need for an individual program plan to be developed
63.30 by the provider according to the respective state and federal licensing and certification
63.31 standards, and additional assessments to be completed or arranged by the provider after
63.32 service initiation;

63.33 ~~(6) identify~~ (9) identifies provider responsibilities to implement and make
63.34 recommendations for modification to the ~~individual service~~ coordinated service and
63.35 support plan;

64.1 ~~(7) include~~ (10) includes notice of the right to request a conciliation conference or a
64.2 hearing under section 256.045;

64.3 ~~(8) be~~ (11) is agreed upon and signed by the person, the person's legal guardian
64.4 or conservator, or the parent if the person is a minor, and the authorized county
64.5 representative; and

64.6 ~~(9) be~~ (12) is reviewed by a health professional if the person has overriding medical
64.7 needs that impact the delivery of services.

64.8 ~~Service planning formats developed for interagency planning such as transition,~~
64.9 ~~vocational, and individual family service plans may be substituted for service planning~~
64.10 ~~formats developed by county agencies.~~

64.11 (b) In developing the coordinated services and support plan, the case manager is
64.12 encouraged to include the use of volunteers, religious organizations, social clubs, and civic
64.13 and service organizations to support the individual in the community. The lead agency
64.14 must be held harmless for damages or injuries sustained through the use of volunteers and
64.15 agencies under this paragraph, including workers' compensation liability.

64.16 Sec. 25. Minnesota Statutes 2010, section 256B.092, subdivision 1e, is amended to
64.17 read:

64.18 Subd. 1e. **Coordination, evaluation, and monitoring of services.** (a) If the
64.19 ~~individual service~~ coordinated service and support plan identifies the need for individual
64.20 program plans for authorized services, the case manager shall assure that individual
64.21 program plans are developed by the providers according to clauses (2) to (5). The
64.22 providers shall assure that the individual program plans:

64.23 (1) are developed according to the respective state and federal licensing and
64.24 certification requirements;

64.25 (2) are designed to achieve the goals of the ~~individual service~~ coordinated service
64.26 and support plan;

64.27 (3) are consistent with other aspects of the ~~individual service~~ coordinated service
64.28 and support plan;

64.29 (4) assure the health and safety of the person; and

64.30 (5) are developed with consistent and coordinated approaches to services among the
64.31 various service providers.

64.32 (b) The case manager shall monitor the provision of services:

64.33 (1) to assure that the ~~individual service~~ coordinated service and support plan is
64.34 being followed according to paragraph (a);

(2) to identify any changes or modifications that might be needed in the ~~individual service~~ coordinated service and support plan, including changes resulting from recommendations of current service providers;

(3) to determine if the person's legal rights are protected, and if not, notify the person's legal guardian or conservator, or the parent if the person is a minor, protection services, or licensing agencies as appropriate; and

(4) to determine if the person, the person's legal guardian or conservator, or the parent if the person is a minor, is satisfied with the services provided.

(c) If the provider fails to develop or carry out the individual program plan according to paragraph (a), the case manager shall notify the person's legal guardian or conservator, or the parent if the person is a minor, the provider, the respective licensing and certification agencies, and the county board where the services are being provided. In addition, the case manager shall identify other steps needed to assure the person receives the services identified in the ~~individual service~~ coordinated service and support plan.

Sec. 26. Minnesota Statutes 2010, section 256B.092, subdivision 1g, is amended to read:

Subd. 1g. **Conditions not requiring development of ~~individual service~~ coordinated service and support plan.** Unless otherwise required by federal law, the county agency is not required to complete ~~an individual service~~ a coordinated service and support plan as defined in subdivision 1b for:

(1) persons whose families are requesting respite care for their family member who resides with them, or whose families are requesting a family support grant and are not requesting purchase or arrangement of habilitative services; and

(2) persons with developmental disabilities, living independently without authorized services or receiving funding for services at a rehabilitation facility as defined in section 268A.01, subdivision 6, and not in need of or requesting additional services.

Sec. 27. Minnesota Statutes 2010, section 256B.092, subdivision 2, is amended to read:

Subd. 2. **Medical assistance.** To assure quality case management to those persons who are eligible for medical assistance, the commissioner shall, upon request:

(1) provide consultation on the case management process;

(2) assist county agencies in the ~~screening and~~ annual reviews of clients review process to assure that appropriate levels of service are provided to persons;

(3) provide consultation on service planning and development of services with appropriate options;

66.1 (4) provide training and technical assistance to county case managers; and
66.2 (5) authorize payment for medical assistance services according to this chapter
66.3 and rules implementing it.

66.4 Sec. 28. Minnesota Statutes 2010, section 256B.092, subdivision 3, is amended to read:

66.5 Subd. 3. **Authorization and termination of services.** County agency case
66.6 managers, under rules of the commissioner, shall authorize and terminate services of
66.7 community and regional treatment center providers according to ~~individual service~~
66.8 support plans. Services provided to persons with developmental disabilities may only be
66.9 authorized and terminated by case managers or certified assessors according to (1) rules of
66.10 the commissioner and (2) the ~~individual service~~ support plan as defined in subdivision
66.11 1b and section 256B.0911. Medical assistance services not needed shall not be authorized
66.12 by county agencies or funded by the commissioner. When purchasing or arranging for
66.13 unlicensed respite care services for persons with overriding health needs, the county
66.14 agency shall seek the advice of a health care professional in assessing provider staff
66.15 training needs and skills necessary to meet the medical needs of the person.

66.16 Sec. 29. Minnesota Statutes 2010, section 256B.092, subdivision 5, is amended to read:

66.17 Subd. 5. **Federal waivers.** (a) The commissioner shall apply for any federal
66.18 waivers necessary to secure, to the extent allowed by law, federal financial participation
66.19 under United States Code, title 42, sections 1396 et seq., as amended, for the provision
66.20 of services to persons who, in the absence of the services, would need the level of care
66.21 provided in a regional treatment center or a community intermediate care facility for
66.22 persons with developmental disabilities. The commissioner may seek amendments to the
66.23 waivers or apply for additional waivers under United States Code, title 42, sections 1396
66.24 et seq., as amended, to contain costs. The commissioner shall ensure that payment for
66.25 the cost of providing home and community-based alternative services under the federal
66.26 waiver plan shall not exceed the cost of intermediate care services including day training
66.27 and habilitation services that would have been provided without the waived services.

66.28 The commissioner shall seek an amendment to the 1915c home and
66.29 community-based waiver to allow properly licensed adult foster care homes to provide
66.30 residential services to up to five individuals with developmental disabilities. If the
66.31 amendment to the waiver is approved, adult foster care providers that can accommodate
66.32 five individuals shall increase their capacity to five beds, provided the providers continue
66.33 to meet all applicable licensing requirements.

(b) The commissioner, in administering home and community-based waivers for persons with developmental disabilities, shall ensure that day services for eligible persons are not provided by the person's residential service provider, unless the person or the person's legal representative is offered a choice of providers and agrees in writing to provision of day services by the residential service provider. The ~~individual service~~ coordinated service and support plan for individuals who choose to have their residential service provider provide their day services must describe how health, safety, protection, and habilitation needs will be met, including how frequent and regular contact with persons other than the residential service provider will occur. The ~~individualized service~~ coordinated service and support plan must address the provision of services during the day outside the residence on weekdays.

(c) When a ~~county~~ lead agency is evaluating denials, reductions, or terminations of home and community-based services under section 256B.0916 for an individual, the ~~case manager~~ lead agency shall offer to meet with the individual or the individual's guardian in order to discuss the prioritization of service needs within the ~~individualized service~~ coordinated service and support plan. The reduction in the authorized services for an individual due to changes in funding for waived services may not exceed the amount needed to ensure medically necessary services to meet the individual's health, safety, and welfare.

Sec. 30. Minnesota Statutes 2010, section 256B.092, subdivision 7, is amended to read:

Subd. 7. ~~Screening teams~~ Assessments. (a) Assessments and reassessments shall be conducted by certified assessors according to section 256B.0911, and must incorporate appropriate referrals to determine eligibility for case management under subdivision 1a.

(b) For persons with developmental disabilities, ~~screening teams shall be established which a certified assessor~~ shall evaluate the need for the level of care provided by residential-based habilitation services, residential services, training and habilitation services, and nursing facility services. The ~~evaluation assessment~~ shall address whether home and community-based services are appropriate for persons who are at risk of placement in an intermediate care facility for persons with developmental disabilities, or for whom there is reasonable indication that they might require this level of care. The ~~screening team~~ certified assessor shall make an evaluation of need ~~within 60 working days of a request for service by a person with a developmental disability, and within five working days of an emergency admission of a person to an intermediate care facility for persons with developmental disabilities. The screening team shall consist of the case manager for persons with developmental disabilities, the person, the person's~~

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~~legal guardian or conservator, or the parent if the person is a minor, and a qualified developmental disability professional, as defined in the Code of Federal Regulations, title 42, section 483.430, as amended through June 3, 1988. The case manager may also act as the qualified developmental disability professional if the case manager meets the federal definition. County social service agencies may contract with a public or private agency or individual who is not a service provider for the person for the public guardianship representation required by the screening or individual service planning process. The contract shall be limited to public guardianship representation for the screening and individual service planning activities. The contract shall require compliance with the commissioner's instructions and may be for paid or voluntary services. For persons determined to have overriding health care needs and are seeking admission to a nursing facility or an ICF/MR, or seeking access to home and community-based waived services, a registered nurse must be designated as either the case manager or the qualified developmental disability professional. For persons under the jurisdiction of a correctional agency, the case manager must consult with the corrections administrator regarding additional health, safety, and supervision needs. The case manager, with the concurrence of the person, the person's legal guardian or conservator, or the parent if the person is a minor, may invite other individuals to attend meetings of the screening team. No member of the screening team shall have any direct or indirect service provider interest in the case. Nothing in this section shall be construed as requiring the screening team meeting to be separate from the service planning meeting.~~

Sec. 31. Minnesota Statutes 2010, section 256B.092, subdivision 8, is amended to read:

Subd. 8. **Screening team Additional certified assessor duties.** In addition to the responsibilities of certified assessors described in section 256B.0911, for persons with developmental disabilities, the screening team certified assessor shall:

- ~~(1) review diagnostic data;~~
- ~~(2) review health, social, and developmental assessment data using a uniform screening tool specified by the commissioner;~~
- ~~(3) identify the level of services appropriate to maintain the person in the most normal and least restrictive setting that is consistent with the person's treatment needs;~~
- ~~(4)~~ (1) identify other noninstitutional public assistance or social service that may prevent or delay long-term residential placement;
- ~~(5)~~ (2) assess whether a person is in need of long-term residential care;
- ~~(6)~~ (3) make recommendations regarding placement and payment for: (i) social service or public assistance support, or both, to maintain a person in the person's own home

or other place of residence; (ii) training and habilitation service, vocational rehabilitation, and employment training activities; (iii) community residential placement; (iv) regional treatment center placement; or (v) a home and community-based service alternative to community residential placement or regional treatment center placement;

~~(7)~~ (4) evaluate the availability, location, and quality of the services listed in clause ~~(6)~~ (3), including the impact of placement alternatives on the person's ability to maintain or improve existing patterns of contact and involvement with parents and other family members;

~~(8)~~ (5) identify the cost implications of recommendations in clause ~~(6)~~ (3); and

~~(9)~~ (6) make recommendations to a court as may be needed to assist the court in making decisions regarding commitment of persons with developmental disabilities; and

~~(10) inform the person and the person's legal guardian or conservator, or the parent if the person is a minor, that appeal may be made to the commissioner pursuant to section 256.045.~~

Sec. 32. Minnesota Statutes 2010, section 256B.092, subdivision 8a, is amended to read:

Subd. 8a. **County concurrence notification.** (a) If the county of financial responsibility wishes to place a person in another county for services, the county of financial responsibility shall ~~seek concurrence from~~ notify the proposed county of service and the placement shall be made cooperatively between the two counties. Arrangements shall be made between the two counties for ongoing social service, including annual reviews of the person's ~~individual service~~ coordinated service and support plan. The county where services are provided may not make changes in the person's ~~service~~ coordinated service and support plan without approval by the county of financial responsibility.

~~(b) When a person has been screened and authorized for services in an intermediate care facility for persons with developmental disabilities or for home and community-based services for persons with developmental disabilities, the case manager shall assist that person in identifying a service provider who is able to meet the needs of the person according to the person's individual service plan. If the identified service is to be provided in a county other than the county of financial responsibility, the county of financial responsibility shall request concurrence of the county where the person is requesting to receive the identified services. The county of service may refuse to concur shall notify the county of financial responsibility if:~~

~~(1) it can demonstrate that the provider is unable to provide the services identified in the person's individual service plan as services that are needed and are to be provided; or~~

(2) in the case of an intermediate care facility for persons with developmental disabilities, there has been no authorization for admission by the admission review team as required in section 256B.0926.

(c) The county of service shall notify the county of financial responsibility of ~~concurrence or refusal to concur~~ any concerns about the chosen provider's capacity to meet the needs of the person seeking to move to residential services in another county no later than 20 working days following receipt of the written request notification. Unless other mutually acceptable arrangements are made by the involved county agencies, the county of financial responsibility is responsible for costs of social services and the costs associated with the development and maintenance of the placement. The county of service may request that the county of financial responsibility purchase case management services from the county of service or from a contracted provider of case management when the county of financial responsibility is not providing case management as defined in this section and rules adopted under this section, unless other mutually acceptable arrangements are made by the involved county agencies. Standards for payment limits under this section may be established by the commissioner. Financial disputes between counties shall be resolved as provided in section 256G.09. This subdivision also applies to home and community-based waiver services provided under section 256B.49.

Sec. 33. Minnesota Statutes 2010, section 256B.092, subdivision 9, is amended to read:

Subd. 9. **Reimbursement.** Payment for services shall not be provided to a service provider for any person placed in an intermediate care facility for persons with developmental disabilities prior to the person ~~being screened by the screening team~~ receiving an assessment by a certified assessor. The commissioner shall not deny reimbursement for: (1) a person admitted to an intermediate care facility for persons with developmental disabilities who is assessed to need long-term supportive services, if long-term supportive services other than intermediate care are not available in that community; (2) any person admitted to an intermediate care facility for persons with developmental disabilities under emergency circumstances; (3) any eligible person placed in the intermediate care facility for persons with developmental disabilities pending an appeal of the ~~screening team's~~ certified assessor's decision; or (4) any medical assistance recipient when, after full discussion of all appropriate alternatives including those that are expected to be less costly than intermediate care for persons with developmental disabilities, the person or the person's legal guardian or conservator, or the parent if the person is a minor, insists on intermediate care placement. The ~~screening team~~ certified

71.1 assessor shall provide documentation that the most cost-effective alternatives available
71.2 were offered to this individual or the individual's legal guardian or conservator.

71.3 Sec. 34. Minnesota Statutes 2010, section 256B.092, subdivision 11, is amended to
71.4 read:

71.5 Subd. 11. **Residential support services.** (a) Upon federal approval, there is
71.6 established a new service called residential support that is available on the community
71.7 alternative care, community alternatives for disabled individuals, developmental
71.8 disabilities, and traumatic brain injury waivers. Existing waiver service descriptions
71.9 must be modified to the extent necessary to ensure there is no duplication between
71.10 other services. Residential support services must be provided by vendors licensed as a
71.11 community residential setting as defined in section 245A.11, subdivision 8.

71.12 (b) Residential support services must meet the following criteria:

71.13 (1) providers of residential support services must own or control the residential site;

71.14 (2) the residential site must not be the primary residence of the license holder;

71.15 (3) the residential site must have a designated program supervisor responsible for
71.16 program oversight, development, and implementation of policies and procedures;

71.17 (4) the provider of residential support services must provide supervision, training,
71.18 and assistance as described in the person's ~~community~~ coordinated services and support
71.19 plan; and

71.20 (5) the provider of residential support services must meet the requirements of
71.21 licensure and additional requirements of the person's ~~community~~ coordinated services and
71.22 support plan.

71.23 (c) Providers of residential support services that meet the definition in paragraph
71.24 (a) must be registered using a process determined by the commissioner beginning July
71.25 1, 2009.

71.26 Sec. 35. Minnesota Statutes 2010, section 256B.49, subdivision 13, is amended to read:

71.27 Subd. 13. **Case management.** (a) Each recipient of a home and community-based
71.28 waiver shall be provided case management services by qualified vendors as described
71.29 in the federally approved waiver application. The case management service activities
71.30 provided ~~will~~ must include:

71.31 ~~(1) assessing the needs of the individual within 20 working days of a recipient's~~
71.32 ~~request;~~

72.1 ~~(2) developing~~ (1) finalizing the written individual service coordinated service and
72.2 support plan within ten working days after the assessment is completed ~~case manager~~
72.3 receives the plan from the certified assessor;

72.4 ~~(3)~~ (2) informing the recipient or the recipient's legal guardian or conservator
72.5 of service options;

72.6 ~~(4)~~ (3) assisting the recipient in the identification of potential service providers and
72.7 available options for case management service and providers;

72.8 ~~(5)~~ (4) assisting the recipient to access services and assisting with appeals under
72.9 section 256.045; and

72.10 ~~(6)~~ (5) coordinating, evaluating, and monitoring of the services identified in the
72.11 service plan;

72.12 ~~(7) completing the annual reviews of the service plan; and~~

72.13 ~~(8) informing the recipient or legal representative of the right to have assessments~~
72.14 ~~completed and service plans developed within specified time periods, and to appeal county~~
72.15 ~~action or inaction under section 256.045, subdivision 3, including the determination of~~
72.16 ~~nursing facility level of care.~~

72.17 (b) The case manager may delegate certain aspects of the case management service
72.18 activities to another individual provided there is oversight by the case manager. The case
72.19 manager may not delegate those aspects which require professional judgment including
72.20 assessments, reassessments, and care plan development.

72.21 (1) finalizing the coordinated service and support plan;

72.22 (2) ongoing assessment and monitoring of the person's needs and adequacy of the
72.23 approved coordinated service and support plan; and

72.24 (3) adjustments to the coordinated service and support plan.

72.25 (c) Case management services must be provided by a public or private agency that
72.26 is enrolled as a medical assistance provider determined by the commissioner to meet all
72.27 of the requirements in the approved federal waiver plans. Case management services
72.28 must not be provided to a recipient by a private agency that has any financial interest in
72.29 the provision of any other services included in the recipient's coordinated services and
72.30 support plan. For purposes of this section, "private agency" means any agency that is not
72.31 identified as a lead agency under section 256B.0911, subdivision 1a, paragraph (d).

72.32 (d) For persons eligible for home and community-based waiver services under this
72.33 section, case management service must be provided and paid for under the terms of the
72.34 approved federal waiver plans and must not be billed as targeted case management.

72.35 Sec. 36. Minnesota Statutes 2010, section 256B.49, subdivision 14, is amended to read:

Subd. 14. **Assessment and reassessment.** (a) ~~Assessments of each recipient's strengths, informal support systems, and need for services shall be completed within 20 working days of the recipient's request. Reassessment of each recipient's strengths, support systems, and need for services shall be conducted at least every 12 months and at other times when there has been a significant change in the recipient's functioning and reassessments shall be conducted by certified assessors according to section 256B.0911, subdivision 2b.~~

(b) There must be a determination that the client requires a hospital level of care or a nursing facility level of care as defined in section 144.0724, subdivision 11, at initial and subsequent assessments to initiate and maintain participation in the waiver program.

(c) Regardless of other assessments identified in section 144.0724, subdivision 4, as appropriate to determine nursing facility level of care for purposes of medical assistance payment for nursing facility services, only face-to-face assessments conducted according to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care determination or a nursing facility level of care determination must be accepted for purposes of initial and ongoing access to waiver services payment.

~~(d) Persons with developmental disabilities who apply for services under the nursing facility level waiver programs shall be screened for the appropriate level of care according to section 256B.092.~~

~~(e)~~ (d) Recipients who are found eligible for home and community-based services under this section before their 65th birthday may remain eligible for these services after their 65th birthday if they continue to meet all other eligibility factors.

Sec. 37. Minnesota Statutes 2010, section 256B.49, subdivision 15, is amended to read:

Subd. 15. **Individualized Coordinated service and support plan.** (a) Each recipient of home and community-based waived services shall be provided a copy of the written ~~service~~ coordinated service and support plan which:

~~(1) is developed and signed by the recipient within ten working days of the completion of the assessment;~~

~~(2) meets the assessed needs of the recipient;~~

~~(3) reasonably ensures the health and safety of the recipient;~~

~~(4) promotes independence;~~

~~(5) allows for services to be provided in the most integrated settings; and~~

~~(6) provides for an informed choice, as defined in section 256B.77, subdivision 2, paragraph (p), of service and support providers~~ meets the requirements in section 256B.092, subdivision 1b.

(b) When a county is evaluating denials, reductions, or terminations of home and community-based services under section 256B.49 for an individual, the case manager shall offer to meet with the individual or the individual's guardian in order to discuss the prioritization of service needs within the ~~individualized service~~ coordinated services and support plan. The reduction in the authorized services for an individual due to changes in funding for waived services may not exceed the amount needed to ensure medically necessary services to meet the individual's health, safety, and welfare.

Sec. 38. Minnesota Statutes 2010, section 256G.02, subdivision 6, is amended to read:

Subd. 6. **Excluded time.** "Excluded time" means:

~~(a)~~ (1) any period an applicant spends in a hospital, sanitarium, nursing home, shelter other than an emergency shelter, halfway house, foster home, semi-independent living domicile or services program, residential facility offering care, board and lodging facility or other institution for the hospitalization or care of human beings, as defined in section 144.50, 144A.01, or 245A.02, subdivision 14; maternity home, battered women's shelter, or correctional facility; or any facility based on an emergency hold under sections 253B.05, subdivisions 1 and 2, and 253B.07, subdivision 6;

~~(b)~~ (2) any period an applicant spends on a placement basis in a training and habilitation program, including: a rehabilitation facility or work or employment program as defined in section 268A.01; ~~or receiving personal care assistance services pursuant to section 256B.0659~~; semi-independent living services provided under section 252.275, and Minnesota Rules, parts 9525.0500 to 9525.0660; or day training and habilitation programs and assisted living services; and

~~(c)~~ (3) any placement for a person with an indeterminate commitment, including independent living.

Sec. 39. **RECOMMENDATIONS FOR FURTHER CASE MANAGEMENT REDESIGN.**

By February 1, 2012, the commissioner of human services shall develop a legislative report with specific recommendations and language for proposed legislation to be effective July 1, 2012, for the following:

(a) definitions of service and consolidation of standards and rates to the extent appropriate for all types of medical assistance case management service services, including targeted case management under Minnesota Statutes, sections 256B.0621, 256B.0924, and 256B.094, and all types of home and community-based waiver case management and case

management under Minnesota Rules, parts 9525.0004 to 9525.0036. This work must be completed in collaboration with efforts under Minnesota Statutes, section 256B.4912;

(b) recommendations on county of financial responsibility requirements and quality assurance measures for case management; and

(c) identification of county administrative functions that may remain entwined in case management service delivery models.

ARTICLE 4

NURSING FACILITIES

Section 1. Minnesota Statutes 2010, section 144A.071, subdivision 3, is amended to read:

Subd. 3. **Exceptions authorizing increase in beds; hardship areas.** (a) The commissioner of health, in coordination with the commissioner of human services, may approve the addition of a new ~~certified bed or the addition of a new~~ licensed and Medicare and Medicaid-certified nursing home ~~bed beds, under using the following conditions:~~ criteria and process in this subdivision.

~~(a) to license or certify a new bed in place of one decertified after July 1, 1993, as long as the number of certified plus newly certified or recertified beds does not exceed the number of beds licensed or certified on July 1, 1993, or to address an extreme hardship situation, in a particular county that, together with all contiguous Minnesota counties, has fewer nursing home beds per 1,000 elderly than the number that is ten percent higher than the national average of nursing home beds per 1,000 elderly individuals. For the purposes of this section, the national average of nursing home beds shall be the most recent figure that can be supplied by the federal Centers for Medicare and Medicaid Services and the number of elderly in the county or the nation shall be determined by the most recent federal census or the most recent estimate of the state demographer as of July 1, of each year of persons age 65 and older, whichever is the most recent at the time of the request for replacement. An extreme hardship situation can only be found after the county documents the existence of unmet medical needs that cannot be addressed by any other alternatives;~~

(b) The commissioner, in cooperation with the commissioner of human services, shall consider the following criteria when determining that an area of the state is a hardship area with regard to access to nursing facility services:

(1) a low number of beds per thousand in a specified area using as a standard an amount lower than the beds per thousand of the county at the 20th percentile, as determined by the commissioner of human services;

(2) a high level of outmigration associated with a described area from the county or counties of residence to other Minnesota counties, as determined by the commissioner of human services, using as a standard an amount greater than the outmigration of the county ranked at the 50th percentile;

(3) an adequate level of availability of noninstitutional services as determined by the commissioner of human services using as a standard an amount greater than the 50th percentile of counties;

(4) there must be a declaration of hardship by local county agencies and area agencies on aging; and

(5) other factors that may demonstrate the need to add new nursing facility beds.

(c) On August 15 of odd-numbered years, the commissioner, in cooperation with the commissioner of human services, may publish in the State Register a request for information in which interested parties, using the data provided under section 144A.351, along with any other relevant data, demonstrate that a specified area is a hardship area with regard to access to nursing facility services. For a response to be considered, the commissioner must receive it by November 15. The commissioner shall make responses to the request for information available to the public and shall allow 30 days for comment. The commissioner shall review responses and comments and determine if any areas of the state are to be declared hardship areas.

(d) For each designated hardship area determined in paragraph (c), the commissioner shall publish a request for proposals in accordance with section 144A.073 and Minnesota Rules, parts 4655.1070 to 4655.1098. The request for proposals must be published in the State Register by March 15 following receipt of responses to the request for information. The request for proposals must specify the number of new beds which may be added in the designated hardship area, which must not exceed the number which, if added to the existing number of beds in the area, including beds in layaway status, would have prevented it from being determined to be a hardship area under paragraph (b), clause (1). Beginning July 1, 2011, the number of new beds approved must not exceed 200 beds statewide per biennium. After June 30, 2019, the number of new beds that may be approved in a biennium must not exceed 300 statewide. For a proposal to be considered, the commissioner must receive it within six months of the publication of the request for proposals. The commissioner shall review responses to the request for proposals and shall approve or disapprove each proposal by the following July 15, in accordance with section 144A.073 and Minnesota Rules, parts 4655.1070 to 4655.1098. The commissioner shall base approvals or disapprovals on a comparison and ranking of proposals using only the criteria in subdivision 4a. Approval of a proposal expires after 18 months

unless the facility has added the new beds using existing space, subject to approval by the commissioner, or has commenced construction as defined in section 144A.071, subdivision 1a, paragraph (d). If fewer than 50 percent of the beds in a facility are newly licensed, after the beds have been added, the operating payment rates previously in effect shall remain. If 50 percent or more of the beds in a facility are newly licensed after the approved beds have been added, then determination of operating payment rates shall be done according to Minnesota Rules, part 9549.0057, using limits determined under section 256B.441. Determination of external fixed payment rates must be done according to section 256B.441, subdivision 53. Determinations of property payment rates for facilities with beds added under this subdivision must be done in the same manner as rate determinations resulting from projects approved and completed under section 144A.073.

~~(b) to~~ (e) The commissioner may:

(1) certify or license new beds in a new facility that is to be operated by the commissioner of veterans affairs or when the costs of constructing and operating the new beds are to be reimbursed by the commissioner of veterans affairs or the United States Veterans Administration; and

~~(e) to~~ (2) license or certify beds in a facility that has been involuntarily delicensed or decertified for participation in the medical assistance program, provided that an application for relicensure or recertification is submitted to the commissioner by an organization that is not a related organization as defined in section 256B.441, subdivision 34, to the prior licensee within 120 days after delicensure or decertification;

~~(d) to certify two existing beds in a facility with 66 licensed beds on January 1, 1994, that had an average occupancy rate of 98 percent or higher in both calendar years 1992 and 1993, and which began construction of four attached assisted living units in April 1993; or~~

~~(e) to certify four existing beds in a facility in Winona with 139 beds, of which 129 beds are certified.~~

Sec. 2. Minnesota Statutes 2010, section 144A.073, subdivision 3c, is amended to read:

Subd. 3c. **Cost neutral relocation projects.** (a) Notwithstanding subdivision 3, the commissioner may at any time accept proposals, or amendments to proposals previously approved under this section, for relocations that are cost neutral with respect to state costs as defined in section 144A.071, subdivision 5a. The commissioner, in consultation with the commissioner of human services, shall evaluate proposals according to subdivision ~~4~~ 4a, clauses (1), ~~(2), (3), and (9)~~ (4), (5), (6), and (8), and other criteria established in rule: or law. The commissioner of human services shall determine the allowable payment rates of the facility receiving the beds in accordance with section 256B.441, subdivision

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~~60. The commissioner shall approve or disapprove a project within 90 days. Proposals and amendments approved under this subdivision are not subject to the six-mile limit in subdivision 5, paragraph (c).~~

(b) For the purposes of paragraph (a), cost neutrality shall be measured over the first three 12-month periods of operation after completion of the project.

Sec. 3. Minnesota Statutes 2010, section 144A.073, is amended by adding a subdivision to read:

Subd. 4a. **Criteria for review.** In reviewing the application materials and submitted costs by an applicant to the moratorium process, the review panel shall consider the following criteria in recommending proposals:

(1) the extent to which the proposed nursing home project is integrated with other health and long-term care services for older adults;

(2) the extent to which the project provides for the complete replacement of an outdated physical plant;

(3) the extent to which the project results in a reduction of nursing facility beds in an area that has a relatively high number of beds per thousand occupied by persons age 85 and over;

(4) the extent to which the project produces improvements in health, safety (including life safety code corrections), quality of life, and privacy of residents;

(5) the extent to which, under the current facility ownership and management, the provider has shown the ability to provide good quality of care based on health-related findings on certification surveys, quality indicator scores, and quality-of-life scores, including those from the Minnesota nursing home report card;

(6) the extent to which the project integrates the latest technology and design features in a way that improves the resident experience and improves the working environment for employees;

(7) the extent to which the sustainability of the nursing facility can be demonstrated based on the need for services in the area and the proposed financing of the project; and

(8) the extent to which the project provides or maintains access to nursing facility services needed in the community.

Sec. 4. Minnesota Statutes 2010, section 144D.03, subdivision 2, is amended to read:

Subd. 2. Registration information. The establishment shall provide the following information to the commissioner in order to be registered:

(1) the business name, street address, and mailing address of the establishment;

(2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners are not natural persons, identification of the type of business entity of the owner or owners, and the names and addresses of the officers and members of the governing body, or comparable persons for partnerships, limited liability corporations, or other types of business organizations of the owner or owners;

(3) the name and mailing address of the managing agent, whether through management agreement or lease agreement, of the establishment, if different from the owner or owners, and the name of the on-site manager, if any;

(4) verification that the establishment has entered into a housing with services contract, as required in section 144D.04, with each resident or resident's representative;

(5) verification that the establishment is complying with the requirements of section 325F.72, if applicable;

(6) the name and address of at least one natural person who shall be responsible for dealing with the commissioner on all matters provided for in sections 144D.01 to 144D.06, and on whom personal service of all notices and orders shall be made, and who shall be authorized to accept service on behalf of the owner or owners and the managing agent, if any;

(7) the signature of the authorized representative of the owner or owners or, if the owner or owners are not natural persons, signatures of at least two authorized representatives of each owner, one of which shall be an officer of the owner; ~~and~~

~~(8) whether which services, as defined in section 144D.01, subdivisions 5 and 6, or any other services, are included in the base rate to be paid by the resident. with the rent in a base rate. "Base rate" means the payment required when services are included with rent. "Rent" means the payment for occupancy of a property and may only include the following when specified in a lease:~~

~~(i) utilities, such as heat, electricity, telephone, garbage, recycling, water, sewer, cable or satellite television service, and Internet service;~~

~~(ii) access to common areas and amenities;~~

~~(iii) vehicle parking;~~

~~(iv) building maintenance; and~~

~~(v) front desk service; and~~

~~(9) whether the establishment requires as a condition of tenancy the purchase of services with the rent.~~

Personal service on the person identified under clause (6) by the owner or owners in the registration shall be considered service on the owner or owners, and it shall not be a defense to any action that personal service was not made on each individual or entity. The

80.1 designation of one or more individuals under this subdivision shall not affect the legal
80.2 responsibility of the owner or owners under sections 144D.01 to 144D.06.

80.3 **EFFECTIVE DATE.** This section is effective March 1, 2012.

80.4 Sec. 5. Minnesota Statutes 2010, section 144D.04, subdivision 2, is amended to read:

80.5 Subd. 2. **Contents of contract.** A housing with services contract, which need not be
80.6 entitled as such to comply with this section, shall include at least the following elements
80.7 in itself or through supporting documents or attachments:

80.8 (1) the name, street address, and mailing address of the establishment;

80.9 (2) the name and mailing address of the owner or owners of the establishment and, if
80.10 the owner or owners is not a natural person, identification of the type of business entity
80.11 of the owner or owners;

80.12 (3) the name and mailing address of the managing agent, through management
80.13 agreement or lease agreement, of the establishment, if different from the owner or owners;

80.14 (4) the name and address of at least one natural person who is authorized to accept
80.15 service of process on behalf of the owner or owners and managing agent;

80.16 (5) a statement describing the registration and licensure status of the establishment
80.17 and any provider providing health-related or supportive services under an arrangement
80.18 with the establishment;

80.19 (6) the term of the contract;

80.20 (7) ~~a description of the services to be provided to the resident in the~~ effective March
80.21 1, 2012, the amount and charge for each of the services defined in section 144D.01,
80.22 subdivision 5 or 6, or any other services included with rent in a base rate to be paid by
80.23 resident, including a delineation of the portion percentage of the base rate that constitutes
80.24 rent and a delineation of charges for each service included in the base rate services;

80.25 (8) a description of any additional services, including home care services, available
80.26 for an additional fee from the establishment directly or through arrangements with the
80.27 establishment, and a schedule of fees charged for these services;

80.28 (9) a description of the process through which the contract may be modified,
80.29 amended, or terminated;

80.30 (10) a description of the establishment's complaint resolution process available
80.31 to residents including the toll-free complaint line for the Office of Ombudsman for
80.32 Long-Term Care;

80.33 (11) the resident's designated representative, if any;

80.34 (12) the establishment's referral procedures if the contract is terminated;

(13) requirements of residency used by the establishment to determine who may reside or continue to reside in the housing with services establishment;

(14) billing and payment procedures and requirements;

(15) a statement regarding the ability of residents to receive services from service providers with whom the establishment does not have an arrangement;

(16) a statement regarding the availability of public funds for payment for residence or services in the establishment; and

(17) a statement regarding the availability of and contact information for long-term care consultation services under section 256B.0911 in the county in which the establishment is located.

Sec. 6. Minnesota Statutes 2010, section 256B.19, subdivision 1e, is amended to read:

Subd. 1e. **Additional local share of certain nursing facility costs.** Beginning on the latter of January 1, 2011, or the first day of the month beginning no less than 45 days following federal approval, local government entities that own the physical plant or are the license holders of nursing facilities receiving rate adjustments under section 256B.441, subdivision 55a, shall be responsible for paying the portion of nonfederal costs calculated under section 256B.441, subdivision 55a, paragraph (d). This responsibility remains in effect through the day before the phase-in under section 256B.441, subdivision 55, is complete. Beginning the day when the phase-in under section 256B.441, subdivision 55, is complete, local government entities that own the physical plant or are the license holders of nursing facilities receiving rate adjustments under section 256B.441, subdivision 55a, shall be responsible for paying the portion of nonfederal costs calculated under section 256B.441, subdivision 55a, paragraph (e). Payments of the nonfederal share shall be made monthly to the commissioner in amounts determined in accordance with section 256B.441, subdivision 55a, paragraph ~~(d)~~ (e). Payments for each month beginning ~~in January 2011 through September 2015~~ on the effective date of the rate adjustment shall be due by the 15th day of the following month. If any provider obligated to pay an amount under this subdivision is more than ~~two months~~ 30 days delinquent in the timely payment of the monthly installment, the commissioner may ~~withhold payments, penalties, and interest in accordance with the methods outlined in section 256.9657, subdivision 7a~~ revoke participation under this subdivision and end payments determined under section 256B.441, subdivision 55a, to the participating nursing facility effective on the first day of the month for which payment was due and not received. Any amounts paid by private residents for days of service after the effective date of revocation must be refunded.

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82.1 Sec. 7. Minnesota Statutes 2010, section 256B.431, subdivision 2t, is amended to read:

82.2 Subd. 2t. **Payment limitation.** For services rendered on or after July 1, 2003,
82.3 for facilities reimbursed under this ~~section or section 256B.434~~ chapter, the Medicaid
82.4 program shall only pay a co-payment during a Medicare-covered skilled nursing facility
82.5 stay if the Medicare rate less the resident's co-payment responsibility is less than the
82.6 Medicaid RUG-III case-mix payment rate, or, beginning January 1, 2012, the Medicaid
82.7 RUG-IV case-mix payment rate. The amount that shall be paid by the Medicaid program
82.8 is equal to the amount by which the Medicaid RUG-III or RUG-IV case-mix payment
82.9 rate exceeds the Medicare rate less the co-payment responsibility. Health plans paying
82.10 for nursing home services under section 256B.69, subdivision 6a, may limit payments as
82.11 allowed under this subdivision.

82.12 Sec. 8. Minnesota Statutes 2010, section 256B.438, subdivision 1, is amended to read:

82.13 Subdivision 1. **Scope.** This section establishes the method and criteria used to
82.14 determine resident reimbursement classifications based upon the assessments of residents
82.15 of nursing homes and boarding care homes whose payment rates are established under
82.16 section 256B.431, 256B.434, or ~~256B.435~~ 256B.441 or any other section. Resident
82.17 reimbursement classifications shall be established according to the 34 group, resource
82.18 utilization groups, version III or RUG-III model as described in section 144.0724.
82.19 Reimbursement classifications established under this section shall be implemented
82.20 after June 30, 2002, but no later than January 1, 2003. Reimbursement classifications
82.21 established under this section shall be implemented no earlier than six weeks after the
82.22 commissioner mails notices of payment rates to the facilities. Effective January 1, 2012,
82.23 resident reimbursement classifications shall be established according to the 48 group,
82.24 resource utilization groups, RUG-IV model under section 144.0724.

82.25 Sec. 9. Minnesota Statutes 2010, section 256B.438, subdivision 3, is amended to read:

82.26 Subd. 3. **Case mix indices.** (a) The commissioner of human services shall assign a
82.27 case mix index to each resident class based on the Centers for Medicare and Medicaid
82.28 Services staff time measurement study and adjusted for Minnesota-specific wage indices.
82.29 The case mix indices assigned to each resident class shall be published in the Minnesota
82.30 State Register at least 120 days prior to the implementation of the 34 group, RUG-III
82.31 resident classification system.

82.32 (b) An index maximization approach shall be used to classify residents.

82.33 (c) After implementation of the revised case mix system, the commissioner of
82.34 human services may annually rebase case mix indices and base rates using more current

data on average wage rates and staff time measurement studies. This rebasing shall be calculated under subdivision 7, paragraph (b). The commissioner shall publish in the Minnesota State Register adjusted case mix indices at least 45 days prior to the effective date of the adjusted case mix indices.

(d) Upon implementation of the 48-group RUG-IV resident classification system, the commissioner of human services shall assign a case mix index to each resident class based on the Centers for Medicare and Medicaid Services staff time measurement study. The case mix indices assigned to each resident class shall be published in the State Register at least 120 days prior to the implementation of the RUG-IV resident classification system.

Sec. 10. Minnesota Statutes 2010, section 256B.438, subdivision 4, is amended to read:

Subd. 4. Resident assessment schedule. (a) Nursing facilities shall conduct and submit case mix assessments according to the schedule established by the commissioner of health under section 144.0724, subdivisions 4 and 5.

(b) The resident reimbursement classifications established under section 144.0724, subdivision 3, shall be effective the day of admission for new admission assessments. The effective date for significant change assessments shall be the assessment reference date. The effective date for annual and quarterly assessments shall be the first day of the month following assessment reference date.

(c) Effective October 1, 2006, the commissioner shall rebase payment rates to account for the change in the resident assessment schedule in section 144.0724, subdivision 4, paragraph (b), clause (4), in a facility specific budget neutral manner, according to subdivision 7, paragraph (b).

(d) Effective January 1, 2012, the commissioner shall determine payment rates to account for the transition to RUG-IV, in a facility-specific, revenue-neutral manner, according to subdivision 8, paragraph (b).

Sec. 11. Minnesota Statutes 2010, section 256B.438, is amended by adding a subdivision to read:

Subd. 8. Rate determination upon transition to RUG-IV payment rates. (a) The commissioner of human services shall determine payment rates at the time of transition to the RUG-IV-based payment model in a facility-specific, revenue-neutral manner. To transition from the current calculation methodology to the RUG-IV-based methodology, nursing facilities shall report to the commissioner of human services the private pay and Medicaid resident days classified according to the categories defined in subdivision 3, paragraphs (a) and (d), for the six-month reporting period ending June 30, 2011. This

report must be submitted to the commissioner, in a form prescribed by the commissioner, by August 15, 2011. The commissioner of human services shall use this data to compute the standardized days for the RUG-III and RUG-IV classification systems.

(b) The commissioner of human services shall determine the case mix adjusted component for the January 1, 2012, rate as follows:

(1) using the September 30, 2010, cost report, determine the case mix portion of the operating cost for each facility;

(2) multiply the 36 operating payment rates in effect on December 31, 2011, by the number of private pay and Medicaid resident days assigned to each group for the reporting period ending June 30, 2011, and compute the total;

(3) compute the product of the amounts in clauses (1) and (2);

(4) determine the private pay and Medicaid RUG standardized days for the reporting period ending June 30, 2011, using the new indices calculated under subdivision 3, paragraph (d);

(5) divide the amount determined in clause (3) by the amount in clause (4), which shall be the default rate (DDF) unadjusted case mix component of the rate under the RUG-IV method; and

(6) determine the case mix adjusted component of each operating rate by multiplying the default rate (DDF) unadjusted case mix component by the case mix weight in subdivision 3, paragraph (d), for each RUG-IV group.

(c) The noncase mix components will be allocated to each RUG group as a constant amount to determine the operating payment rate.

Sec. 12. Minnesota Statutes 2010, section 256B.441, subdivision 55a, is amended to read:

Subd. 55a. **Alternative to phase-in for publicly owned nursing facilities.** (a) For operating payment rates implemented between ~~January 1, 2011, and September 30, 2015,~~ the first day of the month beginning no less than 45 days following federal approval, and the day before the phase-in under subdivision 55 is complete, the commissioner shall allow nursing facilities whose physical plant is owned or whose license is held by a city, county, or hospital district to apply for a higher payment rate under this section if the local government entity agrees to pay a specified portion of the nonfederal share of medical assistance costs. Nursing facilities that apply shall be eligible to select an operating payment rate, with a weight of 1.00, up to the rate calculated in subdivision 54, without application of the phase-in under subdivision 55. The rates for the other ~~RUG's~~ RUGS shall be computed as provided under subdivision 54.

(b) For operating payment rates implemented beginning the day when the phase-in under subdivision 55 is complete, the commissioner shall allow nursing facilities whose physical plant is owned or whose license is held by a city, county, or hospital district to apply for a higher payment rate under this section if the local government entity agrees to pay a specified portion of the nonfederal share of medical assistance costs. Nursing facilities that apply are eligible to select an operating payment rate, with a weight of 1.00, up to an amount determined by the commissioner to be allowable under the Medicare upper payment limit test. The rates for the other RUGS shall be computed under subdivision 54.

~~(b)~~ (c) Rates determined under this subdivision shall take effect beginning on the latter of January 1, 2011, or the first day of the month beginning no less than 45 days following federal approval, based on cost reports for the rate year ending September 30, 2009, and in future rate years, rates determined for nursing facilities participating under this subdivision shall take effect on October 1 of each year, based on the most recent available cost report.

~~(c)~~ (d) Eligible nursing facilities that wish to participate under this subdivision shall make an application to the commissioner by September 30, 2010, or by June 30 of any subsequent year. ~~Participation under this subdivision is irrevocable. If paragraph (a) does not result in a rate greater than what would have been provided without application of this subdivision, a facility's rates shall be calculated as otherwise provided and no payment by the local government entity shall be required under paragraph (d).~~

~~(d)~~ (e) For each participating nursing facility, the public entity that owns the physical plant or is the license holder of the nursing facility shall pay to the state the entire nonfederal share of medical assistance payments received as a result of the difference between the nursing facility's payment rate under ~~subdivision 54~~, paragraph (a) or (b), and the rates that the nursing facility would otherwise be paid without application of this subdivision under subdivision 54 or 55 as determined by the commissioner.

~~(e)~~ (f) The commissioner may, at any time, reduce the payments under this subdivision based on the commissioner's determination that the payments shall cause nursing facility rates to exceed the state's Medicare upper payment limit or any other federal limitation. If the commissioner determines a reduction is necessary, the commissioner shall reduce all payment rates for participating nursing facilities by a percentage applied to the amount of increase they would otherwise receive under this subdivision and shall notify participating facilities of the reductions. If payments to a nursing facility are reduced, payments under section 256B.19, subdivision 1e, shall be reduced accordingly.

Sec. 13. Minnesota Statutes 2010, section 256B.441, is amended by adding a subdivision to read:

Subd. 60. Method for determining budget-neutral nursing facility rates for relocated beds. (a) Nursing facility rates for bed relocations must be calculated by comparing the estimated medical assistance costs prior to and after the proposed bed relocation using the calculations in this subdivision. All payment rates are based on a 1.0 case mix level, with other case mix rates determined accordingly. Nursing facility beds on layaway status that are being moved must be included in the calculation for both the originating and receiving facility and treated as though they were in active status with the occupancy characteristics of the active beds of the originating facility.

(b) Medical assistance costs of the beds in the originating nursing facilities must be calculated as follows:

(1) multiply each originating facility's total payment rate for a RUGS weight of 1.0 by the facility's percentage of medical assistance days on its most recent available cost report;

(2) take the products in clause (1) and multiply by each facility's average case mix score for medical assistance residents on its most recent available cost report;

(3) take the products in clause (2) and multiply by the number of beds being relocated, times 365; and

(4) calculate the sum of the amounts determined in clause (3).

(c) Medical assistance costs in the receiving facility, prior to the bed relocation, must be calculated as follows:

(1) multiply the facility's total payment rate for a RUGS weight of 1.0 by the medical assistance days on the most recent cost report; and

(2) multiply the product in clause (1) by the average case mix weight of medical assistance residents on the most recent cost report.

(d) The commissioner shall determine the medical assistance costs prior to the bed relocation which must be the sum of the amounts determined in paragraphs (b) and (c).

(e) The commissioner shall estimate the medical assistance costs after the bed relocation as follows:

(1) estimate the medical assistance days in the receiving facility after the bed relocation. The commissioner may use the current medical assistance portion, or if data does not exist, may use the statewide average, or may use the provider's estimate of the medical assistance utilization of the relocated beds;

(2) estimate the average case mix weight of medical assistance residents in the receiving facility after the bed relocation. The commissioner may use current average

case mix weight or, if data does not exist, may use the statewide average, or may use the provider's estimate of the average case mix weight; and

(3) multiply the amount determined in clause (1) by the amount determined in clause (2) by the total payment rate for a RUGS weight of 1.0 that is the highest rate of the facilities from which the relocated beds either originate or to which they are being relocated so long as that rate is associated with ten percent or more of the total number of beds to be in the receiving facility after the bed relocation.

(f) If the amount determined in paragraph (e) is less than or equal to the amount determined in paragraph (d), the commissioner shall allow a total payment rate equal to the amount used in paragraph (e), clause (3).

(g) If the amount determined in paragraph (e) is greater than the amount determined in paragraph (d), the commissioner shall allow a rate with a RUGS weight of 1.0 that when used in paragraph (e), clause (3), results in the amount determined in paragraph (e) being equal to the amount determined in paragraph (d).

(h) If the commissioner relies upon provider estimates in paragraph (e), clause (1) or (2), then annually, for three years after the rates determined in this subdivision take effect, the commissioner shall determine the accuracy of the alternative factors of medical assistance case load and RUGS weight used in this subdivision and shall reduce the total payment rate for a RUGS weight of 1.0 if the factors used result in medical assistance costs exceeding the amount in paragraph (d). If the actual medical assistance costs exceed the estimates by more than five percent, the commissioner shall also recover the difference between the estimated costs in paragraph (e) and the actual costs according to section 256B.0641. The commissioner may require submission of data from the receiving facility needed to implement this paragraph.

(i) When beds approved for relocation are put into active service at the destination facility, rates determined in this subdivision must be adjusted by any adjustment amounts that were implemented after the date of the letter of approval.

Sec. 14. REPEALER.

Minnesota Statutes 2010, section 144A.073, subdivisions 4 and 5, are repealed.

ARTICLE 5

TECHNICAL

Section 1. Minnesota Statutes 2010, section 144A.071, subdivision 4a, is amended to read:

Subd. 4a. **Exceptions for replacement beds.** It is in the best interest of the state to ensure that nursing homes and boarding care homes continue to meet the physical plant licensing and certification requirements by permitting certain construction projects. Facilities should be maintained in condition to satisfy the physical and emotional needs of residents while allowing the state to maintain control over nursing home expenditure growth.

The commissioner of health in coordination with the commissioner of human services, may approve the renovation, replacement, upgrading, or relocation of a nursing home or boarding care home, under the following conditions:

(a) to license or certify beds in a new facility constructed to replace a facility or to make repairs in an existing facility that was destroyed or damaged after June 30, 1987, by fire, lightning, or other hazard provided:

(i) destruction was not caused by the intentional act of or at the direction of a controlling person of the facility;

(ii) at the time the facility was destroyed or damaged the controlling persons of the facility maintained insurance coverage for the type of hazard that occurred in an amount that a reasonable person would conclude was adequate;

(iii) the net proceeds from an insurance settlement for the damages caused by the hazard are applied to the cost of the new facility or repairs;

~~(iv) the new facility is constructed on the same site as the destroyed facility or on another site subject to the restrictions in section 144A.073, subdivision 5;~~

~~(v)~~ (iv) the number of licensed and certified beds in the new facility does not exceed the number of licensed and certified beds in the destroyed facility; and

~~(vi)~~ (v) the commissioner determines that the replacement beds are needed to prevent an inadequate supply of beds.

Project construction costs incurred for repairs authorized under this clause shall not be considered in the dollar threshold amount defined in subdivision 2;

(b) to license or certify beds that are moved from one location to another within a nursing home facility, provided the total costs of remodeling performed in conjunction with the relocation of beds does not exceed \$1,000,000;

(c) to license or certify beds in a project recommended for approval under section 144A.073;

(d) to license or certify beds that are moved from an existing state nursing home to a different state facility, provided there is no net increase in the number of state nursing home beds;

89.1 (e) to certify and license as nursing home beds boarding care beds in a certified
89.2 boarding care facility if the beds meet the standards for nursing home licensure, or in a
89.3 facility that was granted an exception to the moratorium under section 144A.073, and if
89.4 the cost of any remodeling of the facility does not exceed \$1,000,000. If boarding care
89.5 beds are licensed as nursing home beds, the number of boarding care beds in the facility
89.6 must not increase beyond the number remaining at the time of the upgrade in licensure.
89.7 The provisions contained in section 144A.073 regarding the upgrading of the facilities
89.8 do not apply to facilities that satisfy these requirements;

89.9 (f) to license and certify up to 40 beds transferred from an existing facility owned and
89.10 operated by the Amherst H. Wilder Foundation in the city of St. Paul to a new unit at the
89.11 same location as the existing facility that will serve persons with Alzheimer's disease and
89.12 other related disorders. The transfer of beds may occur gradually or in stages, provided
89.13 the total number of beds transferred does not exceed 40. At the time of licensure and
89.14 certification of a bed or beds in the new unit, the commissioner of health shall delicense
89.15 and decertify the same number of beds in the existing facility. As a condition of receiving
89.16 a license or certification under this clause, the facility must make a written commitment
89.17 to the commissioner of human services that it will not seek to receive an increase in its
89.18 property-related payment rate as a result of the transfers allowed under this paragraph;

89.19 (g) to license and certify nursing home beds to replace currently licensed and certified
89.20 boarding care beds which may be located either in a remodeled or renovated boarding care
89.21 or nursing home facility or in a remodeled, renovated, newly constructed, or replacement
89.22 nursing home facility within the identifiable complex of health care facilities in which the
89.23 currently licensed boarding care beds are presently located, provided that the number of
89.24 boarding care beds in the facility or complex are decreased by the number to be licensed
89.25 as nursing home beds and further provided that, if the total costs of new construction,
89.26 replacement, remodeling, or renovation exceed ten percent of the appraised value of
89.27 the facility or \$200,000, whichever is less, the facility makes a written commitment to
89.28 the commissioner of human services that it will not seek to receive an increase in its
89.29 property-related payment rate by reason of the new construction, replacement, remodeling,
89.30 or renovation. The provisions contained in section 144A.073 regarding the upgrading of
89.31 facilities do not apply to facilities that satisfy these requirements;

89.32 (h) to license as a nursing home and certify as a nursing facility a facility that is
89.33 licensed as a boarding care facility but not certified under the medical assistance program,
89.34 but only if the commissioner of human services certifies to the commissioner of health that
89.35 licensing the facility as a nursing home and certifying the facility as a nursing facility will
89.36 result in a net annual savings to the state general fund of \$200,000 or more;

(i) to certify, after September 30, 1992, and prior to July 1, 1993, existing nursing home beds in a facility that was licensed and in operation prior to January 1, 1992;

(j) to license and certify new nursing home beds to replace beds in a facility acquired by the Minneapolis Community Development Agency as part of redevelopment activities in a city of the first class, provided the new facility is located within three miles of the site of the old facility. Operating and property costs for the new facility must be determined and allowed under section 256B.431 or 256B.434;

(k) to license and certify up to 20 new nursing home beds in a community-operated hospital and attached convalescent and nursing care facility with 40 beds on April 21, 1991, that suspended operation of the hospital in April 1986. The commissioner of human services shall provide the facility with the same per diem property-related payment rate for each additional licensed and certified bed as it will receive for its existing 40 beds;

(l) to license or certify beds in renovation, replacement, or upgrading projects as defined in section 144A.073, subdivision 1, so long as the cumulative total costs of the facility's remodeling projects do not exceed \$1,000,000;

(m) to license and certify beds that are moved from one location to another for the purposes of converting up to five four-bed wards to single or double occupancy rooms in a nursing home that, as of January 1, 1993, was county-owned and had a licensed capacity of 115 beds;

(n) to allow a facility that on April 16, 1993, was a 106-bed licensed and certified nursing facility located in Minneapolis to layaway all of its licensed and certified nursing home beds. These beds may be relicensed and recertified in a newly constructed teaching nursing home facility affiliated with a teaching hospital upon approval by the legislature. The proposal must be developed in consultation with the interagency committee on long-term care planning. The beds on layaway status shall have the same status as voluntarily delicensed and decertified beds, except that beds on layaway status remain subject to the surcharge in section 256.9657. This layaway provision expires July 1, 1998;

(o) to allow a project which will be completed in conjunction with an approved moratorium exception project for a nursing home in southern Cass County and which is directly related to that portion of the facility that must be repaired, renovated, or replaced, to correct an emergency plumbing problem for which a state correction order has been issued and which must be corrected by August 31, 1993;

(p) to allow a facility that on April 16, 1993, was a 368-bed licensed and certified nursing facility located in Minneapolis to layaway, upon 30 days prior written notice to the commissioner, up to 30 of the facility's licensed and certified beds by converting three-bed wards to single or double occupancy. Beds on layaway status shall have the

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91.1 same status as voluntarily delicensed and decertified beds except that beds on layaway
91.2 status remain subject to the surcharge in section 256.9657, remain subject to the license
91.3 application and renewal fees under section 144A.07 and shall be subject to a \$100 per bed
91.4 reactivation fee. In addition, at any time within three years of the effective date of the
91.5 layaway, the beds on layaway status may be:

91.6 (1) relicensed and recertified upon relocation and reactivation of some or all of
91.7 the beds to an existing licensed and certified facility or facilities located in Pine River,
91.8 Brainerd, or International Falls; provided that the total project construction costs related to
91.9 the relocation of beds from layaway status for any facility receiving relocated beds may
91.10 not exceed the dollar threshold provided in subdivision 2 unless the construction project
91.11 has been approved through the moratorium exception process under section 144A.073;

91.12 (2) relicensed and recertified, upon reactivation of some or all of the beds within the
91.13 facility which placed the beds in layaway status, if the commissioner has determined a
91.14 need for the reactivation of the beds on layaway status.

91.15 The property-related payment rate of a facility placing beds on layaway status
91.16 must be adjusted by the incremental change in its rental per diem after recalculating the
91.17 rental per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The
91.18 property-related payment rate for a facility relicensing and recertifying beds from layaway
91.19 status must be adjusted by the incremental change in its rental per diem after recalculating
91.20 its rental per diem using the number of beds after the relicensing to establish the facility's
91.21 capacity day divisor, which shall be effective the first day of the month following the
91.22 month in which the relicensing and recertification became effective. Any beds remaining
91.23 on layaway status more than three years after the date the layaway status became effective
91.24 must be removed from layaway status and immediately delicensed and decertified;

91.25 (q) to license and certify beds in a renovation and remodeling project to convert 12
91.26 four-bed wards into 24 two-bed rooms, expand space, and add improvements in a nursing
91.27 home that, as of January 1, 1994, met the following conditions: the nursing home was
91.28 located in Ramsey County; had a licensed capacity of 154 beds; and had been ranked
91.29 among the top 15 applicants by the 1993 moratorium exceptions advisory review panel.
91.30 The total project construction cost estimate for this project must not exceed the cost
91.31 estimate submitted in connection with the 1993 moratorium exception process;

91.32 (r) to license and certify up to 117 beds that are relocated from a licensed and
91.33 certified 138-bed nursing facility located in St. Paul to a hospital with 130 licensed
91.34 hospital beds located in South St. Paul, provided that the nursing facility and hospital are
91.35 owned by the same or a related organization and that prior to the date the relocation is
91.36 completed the hospital ceases operation of its inpatient hospital services at that hospital.

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92.1 After relocation, the nursing facility's status under section 256B.431, subdivision 2j, shall
92.2 be the same as it was prior to relocation. The nursing facility's property-related payment
92.3 rate resulting from the project authorized in this paragraph shall become effective no
92.4 earlier than April 1, 1996. For purposes of calculating the incremental change in the
92.5 facility's rental per diem resulting from this project, the allowable appraised value of
92.6 the nursing facility portion of the existing health care facility physical plant prior to the
92.7 renovation and relocation may not exceed \$2,490,000;

92.8 (s) to license and certify two beds in a facility to replace beds that were voluntarily
92.9 delicensed and decertified on June 28, 1991;

92.10 (t) to allow 16 licensed and certified beds located on July 1, 1994, in a 142-bed
92.11 nursing home and 21-bed boarding care home facility in Minneapolis, notwithstanding
92.12 the licensure and certification after July 1, 1995, of the Minneapolis facility as a 147-bed
92.13 nursing home facility after completion of a construction project approved in 1993 under
92.14 section 144A.073, to be laid away upon 30 days' prior written notice to the commissioner.
92.15 Beds on layaway status shall have the same status as voluntarily delicensed or decertified
92.16 beds except that they shall remain subject to the surcharge in section 256.9657. The
92.17 16 beds on layaway status may be relicensed as nursing home beds and recertified at
92.18 any time within five years of the effective date of the layaway upon relocation of some
92.19 or all of the beds to a licensed and certified facility located in Watertown, provided that
92.20 the total project construction costs related to the relocation of beds from layaway status
92.21 for the Watertown facility may not exceed the dollar threshold provided in subdivision
92.22 2 unless the construction project has been approved through the moratorium exception
92.23 process under section 144A.073.

92.24 The property-related payment rate of the facility placing beds on layaway status
92.25 must be adjusted by the incremental change in its rental per diem after recalculating the
92.26 rental per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The
92.27 property-related payment rate for the facility relicensing and recertifying beds from
92.28 layaway status must be adjusted by the incremental change in its rental per diem after
92.29 recalculating its rental per diem using the number of beds after the relicensing to establish
92.30 the facility's capacity day divisor, which shall be effective the first day of the month
92.31 following the month in which the relicensing and recertification became effective. Any
92.32 beds remaining on layaway status more than five years after the date the layaway status
92.33 became effective must be removed from layaway status and immediately delicensed
92.34 and decertified;

92.35 (u) to license and certify beds that are moved within an existing area of a facility or
92.36 to a newly constructed addition which is built for the purpose of eliminating three- and

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93.1 four-bed rooms and adding space for dining, lounge areas, bathing rooms, and ancillary
93.2 service areas in a nursing home that, as of January 1, 1995, was located in Fridley and had
93.3 a licensed capacity of 129 beds;

93.4 (v) to relocate 36 beds in Crow Wing County and four beds from Hennepin County
93.5 to a 160-bed facility in Crow Wing County, provided all the affected beds are under
93.6 common ownership;

93.7 (w) to license and certify a total replacement project of up to 49 beds located in
93.8 Norman County that are relocated from a nursing home destroyed by flood and whose
93.9 residents were relocated to other nursing homes. The operating cost payment rates for
93.10 the new nursing facility shall be determined based on the interim and settle-up payment
93.11 provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of
93.12 section 256B.431, except that subdivision 26, paragraphs (a) and (b), shall not apply until
93.13 the second rate year after the settle-up cost report is filed. Property-related reimbursement
93.14 rates shall be determined under section 256B.431, taking into account any federal or state
93.15 flood-related loans or grants provided to the facility;

93.16 (x) to license and certify a total replacement project of up to 129 beds located
93.17 in Polk County that are relocated from a nursing home destroyed by flood and whose
93.18 residents were relocated to other nursing homes. The operating cost payment rates for
93.19 the new nursing facility shall be determined based on the interim and settle-up payment
93.20 provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of
93.21 section 256B.431, except that subdivision 26, paragraphs (a) and (b), shall not apply until
93.22 the second rate year after the settle-up cost report is filed. Property-related reimbursement
93.23 rates shall be determined under section 256B.431, taking into account any federal or state
93.24 flood-related loans or grants provided to the facility;

93.25 (y) to license and certify beds in a renovation and remodeling project to convert 13
93.26 three-bed wards into 13 two-bed rooms and 13 single-bed rooms, expand space, and
93.27 add improvements in a nursing home that, as of January 1, 1994, met the following
93.28 conditions: the nursing home was located in Ramsey County, was not owned by a hospital
93.29 corporation, had a licensed capacity of 64 beds, and had been ranked among the top 15
93.30 applicants by the 1993 moratorium exceptions advisory review panel. The total project
93.31 construction cost estimate for this project must not exceed the cost estimate submitted in
93.32 connection with the 1993 moratorium exception process;

93.33 (z) to license and certify up to 150 nursing home beds to replace an existing 285
93.34 bed nursing facility located in St. Paul. The replacement project shall include both the
93.35 renovation of existing buildings and the construction of new facilities at the existing
93.36 site. The reduction in the licensed capacity of the existing facility shall occur during the

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94.1 construction project as beds are taken out of service due to the construction process. Prior
94.2 to the start of the construction process, the facility shall provide written information to the
94.3 commissioner of health describing the process for bed reduction, plans for the relocation
94.4 of residents, and the estimated construction schedule. The relocation of residents shall be
94.5 in accordance with the provisions of law and rule;

94.6 (aa) to allow the commissioner of human services to license an additional 36 beds
94.7 to provide residential services for the physically disabled under Minnesota Rules, parts
94.8 9570.2000 to 9570.3400, in a 198-bed nursing home located in Red Wing, provided that
94.9 the total number of licensed and certified beds at the facility does not increase;

94.10 (bb) to license and certify a new facility in St. Louis County with 44 beds
94.11 constructed to replace an existing facility in St. Louis County with 31 beds, which has
94.12 resident rooms on two separate floors and an antiquated elevator that creates safety
94.13 concerns for residents and prevents nonambulatory residents from residing on the second
94.14 floor. The project shall include the elimination of three- and four-bed rooms;

94.15 (cc) to license and certify four beds in a 16-bed certified boarding care home in
94.16 Minneapolis to replace beds that were voluntarily delicensed and decertified on or
94.17 before March 31, 1992. The licensure and certification is conditional upon the facility
94.18 periodically assessing and adjusting its resident mix and other factors which may
94.19 contribute to a potential institution for mental disease declaration. The commissioner of
94.20 human services shall retain the authority to audit the facility at any time and shall require
94.21 the facility to comply with any requirements necessary to prevent an institution for mental
94.22 disease declaration, including delicensure and decertification of beds, if necessary;

94.23 (dd) to license and certify 72 beds in an existing facility in Mille Lacs County with
94.24 80 beds as part of a renovation project. The renovation must include construction of
94.25 an addition to accommodate ten residents with beginning and midstage dementia in a
94.26 self-contained living unit; creation of three resident households where dining, activities,
94.27 and support spaces are located near resident living quarters; designation of four beds
94.28 for rehabilitation in a self-contained area; designation of 30 private rooms; and other
94.29 improvements;

94.30 (ee) to license and certify beds in a facility that has undergone replacement or
94.31 remodeling as part of a planned closure under section 256B.437;

94.32 (ff) to license and certify a total replacement project of up to 124 beds located
94.33 in Wilkin County that are in need of relocation from a nursing home significantly
94.34 damaged by flood. The operating cost payment rates for the new nursing facility shall
94.35 be determined based on the interim and settle-up payment provisions of Minnesota
94.36 Rules, part 9549.0057, and the reimbursement provisions of section 256B.431, except

that section 256B.431, subdivision 26, paragraphs (a) and (b), shall not apply until the second rate year after the settle-up cost report is filed. Property-related reimbursement rates shall be determined under section 256B.431, taking into account any federal or state flood-related loans or grants provided to the facility;

(gg) to allow the commissioner of human services to license an additional nine beds to provide residential services for the physically disabled under Minnesota Rules, parts 9570.2000 to 9570.3400, in a 240-bed nursing home located in Duluth, provided that the total number of licensed and certified beds at the facility does not increase;

(hh) to license and certify up to 120 new nursing facility beds to replace beds in a facility in Anoka County, which was licensed for 98 beds as of July 1, 2000, provided the new facility is located within four miles of the existing facility and is in Anoka County. Operating and property rates shall be determined and allowed under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, or section 256B.434 or 256B.435. The provisions of section 256B.431, subdivision 26, paragraphs (a) and (b), do not apply until the second rate year following settle-up; or

(ii) to transfer up to 98 beds of a 129-licensed bed facility located in Anoka County that, as of March 25, 2001, is in the active process of closing, to a 122-licensed bed nonprofit nursing facility located in the city of Columbia Heights or its affiliate. The transfer is effective when the receiving facility notifies the commissioner in writing of the number of beds accepted. The commissioner shall place all transferred beds on layaway status held in the name of the receiving facility. The layaway adjustment provisions of section 256B.431, subdivision 30, do not apply to this layaway. The receiving facility may only remove the beds from layaway for recertification and relicensure at the receiving facility's current site, or at a newly constructed facility located in Anoka County. The receiving facility must receive statutory authorization before removing these beds from layaway status, or may remove these beds from layaway status if removal from layaway status is part of a moratorium exception project approved by the commissioner under section 144A.073.

Sec. 2. Minnesota Statutes 2010, section 144A.071, subdivision 5a, is amended to read:

Subd. 5a. **Cost estimate of a moratorium exception project.** (a) For the purposes of this section and section 144A.073, the cost estimate of a moratorium exception project shall include the effects of the proposed project on the costs of the state subsidy for community-based services, nursing services, and housing in institutional and noninstitutional settings. The commissioner of health, in cooperation with the commissioner of human services, shall define the method for estimating these costs in the

permanent rule implementing section 144A.073. The commissioner of human services shall prepare an estimate of the total state annual long-term costs of each moratorium exception proposal.

(b) The interest rate to be used for estimating the cost of each moratorium exception project proposal shall be the lesser of either the prime rate plus two percentage points, or the posted yield for standard conventional fixed rate mortgages of the Federal Home Loan Mortgage Corporation plus two percentage points as published in the Wall Street Journal and in effect 56 days prior to the application deadline. If the applicant's proposal uses this interest rate, the commissioner of human services, in determining the facility's actual property-related payment rate to be established upon completion of the project must use the actual interest rate obtained by the facility for the project's permanent financing up to the maximum permitted under ~~subdivision 6~~ Minnesota Rules, part 9549.0060, subpart 6.

The applicant may choose an alternate interest rate for estimating the project's cost. If the applicant makes this election, the commissioner of human services, in determining the facility's actual property-related payment rate to be established upon completion of the project, must use the lesser of the actual interest rate obtained for the project's permanent financing or the interest rate which was used to estimate the proposal's project cost. For succeeding rate years, the applicant is at risk for financing costs in excess of the interest rate selected.

Sec. 3. Minnesota Statutes 2010, section 245B.02, subdivision 20, is amended to read:

Subd. 20. **Residential-based habilitation.** "Residential-based habilitation" means care, supervision, and training provided primarily in the consumer's own home or place of residence but also including community-integrated activities following the individual service plan. Residential habilitation services are provided in coordination with the provision of day training and habilitation services for those persons receiving day training and habilitation services under sections ~~252.40~~ 252.41 to 252.46.

EFFECTIVE DATE. This section is effective January 1, 2013, or on the date the commissioner adopts rules for the administration of home and community-based services waivers under section 256B.4912, subdivision 4, whichever is sooner.

Sec. 4. Minnesota Statutes 2010, section 245B.06, subdivision 7, is amended to read:

Subd. 7. **Staffing requirements.** The license holder must provide supervision to ensure the health, safety, and protection of rights of each consumer and to be able to implement each consumer's individual service plan. Day training and habilitation

97.1 programs must meet the minimum staffing requirements as specified in sections ~~252.40~~
97.2 252.41 to 252.46 and rules promulgated under those sections.

97.3 **EFFECTIVE DATE.** This section is effective January 1, 2013, or on the date the
97.4 commissioner adopts rules for the administration of home and community-based services
97.5 waivers under section 256B.4912, subdivision 4, whichever is sooner.

97.6 Sec. 5. Minnesota Statutes 2010, section 252.41, subdivision 1, is amended to read:

97.7 Subdivision 1. **Scope.** The definitions in this section apply to sections ~~252.40~~ 252.41
97.8 to 252.46.

97.9 **EFFECTIVE DATE.** This section is effective January 1, 2013, or on the date the
97.10 commissioner adopts rules for the administration of home and community-based services
97.11 waivers under section 256B.4912, subdivision 4, whichever is sooner.

97.12 Sec. 6. Minnesota Statutes 2010, section 252.451, subdivision 2, is amended to read:

97.13 Subd. 2. **Vendor participation and reimbursement.** Notwithstanding requirements
97.14 in chapter 245A, and sections 252.28, ~~252.40~~ 252.41 to 252.46, and 256B.501, vendors of
97.15 day training and habilitation services may enter into written agreements with qualified
97.16 businesses to provide additional training and supervision needed by individuals to
97.17 maintain their employment.

97.18 **EFFECTIVE DATE.** This section is effective January 1, 2013, or on the date the
97.19 commissioner adopts rules for the administration of home and community-based services
97.20 waivers under section 256B.4912, subdivision 4, whichever is sooner.

97.21 Sec. 7. Minnesota Statutes 2010, section 256B.431, subdivision 26, is amended to read:

97.22 Subd. 26. **Changes to nursing facility reimbursement beginning July 1, 1997.**

97.23 The nursing facility reimbursement changes in paragraphs (a) to (e) shall apply in the
97.24 sequence specified in Minnesota Rules, parts 9549.0010 to 9549.0080, and this section,
97.25 beginning July 1, 1997.

97.26 (a) For rate years beginning on or after July 1, 1997, the commissioner shall limit a
97.27 nursing facility's allowable operating per diem for each case mix category for each rate
97.28 year. The commissioner shall group nursing facilities into two groups, freestanding and
97.29 nonfreestanding, within each geographic group, using their operating cost per diem for
97.30 the case mix A classification. A nonfreestanding nursing facility is a nursing facility
97.31 whose other operating cost per diem is subject to the hospital attached, short length of
97.32 stay, or the rule 80 limits. All other nursing facilities shall be considered freestanding

nursing facilities. The commissioner shall then array all nursing facilities in each grouping by their allowable case mix A operating cost per diem. In calculating a nursing facility's operating cost per diem for this purpose, the commissioner shall exclude the raw food cost per diem related to providing special diets that are based on religious beliefs, as determined in subdivision 2b, paragraph (h). For those nursing facilities in each grouping whose case mix A operating cost per diem:

(1) is at or below the median of the array, the commissioner shall limit the nursing facility's allowable operating cost per diem for each case mix category to the lesser of the prior reporting year's allowable operating cost per diem as specified in Laws 1996, chapter 451, article 3, section 11, paragraph (h), plus the inflation factor as established in paragraph (d), clause (2), increased by two percentage points, or the current reporting year's corresponding allowable operating cost per diem; or

(2) is above the median of the array, the commissioner shall limit the nursing facility's allowable operating cost per diem for each case mix category to the lesser of the prior reporting year's allowable operating cost per diem as specified in Laws 1996, chapter 451, article 3, section 11, paragraph (h), plus the inflation factor as established in paragraph (d), clause (2), increased by one percentage point, or the current reporting year's corresponding allowable operating cost per diem.

For purposes of paragraph (a), if a nursing facility reports on its cost report a reduction in cost due to a refund or credit for a rate year beginning on or after July 1, 1998, the commissioner shall increase that facility's spend-up limit for the rate year following the current rate year by the amount of the cost reduction divided by its resident days for the reporting year preceding the rate year in which the adjustment is to be made.

(b) For rate years beginning on or after July 1, 1997, the commissioner shall limit the allowable operating cost per diem for high cost nursing facilities. After application of the limits in paragraph (a) to each nursing facility's operating cost per diem, the commissioner shall group nursing facilities into two groups, freestanding or nonfreestanding, within each geographic group. A nonfreestanding nursing facility is a nursing facility whose other operating cost per diem are subject to hospital attached, short length of stay, or rule 80 limits. All other nursing facilities shall be considered freestanding nursing facilities. The commissioner shall then array all nursing facilities within each grouping by their allowable case mix A operating cost per diem. In calculating a nursing facility's operating cost per diem for this purpose, the commissioner shall exclude the raw food cost per diem related to providing special diets that are based on religious beliefs, as determined in subdivision 2b, paragraph (h). For those nursing facilities in each grouping whose case mix A operating cost per diem exceeds 1.0 standard deviation above the median, the commissioner shall

99.1 reduce their allowable operating cost per diem by three percent. For those nursing
99.2 facilities in each grouping whose case mix A operating cost per diem exceeds 0.5 standard
99.3 deviation above the median but is less than or equal to 1.0 standard deviation above the
99.4 median, the commissioner shall reduce their allowable operating cost per diem by two
99.5 percent. However, in no case shall a nursing facility's operating cost per diem be reduced
99.6 below its grouping's limit established at 0.5 standard deviations above the median.

99.7 (c) For rate years beginning on or after July 1, 1997, the commissioner shall
99.8 determine a nursing facility's efficiency incentive by first computing the allowable
99.9 difference, which is the lesser of \$4.50 or the amount by which the facility's other
99.10 operating cost limit exceeds its nonadjusted other operating cost per diem for that rate
99.11 year. The commissioner shall compute the efficiency incentive by:

- 99.12 (1) subtracting the allowable difference from \$4.50 and dividing the result by \$4.50;
99.13 (2) multiplying 0.20 by the ratio resulting from clause (1), and then;
99.14 (3) adding 0.50 to the result from clause (2); and
99.15 (4) multiplying the result from clause (3) times the allowable difference.

99.16 The nursing facility's efficiency incentive payment shall be the lesser of \$2.25 or the
99.17 product obtained in clause (4).

99.18 (d) For rate years beginning on or after July 1, 1997, the forecasted price index for
99.19 a nursing facility's allowable operating cost per diem shall be determined under clauses
99.20 (1) and (2) using the change in the Consumer Price Index-All Items (United States city
99.21 average) (CPI-U) as forecasted by Data Resources, Inc. The commissioner shall use the
99.22 indices as forecasted in the fourth quarter of the calendar year preceding the rate year,
99.23 subject to subdivision 21, paragraph (c).

99.24 (1) The CPI-U forecasted index for allowable operating cost per diem shall be based
99.25 on the 21-month period from the midpoint of the nursing facility's reporting year to the
99.26 midpoint of the rate year following the reporting year.

99.27 (2) For rate years beginning on or after July 1, 1997, the forecasted index for
99.28 operating cost limits referred to in subdivision 21, paragraph (b), shall be based on
99.29 the CPI-U for the 12-month period between the midpoints of the two reporting years
99.30 preceding the rate year.

99.31 (e) After applying these provisions for the respective rate years, the commissioner
99.32 shall index these allowable operating cost per diem by the inflation factor provided for in
99.33 paragraph (d), clause (1), and add the nursing facility's efficiency incentive as computed in
99.34 paragraph (c).

99.35 (f) For the rate years beginning on July 1, 1997, July 1, 1998, and July 1, 1999, a
99.36 nursing facility licensed for 40 beds effective May 1, 1992, with a subsequent increase of

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20 Medicare/Medicaid certified beds, effective January 26, 1993, in accordance with an increase in licensure is exempt from paragraphs (a) and (b).

~~(g) For a nursing facility whose construction project was authorized according to section 144A.073, subdivision 5, paragraph (g), the operating cost payment rates for the new location shall be determined based on Minnesota Rules, part 9549.0057. The relocation allowed under section 144A.073, subdivision 5, paragraph (g), and the rate determination allowed under this paragraph must meet the cost neutrality requirements of section 144A.073, subdivision 3c. Paragraphs (a) and (b) shall not apply until the second rate year after the settle-up cost report is filed. Notwithstanding subdivision 2b, paragraph (g), real estate taxes and special assessments payable by the new location, a 501(c)(3) nonprofit corporation, shall be included in the payment rates determined under this subdivision for all subsequent rate years.~~

~~(h)~~ (g) For the rate year beginning July 1, 1997, the commissioner shall compute the payment rate for a nursing facility licensed for 94 beds on September 30, 1996, that applied in October 1993 for approval of a total replacement under the moratorium exception process in section 144A.073, and completed the approved replacement in June 1995, with other operating cost spend-up limit under paragraph (a), increased by \$3.98, and after computing the facility's payment rate according to this section, the commissioner shall make a one-year positive rate adjustment of \$3.19 for operating costs related to the newly constructed total replacement, without application of paragraphs (a) and (b). The facility's per diem, before the \$3.19 adjustment, shall be used as the prior reporting year's allowable operating cost per diem for payment rate calculation for the rate year beginning July 1, 1998. A facility described in this paragraph is exempt from paragraph (b) for the rate years beginning July 1, 1997, and July 1, 1998.

~~(i)~~ (h) For the purpose of applying the limit stated in paragraph (a), a nursing facility in Kandiyohi County licensed for 86 beds that was granted hospital-attached status on December 1, 1994, shall have the prior year's allowable care-related per diem increased by \$3.207 and the prior year's other operating cost per diem increased by \$4.777 before adding the inflation in paragraph (d), clause (2), for the rate year beginning on July 1, 1997.

~~(j)~~ (i) For the purpose of applying the limit stated in paragraph (a), a 117 bed nursing facility located in Pine County shall have the prior year's allowable other operating cost per diem increased by \$1.50 before adding the inflation in paragraph (d), clause (2), for the rate year beginning on July 1, 1997.

~~(k)~~ (j) For the purpose of applying the limit under paragraph (a), a nursing facility in Hibbing licensed for 192 beds shall have the prior year's allowable other operating cost

101.1 per diem increased by \$2.67 before adding the inflation in paragraph (d), clause (2),
101.2 for the rate year beginning July 1, 1997.

101.3 Sec. 8. Minnesota Statutes 2010, section 256B.5013, subdivision 1, is amended to read:

101.4 Subdivision 1. **Variable rate adjustments.** (a) For rate years beginning on or after
101.5 October 1, 2000, when there is a documented increase in the needs of a current ICF/MR
101.6 recipient, the county of financial responsibility may recommend a variable rate to enable
101.7 the facility to meet the individual's increased needs. Variable rate adjustments made under
101.8 this subdivision replace ~~payments for persons with special needs under section 256B.501,~~
101.9 ~~subdivision 8, and~~ payments for persons with special needs for crisis intervention services
101.10 under section 256B.501, subdivision 8a. Effective July 1, 2003, facilities with a base rate
101.11 above the 50th percentile of the statewide average reimbursement rate for a Class A
101.12 facility or Class B facility, whichever matches the facility licensure, are not eligible for a
101.13 variable rate adjustment. Variable rate adjustments may not exceed a 12-month period,
101.14 except when approved for purposes established in paragraph (b), clause (1). Variable rate
101.15 adjustments approved solely on the basis of changes on a developmental disabilities
101.16 screening document will end June 30, 2002.

101.17 (b) A variable rate may be recommended by the county of financial responsibility
101.18 for increased needs in the following situations:

101.19 (1) a need for resources due to an individual's full or partial retirement from
101.20 participation in a day training and habilitation service when the individual: (i) has reached
101.21 the age of 65 or has a change in health condition that makes it difficult for the person
101.22 to participate in day training and habilitation services over an extended period of time
101.23 because it is medically contraindicated; and (ii) has expressed a desire for change through
101.24 the developmental disability screening process under section 256B.092;

101.25 (2) a need for additional resources for intensive short-term programming which is
101.26 necessary prior to an individual's discharge to a less restrictive, more integrated setting;

101.27 (3) a demonstrated medical need that significantly impacts the type or amount of
101.28 services needed by the individual; or

101.29 (4) a demonstrated behavioral need that significantly impacts the type or amount of
101.30 services needed by the individual.

101.31 (c) The county of financial responsibility must justify the purpose, the projected
101.32 length of time, and the additional funding needed for the facility to meet the needs of
101.33 the individual.

101.34 (d) The facility shall provide an annual report to the county case manager on
101.35 the use of the variable rate funds and the status of the individual on whose behalf the

102.1 funds were approved. The county case manager will forward the facility's report with a
102.2 recommendation to the commissioner to approve or disapprove a continuation of the
102.3 variable rate.

102.4 (e) Funds made available through the variable rate process that are not used by
102.5 the facility to meet the needs of the individual for whom they were approved shall be
102.6 returned to the state.

102.7 **EFFECTIVE DATE.** This section is effective January 1, 2013, or on the date the
102.8 commissioner adopts rules for the administration of home and community-based services
102.9 waivers under section 256B.4912, subdivision 4, whichever is sooner.

102.10 Sec. 9. Minnesota Statutes 2010, section 256B.5015, subdivision 1, is amended to read:

102.11 Subdivision 1. **Day training and habilitation services.** Day training and
102.12 habilitation services costs shall be paid as a pass-through payment at the lowest rate paid
102.13 for the comparable services at that site under sections ~~252.40~~ 252.41 to 252.46. The
102.14 pass-through payments for training and habilitation services shall be paid separately by
102.15 the commissioner and shall not be included in the computation of the ICF/MR facility
102.16 total payment rate.

102.17 **EFFECTIVE DATE.** This section is effective January 1, 2013, or on the date the
102.18 commissioner adopts rules for the administration of home and community-based services
102.19 waivers under section 256B.4912, subdivision 4, whichever is sooner.

102.20 Sec. 10. Minnesota Statutes 2010, section 256B.765, is amended to read:

102.21 **256B.765 PROVIDER RATE INCREASES.**

102.22 (a) Effective July 1, 2001, within the limits of appropriations specifically for this
102.23 purpose, the commissioner shall provide an annual inflation adjustment for the providers
102.24 listed in paragraph (c). The index for the inflation adjustment must be based on the
102.25 change in the Employment Cost Index for Private Industry Workers - Total Compensation
102.26 forecasted by Data Resources, Inc., as forecasted in the fourth quarter of the calendar year
102.27 preceding the fiscal year. The commissioner shall increase reimbursement or allocation
102.28 rates by the percentage of this adjustment, and county boards shall adjust provider
102.29 contracts as needed.

102.30 (b) The commissioner of management and budget shall include an annual
102.31 inflationary adjustment in reimbursement rates for the providers listed in paragraph (c)
102.32 using the inflation factor specified in paragraph (a) as a budget change request in each
102.33 biennial detailed expenditure budget submitted to the legislature under section 16A.11.

(c) The annual adjustment under paragraph (a) shall be provided for home and community-based waiver services for persons with developmental disabilities under section 256B.501; home and community-based waiver services for the elderly under section 256B.0915; waived services under community alternatives for disabled individuals under section 256B.49; community alternative care waived services under section 256B.49; traumatic brain injury waived services under section 256B.49; nursing services and home health services under section 256B.0625, subdivision 6a; personal care services and nursing supervision of personal care services under section 256B.0625, subdivision 19a; private duty nursing services under section 256B.0625, subdivision 7; day training and habilitation services for adults with developmental disabilities under sections ~~252.40~~ 252.41 to 252.46; physical therapy services under sections 256B.0625, subdivision 8, and 256D.03, subdivision 4; occupational therapy services under sections 256B.0625, subdivision 8a, and 256D.03, subdivision 4; speech-language therapy services under section 256D.03, subdivision 4, and Minnesota Rules, part 9505.0390; respiratory therapy services under section 256D.03, subdivision 4, and Minnesota Rules, part 9505.0295; alternative care services under section 256B.0913; adult residential program grants under Minnesota Rules, parts 9535.2000 to 9535.3000; adult and family community support grants under Minnesota Rules, parts 9535.1700 to 9535.1760; semi-independent living services under section 252.275 including SILS funding under county social services grants formerly funded under chapter 256I; and community support services for deaf and hard-of-hearing adults with mental illness who use or wish to use sign language as their primary means of communication.

EFFECTIVE DATE. This section is effective January 1, 2013, or on the date the commissioner adopts rules for the administration of home and community-based services waivers under section 256B.4912, subdivision 4, whichever is sooner.

APPENDIX
Article locations in 11-0157

ARTICLE 1	TELEPHONE EQUIPMENT PROGRAM	Page.Ln 1.29
ARTICLE 2	DISABILITY SERVICES	Page.Ln 9.11
	COMPREHENSIVE ASSESSMENT AND CASE MANAGEMENT	
ARTICLE 3	REFORM	Page.Ln 38.29
ARTICLE 4	NURSING FACILITIES	Page.Ln 75.7
ARTICLE 5	TECHNICAL	Page.Ln 87.30

144A.073 EXCEPTIONS TO MORATORIUM; REVIEW.

Subd. 4. **Criteria for review.** The following criteria shall be used in a consistent manner to compare, evaluate, and rank all proposals submitted. Except for the criteria specified in clause (3), the application of criteria listed under this subdivision shall not reflect any distinction based on the geographic location of the proposed project:

(1) the extent to which the proposal furthers state long-term care goals, including the goal of enhancing the availability and use of alternative care services and the goal of reducing the number of long-term care resident rooms with more than two beds;

(2) the proposal's long-term effects on state costs including the cost estimate of the project according to section 144A.071, subdivision 5a;

(3) the extent to which the proposal promotes equitable access to long-term care services in nursing homes through redistribution of the nursing home bed supply, as measured by the number of beds relative to the population 85 or older using data published according to requirements in section 144A.351;

(4) the extent to which the project improves conditions that affect the health or safety of residents, such as narrow corridors, narrow door frames, unenclosed fire exits, and wood frame construction, and similar provisions contained in fire and life safety codes and licensure and certification rules;

(5) the extent to which the project improves conditions that affect the comfort or quality of life of residents in a facility or the ability of the facility to provide efficient care, such as a relatively high number of residents in a room; inadequate lighting or ventilation; poor access to bathing or toilet facilities; a lack of available ancillary space for dining rooms, day rooms, or rooms used for other activities; problems relating to heating, cooling, or energy efficiency; inefficient location of nursing stations; or other provisions contained in the licensure and certification rules;

(6) the extent to which the applicant demonstrates the delivery of quality care, as defined in state and federal statutes and rules, to residents as evidenced by the two most recent state agency certification surveys and the applicants' response to those surveys;

(7) the extent to which the project removes the need for waivers or variances previously granted by either the licensing agency, certifying agency, fire marshal, or local government entity;

(8) the extent to which the project increases the number of private or single bed rooms;

(9) the extent to which the applicant demonstrates the continuing need for nursing facility care in the community and adjacent communities; and

(10) other factors that may be developed in permanent rule by the commissioner of health that evaluate and assess how the proposed project will further promote or protect the health, safety, comfort, treatment, or well-being of the facility's residents.

Subd. 5. **Replacement restrictions.** (a) Proposals submitted or approved under this section involving replacement must provide for replacement of the facility on the existing site except as allowed in this subdivision.

(b) Facilities located in a metropolitan statistical area other than the Minneapolis-St. Paul seven-county metropolitan area may relocate to a site within the same census tract or a contiguous census tract.

(c) Facilities located in the Minneapolis-St. Paul seven-county metropolitan area may relocate to a site within the same or contiguous health planning area as adopted in March 1982 by the Metropolitan Council.

(d) Facilities located outside a metropolitan statistical area may relocate to a site within the same city or township, or within a contiguous township.

(e) A facility relocated to a different site under paragraph (b), (c), or (d) must not be relocated to a site more than six miles from the existing site.

(f) The relocation of part of an existing first facility to a second location, under paragraphs (d) and (e), may include the relocation to the second location of up to four beds from part of an existing third facility located in a township contiguous to the location of the first facility. The six-mile limit in paragraph (e) does not apply to this relocation from the third facility.

(g) For proposals approved on January 13, 1994, under this section involving the replacement of 102 licensed and certified beds, the relocation of the existing first facility to the new location under paragraphs (d) and (e) may include the relocation of up to 75 beds of the existing facility. The six-mile limit in paragraph (e) does not apply to this relocation.

252.46 PAYMENT RATES.

APPENDIX

Repealed Minnesota Statutes: 11-0157

Subdivision 1. **Rates.** (a) Payment rates to vendors, except regional centers, for county-funded day training and habilitation services and transportation provided to persons receiving day training and habilitation services established by a county board are governed by subdivisions 2 to 19. The commissioner shall approve the following three payment rates for services provided by a vendor:

(1) a full-day service rate for persons who receive at least six service hours a day, including the time it takes to transport the person to and from the service site;

(2) a partial-day service rate that must not exceed 75 percent of the full-day service rate for persons who receive less than a full day of service; and

(3) a transportation rate for providing, or arranging and paying for, transportation of a person to and from the person's residence to the service site.

(b) Notwithstanding any law or rule to the contrary, the commissioner may authorize county participation in a voluntary individualized payment rate structure for day training and habilitation services to allow a county the flexibility to change, after consulting with providers, from a site-based payment rate structure to an individual payment rate structure for the providers of day training and habilitation services in the county. The commissioner shall seek input from providers and consumers in establishing procedures for determining the structure of voluntary individualized payment rates to ensure that there is no additional cost to the state or counties and that the rate structure is cost-neutral to providers of day training and habilitation services, on July 1, 2004, or on day one of the individual rate structure, whichever is later.

(c) Medical assistance rates for home and community-based service provided under section 256B.501, subdivision 4, by licensed vendors of day training and habilitation services must not be greater than the rates for the same services established by counties under sections 252.40 to 252.46. For very dependent persons with special needs the commissioner may approve an exception to the approved payment rate under section 256B.501, subdivision 4 or 8.

Subd. 2. **Rate minimum.** Unless a variance is granted under subdivision 6, the minimum payment rates set by a county board for each vendor must be equal to the payment rates approved by the commissioner for that vendor in effect January 1 of the previous calendar year.

Subd. 3. **Rate maximum.** Unless a variance is granted under subdivision 6, the maximum payment rates for each vendor for a calendar year must be equal to the payment rates approved by the commissioner for that vendor in effect December 1 of the previous calendar year. The commissioner of management and budget shall include as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11 annual inflation adjustments in reimbursement rates for each vendor, based upon the projected percentage change in the Urban Consumer Price Index, all items, published by the United States Department of Labor, for the upcoming calendar year over the current calendar year.

Subd. 4. **New vendors.** (a) Payment rates established by a county for a new vendor for which there were no previous rates must not exceed 95 percent of the greater of 125 percent of the statewide median rates or 125 percent of the average payment rates in the regional development commission district under sections 462.381 to 462.396 in which the new vendor is located unless the criteria in paragraph (b) are met.

(b) A payment rate equal to 200 percent of the statewide average rates shall be assigned to persons served by the new vendor when those persons are persons with very severe self-injurious or assaultive behaviors, persons with medical conditions requiring delivery of physician-prescribed medical interventions at one-to-one staffing for at least 15 minutes each time they are performed, or persons discharged from a regional treatment center after May 1, 1993, to the vendor's program. All other persons for whom the new service is needed must be assigned a rate equal to 95 percent of the greater of 125 percent of the statewide median rates or 125 percent of the regional average rates, whichever is higher, and the maximum payment rate that may be recommended is determined by multiplying the number of clients at each limit by the rate corresponding to that limit and dividing the sum by the total number of clients. When the recommended payment rates exceed 95 percent of 125 percent of the greater of the statewide median or regional average rates, whichever is higher, the county must include documentation verifying the medical or behavioral needs of clients. The approved payment rates must be based on 12 months budgeted expenses divided by at least 90 percent of authorized service units associated with the new vendor's licensed capacity. The county must include documentation verifying the person's discharge from a regional treatment center and that admission of new clients to existing services eligible for a rate variance under subdivision 6 was considered before recommending payment rates for a new vendor. Nothing in this subdivision permits development of a new program that primarily results in refinancing of services for individuals already receiving services in existing programs.

APPENDIX

Repealed Minnesota Statutes: 11-0157

Subd. 5. **Submitting recommended rates.** The county board shall submit recommended payment rates to the commissioner on forms supplied by the commissioner at least 60 days before revised payment rates or payment rates for new vendors are to be effective. The forms must include the county board's written verification of the individual documentation required under section 252.44, clause (a). If a vendor provides services at more than one licensed site, the county board may recommend the same payment rates for each site based on the average rate for all sites. The county board may also recommend differing payment rates for each licensed site if it would result in a total annual payment to the vendor that is equal to or less than the total annual payment that would result if the average rates had been used for all sites. For purposes of this subdivision, the average payment rate for all service sites used by a vendor must be computed by adding the amounts that result when the payment rates for each licensed site are multiplied by the projected annual number of service units to be provided at that site and dividing the sum of those amounts by the total units of service to be provided by the vendor at all sites.

Subd. 6. **Variances.** (a) A variance from the minimum or maximum payment rates in subdivisions 2 and 3 may be granted by the commissioner when the vendor requests and the county board submits to the commissioner a written variance request on forms supplied by the commissioner with the recommended payment rates.

(b) A variance to the rate maximum may be utilized for costs associated with compliance with state administrative rules, compliance with court orders, capital costs required for continued licensure, increased insurance costs, start-up and conversion costs for supported employment, direct service staff salaries and benefits, transportation, and other program related costs when one of the criterion in clauses (1) to (4) is also met:

(1) a determination of need under section 252.28 is approved for a significant program change that is necessary for a vendor to provide authorized services to one or more clients who meet one or more of the following criteria:

(i) the client is a new client and:

(A) exhibits severe behavior as indicated on the screening document;

(B) periodically requires one-to-one staff time for at least 15 minutes at a time to deliver physician prescribed medical interventions; or

(C) has been discharged directly to the vendor's program from a regional treatment center or the Minnesota extended treatment option.

(ii) the client is an existing client who has developed one of the following changed circumstances which increases costs that are not covered by the vendor's current rate, and for whom a significant program change is necessary to ensure the continued provision of authorized services to that client:

(A) severe behavior as indicated on the screening document;

(B) a medical condition periodically requiring one-to-one staff time for at least 15 minutes at a time to deliver physician prescribed medical interventions; or

(C) a permanent decrease in skill functioning, as verified by medical reports or assessments;

(2) a licensing determination requires a program change that the vendor cannot comply with due to funding restraints;

(3) a determination of need under section 252.28 is approved for a significant and permanent decrease in licensed capacity and the vendor demonstrates the need to retain certain staffing levels to serve the remaining clients; or

(4) in cases where conditions in clauses (1) to (3) do not apply, but a determination of need under section 252.28 is approved for an unusual circumstance which exists that significantly impacts the type or amount of services delivered, as evidenced by documentation presented by the vendor and with the concurrence of the commissioner.

(c) A variance to the rate minimum may be granted when:

(1) the county board contracts for increased services from a vendor and for some or all individuals receiving services from the vendor lower per unit fixed costs result; or

(2) the actual costs of delivering authorized service over a 12-month contract period have decreased.

(d) The written variance request under this subdivision must include documentation that all the following criteria have been met:

(1) the commissioner and the county board have both conducted a review and have identified a need for a change in the payment rates and recommended an effective date for the change in the rate;

(2) the vendor documents efforts to reallocate current staff and any additional staffing needs cannot be met by using temporary special needs rate exceptions under Minnesota Rules, parts 9510.1020 to 9510.1140;

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(3) the vendor documents that financial resources have been reallocated before applying for a variance. No variance may be granted for equipment, supplies, or other capital expenditures when depreciation expense for repair and replacement of such items is part of the current rate;

(4) for variances related to loss of clientele, the vendor documents the other program and administrative expenses, if any, that have been reduced;

(5) the county board submits verification of the conditions for which the variance is requested, a description of the nature and cost of the proposed changes, and how the county will monitor the use of money by the vendor to make necessary changes in services;

(6) the county board's recommended payment rates do not exceed 95 percent of the greater of 125 percent of the current statewide median or 125 percent of the regional average payment rates, whichever is higher, for each of the regional commission districts under sections 462.381 to 462.396 in which the vendor is located except for the following: when a variance is recommended to allow authorized service delivery to new clients with severe behaviors or with medical conditions requiring delivery of physician prescribed medical interventions, or to persons being directly discharged from a regional treatment center or Minnesota extended treatment options to the vendor's program, those persons must be assigned a payment rate of 200 percent of the current statewide average rates. All other clients receiving services from the vendor must be assigned a payment rate equal to the vendor's current rate unless the vendor's current rate exceeds 95 percent of 125 percent of the statewide median or 125 percent of the regional average payment rates, whichever is higher. When the vendor's rates exceed 95 percent of 125 percent of the statewide median or 125 percent of the regional average rates, the maximum rates assigned to all other clients must be equal to the greater of 95 percent of 125 percent of the statewide median or 125 percent of the regional average rates. The maximum payment rate that may be recommended for the vendor under these conditions is determined by multiplying the number of clients at each limit by the rate corresponding to that limit and then dividing the sum by the total number of clients.

(e) The commissioner shall have 60 calendar days from the date of the receipt of the complete request to accept or reject it, or the request shall be deemed to have been granted. If the commissioner rejects the request, the commissioner shall state in writing the specific objections to the request and the reasons for its rejection.

Subd. 7. Rate reconsiderations. A host county that disagrees with a rate decision of the commissioner under subdivision 6 or 9 may request reconsideration by the commissioner within 45 days after the date the host county received notification of the commissioner's decision. The request must state the reasons why the host county is requesting reconsideration of the rate decision and present evidence explaining the host county's disagreement with the rate decision.

The commissioner shall review the host county's evidence and provide the host county with written notification of the decision on the request within 60 days. The commissioner's decision on the request is final.

Until a reconsideration request is decided, payments must continue at a rate the commissioner determines complies with this section. If a higher rate is approved, the commissioner shall order a retroactive payment as determined in the commissioner's decision.

Subd. 8. Commissioner's notice to boards, vendors. The commissioner shall notify the county boards and vendors of the average regional payment rates, 95 percent of 125 percent of the average regional payments rates for each of the regional development commission districts designated in sections 462.381 to 462.396, 95 percent of 125 percent of the statewide median rates, and 200 percent of the statewide average rates.

Subd. 9. Approval or denial of rates. The commissioner shall approve the county board's recommended payment rates when the rates and verification justifying the projected service units comply with subdivisions 2 to 18. The commissioner shall notify the county board in writing of the approved payment rates within 60 days of receipt of the rate recommendations. If the rates are not approved, or if rates different from those originally recommended are approved, the commissioner shall within 60 days of receiving the rate recommendation notify the county board in writing of the reasons for denying or substituting a different rate for the recommended rates. Approved payment rates remain effective until the commissioner approves different rates in accordance with subdivisions 2 and 3.

Subd. 10. Vendor's report; audit. The vendor shall report to the commissioner and the county board on forms prescribed by the commissioner at times specified by the commissioner. The reports shall include programmatic and fiscal information. The audit must be done according to generally accepted auditing standards to result in statements that include a balance sheet, income statement, changes in financial position, and the certified public accountant's opinion. The county's annual audit shall satisfy the audit required under this subdivision for any county-operated day training and habilitation program. Except for day training and habilitation

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programs operated by a county, the audit must provide supplemental statements for each day training and habilitation program with an approved unique set of rates.

Subd. 11. **Improper transactions.** Transactions that have the effect of circumventing subdivisions 1 to 18 must not be considered by the commissioner for the purpose of payment rate approval under the principle that the substance of the transaction prevails over the form.

Subd. 16. **Payment rate criteria; allocation of expenditures.** Payment rates approved under subdivision 9 must reflect the payment rate criteria in paragraphs (a) and (b) and the allocation principles in paragraph (c).

(a) Payment rates must be based on reasonable costs that are ordinary, necessary, and related to delivery of authorized client services.

(b) The commissioner shall not pay for:

(1) unauthorized service delivery;

(2) services provided in accordance with receipt of a special grant;

(3) services provided under contract to a local school district;

(4) extended employment services under Minnesota Rules, parts 3300.1950 to 3300.3050, or vocational rehabilitation services provided under Title I, section 110 or Title VI-C, Rehabilitation Act Amendments of 1992, as amended, and not through use of medical assistance or county social service funds; or

(5) services provided to a client by a licensed medical, therapeutic, or rehabilitation practitioner or any other vendor of medical care which are billed separately on a fee for service basis.

(c) On an annual basis, actual and projected contract year expenses must be allocated to standard budget line items corresponding to direct and other program and administrative expenses as submitted to the commissioner with the host county's recommended payment rates. Central or corporate office costs must be allocated to licensed vendor sites within the group served by the central or corporate office according to the cost allocation principles under section 256B.432.

(d) The vendor must maintain records documenting that clients received the billed services.

Subd. 17. **Hourly rate structure.** Counties participating as host counties under the pilot study of hourly rates established under Laws 1988, chapter 689, article 2, section 117, may recommend continuation of the hourly rates for participating vendors. The recommendation must be made annually under subdivision 5 and according to the methods and standards provided by the commissioner. The commissioner shall approve the hourly rates when service authorization, billing, and payment for services is possible through the Medicaid management information system and the other criteria in this subdivision are met. Counties and vendors operating under the pilot study of hourly rates established under Laws 1988, chapter 689, article 2, section 117, shall work with the commissioner to translate the hourly rates and actual expenditures into rates meeting the criteria in subdivisions 1 to 16 unless hourly rates are approved under this subdivision. If the rates meeting the criteria in subdivisions 1 to 16 are lower than the county's or vendor's current rate, the county or vendor must continue to receive the current rate.

Subd. 18. **Pilot study rates.** By January 1, 1994, counties and vendors operating under the pilot study of hourly rates established under Laws 1988, chapter 689, article 2, section 117, shall work with the commissioner to translate the hourly rates and actual expenditures into rates meeting the criteria in subdivisions 1 to 16 unless hourly rates are approved under subdivision 17.

Subd. 19. **Vendor appeals.** With the concurrence of the county board, a vendor may appeal the commissioner's rejection of a variance request which has been submitted by the county under subdivision 6 and may appeal the commissioner's denial under subdivision 9 of a rate which has been recommended by the county. To appeal, the vendor and county board must file a written notice of appeal with the commissioner. The notice of appeal must be filed or received by the commissioner within 45 days of the postmark date on the commissioner's notification to the vendor and county agency that a variance request or county recommended rate has been denied. The notice of appeal must specify the reasons for the appeal, the dollar amount in dispute, and the basis in statute or rule for challenging the commissioner's decision.

Within 45 days of receipt of the notice of appeal, the commissioner must convene a reconciliation conference to attempt to resolve the rate dispute. If the dispute is not resolved to the satisfaction of the parties, the parties may initiate a contested case proceeding under sections 14.57 to 14.69. In a contested case hearing held under this section, the appealing party must demonstrate by a preponderance of the evidence that the commissioner incorrectly applied the governing law or regulations, or that the commissioner improperly exercised the commissioner's discretion, in refusing to grant a variance or in refusing to adopt a county recommended rate.

Until the appeal is fully resolved, payments must continue at the existing rate pending the appeal. Retroactive payments consistent with the final decision shall be made after the appeal is fully resolved.

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Subd. 20. **Study of day training and habilitation vendors.** The commissioner shall study the feasibility of grouping vendors of similar size, location, direct service staffing needs or performance outcomes to establish payment rate limits that define cost-effective service. Based on the conclusions of the feasibility study the department shall consider developing a method to redistribute dollars from less cost-effective to more cost-effective services based on vendor achievement of performance outcomes. The department shall report to the legislature by January 15, 1996, with results of the study and recommendations for further action. The department shall consult with an advisory committee representing counties, service consumers, vendors, and the legislature.

Subd. 21. **Managed care pilot.** (a) The commissioner may initiate a capitated risk-based managed care option for persons with developmental disabilities, which includes capitated payments for day training and habilitation and alternative active treatment services. The commissioner may permit the health plan, care system, or other health plan network participating in this managed care option to negotiate day training and habilitation rates. The commissioner may grant a variance to any of the provisions in sections 252.40 to 252.46 and Minnesota Rules, parts 9525.1200 to 9525.1580, necessary to implement the pilot.

(b) The commissioner shall report to the legislature financial and program results along with a recommendation as to whether the pilot should be expanded.

256.0112 GRANTS AND PURCHASE OF SERVICE CONTRACTS.

Subd. 6. **Contracting within and across county lines; lead county contracts.**

Paragraphs (a) to (e) govern contracting within and across county lines and lead county contracts.

(a) Once a local agency and an approved vendor execute a contract that meets the requirements of this subdivision, the contract governs all other purchases of service from the vendor by all other local agencies for the term of the contract. The local agency that negotiated and entered into the contract becomes the lead county for the contract.

(b) When the local agency in the county where a vendor is located wants to purchase services from that vendor and the vendor has no contract with the local agency or any other county, the local agency must negotiate and execute a contract with the vendor.

(c) When a local agency in one county wants to purchase services from a vendor located in another county, it must notify the local agency in the county where the vendor is located. Within 30 days of being notified, the local agency in the vendor's county must:

(1) if it has a contract with the vendor, send a copy to the inquiring agency;

(2) if there is a contract with the vendor for which another local agency is the lead county, identify the lead county to the inquiring agency; or

(3) if no local agency has a contract with the vendor, inform the inquiring agency whether it will negotiate a contract and become the lead county. If the agency where the vendor is located will not negotiate a contract with the vendor because of concerns related to clients' health and safety, the agency must share those concerns with the inquiring agency.

(d) If the local agency in the county where the vendor is located declines to negotiate a contract with the vendor or fails to respond within 30 days of receiving the notification under paragraph (c), the inquiring agency is authorized to negotiate a contract and must notify the local agency that declined or failed to respond.

(e) When the inquiring county under paragraph (d) becomes the lead county for a contract and the contract expires and needs to be renegotiated, that county must again follow the requirements under paragraph (c) and notify the local agency where the vendor is located. The local agency where the vendor is located has the option of becoming the lead county for the new contract. If the local agency does not exercise the option, paragraph (d) applies.

(f) This subdivision does not affect the requirement to seek county concurrence under section 256B.092, subdivision 8a, when the services are to be purchased for a person with a developmental disability or under section 245.4711, subdivision 3, when the services to be purchased are for an adult with serious and persistent mental illness.

256B.092 SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES.

Subd. 8a. **County concurrence.** (a) If the county of financial responsibility wishes to place a person in another county for services, the county of financial responsibility shall seek concurrence from the proposed county of service and the placement shall be made cooperatively between the two counties. Arrangements shall be made between the two counties for ongoing social service, including annual reviews of the person's individual service plan. The county where

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services are provided may not make changes in the person's service plan without approval by the county of financial responsibility.

(b) When a person has been screened and authorized for services in an intermediate care facility for persons with developmental disabilities or for home and community-based services for persons with developmental disabilities, the case manager shall assist that person in identifying a service provider who is able to meet the needs of the person according to the person's individual service plan. If the identified service is to be provided in a county other than the county of financial responsibility, the county of financial responsibility shall request concurrence of the county where the person is requesting to receive the identified services. The county of service may refuse to concur if:

(1) it can demonstrate that the provider is unable to provide the services identified in the person's individual service plan as services that are needed and are to be provided; or

(2) in the case of an intermediate care facility for persons with developmental disabilities, there has been no authorization for admission by the admission review team as required in section 256B.0926.

(c) The county of service shall notify the county of financial responsibility of concurrence or refusal to concur no later than 20 working days following receipt of the written request. Unless other mutually acceptable arrangements are made by the involved county agencies, the county of financial responsibility is responsible for costs of social services and the costs associated with the development and maintenance of the placement. The county of service may request that the county of financial responsibility purchase case management services from the county of service or from a contracted provider of case management when the county of financial responsibility is not providing case management as defined in this section and rules adopted under this section, unless other mutually acceptable arrangements are made by the involved county agencies. Standards for payment limits under this section may be established by the commissioner. Financial disputes between counties shall be resolved as provided in section 256G.09.

256B.49 HOME AND COMMUNITY-BASED SERVICE WAIVERS FOR DISABLED.

Subd. 16a. **Medical assistance reimbursement.** (a) The commissioner shall seek federal approval for medical assistance reimbursement of independent living skills services, foster care waiver service, supported employment, prevocational service, and structured day service under the home and community-based waiver for persons with a traumatic brain injury, the community alternatives for disabled individuals waivers, and the community alternative care waivers.

(b) Medical reimbursement shall be made only when the provider demonstrates evidence of its capacity to meet basic health, safety, and protection standards through the following methods:

(1) for independent living skills services, supported employment, prevocational service, and structured day service through one of the methods in paragraphs (c) and (d); and

(2) for foster care waiver services through the method in paragraph (e).

(c) The provider is licensed to provide services under chapter 245B and agrees to apply these standards to services funded through the traumatic brain injury, community alternatives for disabled persons, or community alternative care home and community-based waivers.

(d) The commissioner shall certify that the provider has policies and procedures governing the following:

(1) protection of the consumer's rights and privacy;

(2) risk assessment and planning;

(3) record keeping and reporting of incidents and emergencies with documentation of corrective action if needed;

(4) service outcomes, regular reviews of progress, and periodic reports;

(5) complaint and grievance procedures;

(6) service termination or suspension;

(7) necessary training and supervision of direct care staff that includes:

(i) documentation in personnel files of 20 hours of orientation training in providing training related to service provision;

(ii) training in recognizing the symptoms and effects of certain disabilities, health conditions, and positive behavioral supports and interventions;

(iii) a minimum of five hours of related training annually; and

(iv) when applicable:

(A) safe medication administration;

(B) proper handling of consumer funds; and

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(C) compliance with prohibitions and standards developed by the commissioner to satisfy federal requirements regarding the use of restraints and restrictive interventions. The commissioner shall review at least biennially that each service provider's policies and procedures governing basic health, safety, and protection of rights continue to meet minimum standards.

(e) The commissioner shall seek federal approval for Medicaid reimbursement of foster care services under the home and community-based waiver for persons with a traumatic brain injury, the community alternatives for disabled individuals waiver, and community alternative care waiver when the provider demonstrates evidence of its capacity to meet basic health, safety, and protection standards. The commissioner shall verify that the adult foster care provider is licensed under Minnesota Rules, parts 9555.5105 to 9555.6265; that the child foster care provider is licensed as a family foster care or a foster care residence under Minnesota Rules, parts 2960.3000 to 2960.3340, and certify that the provider has policies and procedures that govern:

(1) compliance with prohibitions and standards developed by the commissioner to meet federal requirements regarding the use of restraints and restrictive interventions;

(2) documentation of service needs and outcomes, regular reviews of progress, and periodic reports; and

(3) safe medication management and administration.

The commissioner shall review at least biennially that each service provider's policies and procedures governing basic health, safety, and protection of rights standards continue to meet minimum standards.

256B.501 RATES FOR COMMUNITY-BASED SERVICES FOR DISABLED.

Subd. 8. **Payment for persons with special needs.** The commissioner shall establish by December 31, 1983, procedures to be followed by the counties to seek authorization from the commissioner for medical assistance reimbursement for very dependent persons with special needs in an amount in excess of the rates allowed pursuant to subdivision 2, including rates established under section 252.46 when they apply to services provided to residents of intermediate care facilities for persons with developmental disabilities, and procedures to be followed for rate limitation exemptions for intermediate care facilities for persons with developmental disabilities. Rate payments under subdivision 8a are eligible for a rate exception under this subdivision. No excess payment approved by the commissioner after June 30, 1991, shall be authorized unless:

(1) the need for specific level of service is documented in the individual service plan of the person to be served;

(2) the level of service needed can be provided within the rates established under section 252.46 and Minnesota Rules, parts 9553.0010 to 9553.0080, without a rate exception within 12 months;

(3) staff hours beyond those available under the rates established under section 252.46 and Minnesota Rules, parts 9553.0010 to 9553.0080, necessary to deliver services do not exceed 1,440 hours within 12 months;

(4) there is a basis for the estimated cost of services;

(5) the provider requesting the exception documents that current per diem rates are insufficient to support needed services;

(6) estimated costs, when added to the costs of current medical assistance-funded residential and day training and habilitation services and calculated as a per diem, do not exceed the per diem established for the regional treatment centers for persons with developmental disabilities on July 1, 1990, indexed annually by the urban Consumer Price Index, All Items, as forecasted by Data Resources Inc., for the next fiscal year over the current fiscal year;

(7) any contingencies for an approval as outlined in writing by the commissioner are met; and

(8) any commissioner orders for use of preferred providers are met.

The commissioner shall evaluate the services provided pursuant to this subdivision through program and fiscal audits.

The commissioner may terminate the rate exception at any time under any of the conditions outlined in Minnesota Rules, part 9510.1120, subpart 3, for county termination, or by reason of information obtained through program and fiscal audits which indicate the criteria outlined in this subdivision have not been, or are no longer being, met.

The commissioner may approve no more than one rate exception, up to 12 months duration, for an eligible client.