

HOUSE OF REPRESENTATIVES

NINETIETH SESSION

H. F. No. 3055

02/26/2018 Authored by Kiel
The bill was read for the first time and referred to the Committee on Health and Human Services Reform
03/19/2018 Adoption of Report: Placed on the General Register as Amended
Read for the Second Time

1.1 A bill for an act

1.2 relating to human services; recodifying elderly waiver language; making technical

1.3 corrections; amending Minnesota Statutes 2016, sections 144.0724, subdivision

1.4 11; 144G.05; 245A.11, subdivision 7a; 245D.02, subdivisions 3, 4b, 10; 256B.038;

1.5 256B.059, subdivision 1; 256B.0595, subdivision 1; 256B.06, subdivision 4;

1.6 256B.0659, subdivision 1; 256B.0711, subdivision 1; 256B.0913, subdivisions 4,

1.7 7, 8, 13, 14; 256B.0917, subdivision 1a; 256B.0918, subdivision 2; 256B.0919,

1.8 subdivision 3; 256B.0922, subdivision 2; 256B.15, subdivision 4; 256B.439,

1.9 subdivision 1; 256B.4912, subdivisions 1, 5, 7; 256B.69, subdivision 6b; 256B.765;

1.10 256B.85, subdivisions 2, 3, 6; 295.50, subdivision 9b; Minnesota Statutes 2017

1.11 Supplement, sections 144.0724, subdivision 2; 144D.04, subdivision 2a; 245A.03,

1.12 subdivision 7; 245A.04, subdivision 14; 245A.11, subdivisions 9, 10, 11; 245D.03,

1.13 subdivision 1; 256B.051, subdivision 3; 256B.0911, subdivisions 1a, 3a; proposing

1.14 coding for new law as Minnesota Statutes, chapter 256S; repealing Minnesota

1.15 Statutes 2016, section 256B.0915, subdivisions 1a, 1b, 1d, 2, 3, 3b, 3c, 3d, 3f, 3g,

1.16 3i, 3j, 4, 6, 7, 8, 9, 10; Minnesota Statutes 2017 Supplement, section 256B.0915,

1.17 subdivisions 1, 3a, 3e, 3h, 5, 11, 12, 13, 14, 15, 16, 17.

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

1.19 **ARTICLE 1**

1.20 **ELDERLY WAIVER**

1.21 Section 1. **[256S.01] GENERALLY.**

1.22 Subdivision 1. **Authority.** The commissioner is authorized to apply for a home and

1.23 community-based services waiver for the elderly, authorized under section 1915(c) of the

1.24 Social Security Act, to obtain federal financial participation to expand the availability of

1.25 services for persons who are eligible for medical assistance. The commissioner may apply

1.26 for additional waivers or pursue other federal financial participation that is advantageous

1.27 to the state for funding home care services for the elderly who are eligible for medical

1.28 assistance. The provision of waiver services to an elderly person receiving medical assistance

2.1 must comply with the criteria for service definitions and provider standards approved in the
2.2 elderly waiver.

2.3 Subd. 2. **Transition plan compliance.** The commissioner shall comply with the
2.4 requirements in the federally approved transition plan for the elderly waiver authorized
2.5 under this chapter.

2.6 Subd. 3. **Services and supports requirements.** (a) Services and supports provided under
2.7 this chapter must meet the requirements in United States Code, title 42, section 1396n.

2.8 (b) Services and supports provided under this chapter must promote consumer choice
2.9 and be arranged and provided consistent with individualized, written coordinated service
2.10 and support plans.

2.11 Subd. 4. **Payment for services.** Reimbursement for the services provided to a participant
2.12 under this chapter and under the elderly waiver must be made from the medical assistance
2.13 account through the invoice processing procedures of the department's Medicaid Management
2.14 Information System (MMIS), only with the approval of the participant's case manager.

2.15 Subd. 5. **Expenditure forecast.** The budget for the state share of the Medicaid
2.16 expenditures under this chapter must be forecasted with the medical assistance budget, and
2.17 shall be consistent with the elderly waiver.

2.18 Subd. 6. **Immunity; consumer-directed community supports.** The state of Minnesota,
2.19 or a county, managed care plan, county-based purchasing plan, or tribal government under
2.20 contract to administer the elderly waiver, is not liable for damages, injuries, or liabilities
2.21 sustained as a result of the participant, the participant's family, or the participant's authorized
2.22 representatives purchasing direct supports or goods with funds received through
2.23 consumer-directed community support services under the elderly waiver. Liabilities include,
2.24 but are not limited to, workers' compensation liability, Federal Insurance Contributions Act
2.25 under United States Code, title 26, subtitle c, chapter 21, or Federal Unemployment Tax
2.26 Act under Internal Revenue Code, chapter 23.

2.27 **EFFECTIVE DATE.** This section is effective August 1, 2018.

2.28 Sec. 2. **[256S.02] DEFINITIONS.**

2.29 Subdivision 1. **Application.** For the purposes of this chapter, the terms in this section
2.30 have the meanings given unless otherwise explicitly provided.

2.31 Subd. 2. **Adjusted base wage.** "Adjusted base wage" refers to adjusted base wage
2.32 described in section 256S.214.

3.1 Subd. 3. **Annual average statewide percentage increase in nursing facility operating**
3.2 **payment rates.** "Annual average statewide percentage increase in nursing facility operating
3.3 payment rates" means the percentage change is the average statewide nursing facility
3.4 operating payment rate under chapter 256R effective January 1 when compared to the
3.5 average statewide nursing facility operating payment rate that was effective on the previous
3.6 January 1.

3.7 Subd. 4. **Case mix classification.** "Case mix classification" is the resident class to which
3.8 the elderly waiver participant would be assigned under Minnesota Rules, parts 9549.0051
3.9 to 9549.0059.

3.10 Subd. 5. **Commissioner.** "Commissioner" means the commissioner of the Department
3.11 of Human Services.

3.12 Subd. 6. **Component service.** "Component service" means services that collectively
3.13 comprise customized living services.

3.14 Subd. 7. **Component service rate.** "Component service rate" means the rate established
3.15 for each component service.

3.16 Subd. 8. **Consumer-directed community supports.** "Consumer-directed community
3.17 supports" refers to a service option available under the elderly waiver that provides a
3.18 participant with flexibility and responsibility for directing the participant's services and
3.19 supports, including hiring and managing direct care staff. Consumer-directed community
3.20 supports may include services, supports, or items currently available under the elderly
3.21 waiver, and allowable services that provide needed supports to participants.

3.22 Subd. 9. **Customized living monthly service rate limit.** "Customized living monthly
3.23 service rate limit" means the monthly dollar limit established by the commissioner for all
3.24 component services based on a participant's case mix classification.

3.25 Subd. 10. **Customized living service plan.** "Customized living service plan" means the
3.26 individualized plan for customized living services that details component services to be
3.27 delivered by the provider under the authorized service rate.

3.28 Subd. 11. **Customized living service rate.** "Customized living service rate" means the
3.29 rate established for all combined component services based on an individualized customized
3.30 living service plan approved by the lead agency, not to exceed the customized living monthly
3.31 service rate limit based on the participant's case mix classification.

4.1 Subd. 12. **Customized living services.** "Customized living services" are services
4.2 comprised of component services that are included in an individually designed plan for the
4.3 service.

4.4 Subd. 13. **Department.** "Department" means the Department of Human Services.

4.5 Subd. 14. **Elderly waiver.** "Elderly waiver" means the federally approved home and
4.6 community-based services waiver for persons aged 65 and older, authorized under section
4.7 1915(c) of the Social Security Act.

4.8 Subd. 15. **Lead agency.** "Lead agency" means a county administering long-term care
4.9 consultation, assessment, and support planning services, or a tribe or managed care
4.10 organization under contract with the commissioner to administer long-term care consultation
4.11 assessment and support planning services.

4.12 Subd. 16. **Maintenance needs allowance.** "Maintenance needs allowance" means the
4.13 dollar amount calculated under section 256S.05, subdivision 3.

4.14 Subd. 17. **Managed care organization.** "Managed care organization" means a prepaid
4.15 health plan or county-based purchasing plan with liability for elderly waiver services under
4.16 sections 256B.69, subdivisions 6b and 23, and 256B.692.

4.17 Subd. 18. **Monthly case mix budget cap.** "Monthly case mix budget cap" means the
4.18 total dollar amount available to support elderly waiver and state plan home care services
4.19 for a participant based on the participant's case mix classification.

4.20 Subd. 19. **Nursing facility case mix adjusted total payment rate.** "Nursing facility
4.21 case mix adjusted total payment rate" refers to "case mix adjusted total payment rate"
4.22 described in section 256R.22.

4.23 Subd. 20. **Nursing facility level of care determination.** "Nursing facility level of care
4.24 determination" refers to determination of institutional level of care described in section
4.25 256B.0911, subdivision 4e.

4.26 Subd. 21. **Private agency.** "Private agency" means any agency that provides case
4.27 management but is not a lead agency.

4.28 Subd. 22. **Service rate.** "Service rate" means the rate established by the commissioner
4.29 for elderly waiver and state plan home care services.

4.30 Subd. 23. **Service rate limit.** "Service rate limit" means the service rate limit established
4.31 by the commissioner for certain elderly waiver services.

5.1 Subd. 24. **State plan home care services.** "State plan home care services" refers to
5.2 home care services described in section 256B.0651, subdivision 2.

5.3 Subd. 25. **24-hour customized living monthly service rate limit.** "24-hour customized
5.4 living monthly service rate limit" means the monthly dollar limit for all component services
5.5 based on (1) a participant's case mix classification, and (2) eligibility for 24-hour customized
5.6 living as described in section 256S.20, subdivision 4.

5.7 **EFFECTIVE DATE.** This section is effective August 1, 2018.

5.8 Sec. 3. **[256S.03] ADMINISTRATION BY TRIBES.**

5.9 Notwithstanding any other state laws or rules, the commissioner may develop a model
5.10 for tribal management of the elderly waiver and implement this model through a contract
5.11 between the state and any of the state's federally recognized tribal governments. The model
5.12 shall include the provision of tribal elderly waiver case management, assessment for personal
5.13 care assistance, and administrative requirements otherwise carried out by lead agencies but
5.14 shall not include tribal financial eligibility determination for medical assistance.

5.15 **EFFECTIVE DATE.** This section is effective August 1, 2018.

5.16 Sec. 4. **[256S.04] LIMITS OF ELDERLY WAIVER CASES.**

5.17 The number of elderly waiver participants that a lead agency may serve must be allocated
5.18 according to the number of elderly waiver cases open on July 1 of each fiscal year. Additional
5.19 elderly waiver participants may be served with the approval of the commissioner.

5.20 **EFFECTIVE DATE.** This section is effective August 1, 2018.

5.21 Sec. 5. **[256S.05] ELIGIBILITY.**

5.22 Subdivision 1. **Elderly waiver plan eligibility requirements.** In addition to the
5.23 requirements of this section, applicants and participants must meet all eligibility requirements
5.24 in the elderly waiver plan.

5.25 Subd. 2. **Nursing facility level of care determination required.** Notwithstanding other
5.26 assessments identified in section 144.0724, subdivision 4, only face-to face assessments
5.27 conducted according to section 256B.0911, subdivisions 3, 3a, and 3b, that result in a nursing
5.28 facility level of care determination at initial and subsequent assessments shall be accepted
5.29 for purposes of a participant's initial and ongoing participation in the elderly waiver and a
5.30 service provider's access to service payments under this chapter.

6.1 Subd. 3. **Maintenance needs allowance.** Notwithstanding the provisions of section
6.2 256B.056, when applying posteligibility treatment of income rules to the gross income of
6.3 an elderly waiver participant, unless the participant's income is in excess of the special
6.4 income standard according to Code of Federal Regulations, title 42, section 435.236, the
6.5 participant's maintenance needs allowance is the sum of the MSA equivalent rate, as defined
6.6 in section 256I.03, subdivision 5, plus the medical assistance personal needs allowance, as
6.7 described in section 256B.35, subdivision 1, paragraph (a). Each participant's maintenance
6.8 needs allowance must be adjusted each July 1.

6.9 Subd. 4. **Spousal impoverishment policies.** For the purposes of eligibility for elderly
6.10 waiver services, the commissioner shall apply the spousal impoverishment criteria as
6.11 authorized under United States Code, title 42, section 1396r-5, and as implemented in
6.12 sections 256B.0575, 256B.058, and 256B.059, except that a participant with income at or
6.13 below the special income standard according to Code of Federal Regulations, title 42, section
6.14 435.236, shall receive the maintenance needs allowance in subdivision 3.

6.15 Subd. 5. **Managed care elderly waiver services.** A participant who is enrolled in a
6.16 managed care organization is not eligible to receive county-administered fee-for-service
6.17 elderly waiver services.

6.18 **EFFECTIVE DATE.** This section is effective August 1, 2018.

6.19 Sec. 6. **[256S.06] ASSESSMENTS AND REASSESSMENTS.**

6.20 Subdivision 1. **Initial assessments.** A lead agency shall provide each participant with
6.21 an initial long-term care consultation assessment of strengths, informal supports, and need
6.22 for services according to section 256B.0911, subdivisions 3, 3a, and 3b.

6.23 Subd. 2. **Annual reassessments.** At least every 12 months, a lead agency shall provide
6.24 each participant with an annual long-term care consultation reassessment according to
6.25 section 256B.0911, subdivisions 3, 3a, and 3b.

6.26 Subd. 3. **Change-in-condition reassessments.** (a) The lead agency shall conduct a
6.27 change-in-condition reassessment before the annual reassessment if a participant's condition
6.28 changed due to a major health event, an emerging need or risk, or a worsening health
6.29 condition, or when the current services do not meet the participant's needs.

6.30 (b) A change-in-condition reassessment may be initiated by the lead agency, may be
6.31 requested by the participant, or may be requested on the participant's behalf by another
6.32 party, such as a service provider.

(c) The lead agency shall: (1) complete a change-in-condition reassessment no later than 20 calendar days from the date of a request; (2) conduct change-in-condition reassessments in a timely manner and expedite urgent requests; and (3) evaluate urgent requests based on the participant's needs and the risk to the participant if a change-in-condition reassessment is not completed.

EFFECTIVE DATE. This section is effective August 1, 2018.

Sec. 7. [256S.07] CASE MANAGEMENT ADMINISTRATION.

Subdivision 1. **Elderly waiver case management provided by counties and tribes.** For participants not enrolled in a managed care organization, the county of residence or tribe must provide or arrange to provide elderly waiver case management activities under section 256S.09, subdivisions 2 and 3.

Subd. 2. **Elderly waiver case management provided by managed care organizations.** Notwithstanding any requirements in this chapter and in accordance with contract requirements established by the commissioner, for participants enrolled in a managed care organization, the managed care organization must provide or arrange to provide elderly waiver case management activities under section 256S.09, subdivisions 2 and 3.

EFFECTIVE DATE. This section is effective August 1, 2018.

Sec. 8. [256S.08] CASE MANAGEMENT PROVIDER QUALIFICATIONS AND STANDARDS.

Subdivision 1. **Provider requirements.** (a) Except as provided in section 256S.07, subdivision 2, elderly waiver case management must be provided by a lead agency or by a private agency that is enrolled as a medical assistance provider.

(b) Any private agency that provides case management to a participant must not have a financial interest in the provision of any other services included in the participant's coordinated service and support plan.

Subd. 2. **Provider enrollment.** The commissioner must enroll providers qualified to provide elderly waiver case management under the elderly waiver. The enrollment process must ensure the provider's ability to meet the qualification requirements and standards in this section and other federal and state requirements of this service.

Subd. 3. **Provider qualifications.** Except as provided in section 256S.07, subdivision 2, a case management provider must be an enrolled medical assistance provider who is determined by the commissioner to have 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 the provider 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; and

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

Subd. 4. **Delegation of certain case management activities.** The lead agency may allow a case manager to delegate certain aspects of the case management activity to a case aide if there is oversight of the case aide by the case manager. The case manager may not delegate those aspects that require professional judgment including assessments, reassessments, and coordinated service and support plan development.

Subd. 5. **Case aides.** A case aide shall provide assistance to the case manager in carrying out administrative activities of the elderly waiver case management function. The case aide may not assume responsibilities that require professional judgment including assessments, reassessments, and coordinated service and support plan development. The case manager is responsible for providing oversight of the case aide.

EFFECTIVE DATE. This section is effective August 1, 2018.

Sec. 9. **[256S.09] CASE MANAGEMENT ACTIVITIES.**

Subdivision 1. **Choice of case management provider.** An eligible participant may choose any qualified provider of elderly waiver case management.

Subd. 2. **Case management activities.** Elderly waiver case management activities provided to or arranged for a participant include:

(1) development of the coordinated service and support plan under section 256S.10;

(2) informing the participant or the participant's legal guardian or conservator of service options and options for elderly waiver case management and providers;

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

(4) assisting the participant in identifying potential providers;

(5) assisting the participant with gaining access to needed elderly waiver and other state plan services;

(6) assisting the participant with gaining access to needed medical, social, educational, and other services regardless of the funding source for the services to which access is gained;

(7) coordination of services;

(8) ongoing evaluation and monitoring of the provision of services included in the participant's coordinated service and support plan under subdivision 3; and

(9) assisting the participant in appeals under section 256.045.

Subd. 3. Coordinated service and support plan development, review, and monitoring.

(a) Elderly waiver case managers shall collaborate with the participant, the participant's family, the participant's legal representatives, and relevant medical experts and service providers to develop and periodically review the participant's coordinated service and support plan.

(b) Case managers shall initiate the process of reassessment and review of the participant's coordinated service and support plan and review the plan at intervals specified in the elderly waiver plan.

(c) The case manager's evaluation and monitoring of a participant's services must incorporate at least one annual face-to-face visit by the case manager with each participant.

EFFECTIVE DATE. This section is effective August 1, 2018.

Sec. 10. [256S.10] COORDINATED SERVICE AND SUPPORT PLANS.

Subdivision 1. Written plan required. Each participant's case manager shall provide the participant with a copy of the participant's written coordinated service and support plan.

Subd. 2. Plan development timeline. Within ten working days after the case manager receives from a lead agency assessor the long-term care consultation assessment information and written community support plan as described in section 256B.0911, subdivision 3a, the case manager must develop and the participant must sign the participant's individualized written coordinated service and support plan.

Subd. 3. Plan content. Each participant's coordinated service and support plan must:

(1) include the participant's need for service and identify service needs that will be or that are met by the participant's relatives, friends, and others, as well as community services used by the general public;

10.1 (2) include the use of volunteers, religious organizations, social clubs, and civic and
10.2 service organizations to support the participant in the community;

10.3 (3) reasonably ensure the health and welfare of the participant;

10.4 (4) identify the participant's preferences for services as stated by the participant or the
10.5 participant's legal guardian or conservator;

10.6 (5) reflect the participant's informed choice between institutional and community-based
10.7 services, as well as choice of services, supports, and providers, including available elderly
10.8 waiver case management providers;

10.9 (6) identify the participant's long-range and short-range goals;

10.10 (7) identify specific services and the amount, frequency, duration, and cost of the services
10.11 to be provided to the participant based on assessed needs, preferences, and available
10.12 resources;

10.13 (8) include information about the right to appeal decisions under section 256.045; and

10.14 (9) include the authorized annual and estimated monthly amounts for the services.

10.15 Subd. 4. **Immunity.** The lead agency must be held harmless for damages or injuries
10.16 sustained through the use of volunteers and organizations under subdivision 3, clause (2),
10.17 including workers' compensation liability.

10.18 **EFFECTIVE DATE.** This section is effective August 1, 2018.

10.19 Sec. 11. **[256S.11] APPROVAL REQUIRED FOR CERTAIN STATE PLAN HOME**
10.20 **CARE SERVICES.**

10.21 Medical assistance funding for the following services for a participant must be approved
10.22 by the case manager and included in the participant's coordinated service and support plan:

10.23 (1) skilled nursing services;

10.24 (2) home care nursing;

10.25 (3) home health aide services; and

10.26 (4) personal care assistance services.

10.27 **EFFECTIVE DATE.** This section is effective August 1, 2018.

11.1 Sec. 12. **[256S.12] ADULT DAY SERVICES.**

11.2 Subdivision 1. **Adult day services authorization limits.** Adult day services may be
11.3 authorized for up to 48 units, or 12 hours, per day based on the needs of the participant and
11.4 the participant's family caregivers.

11.5 Subd. 2. **Adult day services bath authorization minimum.** If a bath is authorized for
11.6 a participant receiving adult day services, at least two 15-minute units must be authorized
11.7 to allow for adequate time to meet the participant's needs.

11.8 **EFFECTIVE DATE.** This section is effective August 1, 2018.

11.9 Sec. 13. **[256S.13] INDIVIDUAL COMMUNITY LIVING SUPPORTS.**

11.10 Subdivision 1. **Provider requirements.** A provider of individual community living
11.11 supports must not be the landlord of the participant receiving individual community living
11.12 supports, nor have any interest in the participant's housing.

11.13 Subd. 2. **Licensing standards.** Licensing standards for individual community living
11.14 supports shall be reviewed jointly by the Departments of Health and Human Services to
11.15 avoid conflict with provider regulatory standards pursuant to sections 144A.43 to 144A.483
11.16 and chapter 245D.

11.17 Subd. 3. **Setting requirements.** Individual community living supports must be delivered
11.18 in a single-family home or apartment that the participant or the participant's family owns
11.19 or rents, as demonstrated by a lease agreement, and maintains control over the individual
11.20 unit.

11.21 Subd. 4. **Plan required.** A case manager must develop an individual community living
11.22 support plan in consultation with the participant using a tool developed by the commissioner.

11.23 Subd. 5. **Individual community living support rates.** The commissioner shall establish
11.24 rates and establish mechanisms to align payments with the type and amount of service
11.25 provided, ensure statewide uniformity for rates, and ensure cost-effectiveness.

11.26 **EFFECTIVE DATE.** This section is effective August 1, 2018.

11.27 Sec. 14. **[256S.14] TERMINATION OF ELDERLY WAIVER SERVICES.**

11.28 The case manager must give the participant a ten-day written notice of any denial,
11.29 reduction, or termination of elderly waiver services.

11.30 **EFFECTIVE DATE.** This section is effective August 1, 2018.

12.1 Sec. 15. **[256S.15] ESTABLISHMENT OF ELDERLY WAIVER SERVICE RATES**
12.2 **AND SERVICE RATE LIMITS.**

12.3 Subdivision 1. **Statewide service rates and service rate limits.** The commissioner shall
12.4 establish statewide service rates and service rate limits. The commissioner shall publish
12.5 updated service rates and service rate limits at least annually.

12.6 Subd. 2. **Foster care limit.** The elderly waiver payment for the foster care service in
12.7 combination with the payment for all other elderly waiver services, including case
12.8 management, must not exceed the monthly case mix budget cap for the participant as
12.9 specified in sections 256S.18, subdivision 3, and 256S.19, subdivisions 3 and 4.

12.10 **EFFECTIVE DATE.** This section is effective August 1, 2018.

12.11 Sec. 16. **[256S.16] AUTHORIZATION OF ELDERLY WAIVER SERVICES AND**
12.12 **SERVICE RATES.**

12.13 A lead agency must use the service rates and service rate limits published by the
12.14 commissioner to authorize services.

12.15 **EFFECTIVE DATE.** This section is effective August 1, 2018.

12.16 Sec. 17. **[256S.17] COSTS EXCLUDED FROM ELDERLY WAIVER SERVICE**
12.17 **RATES.**

12.18 Elderly waiver service rates for foster care and customized living shall not include room
12.19 and board, rent, or raw food costs.

12.20 **EFFECTIVE DATE.** This section is effective August 1, 2018.

12.21 Sec. 18. **[256S.18] MONTHLY CASE MIX BUDGET CAPS; GENERALLY.**

12.22 Subdivision 1. **Case mix classifications.** (a) The elderly waiver case mix classifications
12.23 A to K shall be the resident classes A to K established under Minnesota Rules, parts
12.24 9549.0058 and 9549.0059.

12.25 (b) A participant assigned to elderly waiver case mix classification A must be reassigned
12.26 to elderly waiver case mix classification L if an assessment or reassessment performed
12.27 under section 256B.0911 determines that the participant has:

12.28 (1) no dependencies in activities of daily living; or

12.29 (2) up to two dependencies in bathing, dressing, grooming, walking, or eating when the
12.30 dependency score in eating is three or greater.

13.1 (c) A participant must be assigned to elderly waiver case mix classification V if the
13.2 participant meets the definition of ventilator-dependent in section 256B.0651, subdivision
13.3 1, paragraph (g).

13.4 Subd. 2. **Costs included under monthly case mix budget cap.** The monthly total cost,
13.5 as determined under this chapter, for all elderly waiver services authorized for a participant
13.6 must not exceed the participant's monthly case mix budget cap. The monthly total cost must
13.7 include the monthly cost of all elderly waiver services and state plan home care services.

13.8 Subd. 3. **Monthly case mix budget caps.** (a) Effective each July 1, the monthly case
13.9 mix budget cap for all case mix classifications shall be the monthly case mix budget cap in
13.10 effect on the prior June 30 for the case mix classification to which the participant is assigned,
13.11 adjusted as required under subdivisions 5 and 6.

13.12 (b) The commissioner shall determine and publish monthly case mix budget caps for
13.13 each case mix classification at least annually and whenever other adjustments are legislatively
13.14 enacted.

13.15 Subd. 4. **Monthly case mix budget cap prorating for specialized supplies, equipment,**
13.16 **or environmental modifications.** If specialized supplies and equipment or environmental
13.17 accessibility and adaptations are or will be purchased for a participant, these costs may be
13.18 prorated for up to 12 consecutive months beginning with the month of purchase. If the
13.19 monthly cost of a participant's elderly waiver services exceeds the participant's monthly
13.20 case mix budget cap established under subdivision 3, 5, or 6, the annual cost of all elderly
13.21 waiver services shall be determined. In this event, the annual cost of all elderly waiver
13.22 services shall not exceed 12 times the applicable monthly case mix budget cap under
13.23 subdivision 3, 5, or 6.

13.24 Subd. 5. **Home and community-based rate increases; effect on monthly case mix**
13.25 **budget caps.** (a) The commissioner shall adjust the monthly case mix budget caps under
13.26 subdivision 3 by any home and community-based services percentage rate adjustments
13.27 legislatively enacted.

13.28 (b) If a legislatively enacted home and community-based rate adjustment is
13.29 service-specific, the commissioner shall adjust the monthly case mix budget caps under
13.30 subdivision 3 based on the overall effect of the adjustment on the elderly waiver.

13.31 Subd. 6. **Nursing facility average operating payment rate increases; effect on monthly**
13.32 **case mix budget caps.** (a) Each January 1, the commissioner shall increase the monthly
13.33 case mix budget caps under subdivision 3 in effect on the previous December 31 by the
13.34 difference between:

14.1 (1) the sum of any enacted home and community-based provider rate increases effective
14.2 on January 1 and since the previous January 1; and

14.3 (2) the annual average statewide percentage increase in nursing facility operating payment
14.4 rates under chapter 256R, effective the previous January 1.

14.5 (b) This subdivision only applies if the average statewide percentage increase in nursing
14.6 facility operating payment rates is greater than any legislatively enacted home and
14.7 community-based provider rate increases effective on January 1, or occurring since the
14.8 previous January 1.

14.9 **EFFECTIVE DATE.** This section is effective August 1, 2018.

14.10 Sec. 19. **[256S.19] MONTHLY CASE MIX BUDGET CAPS; NURSING FACILITY**
14.11 **RESIDENTS.**

14.12 Subdivision 1. **Requests for elderly waiver monthly conversion budget caps.** A
14.13 participant who is a nursing facility resident when requesting an eligibility determination
14.14 for elderly waiver services may request an elderly waiver monthly conversion budget cap
14.15 for the cost of elderly waiver services.

14.16 Subd. 2. **Eligibility for elderly waiver monthly conversion budget caps.** Only a
14.17 participant discharged from a nursing facility after a minimum 30-day stay is eligible under
14.18 this section for an elderly waiver monthly conversion budget cap.

14.19 Subd. 3. **Calculation of monthly conversion budget cap without consumer-directed**
14.20 **community supports.** (a) The elderly waiver monthly conversion budget cap for the cost
14.21 of elderly waiver services without consumer-directed community supports shall be based
14.22 on the nursing facility case mix adjusted total payment rate of the nursing facility where
14.23 the elderly waiver applicant currently resides for the applicant's case mix classification as
14.24 determined according to section 256R.17.

14.25 (b) The elderly waiver monthly conversion budget cap for the cost of elderly waiver
14.26 services without consumer-directed community supports shall be calculated by multiplying
14.27 the applicable nursing facility case mix adjusted total payment rate by 365, dividing by 12,
14.28 and subtracting the participant's maintenance needs allowance.

14.29 (c) A participant's initially approved monthly conversion budget cap for elderly waiver
14.30 services without consumer-directed community supports shall be adjusted at least annually
14.31 as described in section 256S.18, subdivision 5.

15.1 Subd. 4. **Calculation of monthly conversion budget cap with consumer-directed**
15.2 **community supports.** For the elderly waiver monthly conversion budget cap for the cost
15.3 of elderly waiver services with consumer-directed community support services, the nursing
15.4 facility case mix adjusted total payment rate used under subdivision 3 to calculate the
15.5 monthly conversion budget cap for elderly waiver services without consumer-directed
15.6 community supports must be reduced by a percentage equal to the percentage difference
15.7 between the consumer-directed services budget limit that would be assigned according to
15.8 the elderly waiver plan and the corresponding monthly case mix budget cap under this
15.9 chapter, but not to exceed 50 percent.

15.10 **EFFECTIVE DATE.** This section is effective August 1, 2018.

15.11 Sec. 20. **[256S.20] CUSTOMIZED LIVING SERVICES; POLICY.**

15.12 Subdivision 1. **Customized living services provider requirements.** Only a provider
15.13 licensed by the Department of Health as a comprehensive home care provider may provide
15.14 customized living services or 24-hour customized living services. A licensed home care
15.15 provider is subject to section 256B.0651, subdivision 14.

15.16 Subd. 2. **Customized living services requirements.** Customized living services and
15.17 24-hour customized living services may only be provided in a building that is registered as
15.18 a housing with services establishment under chapter 144D.

15.19 Subd. 3. **Documented need required.** The lead agency, with input from the provider
15.20 of customized living services and within the parameters established by the commissioner,
15.21 shall ensure that there is a documented need for all customized living or 24-hour customized
15.22 living component services the lead agency authorizes.

15.23 Subd. 4. **24-hour customized living services eligibility.** (a) The lead agency shall not
15.24 authorize 24-hour customized living services unless the participant receiving customized
15.25 living services requires assistance, including 24-hour supervision, due to needs related to
15.26 one or more of the following:

15.27 (1) intermittent assistance with toileting, positioning, or transferring;

15.28 (2) cognitive or behavioral issues;

15.29 (3) a medical condition that requires clinical monitoring; or

15.30 (4) the need for medication management, at least 50 hours of services per month, and a
15.31 dependency in at least three of the following activities of daily living as determined by

16.1 assessment under section 256B.0911: bathing, dressing, grooming, walking, or eating when
16.2 the dependency score in eating is three or greater.

16.3 (b) The lead agency must document the need for 24-hour supervision.

16.4 (c) The lead agency shall ensure that the frequency and mode of supervision of the
16.5 participant and the qualifications of staff providing supervision are described and meet the
16.6 needs of the participant.

16.7 Subd. 5. **Billing for additional units of allowable services prohibited.** A provider of
16.8 customized living services or 24-hour customized living services must not bill or otherwise
16.9 charge a participant or the participant's family for: (1) additional units of any allowable
16.10 component service beyond those available under the service rate limits described in section
16.11 256S.202, or (2) additional units of any allowable component service beyond those
16.12 component services in the customized living service plan approved by the lead agency.

16.13 **EFFECTIVE DATE.** This section is effective August 1, 2018.

16.14 Sec. 21. **[256S.201] CUSTOMIZED LIVING SERVICES; RATES.**

16.15 Subdivision 1. **Authorized customized living service rates.** The rates for customized
16.16 living services and 24-hour customized living services shall be the monthly rates authorized
16.17 by the lead agency based on the customized living service plan developed within the
16.18 parameters established by the commissioner and specified in the customized living service
16.19 plan.

16.20 Subd. 2. **Customized living service plan.** The customized living service plan developed
16.21 by a lead agency must delineate the amount of each component service included in each
16.22 participant's customized living service plan.

16.23 Subd. 3. **Customized living service rates.** The authorized rates for customized living
16.24 services and 24-hour customized living services must be based on the amount of component
16.25 services to be provided utilizing component rates established by the commissioner. Counties
16.26 and tribes shall use tools issued by the commissioner to develop and document customized
16.27 living service plans and rates.

16.28 Subd. 4. **Component service rates.** Component service rates for customized living
16.29 services and 24-hour customized living services must not exceed rates for comparable
16.30 elderly waiver or medical assistance services and must reflect economies of scale.

16.31 **EFFECTIVE DATE.** This section is effective August 1, 2018.

17.1 Sec. 22. **[256S.202] CUSTOMIZED LIVING SERVICES; RATE LIMITS.**

17.2 Subdivision 1. Customized living monthly service rate limits. (a) Except for a
17.3 participant assigned to case mix classification L, as described in section 256S.18, subdivision
17.4 1, paragraph (b), the customized living monthly service rate limit shall not exceed 50 percent
17.5 of the monthly case mix budget, less the maintenance needs allowance, adjusted at least
17.6 annually in the manner described under section 256S.18, subdivisions 5 and 6.

17.7 (b) The customized living monthly service rate limit for participants assigned to case
17.8 mix L must be the monthly service rate limit for participants classified as case mix A,
17.9 reduced by 25 percent.

17.10 Subd. 2. 24-hour customized living monthly service rate limits. (a) The 24-hour
17.11 customized living monthly service rate limit is the 95th percentile of statewide monthly
17.12 authorizations for 24-hour customized living services in effect and in the Medicaid
17.13 management information systems on March 31, 2009, for each case mix resident class under
17.14 Minnesota Rules, parts 9549.0051 to 9549.0059, to which elderly waiver service participants
17.15 are assigned, adjusted at least annually in the manner described under section 256S.18,
17.16 subdivisions 5 and 6.

17.17 (b) If there are fewer than 50 authorizations in effect in the case mix resident class, the
17.18 commissioner shall multiply the calculated 24-hour customized living monthly service rate
17.19 limit for the A classification by the standard weight for that classification under Minnesota
17.20 Rules, parts 9549.0051 to 9549.0059, to determine the applicable 24-hour customized living
17.21 monthly service rate limit.

17.22 **EFFECTIVE DATE.** This section is effective August 1, 2018.

17.23 Sec. 23. **[256S.203] CUSTOMIZED LIVING SERVICES; MANAGED CARE RATES.**

17.24 Subdivision 1. Capitation payments. The commissioner shall adjust the elderly waiver
17.25 capitation payment rates for managed care organizations paid to reflect the monthly service
17.26 rate limits for customized living services and 24-hour customized living services established
17.27 under section 256S.202.

17.28 Subd. 2. Reimbursement rates. Medical assistance rates paid to customized living
17.29 providers by managed care organizations under this chapter shall not exceed the monthly
17.30 service rate limits and component rates as determined by the commissioner under sections
17.31 256S.15, and 256S.20 to 256S.202.

17.32 **EFFECTIVE DATE.** This section is effective August 1, 2018.

Sec. 24. **[256S.204] ALTERNATIVE RATE SYSTEM FOR 24-HOUR CUSTOMIZED LIVING SERVICES.**

Notwithstanding the customized living monthly service rate limits under section 256S.202, subdivision 1, the 24-hour customized living monthly service rate limits under section 256S.202, subdivision 2, and the component service rates established under section 256S.201, subdivision 4, the commissioner may establish alternative rate systems for 24-hour customized living services in housing with services establishments that are freestanding buildings with a capacity of 16 or fewer, by applying a single hourly rate for covered component services provided in either:

(1) licensed corporate adult foster homes; or

(2) specialized dementia care units that meet the requirements of section 144D.065 and in which:

(i) participants are offered the option of having their own apartments; or

(ii) the units are licensed as board and lodge establishments with a maximum capacity of eight residents and meet the requirements of Minnesota Rules, part 9555.6205, subparts 1, 2, 3, and 4, item A.

EFFECTIVE DATE. This section is effective August 1, 2018.

Sec. 25. **[256S.21] RATE SETTING; APPLICATION.**

The payment methodologies in sections 256S.2101 to 256S.215 apply to elderly waiver, elderly waiver customized living, elderly waiver foster care, and elderly waiver residential care under this chapter, alternative care under section 256B.0913, essential community supports under section 256B.0922, and community access for disability inclusion customized living and brain injury customized living under section 256B.49.

EFFECTIVE DATE. This section is effective August 1, 2018.

Sec. 26. **[256S.2101] RATE SETTING; PHASE-IN.**

All rates and rate components for services listed in section 256S.21 shall be the sum of ten percent of the rates calculated under sections 256S.211 to 256S.215 and 90 percent of the rates calculated using the rate methodology in effect as of June 30, 2017.

EFFECTIVE DATE. This section is effective January 1, 2019.

19.1 Sec. 27. **[256S.211] RATE SETTING; RATE ESTABLISHMENT.**

19.2 Subdivision 1. **Establishing base wages.** When establishing the base wages according
19.3 to section 256S.212, the commissioner shall use standard occupational classification (SOC)
19.4 codes from the Bureau of Labor Statistics as defined in the edition of the Occupational
19.5 Handbook published immediately prior to January 1, 2019, using Minnesota-specific wages
19.6 taken from job descriptions.

19.7 Subd. 2. **Establishing rates.** By January 1 of each year, the commissioner shall establish
19.8 factors, component rates, and rates according to sections 256S.213 and 256S.215, using
19.9 base wages established according to section 256S.212.

19.10 **EFFECTIVE DATE.** Subdivision 1 is effective August 1, 2018. Subdivision 2 is
19.11 effective January 1, 2019.

19.12 Sec. 28. **[256S.212] RATE SETTING; BASE WAGE INDEX.**

19.13 Subdivision 1. **Updating SOC codes.** If any of the SOC codes and positions used in
19.14 this section are no longer available, the commissioner shall, in consultation with stakeholders,
19.15 select a new SOC code and position that is the closest match to the previously used SOC
19.16 position.

19.17 Subd. 2. **Home management and support services base wage.** For customized living,
19.18 foster care, and residential care component services, the home management and support
19.19 services base wage equals 33.33 percent of the Minneapolis-St. Paul-Bloomington, MN-WI
19.20 MetroSA average wage for personal and home care aide (SOC code 39-9021); 33.33 percent
19.21 of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for food
19.22 preparation workers (SOC code 35-2021); and 33.34 percent of the Minneapolis-St.
19.23 Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners
19.24 (SOC code 37-2012).

19.25 Subd. 3. **Home care aide base wage.** For customized living, foster care, and residential
19.26 care component services, the home care aide base wage equals 50 percent of the
19.27 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for home health aides
19.28 (SOC code 31-1011); and 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI
19.29 MetroSA average wage for nursing assistants (SOC code 31-1014).

19.30 Subd. 4. **Home health aide base wage.** For customized living, foster care, and residential
19.31 care component services, the home health aide base wage equals 20 percent of the
19.32 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical
19.33 and licensed vocational nurses (SOC code 29-2061); and 80 percent of the Minneapolis-St.

20.1 Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code
20.2 31-1014).

20.3 Subd. 5. **Medication setups by licensed nurse base wage.** For customized living, foster
20.4 care, and residential care component services, the medication setups by licensed nurse base
20.5 wage equals ten percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average
20.6 wage for licensed practical and licensed vocational nurses (SOC code 29-2061); and 90
20.7 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for
20.8 registered nurses (SOC code 29-1141).

20.9 Subd. 6. **Chore services base wage.** The chore services base wage equals 100 percent
20.10 of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for landscaping
20.11 and groundskeeping workers (SOC code 37-3011).

20.12 Subd. 7. **Companion services base wage.** The companion services base wage equals
20.13 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for
20.14 personal and home care aides (SOC code 39-9021); and 50 percent of the Minneapolis-St.
20.15 Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners
20.16 (SOC code 37-2012).

20.17 Subd. 8. **Homemaker services and assistance with personal care base wage.** The
20.18 homemaker services and assistance with personal care base wage equals 60 percent of the
20.19 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home
20.20 care aide (SOC code 39-9021); 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI
20.21 MetroSA average wage for nursing assistants (SOC code 31-1014); and 20 percent of the
20.22 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and
20.23 housekeeping cleaners (SOC code 37-2012).

20.24 Subd. 9. **Homemaker services and cleaning base wage.** The homemaker services and
20.25 cleaning base wage equals 60 percent of the Minneapolis-St. Paul-Bloomington, MN-WI
20.26 MetroSA average wage for personal and home care aide (SOC code 39-9021); 20 percent
20.27 of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing
20.28 assistants (SOC code 31-1014); and 20 percent of the Minneapolis-St. Paul-Bloomington,
20.29 MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012).

20.30 Subd. 10. **Homemaker services and home management base wage.** The homemaker
20.31 services and home management base wage equals 60 percent of the Minneapolis-St.
20.32 Paul-Bloomington, MN-WI MetroSA average wage for personal and home care aide (SOC
20.33 code 39-9021); 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA
20.34 average wage for nursing assistants (SOC code 31-1014); and 20 percent of the

21.1 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and
21.2 housekeeping cleaners (SOC code 37-2012).

21.3 Subd. 11. **In-home respite care services base wage.** The in-home respite care services
21.4 base wage equals five percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA
21.5 average wage for registered nurses (SOC code 29-1141); 75 percent of the Minneapolis-St.
21.6 Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code
21.7 31-1014); and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA
21.8 average wage for licensed practical and licensed vocational nurses (SOC code 29-2061).

21.9 Subd. 12. **Out-of-home respite care services base wage.** The out-of-home respite care
21.10 services base wage equals five percent of the Minneapolis-St. Paul-Bloomington, MN-WI
21.11 MetroSA average wage for registered nurses (SOC code 29-1141); 75 percent of the
21.12 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants
21.13 (SOC code 31-1014); and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI
21.14 MetroSA average wage for licensed practical and licensed vocational nurses (SOC code
21.15 29-2061).

21.16 Subd. 13. **Individual community living support base wage.** The individual community
21.17 living support base wage equals 20 percent of the Minneapolis-St. Paul-Bloomington,
21.18 MN-WI MetroSA average wage for licensed practical and licensed vocational nurses (SOC
21.19 code 29-2061); and 80 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA
21.20 average wage for nursing assistants (SOC code 31-1014).

21.21 Subd. 14. **Registered nurse base wage.** The registered nurse base wage equals 100
21.22 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for
21.23 registered nurses (SOC code 29-1141).

21.24 Subd. 15. **Social worker base wage.** The social worker base wage equals 100 percent
21.25 of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for medical and
21.26 public health social workers (SOC code 21-1022).

21.27 **EFFECTIVE DATE.** This section is effective August 1, 2018.

21.28 Sec. 29. **[256S.213] RATE SETTING; FACTORS.**

21.29 Subdivision 1. **Payroll taxes and benefits factor.** The payroll taxes and benefits factor
21.30 is the sum of net payroll taxes and benefits, divided by the sum of all salaries for all nursing
21.31 facilities on the most recent and available cost report.

22.1 Subd. 2. **General and administrative factor.** The general and administrative factor is
22.2 the difference of net general and administrative expenses and administrative salaries, divided
22.3 by total operating expenses for all nursing facilities on the most recent and available cost
22.4 report.

22.5 Subd. 3. **Program plan support factor.** The program plan support factor is 12.8 percent
22.6 to cover the cost of direct service staff needed to provide support for home and
22.7 community-based service when not engaged in direct contact with participants.

22.8 Subd. 4. **Registered nurse management and supervision factor.** The registered nurse
22.9 management and supervision factor equals 15 percent of the product of the registered nurse
22.10 base wage and the sum of the factors in subdivisions 1 to 3.

22.11 Subd. 5. **Social worker supervision factor.** The social worker supervision factor equals
22.12 15 percent of the product of the social worker base wage and the sum of the factors in
22.13 subdivisions 1 to 3.

22.14 **EFFECTIVE DATE.** This section is effective August 1, 2018.

22.15 Sec. 30. **[256S.214] RATE SETTING; ADJUSTED BASE WAGE.**

22.16 For the purposes of section 256S.215, the adjusted base wage for each position equals
22.17 the position's base wage under section 256S.212 plus:

22.18 (1) the position's base wage multiplied by the payroll taxes and benefits factor under
22.19 section 256S.213, subdivision 1;

22.20 (2) the position's base wage multiplied by the general and administrative factor under
22.21 section 256S.213, subdivision 2; and

22.22 (3) the position's base wage multiplied by the program plan support factor under section
22.23 256S.213, subdivision 3.

22.24 **EFFECTIVE DATE.** This section is effective August 1, 2018.

22.25 Sec. 31. **[256S.215] RATE SETTING; COMPONENT RATES.**

22.26 Subdivision 1. **Medication setups by licensed nurse component rate.** The component
22.27 rate for medication setups by a licensed nurse equals the medication setups by licensed
22.28 nurse adjusted base wage.

22.29 Subd. 2. **Home management and support services component rate.** The component
22.30 rate for home management and support services is the home management and support
22.31 services adjusted base wage plus the registered nurse management and supervision factor.

23.1 Subd. 3. **Home care aide services component rate.** The component rate for home care
23.2 aid services is the home health aide services adjusted base wage plus the registered nurse
23.3 management and supervision factor.

23.4 Subd. 4. **Home health aide services component rate.** The component rate for home
23.5 health aid services is the home health aide services adjusted base wage plus the registered
23.6 nurse management and supervision factor.

23.7 Subd. 5. **Socialization component rate.** The component rate under elderly waiver
23.8 customized living for one-to-one socialization equals the home management and support
23.9 services component rate.

23.10 Subd. 6. **Transportation component rate.** The component rate under elderly waiver
23.11 customized living for one-to-one transportation equals the home management and support
23.12 services component rate.

23.13 Subd. 7. **Chore services rate.** The 15-minute unit rate for chore services is calculated
23.14 as follows:

23.15 (1) sum the chore services adjusted base wage and the social worker supervision factor;
23.16 and

23.17 (2) divide the result of clause (1) by four.

23.18 Subd. 8. **Companion services rate.** The 15-minute unit rate for companion services is
23.19 calculated as follows:

23.20 (1) sum the companion services adjusted base wage and the social worker supervision
23.21 factor; and

23.22 (2) divide the result of clause (1) by four.

23.23 Subd. 9. **Homemaker services and assistance with personal care rate.** The 15-minute
23.24 unit rate for homemaker services and assistance with personal care is calculated as follows:

23.25 (1) sum the homemaker services and assistance with personal care adjusted base wage
23.26 and the registered nurse management and supervision factor; and

23.27 (2) divide the result of clause (1) by four.

23.28 Subd. 10. **Homemaker services and cleaning rate.** The 15-minute unit rate for
23.29 homemaker services and cleaning is calculated as follows:

23.30 (1) sum the homemaker services and cleaning adjusted base wage and the registered
23.31 nurse management and supervision factor; and

24.1 (2) divide the result of clause (1) by four.

24.2 Subd. 11. **Homemaker services and home management rate.** The 15-minute unit rate
24.3 for homemaker services and home management is calculated as follows:

24.4 (1) sum the homemaker services and home management adjusted base wage and the
24.5 registered nurse management and supervision factor; and

24.6 (2) divide the result of clause (1) by four.

24.7 Subd. 12. **In-home respite care services rates.** (a) The 15-minute unit rate for in-home
24.8 respite care services is calculated as follows:

24.9 (1) sum the in-home respite care services adjusted base wage and the registered nurse
24.10 management and supervision factor; and

24.11 (2) divide the result of clause (1) by four.

24.12 (b) The in-home respite care services daily rate equals the in-home respite care services
24.13 15-minute unit rate multiplied by 18.

24.14 Subd. 13. **Out-of-home respite care services rates.** (a) The 15-minute unit rate for
24.15 out-of-home respite care is calculated as follows:

24.16 (1) sum the out-of-home respite care services adjusted base wage and the registered
24.17 nurse management and supervision factor; and

24.18 (2) divide the result of clause (1) by four.

24.19 (b) The out-of-home respite care services daily rate equals the 15-minute unit rate for
24.20 out-of-home respite care services multiplied by 18.

24.21 Subd. 14. **Individual community living support rate.** The individual community living
24.22 support rate is calculated as follows:

24.23 (1) sum the home care aide adjusted base wage and the social worker supervision factor;
24.24 and

24.25 (2) divide the result of clause (1) by four.

24.26 Subd. 15. **Home-delivered meals rate.** The home-delivered meals rate equals \$9.30.

24.27 The commissioner shall increase the home delivered meals rate every July 1 by the percent
24.28 increase in the nursing facility dietary per diem using the two most recent and available
24.29 nursing facility cost reports.

24.30 Subd. 16. **Adult day services rate.** The 15-minute unit rate for adult day services, with
24.31 an assumed staffing ratio of one staff person to four participants, is the sum of:

25.1 (1) one-sixteenth of the home care aide services adjusted base wage, except that the
25.2 general and administrative factor used to determine the home care aide services adjusted
25.3 base wage is 20 percent;

25.4 (2) one-fourth of the registered nurse management and supervision factor; and

25.5 (3) \$0.63 to cover the cost of meals.

25.6 Subd. 17. **Adult day services bath rate.** The 15-minute unit rate for adult day services
25.7 is the sum of:

25.8 (1) one-fourth of the home care aide services adjusted base wage, except that the general
25.9 and administrative factor used to determine the home care aide services adjusted base wage
25.10 is 20 percent;

25.11 (2) one-fourth of the registered nurse management and supervision factor; and

25.12 (3) \$0.63 to cover the cost of meals.

25.13 **EFFECTIVE DATE.** Subdivisions 1 to 14, 16, and 17 are effective August 1, 2018.
25.14 Subdivision 15 is effective July 1, 2018.

25.15 Sec. 32. **[256S.2199] RATE SETTING; REVIEW AND EVALUATION.**

25.16 (a) The commissioner, in consultation with stakeholders, shall conduct a study to evaluate
25.17 the following:

25.18 (1) base wages in section 256S.212, to determine if the standard occupational
25.19 classification codes for each rate and component rate are an appropriate representation of
25.20 staff who deliver the services; and

25.21 (2) factors in section 256S.213, and adjusted base wage calculation in section 256S.214,
25.22 to determine if the factors and calculations appropriately address nonwage provider costs.

25.23 (b) By January 1, 2019, the commissioner shall submit a report to the legislature on the
25.24 changes to the rate methodology in this statute, based on the results of the evaluation. Where
25.25 feasible, the report shall address the impact of the new rates on the workforce shortage and
25.26 participant access to services. The report should include any changes to the rate calculations
25.27 methods that the commissioner recommends.

25.28 **EFFECTIVE DATE.** This section is effective August 1, 2018.

26.1 Sec. 33. **DIRECTION TO COMMISSIONER; TRANSITION PROCESS.**

26.2 (a) The commissioner of human services shall update references to statutes recodified
26.3 in this act when printed material is replaced and new printed material is obtained in the
26.4 normal course of business. The commissioner is not required to replace existing printed
26.5 material to comply with this act.

26.6 (b) The commissioner of human services shall update references to statutes recodified
26.7 in this act when online documents and Web sites are edited in the normal course of business.
26.8 The commissioner is not required to edit online documents and Web sites merely to comply
26.9 with this act.

26.10 (c) The commissioner of human services shall update references to statutes recodified
26.11 in this act when the home and community-based service waiver plans are updated in the
26.12 normal course of business. The commissioner is not required to update the home and
26.13 community-based service waiver plans merely to comply with this act.

26.14 Sec. 34. **REVISOR'S INSTRUCTION.**

26.15 The revisor of statutes, in consultation with the House Research Department, the Office
26.16 of Senate Counsel, Research, and Fiscal Analysis, and the Department of Human Services,
26.17 shall make necessary cross-reference changes and remove statutory cross-references in
26.18 Minnesota Statutes and Minnesota Rules to conform with the recodification and repealer
26.19 in this act. The revisor may make technical and other necessary changes to sentence structure
26.20 to preserve the meaning of the text. The revisor may alter the coding in this act to incorporate
26.21 statutory changes made by other law in the 2018 regular legislative session. If a provision
26.22 repealed in this act is also amended in the 2018 regular legislative session by other law, the
26.23 revisor shall merge the amendment into the recodification, notwithstanding Minnesota
26.24 Statutes, section 645.30.

26.25 **EFFECTIVE DATE.** This section is effective August 1, 2018.

26.26 Sec. 35. **REPEALER.**

26.27 (a) Minnesota Statutes 2016, section 256B.0915, subdivisions 1a, 1b, 1d, 2, 3, 3b, 3c,
26.28 3d, 3f, 3g, 3i, 3j, 4, 6, 7, 8, 9, and 10, are repealed.

26.29 (b) Minnesota Statutes 2017 Supplement, section 256B.0915, subdivisions 1, 3a, 3e, 3h,
26.30 5, 11, 12, 13, 14, 15, 16, and 17, are repealed.

26.31 **EFFECTIVE DATE.** This section is effective August 1, 2018.

27.1 **ARTICLE 2**

27.2 **ELDERLY WAIVER TECHNICAL CORRECTIONS**

27.3 Section 1. Minnesota Statutes 2017 Supplement, section 144.0724, subdivision 2, is
27.4 amended to read:

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

27.7 (a) "Assessment reference date" or "ARD" means the specific end point for look-back
27.8 periods in the MDS assessment process. This look-back period is also called the observation
27.9 or assessment period.

27.10 (b) "Case mix index" means the weighting factors assigned to the RUG-IV classifications.

27.11 (c) "Index maximization" means classifying a resident who could be assigned to more
27.12 than one category, to the category with the highest case mix index.

27.13 (d) "Minimum data set" or "MDS" means a core set of screening, clinical assessment,
27.14 and functional status elements, that include common definitions and coding categories
27.15 specified by the Centers for Medicare and Medicaid Services and designated by the
27.16 Minnesota Department of Health.

27.17 (e) "Representative" means a person who is the resident's guardian or conservator, the
27.18 person authorized to pay the nursing home expenses of the resident, a representative of the
27.19 Office of Ombudsman for Long-Term Care whose assistance has been requested, or any
27.20 other individual designated by the resident.

27.21 (f) "Resource utilization groups" or "RUG" means the system for grouping a nursing
27.22 facility's residents according to their clinical and functional status identified in data supplied
27.23 by the facility's minimum data set.

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

27.26 (h) "Nursing facility level of care determination" means the assessment process that
27.27 results in a determination of a resident's or prospective resident's need for nursing facility
27.28 level of care as established in subdivision 11 for purposes of medical assistance payment
27.29 of long-term care services for:

27.30 (1) nursing facility services under section 256B.434 or chapter 256R;

27.31 (2) elderly waiver services under ~~section 256B.0915~~ chapter 256S;

28.1 (3) CADI and BI waiver services under section 256B.49; and

28.2 (4) state payment of alternative care services under section 256B.0913.

28.3 **EFFECTIVE DATE.** This section is effective August 1, 2018.

28.4 Sec. 2. Minnesota Statutes 2016, section 144.0724, subdivision 11, is amended to read:

28.5 Subd. 11. **Nursing facility level of care.** (a) For purposes of medical assistance payment
28.6 of long-term care services, a recipient must be determined, using assessments defined in
28.7 subdivision 4, to meet one of the following nursing facility level of care criteria:

28.8 (1) the person requires formal clinical monitoring at least once per day;

28.9 (2) the person needs the assistance of another person or constant supervision to begin
28.10 and complete at least four of the following activities of living: bathing, bed mobility, dressing,
28.11 eating, grooming, toileting, transferring, and walking;

28.12 (3) the person needs the assistance of another person or constant supervision to begin
28.13 and complete toileting, transferring, or positioning and the assistance cannot be scheduled;

28.14 (4) the person has significant difficulty with memory, using information, daily decision
28.15 making, or behavioral needs that require intervention;

28.16 (5) the person has had a qualifying nursing facility stay of at least 90 days;

28.17 (6) the person meets the nursing facility level of care criteria determined 90 days after
28.18 admission or on the first quarterly assessment after admission, whichever is later; or

28.19 (7) the person is determined to be at risk for nursing facility admission or readmission
28.20 through a face-to-face long-term care consultation assessment as specified in section
28.21 256B.0911, subdivision 3a, 3b, or 4d, by a county, tribe, or managed care organization
28.22 under contract with the Department of Human Services. The person is considered at risk
28.23 under this clause if the person currently lives alone or will live alone or be homeless without
28.24 the person's current housing and also meets one of the following criteria:

28.25 (i) the person has experienced a fall resulting in a fracture;

28.26 (ii) the person has been determined to be at risk of maltreatment or neglect, including
28.27 self-neglect; or

28.28 (iii) the person has a sensory impairment that substantially impacts functional ability
28.29 and maintenance of a community residence.

28.30 (b) The assessment used to establish medical assistance payment for nursing facility
28.31 services must be the most recent assessment performed under subdivision 4, paragraph (b),

that occurred no more than 90 calendar days before the effective date of medical assistance eligibility for payment of long-term care services. In no case shall medical assistance payment for long-term care services occur prior to the date of the determination of nursing facility level of care.

(c) The assessment used to establish medical assistance payment for long-term care services provided under ~~sections 256B.0915~~ chapter 256S and section 256B.49 and alternative care payment for services provided under section 256B.0913 must be the most recent face-to-face assessment performed under section 256B.0911, subdivision 3a, 3b, or 4d, that occurred no more than 60 calendar days before the effective date of medical assistance eligibility for payment of long-term care services.

EFFECTIVE DATE. This section is effective August 1, 2018.

Sec. 3. Minnesota Statutes 2017 Supplement, section 144D.04, subdivision 2a, is amended to read:

Subd. 2a. **Additional contract requirements.** (a) For a resident receiving one or more health-related services from the establishment's arranged home care provider, as defined in section 144D.01, subdivision 6, the contract must include the requirements in paragraph (b). A restriction of a resident's rights under this subdivision is allowed only if determined necessary for health and safety reasons identified by the home care provider's registered nurse in an initial assessment or reassessment, as defined under section 144A.4791, subdivision 8, and documented in the written service plan under section 144A.4791, subdivision 9. Any restrictions of those rights for people served under ~~sections 256B.0915~~ chapter 256S and section 256B.49 must be documented in the resident's coordinated service and support plan (CSSP), as defined under sections ~~256B.0915, subdivision 6~~ and 256B.49, subdivision 15, and 256S.10.

(b) The contract must include a statement:

(1) regarding the ability of a resident to furnish and decorate the resident's unit within the terms of the lease;

(2) regarding the resident's right to access food at any time;

(3) regarding a resident's right to choose the resident's visitors and times of visits;

(4) regarding the resident's right to choose a roommate if sharing a unit; and

(5) notifying the resident of the resident's right to have and use a lockable door to the resident's unit. The landlord shall provide the locks on the unit. Only a staff member with

30.1 a specific need to enter the unit shall have keys, and advance notice must be given to the
30.2 resident before entrance, when possible.

30.3 **EFFECTIVE DATE.** This section is effective August 1, 2018.

30.4 Sec. 4. Minnesota Statutes 2016, section 144G.05, is amended to read:

30.5 **144G.05 REIMBURSEMENT UNDER ASSISTED LIVING SERVICE**
30.6 **PACKAGES.**

30.7 Notwithstanding the provisions of this chapter, the requirements for the elderly waiver
30.8 program's assisted living payment rates under ~~section 256B.0915, subdivision 3e,~~ sections
30.9 256S.201 and 256S.202 shall continue to be effective and providers who do not meet the
30.10 requirements of this chapter may continue to receive payment under ~~section 256B.0915,~~
30.11 ~~subdivision 3e~~ sections 256S.201 and 256S.202, as long as they continue to meet the
30.12 definitions and standards for assisted living and assisted living plus set forth in the federally
30.13 approved Elderly Home and Community Based Services Waiver Program (Control Number
30.14 0025.91). Providers of assisted living for the community access for disability inclusion
30.15 (CADI) and Brain Injury (BI) waivers shall continue to receive payment as long as they
30.16 continue to meet the definitions and standards for assisted living and assisted living plus
30.17 set forth in the federally approved CADI and BI waiver plans.

30.18 **EFFECTIVE DATE.** This section is effective August 1, 2018.

30.19 Sec. 5. Minnesota Statutes 2017 Supplement, section 245A.03, subdivision 7, is amended
30.20 to read:

30.21 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license
30.22 for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult
30.23 foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter
30.24 for a physical location that will not be the primary residence of the license holder for the
30.25 entire period of licensure. If a license is issued during this moratorium, and the license
30.26 holder changes the license holder's primary residence away from the physical location of
30.27 the foster care license, the commissioner shall revoke the license according to section
30.28 245A.07. The commissioner shall not issue an initial license for a community residential
30.29 setting licensed under chapter 245D. When approving an exception under this paragraph,
30.30 the commissioner shall consider the resource need determination process in paragraph (h),
30.31 the availability of foster care licensed beds in the geographic area in which the licensee
30.32 seeks to operate, the results of a person's choices during their annual assessment and service

31.1 plan review, and the recommendation of the local county board. The determination by the
31.2 commissioner is final and not subject to appeal. Exceptions to the moratorium include:

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

31.4 (2) foster care licenses replacing foster care licenses in existence on May 15, 2009, or
31.5 community residential setting licenses replacing adult foster care licenses in existence on
31.6 December 31, 2013, and determined to be needed by the commissioner under paragraph
31.7 (b);

31.8 (3) new foster care licenses or community residential setting licenses determined to be
31.9 needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD,
31.10 or regional treatment center; restructuring of state-operated services that limits the capacity
31.11 of state-operated facilities; or allowing movement to the community for people who no
31.12 longer require the level of care provided in state-operated facilities as provided under section
31.13 256B.092, subdivision 13, or 256B.49, subdivision 24;

31.14 (4) new foster care licenses or community residential setting licenses determined to be
31.15 needed by the commissioner under paragraph (b) for persons requiring hospital level care;

31.16 (5) new foster care licenses or community residential setting licenses determined to be
31.17 needed by the commissioner for the transition of people from personal care assistance to
31.18 the home and community-based services;

31.19 (6) new foster care licenses or community residential setting licenses determined to be
31.20 needed by the commissioner for the transition of people from the residential care waiver
31.21 services to foster care services. This exception applies only when:

31.22 (i) the person's case manager provided the person with information about the choice of
31.23 service, service provider, and location of service to help the person make an informed choice;
31.24 and

31.25 (ii) the person's foster care services are less than or equal to the cost of the person's
31.26 services delivered in the residential care waiver service setting as determined by the lead
31.27 agency; or

31.28 (7) new foster care licenses or community residential setting licenses for people receiving
31.29 services under chapter 245D and residing in an unlicensed setting before May 1, 2017, and
31.30 for which a license is required. This exception does not apply to people living in their own
31.31 home. For purposes of this clause, there is a presumption that a foster care or community
31.32 residential setting license is required for services provided to three or more people in a
31.33 dwelling unit when the setting is controlled by the provider. A license holder subject to this

32.1 exception may rebut the presumption that a license is required by seeking a reconsideration
32.2 of the commissioner's determination. The commissioner's disposition of a request for
32.3 reconsideration is final and not subject to appeal under chapter 14. The exception is available
32.4 until June 30, 2018. This exception is available when:

32.5 (i) the person's case manager provided the person with information about the choice of
32.6 service, service provider, and location of service, including in the person's home, to help
32.7 the person make an informed choice; and

32.8 (ii) the person's services provided in the licensed foster care or community residential
32.9 setting are less than or equal to the cost of the person's services delivered in the unlicensed
32.10 setting as determined by the lead agency.

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

32.17 (c) When an adult resident served by the program moves out of a foster home that is not
32.18 the primary residence of the license holder according to section 256B.49, subdivision 15,
32.19 paragraph (f), or the adult community residential setting, the county shall immediately
32.20 inform the Department of Human Services Licensing Division. The department may decrease
32.21 the statewide licensed capacity for adult foster care settings.

32.22 (d) Residential settings that would otherwise be subject to the decreased license capacity
32.23 established in paragraph (c) shall be exempt if the license holder's beds are occupied by
32.24 residents whose primary diagnosis is mental illness and the license holder is certified under
32.25 the requirements in subdivision 6a or section 245D.33.

32.26 (e) A resource need determination process, managed at the state level, using the available
32.27 reports required by section 144A.351, and other data and information shall be used to
32.28 determine where the reduced capacity determined under section 256B.493 will be
32.29 implemented. The commissioner shall consult with the stakeholders described in section
32.30 144A.351, and employ a variety of methods to improve the state's capacity to meet the
32.31 informed decisions of those people who want to move out of corporate foster care or
32.32 community residential settings, long-term service needs within budgetary limits, including
32.33 seeking proposals from service providers or lead agencies to change service type, capacity,
32.34 or location to improve services, increase the independence of residents, and better meet

33.1 needs identified by the long-term services and supports reports and statewide data and
33.2 information.

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

33.11 (g) License holders of foster care homes identified under paragraph (f) that are not the
33.12 primary residence of the license holder and that also provide services in the foster care home
33.13 that are covered by a federally approved home and community-based services waiver, as
33.14 authorized under chapter 256S or section ~~256B.0915~~, 256B.092, or 256B.49, must inform
33.15 the human services licensing division that the license holder provides or intends to provide
33.16 these waiver-funded services.

33.17 (h) The commissioner may adjust capacity to address needs identified in section
33.18 144A.351. Under this authority, the commissioner may approve new licensed settings or
33.19 delicense existing settings. Delicensing of settings will be accomplished through a process
33.20 identified in section 256B.493. Annually, by August 1, the commissioner shall provide
33.21 information and data on capacity of licensed long-term services and supports, actions taken
33.22 under the subdivision to manage statewide long-term services and supports resources, and
33.23 any recommendations for change to the legislative committees with jurisdiction over the
33.24 health and human services budget.

33.25 (i) The commissioner must notify a license holder when its corporate foster care or
33.26 community residential setting licensed beds are reduced under this section. The notice of
33.27 reduction of licensed beds must be in writing and delivered to the license holder by certified
33.28 mail or personal service. The notice must state why the licensed beds are reduced and must
33.29 inform the license holder of its right to request reconsideration by the commissioner. The
33.30 license holder's request for reconsideration must be in writing. If mailed, the request for
33.31 reconsideration must be postmarked and sent to the commissioner within 20 calendar days
33.32 after the license holder's receipt of the notice of reduction of licensed beds. If a request for
33.33 reconsideration is made by personal service, it must be received by the commissioner within
33.34 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

(j) The commissioner shall not issue an initial license for children's residential treatment services licensed under Minnesota Rules, parts 2960.0580 to 2960.0700, under this chapter for a program that Centers for Medicare and Medicaid Services would consider an institution for mental diseases. Facilities that serve only private pay clients are exempt from the moratorium described in this paragraph. The commissioner has the authority to manage existing statewide capacity for children's residential treatment services subject to the moratorium under this paragraph and may issue an initial license for such facilities if the initial license would not increase the statewide capacity for children's residential treatment services subject to the moratorium under this paragraph.

EFFECTIVE DATE. This section is effective August 1, 2018.

Sec. 6. Minnesota Statutes 2017 Supplement, section 245A.04, subdivision 14, is amended to read:

Subd. 14. **Policies and procedures for program administration required and enforceable.** (a) The license holder shall develop program policies and procedures necessary to maintain compliance with licensing requirements under Minnesota Statutes and Minnesota Rules.

(b) The license holder shall:

(1) provide training to program staff related to their duties in implementing the program's policies and procedures developed under paragraph (a);

(2) document the provision of this training; and

(3) monitor implementation of policies and procedures by program staff.

(c) The license holder shall keep program policies and procedures readily accessible to staff and index the policies and procedures with a table of contents or another method approved by the commissioner.

(d) An adult foster care license holder that provides foster care services to a resident under ~~section 256B.0915~~ chapter 256S must annually provide a copy of the resident termination policy under section 245A.11, subdivision 11, to a resident covered by the policy.

EFFECTIVE DATE. This section is effective August 1, 2018.

Sec. 7. Minnesota Statutes 2016, section 245A.11, subdivision 7a, is amended to read:

Subd. 7a. **Alternate overnight supervision technology; adult foster care and community residential setting licenses.** (a) The commissioner may grant an applicant or license holder an adult foster care or community residential setting license for a residence that does not have a caregiver in the residence during normal sleeping hours as required under Minnesota Rules, part 9555.5105, subpart 37, item B, or section 245D.02, subdivision 33b, but uses monitoring technology to alert the license holder when an incident occurs that may jeopardize the health, safety, or rights of a foster care recipient. The applicant or license holder must comply with all other requirements under Minnesota Rules, parts 9555.5105 to 9555.6265, or applicable requirements under chapter 245D, and the requirements under this subdivision. The license printed by the commissioner must state in bold and large font:

(1) that the facility is under electronic monitoring; and

(2) the telephone number of the county's common entry point for making reports of suspected maltreatment of vulnerable adults under section 626.557, subdivision 9.

(b) Applications for a license under this section must be submitted directly to the Department of Human Services licensing division. The licensing division must immediately notify the county licensing agency. The licensing division must collaborate with the county licensing agency in the review of the application and the licensing of the program.

(c) Before a license is issued by the commissioner, and for the duration of the license, the applicant or license holder must establish, maintain, and document the implementation of written policies and procedures addressing the requirements in paragraphs (d) through (f).

(d) The applicant or license holder must have policies and procedures that:

(1) establish characteristics of target populations that will be admitted into the home, and characteristics of populations that will not be accepted into the home;

(2) explain the discharge process when a resident served by the program requires overnight supervision or other services that cannot be provided by the license holder due to the limited hours that the license holder is on site;

(3) describe the types of events to which the program will respond with a physical presence when those events occur in the home during time when staff are not on site, and how the license holder's response plan meets the requirements in paragraph (e), clause (1) or (2);

(4) establish a process for documenting a review of the implementation and effectiveness of the response protocol for the response required under paragraph (e), clause (1) or (2).

The documentation must include:

(i) a description of the triggering incident;

(ii) the date and time of the triggering incident;

(iii) the time of the response or responses under paragraph (e), clause (1) or (2);

(iv) whether the response met the resident's needs;

(v) whether the existing policies and response protocols were followed; and

(vi) whether the existing policies and protocols are adequate or need modification.

When no physical presence response is completed for a three-month period, the license holder's written policies and procedures must require a physical presence response drill to be conducted for which the effectiveness of the response protocol under paragraph (e), clause (1) or (2), will be reviewed and documented as required under this clause; and

(5) establish that emergency and nonemergency phone numbers are posted in a prominent location in a common area of the home where they can be easily observed by a person responding to an incident who is not otherwise affiliated with the home.

(e) The license holder must document and include in the license application which response alternative under clause (1) or (2) is in place for responding to situations that present a serious risk to the health, safety, or rights of residents served by the program:

(1) response alternative (1) requires only the technology to provide an electronic notification or alert to the license holder that an event is underway that requires a response. Under this alternative, no more than ten minutes will pass before the license holder will be physically present on site to respond to the situation; or

(2) response alternative (2) requires the electronic notification and alert system under alternative (1), but more than ten minutes may pass before the license holder is present on site to respond to the situation. Under alternative (2), all of the following conditions are met:

(i) the license holder has a written description of the interactive technological applications that will assist the license holder in communicating with and assessing the needs related to the care, health, and safety of the foster care recipients. This interactive technology must permit the license holder to remotely assess the well being of the resident served by the

37.1 program without requiring the initiation of the foster care recipient. Requiring the foster
37.2 care recipient to initiate a telephone call does not meet this requirement;

37.3 (ii) the license holder documents how the remote license holder is qualified and capable
37.4 of meeting the needs of the foster care recipients and assessing foster care recipients' needs
37.5 under item (i) during the absence of the license holder on site;

37.6 (iii) the license holder maintains written procedures to dispatch emergency response
37.7 personnel to the site in the event of an identified emergency; and

37.8 (iv) each resident's individualized plan of care, coordinated service and support plan
37.9 under sections 256B.0913, subdivision 8; ~~256B.0915, subdivision 6~~; 256B.092, subdivision
37.10 1b; ~~and~~ 256B.49, subdivision 15; and 256S.10, if required, or individual resident placement
37.11 agreement under Minnesota Rules, part 9555.5105, subpart 19, if required, identifies the
37.12 maximum response time, which may be greater than ten minutes, for the license holder to
37.13 be on site for that resident.

37.14 (f) Each resident's placement agreement, individual service agreement, and plan must
37.15 clearly state that the adult foster care or community residential setting license category is
37.16 a program without the presence of a caregiver in the residence during normal sleeping hours;
37.17 the protocols in place for responding to situations that present a serious risk to the health,
37.18 safety, or rights of residents served by the program under paragraph (e), clause (1) or (2);
37.19 and a signed informed consent from each resident served by the program or the person's
37.20 legal representative documenting the person's or legal representative's agreement with
37.21 placement in the program. If electronic monitoring technology is used in the home, the
37.22 informed consent form must also explain the following:

37.23 (1) how any electronic monitoring is incorporated into the alternative supervision system;

37.24 (2) the backup system for any electronic monitoring in times of electrical outages or
37.25 other equipment malfunctions;

37.26 (3) how the caregivers or direct support staff are trained on the use of the technology;

37.27 (4) the event types and license holder response times established under paragraph (e);

37.28 (5) how the license holder protects each resident's privacy related to electronic monitoring
37.29 and related to any electronically recorded data generated by the monitoring system. A
37.30 resident served by the program may not be removed from a program under this subdivision
37.31 for failure to consent to electronic monitoring. The consent form must explain where and
37.32 how the electronically recorded data is stored, with whom it will be shared, and how long
37.33 it is retained; and

38.1 (6) the risks and benefits of the alternative overnight supervision system.

38.2 The written explanations under clauses (1) to (6) may be accomplished through
38.3 cross-references to other policies and procedures as long as they are explained to the person
38.4 giving consent, and the person giving consent is offered a copy.

38.5 (g) Nothing in this section requires the applicant or license holder to develop or maintain
38.6 separate or duplicative policies, procedures, documentation, consent forms, or individual
38.7 plans that may be required for other licensing standards, if the requirements of this section
38.8 are incorporated into those documents.

38.9 (h) The commissioner may grant variances to the requirements of this section according
38.10 to section 245A.04, subdivision 9.

38.11 (i) For the purposes of paragraphs (d) through (h), "license holder" has the meaning
38.12 under section 245A.2, subdivision 9, and additionally includes all staff, volunteers, and
38.13 contractors affiliated with the license holder.

38.14 (j) For the purposes of paragraph (e), the terms "assess" and "assessing" mean to remotely
38.15 determine what action the license holder needs to take to protect the well-being of the foster
38.16 care recipient.

38.17 (k) The commissioner shall evaluate license applications using the requirements in
38.18 paragraphs (d) to (f). The commissioner shall provide detailed application forms, including
38.19 a checklist of criteria needed for approval.

38.20 (l) To be eligible for a license under paragraph (a), the adult foster care or community
38.21 residential setting license holder must not have had a conditional license issued under section
38.22 245A.06 or any licensing sanction under section 245A.07 during the prior 24 months based
38.23 on failure to provide adequate supervision, health care services, or resident safety in the
38.24 adult foster care home or community residential setting.

38.25 (m) The commissioner shall review an application for an alternative overnight supervision
38.26 license within 60 days of receipt of the application. When the commissioner receives an
38.27 application that is incomplete because the applicant failed to submit required documents or
38.28 that is substantially deficient because the documents submitted do not meet licensing
38.29 requirements, the commissioner shall provide the applicant written notice that the application
38.30 is incomplete or substantially deficient. In the written notice to the applicant, the
38.31 commissioner shall identify documents that are missing or deficient and give the applicant
38.32 45 days to resubmit a second application that is substantially complete. An applicant's failure
38.33 to submit a substantially complete application after receiving notice from the commissioner

39.1 is a basis for license denial under section 245A.05. The commissioner shall complete
39.2 subsequent review within 30 days.

39.3 (n) Once the application is considered complete under paragraph (m), the commissioner
39.4 will approve or deny an application for an alternative overnight supervision license within
39.5 60 days.

39.6 (o) For the purposes of this subdivision, "supervision" means:

39.7 (1) oversight by a caregiver or direct support staff as specified in the individual resident's
39.8 place agreement or coordinated service and support plan and awareness of the resident's
39.9 needs and activities; and

39.10 (2) the presence of a caregiver or direct support staff in a residence during normal sleeping
39.11 hours, unless a determination has been made and documented in the individual's coordinated
39.12 service and support plan that the individual does not require the presence of a caregiver or
39.13 direct support staff during normal sleeping hours.

39.14 **EFFECTIVE DATE.** This section is effective August 1, 2018.

39.15 Sec. 8. Minnesota Statutes 2017 Supplement, section 245A.11, subdivision 9, is amended
39.16 to read:

39.17 Subd. 9. **Adult foster care bedrooms.** (a) A resident receiving services must have a
39.18 choice of roommate. Each roommate must consent in writing to sharing a bedroom with
39.19 one another. The license holder is responsible for notifying a resident of the resident's right
39.20 to request a change of roommate.

39.21 (b) The license holder must provide a lock for each resident's bedroom door, unless
39.22 otherwise indicated for the resident's health, safety, or well-being. A restriction on the use
39.23 of the lock must be documented and justified in the resident's individual abuse prevention
39.24 plan required by sections 245A.65, subdivision 2, paragraph (b), and 626.557, subdivision
39.25 14. For a resident served under ~~section 256B.0915~~ chapter 256S, the case manager must be
39.26 part of the interdisciplinary team under section 245A.65, subdivision 2, paragraph (b).

39.27 **EFFECTIVE DATE.** This section is effective August 1, 2018.

39.28 Sec. 9. Minnesota Statutes 2017 Supplement, section 245A.11, subdivision 10, is amended
39.29 to read:

39.30 Subd. 10. **Adult foster care resident rights.** (a) The license holder shall ensure that a
39.31 resident and a resident's legal representative are given, at admission:

- 40.1 (1) an explanation and copy of the resident's rights specified in paragraph (b);
- 40.2 (2) a written summary of the Vulnerable Adults Protection Act prepared by the
- 40.3 department; and
- 40.4 (3) the name, address, and telephone number of the local agency to which a resident or
- 40.5 a resident's legal representative may submit an oral or written complaint.
- 40.6 (b) Adult foster care resident rights include the right to:
- 40.7 (1) have daily, private access to and use of a non-coin-operated telephone for local and
- 40.8 long-distance telephone calls made collect or paid for by the resident;
- 40.9 (2) receive and send, without interference, uncensored, unopened mail or electronic
- 40.10 correspondence or communication;
- 40.11 (3) have use of and free access to common areas in the residence and the freedom to
- 40.12 come and go from the residence at will;
- 40.13 (4) have privacy for visits with the resident's spouse, next of kin, legal counsel, religious
- 40.14 adviser, or others, according to section 363A.09 of the Human Rights Act, including privacy
- 40.15 in the resident's bedroom;
- 40.16 (5) keep, use, and access the resident's personal clothing and possessions as space permits,
- 40.17 unless this right infringes on the health, safety, or rights of another resident or household
- 40.18 member, including the right to access the resident's personal possessions at any time;
- 40.19 (6) choose the resident's visitors and time of visits and participate in activities of
- 40.20 commercial, religious, political, and community groups without interference if the activities
- 40.21 do not infringe on the rights of another resident or household member;
- 40.22 (7) if married, privacy for visits by the resident's spouse, and, if both spouses are residents
- 40.23 of the adult foster home, the residents have the right to share a bedroom and bed;
- 40.24 (8) privacy, including use of the lock on the resident's bedroom door or unit door. A
- 40.25 resident's privacy must be respected by license holders, caregivers, household members,
- 40.26 and volunteers by knocking on the door of a resident's bedroom or bathroom and seeking
- 40.27 consent before entering, except in an emergency;
- 40.28 (9) furnish and decorate the resident's bedroom or living unit;
- 40.29 (10) engage in chosen activities and have an individual schedule supported by the license
- 40.30 holder that meets the resident's preferences;
- 40.31 (11) freedom and support to access food at any time;

41.1 (12) have personal, financial, service, health, and medical information kept private, and
41.2 be advised of disclosure of this information by the license holder;

41.3 (13) access records and recorded information about the resident according to applicable
41.4 state and federal law, regulation, or rule;

41.5 (14) be free from maltreatment;

41.6 (15) be treated with courtesy and respect and receive respectful treatment of the resident's
41.7 property;

41.8 (16) reasonable observance of cultural and ethnic practice and religion;

41.9 (17) be free from bias and harassment regarding race, gender, age, disability, spirituality,
41.10 and sexual orientation;

41.11 (18) be informed of and use the license holder's grievance policy and procedures,
41.12 including how to contact the highest level of authority in the program;

41.13 (19) assert the resident's rights personally, or have the rights asserted by the resident's
41.14 family, authorized representative, or legal representative, without retaliation; and

41.15 (20) give or withhold written informed consent to participate in any research or
41.16 experimental treatment.

41.17 (c) A restriction of a resident's rights under paragraph (b), clauses (1) to (4), (6), (8),
41.18 (10), and (11), is allowed only if determined necessary to ensure the health, safety, and
41.19 well-being of the resident. Any restriction of a resident's right must be documented and
41.20 justified in the resident's individual abuse prevention plan required by sections 245A.65,
41.21 subdivision 2, paragraph (b) and 626.557, subdivision 14. For a resident served under ~~section~~
41.22 ~~256B.0915~~ chapter 256S, the case manager must be part of the interdisciplinary team under
41.23 section 245A.65, subdivision 2, paragraph (b). The restriction must be implemented in the
41.24 least restrictive manner necessary to protect the resident and provide support to reduce or
41.25 eliminate the need for the restriction.

41.26 **EFFECTIVE DATE.** This section is effective August 1, 2018.

41.27 Sec. 10. Minnesota Statutes 2017 Supplement, section 245A.11, subdivision 11, is amended
41.28 to read:

41.29 Subd. 11. **Adult foster care service termination for elderly waiver participants.** (a)
41.30 This subdivision applies to foster care services for a resident served under ~~section 256B.0915~~
41.31 chapter 256S.

42.1 (b) The foster care license holder must establish policies and procedures for service
42.2 termination that promote continuity of care and service coordination with the resident and
42.3 the case manager and with another licensed caregiver, if any, who also provides support to
42.4 the resident. The policy must include the requirements specified in paragraphs (c) to (h).

42.5 (c) The license holder must allow a resident to remain in the program and cannot terminate
42.6 services unless:

42.7 (1) the termination is necessary for the resident's health, safety, and well-being and the
42.8 resident's needs cannot be met in the facility;

42.9 (2) the safety of the resident or another resident in the program is endangered and positive
42.10 support strategies were attempted and have not achieved and effectively maintained safety
42.11 for the resident or another resident in the program;

42.12 (3) the health, safety, and well-being of the resident or another resident in the program
42.13 would otherwise be endangered;

42.14 (4) the program was not paid for services;

42.15 (5) the program ceases to operate; or

42.16 (6) the resident was terminated by the lead agency from waiver eligibility.

42.17 (d) Before giving notice of service termination, the license holder must document the
42.18 action taken to minimize or eliminate the need for termination. The action taken by the
42.19 license holder must include, at a minimum:

42.20 (1) consultation with the resident's interdisciplinary team to identify and resolve issues
42.21 leading to a notice of service termination; and

42.22 (2) a request to the case manager or other professional consultation or intervention
42.23 services to support the resident in the program. This requirement does not apply to a notice
42.24 of service termination issued under paragraph (c), clause (4) or (5).

42.25 (e) If, based on the best interests of the resident, the circumstances at the time of notice
42.26 were such that the license holder was unable to take the action specified in paragraph (d),
42.27 the license holder must document the specific circumstances and the reason the license
42.28 holder was unable to take the action.

42.29 (f) The license holder must notify the resident or the resident's legal representative and
42.30 the case manager in writing of the intended service termination. The notice must include:

42.31 (1) the reason for the action;

(2) except for service termination under paragraph (c), clause (4) or (5), a summary of the action taken to minimize or eliminate the need for termination and the reason the action failed to prevent the termination;

(3) the resident's right to appeal the service termination under section 256.045, subdivision 3, paragraph (a); and

(4) the resident's right to seek a temporary order staying the service termination according to the procedures in section 256.045, subdivision 4a, or subdivision 6, paragraph (c).

(g) Notice of the proposed service termination must be given at least 30 days before terminating a resident's service.

(h) After the resident receives the notice of service termination and before the services are terminated, the license holder must:

(1) work with the support team or expanded support team to develop reasonable alternatives to support continuity of care and to protect the resident;

(2) provide information requested by the resident or case manager; and

(3) maintain information about the service termination, including the written notice of service termination, in the resident's record.

EFFECTIVE DATE. This section is effective August 1, 2018.

Sec. 11. Minnesota Statutes 2016, section 245D.02, subdivision 3, is amended to read:

Subd. 3. **Case manager.** "Case manager" means the individual designated to provide waiver case management services, care coordination, or long-term care consultation, as specified in chapter 256S and sections 256B.0913, ~~256B.0915~~, 256B.092, and 256B.49, or successor provisions. For purposes of this chapter, "case manager" includes case management services as defined in Minnesota Rules, part 9520.0902, subpart 3.

EFFECTIVE DATE. This section is effective August 1, 2018.

Sec. 12. Minnesota Statutes 2016, section 245D.02, subdivision 4b, is amended to read:

Subd. 4b. **Coordinated service and support plan.** "Coordinated service and support plan" has the meaning given in sections 256B.0913, subdivision 8; ~~256B.0915, subdivision 6;~~ 256B.092, subdivision 1b; ~~and~~ 256B.49, subdivision 15; and 256S.10, or successor provisions. For purposes of this chapter, "coordinated service and support plan" includes the individual program plan or individual treatment plan as defined in Minnesota Rules, part 9520.0510, subpart 12.

44.1 **EFFECTIVE DATE.** This section is effective August 1, 2018.

44.2 Sec. 13. Minnesota Statutes 2016, section 245D.02, subdivision 10, is amended to read:

44.3 Subd. 10. **Home and community-based services.** "Home and community-based services"
44.4 means the services identified in section 245D.03, subdivision 1, and as defined in:

44.5 (1) the federally approved waiver plans governed by United States Code, title 42, sections
44.6 1396 et seq., including the waivers for persons with disabilities under section 256B.49,
44.7 subdivision 11, including the brain injury (BI) waiver plan; the community alternative care
44.8 (CAC) waiver plan; the community access for disability inclusion (CADI) waiver plan; the
44.9 developmental disability (DD) waiver plan under section 256B.092, subdivision 5; the
44.10 elderly waiver (EW) plan under section ~~256B.0915~~ 256S.01, subdivision 1; or successor
44.11 plans respective to each waiver; or

44.12 (2) the alternative care (AC) program under section 256B.0913.

44.13 **EFFECTIVE DATE.** This section is effective August 1, 2018.

44.14 Sec. 14. Minnesota Statutes 2017 Supplement, section 245D.03, subdivision 1, is amended
44.15 to read:

44.16 Subdivision 1. **Applicability.** (a) The commissioner shall regulate the provision of home
44.17 and community-based services to persons with disabilities and persons age 65 and older
44.18 pursuant to this chapter. The licensing standards in this chapter govern the provision of
44.19 basic support services and intensive support services.

44.20 (b) Basic support services provide the level of assistance, supervision, and care that is
44.21 necessary to ensure the health and welfare of the person and do not include services that
44.22 are specifically directed toward the training, treatment, habilitation, or rehabilitation of the
44.23 person. Basic support services include:

44.24 (1) in-home and out-of-home respite care services as defined in section 245A.02,
44.25 subdivision 15, and under the brain injury, community alternative care, community access
44.26 for disability inclusion, developmental disability, and elderly waiver plans, excluding
44.27 out-of-home respite care provided to children in a family child foster care home licensed
44.28 under Minnesota Rules, parts 2960.3000 to 2960.3100, when the child foster care license
44.29 holder complies with the requirements under section 245D.06, subdivisions 5, 6, 7, and 8,
44.30 or successor provisions; and section 245D.061 or successor provisions, which must be
44.31 stipulated in the statement of intended use required under Minnesota Rules, part 2960.3000,
44.32 subpart 4;

(2) adult companion services as defined under the brain injury, community access for disability inclusion, and elderly waiver plans, excluding adult companion services provided under the Corporation for National and Community Services Senior Companion Program established under the Domestic Volunteer Service Act of 1973, Public Law 98-288;

(3) personal support as defined under the developmental disability waiver plan;

(4) 24-hour emergency assistance, personal emergency response as defined under the community access for disability inclusion and developmental disability waiver plans;

(5) night supervision services as defined under the brain injury waiver plan;

(6) homemaker services as defined under the community access for disability inclusion, brain injury, community alternative care, developmental disability, and elderly waiver plans, excluding providers licensed by the Department of Health under chapter 144A and those providers providing cleaning services only; and

(7) individual community living support under section ~~256B.0915, subdivision 3~~ 256S.13.

(c) Intensive support services provide assistance, supervision, and care that is necessary to ensure the health and welfare of the person and services specifically directed toward the training, habilitation, or rehabilitation of the person. Intensive support services include:

(1) intervention services, including:

(i) behavioral support services as defined under the brain injury and community access for disability inclusion waiver plans;

(ii) in-home or out-of-home crisis respite services as defined under the developmental disability waiver plan; and

(iii) specialist services as defined under the current developmental disability waiver plan;

(2) in-home support services, including:

(i) in-home family support and supported living services as defined under the developmental disability waiver plan;

(ii) independent living services training as defined under the brain injury and community access for disability inclusion waiver plans;

(iii) semi-independent living services; and

(iv) individualized home supports services as defined under the brain injury, community alternative care, and community access for disability inclusion waiver plans;

46.1 (3) residential supports and services, including:

46.2 (i) supported living services as defined under the developmental disability waiver plan
46.3 provided in a family or corporate child foster care residence, a family adult foster care
46.4 residence, a community residential setting, or a supervised living facility;

46.5 (ii) foster care services as defined in the brain injury, community alternative care, and
46.6 community access for disability inclusion waiver plans provided in a family or corporate
46.7 child foster care residence, a family adult foster care residence, or a community residential
46.8 setting; and

46.9 (iii) residential services provided to more than four persons with developmental
46.10 disabilities in a supervised living facility, including ICFs/DD;

46.11 (4) day services, including:

46.12 (i) structured day services as defined under the brain injury waiver plan;

46.13 (ii) day training and habilitation services under sections 252.41 to 252.46, and as defined
46.14 under the developmental disability waiver plan; and

46.15 (iii) prevocational services as defined under the brain injury and community access for
46.16 disability inclusion waiver plans; and

46.17 (5) employment exploration services as defined under the brain injury, community
46.18 alternative care, community access for disability inclusion, and developmental disability
46.19 waiver plans;

46.20 (6) employment development services as defined under the brain injury, community
46.21 alternative care, community access for disability inclusion, and developmental disability
46.22 waiver plans; and

46.23 (7) employment support services as defined under the brain injury, community alternative
46.24 care, community access for disability inclusion, and developmental disability waiver plans.

46.25 **EFFECTIVE DATE.** This section is effective August 1, 2018.

46.26 Sec. 15. Minnesota Statutes 2016, section 256B.038, is amended to read:

46.27 **256B.038 PROVIDER RATE INCREASES AFTER JUNE 30, 1999.**

46.28 (a) For fiscal years beginning on or after July 1, 1999, the commissioner of management
46.29 and budget shall include an annual inflationary adjustment in payment rates for the services
46.30 listed in paragraph (b) as a budget change request in each biennial detailed expenditure
46.31 budget submitted to the legislature under section 16A.11. The adjustment shall be

accomplished by indexing the rates in effect for inflation based on the change in the Consumer Price Index-All Items (United States city average)(CPI-U) as forecasted by Data Resources, Inc., in the fourth quarter of the prior year for the calendar year during which the rate increase occurs.

(b) Within the limits of appropriations specifically for this purpose, the commissioner shall apply the rate increases in paragraph (a) to 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~~ chapter 256S; waived services under community access for disability inclusion under section 256B.49; community alternative care waived services under section 256B.49; 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; home care nursing services under section 256B.0625, subdivision 7; day training and habilitation services for adults with developmental disabilities under sections 252.41 to 252.46; physical therapy services under section 256B.0625, subdivision 8; occupational therapy services under section 256B.0625, subdivision 8a; speech-language therapy services under Minnesota Rules, part 9505.0390; respiratory therapy services under Minnesota Rules, part 9505.0295; physician services under section 256B.0625, subdivision 3; dental services under section 256B.0625, subdivision 9; alternative care services under section 256B.0913; adult residential program grants under section 245.73; adult and family community support grants under Minnesota Rules, parts 9535.1700 to 9535.1760; and semi-independent living services under section 252.275, including SILS funding under county social services grants formerly funded under chapter 256I.

(c) The commissioner shall increase prepaid medical assistance program capitation rates as appropriate to reflect the rate increases in this section.

(d) In implementing this section, the commissioner shall consider proposing a schedule to equalize rates paid by different programs for the same service.

EFFECTIVE DATE. This section is effective August 1, 2018.

Sec. 16. Minnesota Statutes 2017 Supplement, section 256B.051, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** An individual with a disability is eligible for housing support services if the individual:

- 48.1 (1) is 18 years of age or older;
- 48.2 (2) is enrolled in medical assistance;
- 48.3 (3) has an assessment of functional need that determines a need for services due to
- 48.4 limitations caused by the individual's disability;
- 48.5 (4) resides in or plans to transition to a community-based setting as defined in Code of
- 48.6 Federal Regulations, title 42, section 441.301 (c); and
- 48.7 (5) has housing instability evidenced by:
- 48.8 (i) being homeless or at-risk of homelessness;
- 48.9 (ii) being in the process of transitioning from, or having transitioned in the past six
- 48.10 months from, an institution or licensed or registered setting;
- 48.11 (iii) being eligible for waiver services under ~~section 256B.0915~~, chapter 256S, or section
- 48.12 256B.092; or 256B.49; or
- 48.13 (iv) having been identified by a long-term care consultation under section 256B.0911
- 48.14 as at risk of institutionalization.

48.15 **EFFECTIVE DATE.** This section is effective August 1, 2018.

48.16 Sec. 17. Minnesota Statutes 2016, section 256B.059, subdivision 1, is amended to read:

48.17 Subdivision 1. **Definitions.** (a) For purposes of this section and sections 256B.058 and

48.18 256B.0595, the terms defined in this subdivision have the meanings given them.

48.19 (b) "Community spouse" means the spouse of an institutionalized spouse.

48.20 (c) "Assets otherwise available to the community spouse" means assets individually or

48.21 jointly owned by the community spouse, other than assets excluded by subdivision 5,

48.22 paragraph (c).

48.23 (d) "Community spouse asset allowance" is the value of assets that can be transferred

48.24 under subdivision 3.

48.25 (e) "Institutionalized spouse" means a person who is:

48.26 (1) in a hospital, nursing facility, or intermediate care facility for persons with

48.27 developmental disabilities, or receiving home and community-based services under ~~section~~

48.28 ~~256B.0915~~ chapter 256S, and is expected to remain in the facility or institution or receive

48.29 the home and community-based services for at least 30 consecutive days; and

(2) married to a person who is not in a hospital, nursing facility, or intermediate care facility for persons with developmental disabilities, and is not receiving home and community-based services under ~~section 256B.0915~~, chapter 256S or section 256B.092; or 256B.49.

(f) "For the sole benefit of" means no other individual or entity can benefit in any way from the assets or income at the time of a transfer or at any time in the future.

(g) "Continuous period of institutionalization" means a 30-consecutive-day period of time in which a person is expected to stay in a medical or long-term care facility, or receive home and community-based services that would qualify for coverage under the elderly waiver (EW) or alternative care (AC) programs. For a stay in a facility, the 30-consecutive-day period begins on the date of entry into a medical or long-term care facility. For receipt of home and community-based services, the 30-consecutive-day period begins on the date that the following conditions are met:

(1) the person is receiving services that meet the nursing facility level of care determined by a long-term care consultation;

(2) the person has received the long-term care consultation within the past 60 days;

(3) the services are paid by the EW program under ~~section 256B.0915~~ chapter 256S or the AC program under section 256B.0913 or would qualify for payment under the EW or AC programs if the person were otherwise eligible for either program, and but for the receipt of such services the person would have resided in a nursing facility; and

(4) the services are provided by a licensed provider qualified to provide home and community-based services.

EFFECTIVE DATE. This section is effective August 1, 2018.

Sec. 18. Minnesota Statutes 2016, section 256B.0595, subdivision 1, is amended to read:

Subdivision 1. **Prohibited transfers.** (a) Effective for transfers made after August 10, 1993, an institutionalized person, an institutionalized person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the institutionalized person or institutionalized person's spouse, may not give away, sell, or dispose of, for less than fair market value, any asset or interest therein, except assets other than the homestead that are excluded under the Supplemental Security Income program, for the purpose of establishing or maintaining medical assistance eligibility. This applies to all transfers, including those made by a community spouse after the month in which the institutionalized spouse is determined eligible for medical assistance.

For purposes of determining eligibility for long-term care services, any transfer of such assets within 36 months before or any time after an institutionalized person requests medical assistance payment of long-term care services, or 36 months before or any time after a medical assistance recipient becomes an institutionalized person, for less than fair market value may be considered. Any such transfer is presumed to have been made for the purpose of establishing or maintaining medical assistance eligibility and the institutionalized person is ineligible for long-term care services for the period of time determined under subdivision 2, unless the institutionalized person furnishes convincing evidence to establish that the transaction was exclusively for another purpose, or unless the transfer is permitted under subdivision 3 or 4. In the case of payments from a trust or portions of a trust that are considered transfers of assets under federal law, or in the case of any other disposal of assets made on or after February 8, 2006, any transfers made within 60 months before or any time after an institutionalized person requests medical assistance payment of long-term care services and within 60 months before or any time after a medical assistance recipient becomes an institutionalized person, may be considered.

(b) This section applies to transfers, for less than fair market value, of income or assets, including assets that are considered income in the month received, such as inheritances, court settlements, and retroactive benefit payments or income to which the institutionalized person or the institutionalized person's spouse is entitled but does not receive due to action by the institutionalized person, the institutionalized person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the institutionalized person or the institutionalized person's spouse.

(c) This section applies to payments for care or personal services provided by a relative, unless the compensation was stipulated in a notarized, written agreement which was in existence when the service was performed, the care or services directly benefited the person, and the payments made represented reasonable compensation for the care or services provided. A notarized written agreement is not required if payment for the services was made within 60 days after the service was provided.

(d) This section applies to the portion of any asset or interest that an institutionalized person, an institutionalized person's spouse, or any person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the institutionalized person or the institutionalized person's spouse, transfers to any annuity that exceeds the value of the benefit likely to be returned to the institutionalized person or institutionalized person's spouse while alive, based on estimated life expectancy as determined according to the current actuarial tables published by the Office of the Chief

51.1 Actuary of the Social Security Administration. The commissioner may adopt rules reducing
51.2 life expectancies based on the need for long-term care. This section applies to an annuity
51.3 purchased on or after March 1, 2002, that:

51.4 (1) is not purchased from an insurance company or financial institution that is subject
51.5 to licensing or regulation by the Minnesota Department of Commerce or a similar regulatory
51.6 agency of another state;

51.7 (2) does not pay out principal and interest in equal monthly installments; or

51.8 (3) does not begin payment at the earliest possible date after annuitization.

51.9 (e) Effective for transactions, including the purchase of an annuity, occurring on or after
51.10 February 8, 2006, by or on behalf of an institutionalized person who has applied for or is
51.11 receiving long-term care services or the institutionalized person's spouse shall be treated as
51.12 the disposal of an asset for less than fair market value unless the department is named a
51.13 preferred remainder beneficiary as described in section 256B.056, subdivision 11. Any
51.14 subsequent change to the designation of the department as a preferred remainder beneficiary
51.15 shall result in the annuity being treated as a disposal of assets for less than fair market value.
51.16 The amount of such transfer shall be the maximum amount the institutionalized person or
51.17 the institutionalized person's spouse could receive from the annuity or similar financial
51.18 instrument. Any change in the amount of the income or principal being withdrawn from the
51.19 annuity or other similar financial instrument at the time of the most recent disclosure shall
51.20 be deemed to be a transfer of assets for less than fair market value unless the institutionalized
51.21 person or the institutionalized person's spouse demonstrates that the transaction was for fair
51.22 market value. In the event a distribution of income or principal has been improperly
51.23 distributed or disbursed from an annuity or other retirement planning instrument of an
51.24 institutionalized person or the institutionalized person's spouse, a cause of action exists
51.25 against the individual receiving the improper distribution for the cost of medical assistance
51.26 services provided or the amount of the improper distribution, whichever is less.

51.27 (f) Effective for transactions, including the purchase of an annuity, occurring on or after
51.28 February 8, 2006, by or on behalf of an institutionalized person applying for or receiving
51.29 long-term care services shall be treated as a disposal of assets for less than fair market value
51.30 unless it is:

51.31 (1) an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue
51.32 Code of 1986; or

51.33 (2) purchased with proceeds from:

52.1 (A) an account or trust described in subsection (a), (c), or (p) of section 408 of the Internal
52.2 Revenue Code;

52.3 (B) a simplified employee pension within the meaning of section 408(k) of the Internal
52.4 Revenue Code; or

52.5 (C) a Roth IRA described in section 408A of the Internal Revenue Code; or

52.6 (3) an annuity that is irrevocable and nonassignable; is actuarially sound as determined
52.7 in accordance with actuarial publications of the Office of the Chief Actuary of the Social
52.8 Security Administration; and provides for payments in equal amounts during the term of
52.9 the annuity, with no deferral and no balloon payments made.

52.10 (g) For purposes of this section, long-term care services include services in a nursing
52.11 facility, services that are eligible for payment according to section 256B.0625, subdivision
52.12 2, because they are provided in a swing bed, intermediate care facility for persons with
52.13 developmental disabilities, and home and community-based services provided pursuant to
52.14 ~~sections 256B.0915, chapter 256S and sections 256B.092, and 256B.49.~~ For purposes of
52.15 this subdivision and subdivisions 2, 3, and 4, "institutionalized person" includes a person
52.16 who is an inpatient in a nursing facility or in a swing bed, or intermediate care facility for
52.17 persons with developmental disabilities or who is receiving home and community-based
52.18 services under ~~sections 256B.0915, chapter 256S and sections 256B.092, and 256B.49.~~

52.19 (h) This section applies to funds used to purchase a promissory note, loan, or mortgage
52.20 unless the note, loan, or mortgage:

52.21 (1) has a repayment term that is actuarially sound;

52.22 (2) provides for payments to be made in equal amounts during the term of the loan, with
52.23 no deferral and no balloon payments made; and

52.24 (3) prohibits the cancellation of the balance upon the death of the lender.

52.25 In the case of a promissory note, loan, or mortgage that does not meet an exception in
52.26 clauses (1) to (3), the value of such note, loan, or mortgage shall be the outstanding balance
52.27 due as of the date of the institutionalized person's request for medical assistance payment
52.28 of long-term care services.

52.29 (i) This section applies to the purchase of a life estate interest in another person's home
52.30 unless the purchaser resides in the home for a period of at least one year after the date of
52.31 purchase.

53.1 (j) This section applies to transfers into a pooled trust that qualifies under United States
53.2 Code, title 42, section 1396p(d)(4)(C), by:

53.3 (1) a person age 65 or older or the person's spouse; or

53.4 (2) any person, court, or administrative body with legal authority to act in place of, on
53.5 behalf of, at the direction of, or upon the request of a person age 65 or older or the person's
53.6 spouse.

53.7 **EFFECTIVE DATE.** This section is effective August 1, 2018.

53.8 Sec. 19. Minnesota Statutes 2016, section 256B.06, subdivision 4, is amended to read:

53.9 Subd. 4. **Citizenship requirements.** (a) Eligibility for medical assistance is limited to
53.10 citizens of the United States, qualified noncitizens as defined in this subdivision, and other
53.11 persons residing lawfully in the United States. Citizens or nationals of the United States
53.12 must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality
53.13 according to the requirements of the federal Deficit Reduction Act of 2005, Public Law
53.14 109-171.

53.15 (b) "Qualified noncitizen" means a person who meets one of the following immigration
53.16 criteria:

53.17 (1) admitted for lawful permanent residence according to United States Code, title 8;

53.18 (2) admitted to the United States as a refugee according to United States Code, title 8,
53.19 section 1157;

53.20 (3) granted asylum according to United States Code, title 8, section 1158;

53.21 (4) granted withholding of deportation according to United States Code, title 8, section
53.22 1253(h);

53.23 (5) paroled for a period of at least one year according to United States Code, title 8,
53.24 section 1182(d)(5);

53.25 (6) granted conditional entrant status according to United States Code, title 8, section
53.26 1153(a)(7);

53.27 (7) determined to be a battered noncitizen by the United States Attorney General
53.28 according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996,
53.29 title V of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;

53.30 (8) is a child of a noncitizen determined to be a battered noncitizen by the United States
53.31 Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility

54.1 Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;
54.2 or

54.3 (9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public
54.4 Law 96-422, the Refugee Education Assistance Act of 1980.

54.5 (c) All qualified noncitizens who were residing in the United States before August 22,
54.6 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for medical
54.7 assistance with federal financial participation.

54.8 (d) Beginning December 1, 1996, qualified noncitizens who entered the United States
54.9 on or after August 22, 1996, and who otherwise meet the eligibility requirements of this
54.10 chapter are eligible for medical assistance with federal participation for five years if they
54.11 meet one of the following criteria:

54.12 (1) refugees admitted to the United States according to United States Code, title 8, section
54.13 1157;

54.14 (2) persons granted asylum according to United States Code, title 8, section 1158;

54.15 (3) persons granted withholding of deportation according to United States Code, title 8,
54.16 section 1253(h);

54.17 (4) veterans of the United States armed forces with an honorable discharge for a reason
54.18 other than noncitizen status, their spouses and unmarried minor dependent children; or

54.19 (5) persons on active duty in the United States armed forces, other than for training,
54.20 their spouses and unmarried minor dependent children.

54.21 Beginning July 1, 2010, children and pregnant women who are noncitizens described
54.22 in paragraph (b) or who are lawfully present in the United States as defined in Code of
54.23 Federal Regulations, title 8, section 103.12, and who otherwise meet eligibility requirements
54.24 of this chapter, are eligible for medical assistance with federal financial participation as
54.25 provided by the federal Children's Health Insurance Program Reauthorization Act of 2009,
54.26 Public Law 111-3.

54.27 (e) Nonimmigrants who otherwise meet the eligibility requirements of this chapter are
54.28 eligible for the benefits as provided in paragraphs (f) to (h). For purposes of this subdivision,
54.29 a "nonimmigrant" is a person in one of the classes listed in United States Code, title 8,
54.30 section 1101(a)(15).

54.31 (f) Payment shall also be made for care and services that are furnished to noncitizens,
54.32 regardless of immigration status, who otherwise meet the eligibility requirements of this

55.1 chapter, if such care and services are necessary for the treatment of an emergency medical
55.2 condition.

55.3 (g) For purposes of this subdivision, the term "emergency medical condition" means a
55.4 medical condition that meets the requirements of United States Code, title 42, section
55.5 1396b(v).

55.6 (h)(1) Notwithstanding paragraph (g), services that are necessary for the treatment of
55.7 an emergency medical condition are limited to the following:

55.8 (i) services delivered in an emergency room or by an ambulance service licensed under
55.9 chapter 144E that are directly related to the treatment of an emergency medical condition;

55.10 (ii) services delivered in an inpatient hospital setting following admission from an
55.11 emergency room or clinic for an acute emergency condition; and

55.12 (iii) follow-up services that are directly related to the original service provided to treat
55.13 the emergency medical condition and are covered by the global payment made to the
55.14 provider.

55.15 (2) Services for the treatment of emergency medical conditions do not include:

55.16 (i) services delivered in an emergency room or inpatient setting to treat a nonemergency
55.17 condition;

55.18 (ii) organ transplants, stem cell transplants, and related care;

55.19 (iii) services for routine prenatal care;

55.20 (iv) continuing care, including long-term care, nursing facility services, home health
55.21 care, adult day care, day training, or supportive living services;

55.22 (v) elective surgery;

55.23 (vi) outpatient prescription drugs, unless the drugs are administered or dispensed as part
55.24 of an emergency room visit;

55.25 (vii) preventative health care and family planning services;

55.26 (viii) rehabilitation services;

55.27 (ix) physical, occupational, or speech therapy;

55.28 (x) transportation services;

55.29 (xi) case management;

55.30 (xii) prosthetics, orthotics, durable medical equipment, or medical supplies;

- 56.1 (xiii) dental services;
- 56.2 (xiv) hospice care;
- 56.3 (xv) audiology services and hearing aids;
- 56.4 (xvi) podiatry services;
- 56.5 (xvii) chiropractic services;
- 56.6 (xviii) immunizations;
- 56.7 (xix) vision services and eyeglasses;
- 56.8 (xx) waiver services;
- 56.9 (xxi) individualized education programs; or
- 56.10 (xxii) chemical dependency treatment.

56.11 (i) Pregnant noncitizens who are ineligible for federally funded medical assistance
56.12 because of immigration status, are not covered by a group health plan or health insurance
56.13 coverage according to Code of Federal Regulations, title 42, section 457.310, and who
56.14 otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance
56.15 through the period of pregnancy, including labor and delivery, and 60 days postpartum, to
56.16 the extent federal funds are available under title XXI of the Social Security Act, and the
56.17 state children's health insurance program.

56.18 (j) Beginning October 1, 2003, persons who are receiving care and rehabilitation services
56.19 from a nonprofit center established to serve victims of torture and are otherwise ineligible
56.20 for medical assistance under this chapter are eligible for medical assistance without federal
56.21 financial participation. These individuals are eligible only for the period during which they
56.22 are receiving services from the center. Individuals eligible under this paragraph shall not
56.23 be required to participate in prepaid medical assistance. The nonprofit center referenced
56.24 under this paragraph may establish itself as a provider of mental health targeted case
56.25 management services through a county contract under section 256.0112, subdivision 6. If
56.26 the nonprofit center is unable to secure a contract with a lead county in its service area, then,
56.27 notwithstanding the requirements of section 256B.0625, subdivision 20, the commissioner
56.28 may negotiate a contract with the nonprofit center for provision of mental health targeted
56.29 case management services. When serving clients who are not the financial responsibility
56.30 of their contracted lead county, the nonprofit center must gain the concurrence of the county
56.31 of financial responsibility prior to providing mental health targeted case management services
56.32 for those clients.

(k) Notwithstanding paragraph (h), clause (2), the following services are covered as emergency medical conditions under paragraph (f) except where coverage is prohibited under federal law for services under clauses (1) and (2):

(1) dialysis services provided in a hospital or freestanding dialysis facility;

(2) surgery and the administration of chemotherapy, radiation, and related services necessary to treat cancer if the recipient has a cancer diagnosis that is not in remission and requires surgery, chemotherapy, or radiation treatment; and

(3) kidney transplant if the person has been diagnosed with end stage renal disease, is currently receiving dialysis services, and is a potential candidate for a kidney transplant.

(l) Effective July 1, 2013, recipients of emergency medical assistance under this subdivision are eligible for coverage of the elderly waiver services provided under ~~section 256B.0915~~ chapter 256S, and coverage of rehabilitative services provided in a nursing facility. The age limit for elderly waiver services does not apply. In order to qualify for coverage, a recipient of emergency medical assistance is subject to the assessment and reassessment requirements of section 256B.0911. Initial and continued enrollment under this paragraph is subject to the limits of available funding.

EFFECTIVE DATE. This section is effective August 1, 2018.

Sec. 20. Minnesota Statutes 2016, 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) "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 physical aggression towards self, others, or destruction of property that requires the immediate response of another person.

(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 assistance to begin and complete one or more of the activities of daily living.

(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, chapter 256S and sections 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 reduced; 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, nebulizer, 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.

EFFECTIVE DATE. This section is effective August 1, 2018.

Sec. 21. Minnesota Statutes 2016, section 256B.0711, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** For purposes of this section:

(a) "Commissioner" means the commissioner of human services unless otherwise indicated.

(b) "Covered program" means a program to provide direct support services funded in whole or in part by the state of Minnesota, including the Community First Services and Supports program; Consumer Directed Community Supports services and extended state plan personal care assistance services available under programs established pursuant to home and community-based service waivers authorized under section 1915(c) of the Social Security Act, and Minnesota Statutes, including, but not limited to, ~~sections 256B.0915, chapter 256S and sections 256B.092, and 256B.49,~~ and under the alternative care program, as offered pursuant to section 256B.0913; the personal care assistance choice program, as established pursuant to section 256B.0659, subdivisions 18 to 20; and any similar program that may provide similar services in the future.

(c) "Direct support services" means personal care assistance services covered by medical assistance under section 256B.0625, subdivisions 19a and 19c; assistance with activities of daily living as defined in section 256B.0659, subdivision 1, paragraph (b), and instrumental activities of daily living as defined in section 256B.0659, subdivision 1, paragraph (i); and other similar, in-home, nonprofessional long-term services and supports provided to an elderly person or person with a disability by the person's employee or the employee of the person's representative to meet such person's daily living needs and ensure that such person may adequately function in the person's home and have safe access to the community.

(d) "Individual provider" means an individual selected by and working under the direction of a participant in a covered program, or a participant's representative, to provide direct support services to the participant, but does not include an employee of a provider agency, subject to the agency's direction and control commensurate with agency employee status.

(e) "Participant" means a person who receives direct support services through a covered program.

(f) "Participant's representative" means a participant's legal guardian or an individual having the authority and responsibility to act on behalf of a participant with respect to the provision of direct support services through a covered program.

EFFECTIVE DATE. This section is effective August 1, 2018.

Sec. 22. Minnesota Statutes 2017 Supplement, section 256B.0911, subdivision 1a, is amended to read:

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

(a) Until additional requirements apply under paragraph (b), "long-term care consultation services" means:

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

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

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

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

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

(6) determination of home and community-based waiver and other service eligibility as required under chapter 256S and sections 256B.0913, ~~256B.0915~~, and 256B.49, including level of care determination for individuals who need an institutional level of care as determined under subdivision 4e, based on assessment and community support plan development, appropriate referrals to obtain necessary diagnostic information, and including an eligibility determination for consumer-directed community supports;

61.1 (7) providing recommendations for institutional placement when there are no
61.2 cost-effective community services available;

61.3 (8) providing access to assistance to transition people back to community settings after
61.4 institutional admission; and

61.5 (9) providing information about competitive employment, with or without supports, for
61.6 school-age youth and working-age adults and referrals to the Disability Linkage Line and
61.7 Disability Benefits 101 to ensure that an informed choice about competitive employment
61.8 can be made. For the purposes of this subdivision, "competitive employment" means work
61.9 in the competitive labor market that is performed on a full-time or part-time basis in an
61.10 integrated setting, and for which an individual is compensated at or above the minimum
61.11 wage, but not less than the customary wage and level of benefits paid by the employer for
61.12 the same or similar work performed by individuals without disabilities.

61.13 (b) Upon statewide implementation of lead agency requirements in subdivisions 2b, 2c,
61.14 and 3a, "long-term care consultation services" also means:

61.15 (1) service eligibility determination for state plan home care services identified in:

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

61.17 (ii) consumer support grants under section 256.476; or

61.18 (iii) section 256B.85;

61.19 (2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024,
61.20 determination of eligibility for case management services available under sections 256B.0621,
61.21 subdivision 2, paragraph (4), and 256B.0924 and Minnesota Rules, part 9525.0016;

61.22 (3) determination of institutional level of care, home and community-based service
61.23 waiver, and other service eligibility as required under section 256B.092, determination of
61.24 eligibility for family support grants under section 252.32, semi-independent living services
61.25 under section 252.275, and day training and habilitation services under section 256B.092;
61.26 and

61.27 (4) obtaining necessary diagnostic information to determine eligibility under clauses (2)
61.28 and (3).

61.29 (c) "Long-term care options counseling" means the services provided by the linkage
61.30 lines as mandated by sections 256.01, subdivision 24, and 256.975, subdivision 7, and also
61.31 includes telephone assistance and follow up once a long-term care consultation assessment
61.32 has been completed.

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

(e) "Lead agencies" means counties administering or tribes and health plans under contract with the commissioner to administer long-term care consultation assessment and support planning services.

(f) "Person-centered planning" is a process that includes the active participation of a person in the planning of the person's services, including in making meaningful and informed choices about the person's own goals, talents, and objectives, as well as making meaningful and informed choices about the services the person receives. For the purposes of this section, "informed choice" means a voluntary choice of services by a person from all available service options based on accurate and complete information concerning all available service options and concerning the person's own preferences, abilities, goals, and objectives. In order for a person to make an informed choice, all available options must be developed and presented to the person to empower the person to make decisions.

EFFECTIVE DATE. This section is effective August 1, 2018.

Sec. 23. Minnesota Statutes 2017 Supplement, section 256B.0911, subdivision 3a, is amended to 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 20 calendar days after the date on which an assessment was requested or recommended. Upon statewide implementation of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person requesting personal care assistance services and home care nursing. The commissioner shall provide at least a 90-day notice to lead agencies prior to the effective date of this requirement. Face-to-face assessments must be conducted according to paragraphs (b) to (i).

(b) Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified assessors to conduct the assessment. For a person with complex health care needs, a public health or registered nurse from the team must be consulted.

(c) The MnCHOICES assessment provided by the commissioner to lead agencies must be used to complete a comprehensive, person-centered assessment. The assessment must include the health, psychological, functional, environmental, and social needs of the

63.1 individual necessary to develop a community support plan that meets the individual's needs
63.2 and preferences.

63.3 (d) The assessment must be conducted in a face-to-face interview with the person being
63.4 assessed and the person's legal representative. At the request of the person, other individuals
63.5 may participate in the assessment to provide information on the needs, strengths, and
63.6 preferences of the person necessary to develop a community support plan that ensures the
63.7 person's health and safety. Except for legal representatives or family members invited by
63.8 the person, persons participating in the assessment may not be a provider of service or have
63.9 any financial interest in the provision of services. For persons who are to be assessed for
63.10 elderly waiver customized living or adult day services under ~~section 256B.0915~~ chapter
63.11 256S, with the permission of the person being assessed or the person's designated or legal
63.12 representative, the client's current or proposed provider of services may submit a copy of
63.13 the provider's nursing assessment or written report outlining its recommendations regarding
63.14 the client's care needs. The person conducting the assessment must notify the provider of
63.15 the date by which this information is to be submitted. This information shall be provided
63.16 to the person conducting the assessment prior to the assessment. For a person who is to be
63.17 assessed for waiver services under section 256B.092 or 256B.49, with the permission of
63.18 the person being assessed or the person's designated legal representative, the person's current
63.19 provider of services may submit a written report outlining recommendations regarding the
63.20 person's care needs prepared by a direct service employee with at least 20 hours of service
63.21 to that client. The person conducting the assessment or reassessment must notify the provider
63.22 of the date by which this information is to be submitted. This information shall be provided
63.23 to the person conducting the assessment and the person or the person's legal representative,
63.24 and must be considered prior to the finalization of the assessment or reassessment.

63.25 (e) The person or the person's legal representative must be provided with a written
63.26 community support plan within 40 calendar days of the assessment visit, regardless of
63.27 whether the individual is eligible for Minnesota health care programs.

63.28 (f) For a person being assessed for elderly waiver services under ~~section 256B.0915~~,
63.29 chapter 256S, a provider who submitted information under paragraph (d) shall receive the
63.30 final written community support plan when available and the Residential Services Workbook.

63.31 (g) The written community support plan must include:

63.32 (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, including service provided in a non-disability-specific setting;

(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 a person determined eligible for state plan home care under subdivision 1a, paragraph (b), clause (1), the person or person's representative must also receive a copy of the home care service plan developed by the certified assessor.

(h) 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 long-term care options counseling services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for telephone assistance and follow up.

(i) 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 section 256.975, subdivision 7a, paragraph (d).

(j) The 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. For an individual found to meet eligibility criteria for home and community-based service programs under ~~section 256B.0915~~ chapter 256S or section 256B.49, "cost-effectiveness" has the meaning found in the federally approved waiver plan for each program;

(3) the need for and purpose of preadmission screening conducted by long-term care options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects nursing facility placement. If the individual selects nursing facility placement, the lead agency shall forward information needed to complete the level of care determinations and

65.1 screening for developmental disability and mental illness collected during the assessment
65.2 to the long-term care options counselor using forms provided by the commissioner;

65.3 (4) the role of long-term care consultation assessment and support planning in eligibility
65.4 determination for waiver and alternative care programs, and state plan home care, case
65.5 management, and other services as defined in subdivision 1a, paragraphs (a), clause (6),
65.6 and (b);

65.7 (5) information about Minnesota health care programs;

65.8 (6) the person's freedom to accept or reject the recommendations of the team;

65.9 (7) the person's right to confidentiality under the Minnesota Government Data Practices
65.10 Act, chapter 13;

65.11 (8) the certified assessor's decision regarding the person's need for institutional level of
65.12 care as determined under criteria established in subdivision 4e and the certified assessor's
65.13 decision regarding eligibility for all services and programs as defined in subdivision 1a,
65.14 paragraphs (a), clause (6), and (b); and

65.15 (9) the person's right to appeal the certified assessor's decision regarding eligibility for
65.16 all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and
65.17 (8), and (b), and incorporating the decision regarding the need for institutional level of care
65.18 or the lead agency's final decisions regarding public programs eligibility according to section
65.19 256.045, subdivision 3.

65.20 (k) Face-to-face assessment completed as part of eligibility determination for the
65.21 alternative care, elderly waiver, community access for disability inclusion, community
65.22 alternative care, and brain injury waiver programs under chapter 256S and sections
65.23 256B.0913, ~~256B.0915~~, and 256B.49 is valid to establish service eligibility for no more
65.24 than 60 calendar days after the date of assessment.

65.25 (l) The effective eligibility start date for programs in paragraph (k) can never be prior
65.26 to the date of assessment. If an assessment was completed more than 60 days before the
65.27 effective waiver or alternative care program eligibility start date, assessment and support
65.28 plan information must be updated and documented in the department's Medicaid Management
65.29 Information System (MMIS). Notwithstanding retroactive medical assistance coverage of
65.30 state plan services, the effective date of eligibility for programs included in paragraph (k)
65.31 cannot be prior to the date the most recent updated assessment is completed.

65.32 (m) If an eligibility update is completed within 90 days of the previous face-to-face
65.33 assessment and documented in the department's Medicaid Management Information System

(MMIS), the effective date of eligibility for programs included in paragraph (k) is the date of the previous face-to-face assessment when all other eligibility requirements are met.

(n) At the time of reassessment, the certified assessor shall assess each person receiving waiver services currently residing in a community residential setting, or licensed adult foster care home that is not the primary residence of the license holder, or in which the license holder is not the primary caregiver, to determine if that person would prefer to be served in a community-living setting as defined in section 256B.49, subdivision 23. The certified assessor shall offer the person, through a person-centered planning process, the option to receive alternative housing and service options.

EFFECTIVE DATE. This section is effective August 1, 2018.

Sec. 24. Minnesota Statutes 2016, section 256B.0913, subdivision 4, is amended to read:

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

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

(1) the person is a citizen of the United States or a United States national;

(2) the person has been determined by a community assessment under section 256B.0911 to be a person who would require the level of care provided in a nursing facility, as determined under section 256B.0911, subdivision 4e, but for the provision of services under the alternative care program;

(3) the person is age 65 or older;

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

(5) the person is not ineligible for the payment of long-term care services by the medical assistance program due to an asset transfer penalty under section 256B.0595 or equity interest in the home exceeding \$500,000 as stated in section 256B.056;

(6) the person needs long-term care services that are not funded through other state or federal funding, or other health insurance or other third-party insurance such as long-term care insurance;

(7) except for individuals described in clause (8), the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the monthly limit described under section ~~256B.0915, subdivision 3a~~ 256S.18. This monthly limit does not prohibit the alternative care client from payment for additional services, but

in no case may the cost of additional services purchased under this section exceed the difference between the client's monthly service limit defined under section ~~256B.0915, subdivision 3~~ 256S.04, and the alternative care program monthly service limit defined in this paragraph. If care-related supplies and equipment or environmental modifications and adaptations are or will be purchased for an alternative care services recipient, the costs may be prorated on a monthly basis for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's other alternative care services exceeds the monthly limit established in this paragraph, the annual cost of the alternative care services shall be determined. In this event, the annual cost of alternative care services shall not exceed 12 times the monthly limit described in this paragraph;

(8) for individuals assigned a case mix classification A as described under section ~~256B.0915, subdivision 3a, paragraph (a)~~ 256S.18, with (i) no dependencies in activities of daily living, or (ii) up to two dependencies in bathing, dressing, grooming, walking, and eating when the dependency score in eating is three or greater as determined by an assessment performed under section 256B.0911, the monthly cost of alternative care services funded by the program cannot exceed \$593 per month for all new participants enrolled in the program on or after July 1, 2011. This monthly limit shall be applied to all other participants who meet this criteria at reassessment. This monthly limit shall be increased annually as described in section ~~256B.0915, subdivision 3a, paragraphs (a) and (e)~~ 256S.18. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased exceed the difference between the client's monthly service limit defined in this clause and the limit described in clause (7) for case mix classification A; and

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

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

(i) the appointment of a representative payee;

(ii) automatic payment from a financial account;

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

(iv) another method acceptable to the lead agency to ensure prompt fee payments.

The lead agency may extend the client's eligibility as necessary while making arrangements to facilitate payment of past-due amounts and future premium payments.

Following disenrollment due to nonpayment of a monthly fee, eligibility shall not be reinstated for a period of 30 days.

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

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

(d) Alternative care funding is not available for a person whose income is greater than the maintenance needs allowance under section ~~256B.0915, subdivision 1d~~ 256S.05, but equal to or less than 120 percent of the federal poverty guideline effective July 1 in the fiscal year for which alternative care eligibility is determined, who would be eligible for the elderly waiver with a waiver obligation.

EFFECTIVE DATE. This section is effective August 1, 2018.

Sec. 25. Minnesota Statutes 2016, 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~~ sections 256S.07 to 256S.09.

(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 coordinated service and support plan and must not approve any plan in which

the cost of services funded by alternative care and client contributions exceeds the limit specified in section ~~256B.0915, subdivision 3a, paragraphs (a) and (c)~~ 256S.18.

(d) Case manager responsibilities include those in section ~~256B.0915, subdivision 1a, paragraph (g)~~ 256S.09, subdivision 2.

EFFECTIVE DATE. This section is effective August 1, 2018.

Sec. 26. Minnesota Statutes 2016, section 256B.0913, subdivision 8, is amended to read:

Subd. 8. **Requirements for individual coordinated service and support plan.** (a) The case manager shall implement the coordinated service and support plan for each alternative care client and ensure that a client's service needs and eligibility are reassessed at least every 12 months. The coordinated service and support plan must meet the requirements in section ~~256B.0915, subdivision 6~~ 256S.10. 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 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 service 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.

EFFECTIVE DATE. This section is effective August 1, 2018.

70.1 Sec. 27. Minnesota Statutes 2016, section 256B.0913, subdivision 13, is amended to read:

70.2 Subd. 13. **Lead agency biennial plan.** The lead agency biennial plan for long-term care
70.3 consultation services under section 256B.0911, the alternative care program under this
70.4 section, and waivers for the elderly under ~~section 256B.0915~~ chapter 256S, shall be submitted
70.5 by the lead agency as the home and community-based services quality assurance plan on a
70.6 form provided by the commissioner.

70.7 **EFFECTIVE DATE.** This section is effective August 1, 2018.

70.8 Sec. 28. Minnesota Statutes 2016, section 256B.0913, subdivision 14, is amended to read:

70.9 Subd. 14. **Provider requirements, payment, and rate adjustments.** (a) Unless otherwise
70.10 specified in statute, providers must be enrolled as Minnesota health care program providers
70.11 and abide by the requirements for provider participation according to Minnesota Rules, part
70.12 9505.0195.

70.13 (b) Payment for provided alternative care services as approved by the client's case
70.14 manager shall occur through the invoice processing procedures of the department's Medicaid
70.15 Management Information System (MMIS). To receive payment, the lead agency or vendor
70.16 must submit invoices within 12 months following the date of service. The lead agency and
70.17 its vendors shall not be reimbursed for services which exceed the county allocation. Service
70.18 rates are governed by section ~~256B.0915, subdivision 3g~~ 256S.15.

70.19 **EFFECTIVE DATE.** This section is effective August 1, 2018.

70.20 Sec. 29. Minnesota Statutes 2016, section 256B.0917, subdivision 1a, is amended to read:

70.21 Subd. 1a. **Home and community-based services for older adults.** (a) The purpose of
70.22 projects selected by the commissioner of human services under this section is to make
70.23 strategic changes in the long-term services and supports system for older adults including
70.24 statewide capacity for local service development and technical assistance, and statewide
70.25 availability of home and community-based services for older adult services, caregiver
70.26 support and respite care services, and other supports in the state of Minnesota. These projects
70.27 are intended to create incentives for new and expanded home and community-based services
70.28 in Minnesota in order to:

70.29 (1) reach older adults early in the progression of their need for long-term services and
70.30 supports, providing them with low-cost, high-impact services that will prevent or delay the
70.31 use of more costly services;

70.32 (2) support older adults to live in the most integrated, least restrictive community setting;

- 71.1 (3) support the informal caregivers of older adults;
- 71.2 (4) develop and implement strategies to integrate long-term services and supports with
- 71.3 health care services, in order to improve the quality of care and enhance the quality of life
- 71.4 of older adults and their informal caregivers;
- 71.5 (5) ensure cost-effective use of financial and human resources;
- 71.6 (6) build community-based approaches and community commitment to delivering
- 71.7 long-term services and supports for older adults in their own homes;
- 71.8 (7) achieve a broad awareness and use of lower-cost in-home services as an alternative
- 71.9 to nursing homes and other residential services;
- 71.10 (8) strengthen and develop additional home and community-based services and
- 71.11 alternatives to nursing homes and other residential services; and
- 71.12 (9) strengthen programs that use volunteers.

71.13 (b) The services provided by these projects are available to older adults who are eligible

71.14 for medical assistance and the elderly waiver under ~~section 256B.0915~~ chapter 256S, the

71.15 alternative care program under section 256B.0913, or essential community supports grant

71.16 under section 256B.0922, and to persons who have their own funds to pay for services.

71.17 **EFFECTIVE DATE.** This section is effective August 1, 2018.

71.18 Sec. 30. Minnesota Statutes 2016, section 256B.0918, subdivision 2, is amended to read:

71.19 Subd. 2. **Participating providers.** The commissioner shall publish a request for proposals

71.20 in the State Register by August 15, 2005, specifying provider eligibility requirements,

71.21 provider selection criteria, program specifics, funding mechanism, and methods of evaluation.

71.22 The commissioner may publish additional requests for proposals in subsequent years.

71.23 Providers who provide services funded through the following programs are eligible to apply

71.24 to participate in the scholarship program: home and community-based waived services

71.25 for persons with developmental disabilities under section 256B.501; home and

71.26 community-based waived services for the elderly under ~~section 256B.0915~~ chapter 256S;

71.27 waived services under community access for disability inclusion under section 256B.49;

71.28 community alternative care waived services under section 256B.49; brain injury waived

71.29 services under section 256B.49; nursing services and home health services under section

71.30 256B.0625, subdivision 6a; personal care services and nursing supervision of personal care

71.31 services under section 256B.0625, subdivision 19a; home care nursing services under section

71.32 256B.0625, subdivision 7; day training and habilitation services for adults with developmental

72.1 disabilities under sections 252.41 to 252.46; and intermediate care facilities for persons
72.2 with developmental disabilities under section 256B.5012.

72.3 **EFFECTIVE DATE.** This section is effective August 1, 2018.

72.4 Sec. 31. Minnesota Statutes 2016, section 256B.0919, subdivision 3, is amended to read:

72.5 Subd. 3. **County certification of persons providing adult foster care to related**
72.6 **persons.** A person exempt from licensure under section 245A.03, subdivision 2, who
72.7 provides adult foster care to a related individual age 65 and older, and who meets the
72.8 requirements in Minnesota Rules, parts 9555.5105 to 9555.6265, may be certified by the
72.9 county to provide adult foster care. A person certified by the county to provide adult foster
72.10 care may be reimbursed for services provided and eligible for funding under ~~section~~
72.11 ~~256B.0915~~ chapter 256S, if the relative would suffer a financial hardship as a result of
72.12 providing care. For purposes of this subdivision, financial hardship refers to a situation in
72.13 which a relative incurs a substantial reduction in income as a result of resigning from a
72.14 full-time job or taking a leave of absence without pay from a full-time job to care for the
72.15 client.

72.16 **EFFECTIVE DATE.** This section is effective August 1, 2018.

72.17 Sec. 32. Minnesota Statutes 2016, section 256B.0922, subdivision 2, is amended to read:

72.18 Subd. 2. **Essential community supports for people in transition.** (a) Essential
72.19 community supports under subdivision 1 are also available to an individual who:

72.20 (1) is receiving nursing facility services or home and community-based long-term services
72.21 and supports under ~~section 256B.0915~~ chapter 256S or section 256B.49 on the effective
72.22 date of implementation of the revised nursing facility level of care under section 144.0724,
72.23 subdivision 11;

72.24 (2) meets one of the following criteria:

72.25 (i) due to the implementation of the revised nursing facility level of care, loses eligibility
72.26 for continuing medical assistance payment of nursing facility services at the first reassessment
72.27 under section 144.0724, subdivision 11, paragraph (b), that occurs on or after the effective
72.28 date of the revised nursing facility level of care criteria under section 144.0724, subdivision
72.29 11; or

72.30 (ii) due to the implementation of the revised nursing facility level of care, loses eligibility
72.31 for continuing medical assistance payment of home and community-based long-term services
72.32 and supports under ~~section 256B.0915~~ chapter 256S or section 256B.49 at the first

73.1 reassessment required under those sections that occurs on or after the effective date of
73.2 implementation of the revised nursing facility level of care under section 144.0724,
73.3 subdivision 11;

73.4 (3) is not eligible for personal care attendant services; and

73.5 (4) has an assessed need for one or more of the supportive services offered under essential
73.6 community supports under subdivision 1, paragraph (b), clause (6).

73.7 Individuals eligible under this paragraph includes individuals who continue to be eligible
73.8 for medical assistance state plan benefits and those who are not or are no longer financially
73.9 eligible for medical assistance.

73.10 (b) Additional onetime case management is available for participants under paragraph
73.11 (a), not to exceed \$600 per person to be used within one authorization period not to exceed
73.12 12 months. This service is provided in addition to the essential community supports benefit
73.13 described under subdivision 1, paragraph (b).

73.14 **EFFECTIVE DATE.** This section is effective August 1, 2018.

73.15 Sec. 33. Minnesota Statutes 2016, section 256B.15, subdivision 4, is amended to read:

73.16 Subd. 4. **Other survivors.** (a) If the decedent who was single or the surviving spouse
73.17 of a married couple is survived by one of the following persons, a claim exists against the
73.18 estate payable first from the value of the nonhomestead property included in the estate and
73.19 the personal representative shall make, execute, and deliver to the county agency a lien
73.20 against the homestead property in the estate for any unpaid balance of the claim to the
73.21 claimant as provided under this section:

73.22 (1) a sibling who resided in the decedent medical assistance recipient's home at least
73.23 one year before the decedent's institutionalization and continuously since the date of
73.24 institutionalization; or

73.25 (2) a son or daughter or a grandchild who resided in the decedent medical assistance
73.26 recipient's home for at least two years immediately before the parent's or grandparent's
73.27 institutionalization and continuously since the date of institutionalization, and who establishes
73.28 by a preponderance of the evidence having provided care to the parent or grandparent who
73.29 received medical assistance, that the care was provided before institutionalization, and that
73.30 the care permitted the parent or grandparent to reside at home rather than in an institution.

73.31 (b) For purposes of this subdivision, "institutionalization" means receiving care:

(1) in a nursing facility or swing bed, or intermediate care facility for persons with developmental disabilities; or

(2) through home and community-based services under ~~section 256B.0915~~, chapter 256S or section 256B.092; or 256B.49.

EFFECTIVE DATE. This section is effective August 1, 2018.

Sec. 34. Minnesota Statutes 2016, section 256B.439, subdivision 1, is amended to read:

Subdivision 1. **Development and implementation of quality profiles.** (a) The commissioner of human services, in cooperation with the commissioner of health, shall develop and implement quality profiles for nursing facilities and, beginning not later than July 1, 2014, for home and community-based services providers, except when the quality profile system would duplicate requirements under section 256B.5011, 256B.5012, or 256B.5013. For purposes of this section, home and community-based services providers are defined as providers of home and community-based services under chapter 256S and sections 256B.0625, subdivisions 6a, 7, and 19a; 256B.0913; ~~256B.0915~~; 256B.092; 256B.49; and 256B.85, and intermediate care facilities for persons with developmental disabilities providers under section 256B.5013. To the extent possible, quality profiles must be developed for providers of services to older adults and people with disabilities, regardless of payor source, for the purposes of providing information to consumers. The quality profiles must be developed using existing data sets maintained by the commissioners of health and human services to the extent possible. The profiles must incorporate or be coordinated with information on quality maintained by area agencies on aging, long-term care trade associations, the ombudsman offices, counties, tribes, health plans, and other entities and the long-term care database maintained under section 256.975, subdivision 7. The profiles must be designed to provide information on quality to:

(1) consumers and their families to facilitate informed choices of service providers;

(2) providers to enable them to measure the results of their quality improvement efforts and compare quality achievements with other service providers; and

(3) public and private purchasers of long-term care services to enable them to purchase high-quality care.

(b) The profiles must be developed in consultation with the long-term care task force, area agencies on aging, and representatives of consumers, providers, and labor unions. Within the limits of available appropriations, the commissioners may employ consultants to assist with this project.

75.1 **EFFECTIVE DATE.** This section is effective August 1, 2018.

75.2 Sec. 35. Minnesota Statutes 2016, section 256B.4912, subdivision 1, is amended to read:

75.3 Subdivision 1. **Provider qualifications.** (a) For the home and community-based waivers
75.4 providing services to seniors and individuals with disabilities under chapter 256S and
75.5 sections 256B.0913, ~~256B.0915~~, 256B.092, and 256B.49, the commissioner shall establish:

75.6 (1) agreements with enrolled waiver service providers to ensure providers meet Minnesota
75.7 health care program requirements;

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

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

75.11 (b) Beginning July 1, 2012, staff that provide direct contact, as defined in section 245C.02,
75.12 subdivision 11, for services specified in the federally approved waiver plans must meet the
75.13 requirements of chapter 245C prior to providing waiver services and as part of ongoing
75.14 enrollment. Upon federal approval, this requirement must also apply to consumer-directed
75.15 community supports.

75.16 (c) Beginning January 1, 2014, service owners and managerial officials overseeing the
75.17 management or policies of services that provide direct contact as specified in the federally
75.18 approved waiver plans must meet the requirements of chapter 245C prior to reenrollment
75.19 or revalidation or, for new providers, prior to initial enrollment if they have not already
75.20 done so as a part of service licensure requirements.

75.21 **EFFECTIVE DATE.** This section is effective August 1, 2018.

75.22 Sec. 36. Minnesota Statutes 2016, section 256B.4912, subdivision 5, is amended to read:

75.23 Subd. 5. **County and tribal provider contract elimination.** County and tribal contracts
75.24 with providers of home and community-based waiver services provided under chapter 256S
75.25 and sections 256B.0913, ~~256B.0915~~, 256B.092, and 256B.49 are eliminated effective January
75.26 1, 2014.

75.27 **EFFECTIVE DATE.** This section is effective August 1, 2018.

75.28 Sec. 37. Minnesota Statutes 2016, section 256B.4912, subdivision 7, is amended to read:

75.29 Subd. 7. **Applicant and license holder training.** An applicant or license holder for the
75.30 home and community-based waivers providing services to seniors and individuals with

disabilities under chapter 256S and sections 256B.0913, ~~256B.0915~~, 256B.092, and 256B.49 that is not enrolled as a Minnesota health care program home and community-based services waiver provider at the time of application must ensure that at least one controlling individual completes a onetime training on the requirements for providing home and community-based services as determined by the commissioner, before a provider is enrolled or license is issued. Within six months of enrollment, a newly enrolled home and community-based waiver service provider must ensure that at least one controlling individual has completed training on waiver and related program billing. Exemptions to new waiver provider training requirements may be granted, as determined by the commissioner.

EFFECTIVE DATE. This section is effective August 1, 2018.

Sec. 38. Minnesota Statutes 2016, section 256B.69, subdivision 6b, is amended to read:

Subd. 6b. **Home and community-based waiver services.** (a) For individuals enrolled in the Minnesota senior health options project authorized under subdivision 23, elderly waiver services shall be covered according to the terms and conditions of the federal agreement governing that demonstration project.

(b) For individuals under age 65 enrolled in demonstrations authorized under subdivision 23, home and community-based waiver services shall be covered according to the terms and conditions of the federal agreement governing that demonstration project.

(c) The commissioner of human services shall issue requests for proposals for collaborative service models between counties and managed care organizations to integrate the home and community-based elderly waiver services and additional nursing home services into the prepaid medical assistance program.

(d) Notwithstanding Minnesota Rules, part 9500.1457, subpart 1, item C, elderly waiver services shall be covered statewide under the prepaid medical assistance program for all individuals who are eligible according to ~~section 256B.0915~~ chapter 256S. The commissioner may develop a schedule to phase in implementation of these waiver services, including collaborative service models under paragraph (c). The commissioner shall phase in implementation beginning with those counties participating under section 256B.692, and those counties where a viable collaborative service model has been developed. In consultation with counties and all managed care organizations that have expressed an interest in participating in collaborative service models, the commissioner shall evaluate the models. The commissioner shall consider the evaluation in selecting the most appropriate models for statewide implementation.

77.1 **EFFECTIVE DATE.** This section is effective August 1, 2018.

77.2 Sec. 39. Minnesota Statutes 2016, section 256B.765, is amended to read:

77.3 **256B.765 PROVIDER RATE INCREASES.**

77.4 (a) Effective July 1, 2001, within the limits of appropriations specifically for this purpose,
77.5 the commissioner shall provide an annual inflation adjustment for the providers listed in
77.6 paragraph (c). The index for the inflation adjustment must be based on the change in the
77.7 Employment Cost Index for Private Industry Workers - Total Compensation forecasted by
77.8 Data Resources, Inc., as forecasted in the fourth quarter of the calendar year preceding the
77.9 fiscal year. The commissioner shall increase reimbursement or allocation rates by the
77.10 percentage of this adjustment, and county boards shall adjust provider contracts as needed.

77.11 (b) The commissioner of management and budget shall include an annual inflationary
77.12 adjustment in reimbursement rates for the providers listed in paragraph (c) using the inflation
77.13 factor specified in paragraph (a) as a budget change request in each biennial detailed
77.14 expenditure budget submitted to the legislature under section 16A.11.

77.15 (c) The annual adjustment under paragraph (a) shall be provided for home and
77.16 community-based waiver services for persons with developmental disabilities under section
77.17 256B.501; home and community-based waiver services for the elderly under ~~section~~
77.18 ~~256B.0915~~ chapter 256S; waived services under community access for disability inclusion
77.19 under section 256B.49; community alternative care waived services under section 256B.49;
77.20 brain injury waived services under section 256B.49; nursing services and home health
77.21 services under section 256B.0625, subdivision 6a; personal care services and nursing
77.22 supervision of personal care services under section 256B.0625, subdivision 19a; home care
77.23 nursing services under section 256B.0625, subdivision 7; day training and habilitation
77.24 services for adults with developmental disabilities under sections 252.41 to 252.46; physical
77.25 therapy services under section 256B.0625, subdivision 8; occupational therapy services
77.26 under section 256B.0625, subdivision 8a; speech-language therapy services under Minnesota
77.27 Rules, part 9505.0390; respiratory therapy services under Minnesota Rules, part 9505.0295;
77.28 alternative care services under section 256B.0913; adult residential program grants under
77.29 section 245.73; adult and family community support grants under Minnesota Rules, parts
77.30 9535.1700 to 9535.1760; semi-independent living services under section 252.275 including
77.31 SILS funding under county social services grants formerly funded under chapter 256I; and
77.32 community support services for deaf and hard-of-hearing adults with mental illness who
77.33 use or wish to use sign language as their primary means of communication.

77.34 **EFFECTIVE DATE.** This section is effective August 1, 2018.

78.1 Sec. 40. Minnesota Statutes 2016, section 256B.85, subdivision 2, is amended to read:

78.2 Subd. 2. **Definitions.** (a) For the purposes of this section, the terms defined in this
78.3 subdivision have the meanings given.

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

78.6 (c) "Agency-provider model" means a method of CFSS under which a qualified agency
78.7 provides services and supports through the agency's own employees and policies. The agency
78.8 must allow the participant to have a significant role in the selection and dismissal of support
78.9 workers of their choice for the delivery of their specific services and supports.

78.10 (d) "Behavior" means a description of a need for services and supports used to determine
78.11 the home care rating and additional service units. The presence of Level I behavior is used
78.12 to determine the home care rating.

78.13 (e) "Budget model" means a service delivery method of CFSS that allows the use of a
78.14 service budget and assistance from a financial management services (FMS) provider for a
78.15 participant to directly employ support workers and purchase supports and goods.

78.16 (f) "Complex health-related needs" means an intervention listed in clauses (1) to (8) that
78.17 has been ordered by a physician, and is specified in a community services and support plan,
78.18 including:

78.19 (1) tube feedings requiring:

78.20 (i) a gastrojejunostomy tube; or

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

78.22 (2) wounds described as:

78.23 (i) stage III or stage IV;

78.24 (ii) multiple wounds;

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

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

78.28 (3) parenteral therapy described as:

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

- 79.1 (ii) total parenteral nutrition (TPN) daily;
- 79.2 (4) respiratory interventions, including:
- 79.3 (i) oxygen required more than eight hours per day;
- 79.4 (ii) respiratory vest more than one time per day;
- 79.5 (iii) bronchial drainage treatments more than two times per day;
- 79.6 (iv) sterile or clean suctioning more than six times per day;
- 79.7 (v) dependence on another to apply respiratory ventilation augmentation devices such
- 79.8 as BiPAP and CPAP; and
- 79.9 (vi) ventilator dependence under section 256B.0651;
- 79.10 (5) insertion and maintenance of catheter, including:
- 79.11 (i) sterile catheter changes more than one time per month;
- 79.12 (ii) clean intermittent catheterization, and including self-catheterization more than six
- 79.13 times per day; or
- 79.14 (iii) bladder irrigations;
- 79.15 (6) bowel program more than two times per week requiring more than 30 minutes to
- 79.16 perform each time;
- 79.17 (7) neurological intervention, including:
- 79.18 (i) seizures more than two times per week and requiring significant physical assistance
- 79.19 to maintain safety; or
- 79.20 (ii) swallowing disorders diagnosed by a physician and requiring specialized assistance
- 79.21 from another on a daily basis; and
- 79.22 (8) other congenital or acquired diseases creating a need for significantly increased direct
- 79.23 hands-on assistance and interventions in six to eight activities of daily living.
- 79.24 (g) "Community first services and supports" or "CFSS" means the assistance and supports
- 79.25 program under this section needed for accomplishing activities of daily living, instrumental
- 79.26 activities of daily living, and health-related tasks through hands-on assistance to accomplish
- 79.27 the task or constant supervision and cueing to accomplish the task, or the purchase of goods
- 79.28 as defined in subdivision 7, clause (3), that replace the need for human assistance.
- 79.29 (h) "Community first services and supports service delivery plan" or "CFSS service
- 79.30 delivery plan" means a written document detailing the services and supports chosen by the

participant to meet assessed needs that are within the approved CFSS service authorization, as determined in subdivision 8. Services and supports are based on the coordinated service and support plan identified in section ~~256B.0915, subdivision 6~~ 256S.10.

(i) "Consultation services" means a Minnesota health care program enrolled provider organization that provides assistance to the participant in making informed choices about CFSS services in general and self-directed tasks in particular, and in developing a person-centered CFSS service delivery plan to achieve quality service outcomes.

(j) "Critical activities of daily living" means transferring, mobility, eating, and toileting.

(k) "Dependency" in activities of daily living means a person requires hands-on assistance or constant supervision and cueing to accomplish one or more of the activities of daily living every day or on the days during the week that the activity is performed; however, a child may not be found to be dependent in an activity of daily living if, because of the child's age, an adult would either perform the activity for the child or assist the child with the activity and the assistance needed is the assistance appropriate for a typical child of the same age.

(l) "Extended CFSS" means CFSS services and supports provided under CFSS that are included in the CFSS service delivery plan through one of the home and community-based services waivers and as approved and authorized under chapter 256S; and sections ~~256B.0915; 256B.092, subdivision 5; and 256B.49~~, which exceed the amount, duration, and frequency of the state plan CFSS services for participants.

(m) "Financial management services provider" or "FMS provider" means a qualified organization required for participants using the budget model under subdivision 13 that is an enrolled provider with the department to provide vendor fiscal/employer agent financial management services (FMS).

(n) "Health-related procedures and tasks" means procedures and tasks related to the specific assessed health needs of a participant that can be taught or assigned by a state-licensed health care or mental health professional and performed by a support worker.

(o) "Instrumental activities of daily living" means activities related to living independently in the community, including but not limited to: meal planning, preparation, and cooking; shopping for food, clothing, or other essential items; laundry; housecleaning; assistance with medications; managing finances; communicating needs and preferences during activities; arranging supports; and assistance with traveling around and participating in the community.

(p) "Lead agency" has the meaning given in section 256B.0911, subdivision 1a, paragraph (e).

81.1 (q) "Legal representative" means parent of a minor, a court-appointed guardian, or
81.2 another representative with legal authority to make decisions about services and supports
81.3 for the participant. Other representatives with legal authority to make decisions include but
81.4 are not limited to a health care agent or an attorney-in-fact authorized through a health care
81.5 directive or power of attorney.

81.6 (r) "Level I behavior" means physical aggression towards self or others or destruction
81.7 of property that requires the immediate response of another person.

81.8 (s) "Medication assistance" means providing verbal or visual reminders to take regularly
81.9 scheduled medication, and includes any of the following supports listed in clauses (1) to
81.10 (3) and other types of assistance, except that a support worker may not determine medication
81.11 dose or time for medication or inject medications into veins, muscles, or skin:

81.12 (1) under the direction of the participant or the participant's representative, bringing
81.13 medications to the participant including medications given through a nebulizer, opening a
81.14 container of previously set-up medications, emptying the container into the participant's
81.15 hand, opening and giving the medication in the original container to the participant, or
81.16 bringing to the participant liquids or food to accompany the medication;

81.17 (2) organizing medications as directed by the participant or the participant's representative;
81.18 and

81.19 (3) providing verbal or visual reminders to perform regularly scheduled medications.

81.20 (t) "Participant" means a person who is eligible for CFSS.

81.21 (u) "Participant's representative" means a parent, family member, advocate, or other
81.22 adult authorized by the participant or participant's legal representative, if any, to serve as a
81.23 representative in connection with the provision of CFSS. This authorization must be in
81.24 writing or by another method that clearly indicates the participant's free choice and may be
81.25 withdrawn at any time. The participant's representative must have no financial interest in
81.26 the provision of any services included in the participant's CFSS service delivery plan and
81.27 must be capable of providing the support necessary to assist the participant in the use of
81.28 CFSS. If through the assessment process described in subdivision 5 a participant is
81.29 determined to be in need of a participant's representative, one must be selected. If the
81.30 participant is unable to assist in the selection of a participant's representative, the legal
81.31 representative shall appoint one. Two persons may be designated as a participant's
81.32 representative for reasons such as divided households and court-ordered custodies. Duties
81.33 of a participant's representatives may include:

82.1 (1) being available while services are provided in a method agreed upon by the participant
82.2 or the participant's legal representative and documented in the participant's CFSS service
82.3 delivery plan;

82.4 (2) monitoring CFSS services to ensure the participant's CFSS service delivery plan is
82.5 being followed; and

82.6 (3) reviewing and signing CFSS time sheets after services are provided to provide
82.7 verification of the CFSS services.

82.8 (v) "Person-centered planning process" means a process that is directed by the participant
82.9 to plan for CFSS services and supports.

82.10 (w) "Service budget" means the authorized dollar amount used for the budget model or
82.11 for the purchase of goods.

82.12 (x) "Shared services" means the provision of CFSS services by the same CFSS support
82.13 worker to two or three participants who voluntarily enter into an agreement to receive
82.14 services at the same time and in the same setting by the same employer.

82.15 (y) "Support worker" means a qualified and trained employee of the agency-provider
82.16 as required by subdivision 11b or of the participant employer under the budget model as
82.17 required by subdivision 14 who has direct contact with the participant and provides services
82.18 as specified within the participant's CFSS service delivery plan.

82.19 (z) "Unit" means the increment of service based on hours or minutes identified in the
82.20 service agreement.

82.21 (aa) "Vendor fiscal employer agent" means an agency that provides financial management
82.22 services.

82.23 (bb) "Wages and benefits" means the hourly wages and salaries, the employer's share
82.24 of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation,
82.25 mileage reimbursement, health and dental insurance, life insurance, disability insurance,
82.26 long-term care insurance, uniform allowance, contributions to employee retirement accounts,
82.27 or other forms of employee compensation and benefits.

82.28 (cc) "Worker training and development" means services provided according to subdivision
82.29 18a for developing workers' skills as required by the participant's individual CFSS service
82.30 delivery plan that are arranged for or provided by the agency-provider or purchased by the
82.31 participant employer. These services include training, education, direct observation and
82.32 supervision, and evaluation and coaching of job skills and tasks, including supervision of
82.33 health-related tasks or behavioral supports.

83.1 **EFFECTIVE DATE.** This section is effective August 1, 2018.

83.2 Sec. 41. Minnesota Statutes 2016, section 256B.85, subdivision 3, is amended to read:

83.3 Subd. 3. **Eligibility.** (a) CFSS is available to a person who meets one of the following:

83.4 (1) is an enrollee of medical assistance as determined under section 256B.055, 256B.056,
83.5 or 256B.057, subdivisions 5 and 9;

83.6 (2) is a participant in the alternative care program under section 256B.0913;

83.7 (3) is a waiver participant as defined under chapter 256S or section ~~256B.0915~~, 256B.092,
83.8 256B.093, or 256B.49; or

83.9 (4) has medical services identified in a person's individualized education program and
83.10 is eligible for services as determined in section 256B.0625, subdivision 26.

83.11 (b) In addition to meeting the eligibility criteria in paragraph (a), a person must also
83.12 meet all of the following:

83.13 (1) require assistance and be determined dependent in one activity of daily living or
83.14 Level I behavior based on assessment under section 256B.0911; and

83.15 (2) is not a participant under a family support grant under section 252.32.

83.16 **EFFECTIVE DATE.** This section is effective August 1, 2018.

83.17 Sec. 42. Minnesota Statutes 2016, section 256B.85, subdivision 6, is amended to read:

83.18 Subd. 6. **Community first services and supports service delivery plan.** (a) The CFSS
83.19 service delivery plan must be developed and evaluated through a person-centered planning
83.20 process by the participant, or the participant's representative or legal representative who
83.21 may be assisted by a consultation services provider. The CFSS service delivery plan must
83.22 reflect the services and supports that are important to the participant and for the participant
83.23 to meet the needs assessed by the certified assessor and identified in the coordinated service
83.24 and support plan identified in section ~~256B.0915, subdivision 6~~ 256S.10. The CFSS service
83.25 delivery plan must be reviewed by the participant, the consultation services provider, and
83.26 the agency-provider or FMS provider prior to starting services and at least annually upon
83.27 reassessment, or when there is a significant change in the participant's condition, or a change
83.28 in the need for services and supports.

83.29 (b) The commissioner shall establish the format and criteria for the CFSS service delivery
83.30 plan.

- 84.1 (c) The CFSS service delivery plan must be person-centered and:
- 84.2 (1) specify the consultation services provider, agency-provider, or FMS provider selected
- 84.3 by the participant;
- 84.4 (2) reflect the setting in which the participant resides that is chosen by the participant;
- 84.5 (3) reflect the participant's strengths and preferences;
- 84.6 (4) include the methods and supports used to address the needs as identified through an
- 84.7 assessment of functional needs;
- 84.8 (5) include the participant's identified goals and desired outcomes;
- 84.9 (6) reflect the services and supports, paid and unpaid, that will assist the participant to
- 84.10 achieve identified goals, including the costs of the services and supports, and the providers
- 84.11 of those services and supports, including natural supports;
- 84.12 (7) identify the amount and frequency of face-to-face supports and amount and frequency
- 84.13 of remote supports and technology that will be used;
- 84.14 (8) identify risk factors and measures in place to minimize them, including individualized
- 84.15 backup plans;
- 84.16 (9) be understandable to the participant and the individuals providing support;
- 84.17 (10) identify the individual or entity responsible for monitoring the plan;
- 84.18 (11) be finalized and agreed to in writing by the participant and signed by all individuals
- 84.19 and providers responsible for its implementation;
- 84.20 (12) be distributed to the participant and other people involved in the plan;
- 84.21 (13) prevent the provision of unnecessary or inappropriate care;
- 84.22 (14) include a detailed budget for expenditures for budget model participants or
- 84.23 participants under the agency-provider model if purchasing goods; and
- 84.24 (15) include a plan for worker training and development provided according to
- 84.25 subdivision 18a detailing what service components will be used, when the service components
- 84.26 will be used, how they will be provided, and how these service components relate to the
- 84.27 participant's individual needs and CFSS support worker services.
- 84.28 (d) The total units of agency-provider services or the service budget amount for the
- 84.29 budget model include both annual totals and a monthly average amount that cover the
- 84.30 number of months of the service agreement. The amount used each month may vary, but
- 84.31 additional funds must not be provided above the annual service authorization amount,

85.1 determined according to subdivision 8, unless a change in condition is assessed and
85.2 authorized by the certified assessor and documented in the coordinated service and support
85.3 plan and CFSS service delivery plan.

85.4 (e) In assisting with the development or modification of the CFSS service delivery plan
85.5 during the authorization time period, the consultation services provider shall:

85.6 (1) consult with the FMS provider on the spending budget when applicable; and

85.7 (2) consult with the participant or participant's representative, agency-provider, and case
85.8 manager/care coordinator.

85.9 (f) The CFSS service delivery plan must be approved by the consultation services provider
85.10 for participants without a case manager or care coordinator who is responsible for authorizing
85.11 services. A case manager or care coordinator must approve the plan for a waiver or alternative
85.12 care program participant.

85.13 **EFFECTIVE DATE.** This section is effective August 1, 2018.

85.14 Sec. 43. Minnesota Statutes 2016, section 295.50, subdivision 9b, is amended to read:

85.15 Subd. 9b. **Patient services.** (a) "Patient services" means inpatient and outpatient services
85.16 and other goods and services provided by hospitals, surgical centers, or health care providers.
85.17 They include the following health care goods and services provided to a patient or consumer:

85.18 (1) bed and board;

85.19 (2) nursing services and other related services;

85.20 (3) use of hospitals, surgical centers, or health care provider facilities;

85.21 (4) medical social services;

85.22 (5) drugs, biologicals, supplies, appliances, and equipment;

85.23 (6) other diagnostic or therapeutic items or services;

85.24 (7) medical or surgical services;

85.25 (8) items and services furnished to ambulatory patients not requiring emergency care;

85.26 and

85.27 (9) emergency services.

85.28 (b) "Patient services" does not include:

85.29 (1) services provided to nursing homes licensed under chapter 144A;

86.1 (2) examinations for purposes of utilization reviews, insurance claims or eligibility,
86.2 litigation, and employment, including reviews of medical records for those purposes;

86.3 (3) services provided to and by community residential mental health facilities licensed
86.4 under Minnesota Rules, parts 9520.0500 to 9520.0670, and to and by residential treatment
86.5 programs for children with severe emotional disturbance licensed or certified under chapter
86.6 245A;

86.7 (4) services provided to and by community support programs and family community
86.8 support programs approved under Minnesota Rules, parts 9535.1700 to 9535.1760, or
86.9 certified as mental health rehabilitative services under chapter 256B;

86.10 (5) services provided to and by community mental health centers as defined in section
86.11 245.62, subdivision 2;

86.12 (6) services provided to and by assisted living programs and congregate housing
86.13 programs;

86.14 (7) hospice care services;

86.15 (8) home and community-based waived services under chapter 256S and sections
86.16 ~~256B.0915, 256B.49, and 256B.501~~;

86.17 (9) targeted case management services under sections 256B.0621; 256B.0625,
86.18 subdivisions 20, 20a, 33, and 44; and 256B.094; and

86.19 (10) services provided to the following: supervised living facilities for persons with
86.20 developmental disabilities licensed under Minnesota Rules, parts 4665.0100 to 4665.9900;
86.21 housing with services establishments required to be registered under chapter 144D; board
86.22 and lodging establishments providing only custodial services that are licensed under chapter
86.23 157 and registered under section 157.17 to provide supportive services or health supervision
86.24 services; adult foster homes as defined in Minnesota Rules, part 9555.5105; day training
86.25 and habilitation services for adults with developmental disabilities as defined in section
86.26 252.41, subdivision 3; boarding care homes as defined in Minnesota Rules, part 4655.0100;
86.27 adult day care services as defined in section 245A.02, subdivision 2a; and home health
86.28 agencies as defined in Minnesota Rules, part 9505.0175, subpart 15, or licensed under
86.29 chapter 144A.

86.30 **EFFECTIVE DATE.** This section is effective August 1, 2018.

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256B.0915 MEDICAID WAIVER FOR ELDERLY SERVICES.

Subdivision 1. **Authority.** (a) The commissioner is authorized to apply for a home and community-based services waiver for the elderly, authorized under section 1915(c) of the Social Security Act, in order to obtain federal financial participation to expand the availability of services for persons who are eligible for medical assistance. The commissioner may apply for additional waivers or pursue other federal financial participation which is advantageous to the state for funding home care services for the frail elderly who are eligible for medical assistance. The provision of waived services to elderly and disabled medical assistance recipients must comply with the criteria for service definitions and provider standards approved in the waiver.

(b) The commissioner shall comply with the requirements in the federally approved transition plan for the home and community-based services waivers authorized under this section.

Subd. 1a. **Elderly waiver case management services.** (a) Except as provided to individuals under prepaid medical assistance programs as described in paragraph (h), 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 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 service 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 the process of reassessment of the individual's coordinated service and support plan and review the plan 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) Except as described in paragraph (h), 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 (e).

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

- (1) development of the coordinated service 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, which must incorporate at least one annual face-to-face visit by the case manager with each person.

(h) Notwithstanding any requirements in this section, for individuals enrolled in prepaid medical assistance programs under section 256B.69, subdivisions 6b and 23, the health plan shall provide

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or arrange to provide elderly waiver case management services in paragraph (g), in accordance with contract requirements established by the commissioner.

Subd. 1b. **Provider qualifications and standards.** (a) The commissioner must enroll qualified providers of 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. A 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 coordinated service and support plan development. Lead agencies include counties, health plans, and federally recognized tribes who authorize services under this section.

(b) A health plan shall provide or arrange to provide elderly waiver case management services in subdivision 1a, paragraph (g), in accordance with contract requirements established by the commissioner related to provider standards and qualifications.

Subd. 1d. **Posteligibility treatment of income and resources for elderly waiver.** Notwithstanding the provisions of section 256B.056, the commissioner shall make the following amendment to the medical assistance elderly waiver program effective July 1, 1999, or upon federal approval, whichever is later.

A recipient's maintenance needs will be an amount equal to the Minnesota supplemental aid equivalent rate as defined in section 256I.03, subdivision 5, plus the medical assistance personal needs allowance as defined in section 256B.35, subdivision 1, paragraph (a), when applying posteligibility treatment of income rules to the gross income of elderly waiver recipients, except for individuals whose income is in excess of the special income standard according to Code of Federal Regulations, title 42, section 435.236. Recipient maintenance needs shall be adjusted under this provision each July 1.

Subd. 2. **Spousal impoverishment policies.** The commissioner shall apply the spousal impoverishment criteria as authorized under United States Code, title 42, section 1396r-5, and as implemented in sections 256B.0575, 256B.058, and 256B.059, except that individuals with income at or below the special income standard according to Code of Federal Regulations, title 42, section 435.236, receive the maintenance needs amount in subdivision 1d.

Subd. 3. **Limits of cases.** The number of medical assistance waiver recipients that a lead agency may serve must be allocated according to the number of medical assistance waiver cases open on July 1 of each fiscal year. Additional recipients may be served with the approval of the commissioner.

Subd. 3a. **Elderly waiver cost limits.** (a) Effective on the first day of the state fiscal year in which the resident assessment system as described in section 256R.17 for nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the monthly limit for the cost of waived services to an individual elderly waiver client shall be the monthly limit of the case mix resident class to which the waiver client would be assigned under Minnesota Rules, parts 9549.0051 to 9549.0059, in effect on the last day of the previous state fiscal year, adjusted by any legislatively adopted home and community-based services percentage rate adjustment. If a legislatively authorized increase is service-specific, the monthly cost limit shall be adjusted based on the overall average increase to the elderly waiver program.

(b) The monthly limit for the cost of waived services under paragraph (a) to an individual elderly waiver client assigned to a case mix classification A with:

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(1) no dependencies in activities of daily living; or

(2) up to two dependencies in bathing, dressing, grooming, walking, and eating when the dependency score in eating is three or greater as determined by an assessment performed under section 256B.0911 shall be \$1,750 per month effective on July 1, 2011, for all new participants enrolled in the program on or after July 1, 2011. This monthly limit shall be applied to all other participants who meet this criteria at reassessment. This monthly limit shall be increased annually as described in paragraphs (a) and (e).

(c) If extended medical supplies and equipment or environmental modifications are or will be purchased for an elderly waiver client, the costs may be prorated for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's waived services exceeds the monthly limit established in paragraph (a), (b), (d), or (e), the annual cost of all waived services shall be determined. In this event, the annual cost of all waived services shall not exceed 12 times the monthly limit of waived services as described in paragraph (a), (b), (d), or (e).

(d) Effective July 1, 2013, the monthly cost limit of waiver services, including any necessary home care services described in section 256B.0651, subdivision 2, for individuals who meet the criteria as ventilator-dependent given in section 256B.0651, subdivision 1, paragraph (g), shall be the average of the monthly medical assistance amount established for home care services as described in section 256B.0652, subdivision 7, and the annual average contracted amount established by the commissioner for nursing facility services for ventilator-dependent individuals. This monthly limit shall be increased annually as described in paragraphs (a) and (e).

(e) Effective January 1, 2018, and each January 1 thereafter, the monthly cost limits for elderly waiver services in effect on the previous December 31 shall be increased by the difference between any legislatively adopted home and community-based provider rate increases effective on January 1 or since the previous January 1 and the average statewide percentage increase in nursing facility operating payment rates under chapter 256R, effective the previous January 1. This paragraph shall only apply if the average statewide percentage increase in nursing facility operating payment rates is greater than any legislatively adopted home and community-based provider rate increases effective on January 1, or occurring since the previous January 1.

Subd. 3b. Cost limits for elderly waiver applicants who reside in a nursing facility. (a) For a person who is a nursing facility resident at the time of requesting a determination of eligibility for elderly waived services, a monthly conversion budget limit for the cost of elderly waived services may be requested. The monthly conversion budget limit for the cost of elderly waiver services shall be the resident class assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, for that resident in the nursing facility where the resident currently resides until July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented. Effective on July 1 of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented, the monthly conversion budget limit for the cost of elderly waiver services shall be based on the per diem nursing facility rate as determined by the resident assessment system as described in section 256B.438 for residents in the nursing facility where the elderly waiver applicant currently resides. The monthly conversion budget limit shall be calculated by multiplying the per diem by 365, divided by 12, and reduced by the recipient's maintenance needs allowance as described in subdivision 1d. The initially approved monthly conversion budget limit shall be adjusted annually as described in subdivision 3a, paragraph (a). The limit under this subdivision only applies to persons discharged from a nursing facility after a minimum 30-day stay and found eligible for waived services on or after July 1, 1997. For conversions from the nursing home to the elderly waiver with consumer directed community support services, the nursing facility per diem used to calculate the monthly conversion budget limit must be reduced by a percentage equal to the percentage difference between the consumer directed services budget limit that would be assigned according to the federally approved waiver plan and the corresponding community case mix cap, but not to exceed 50 percent.

(b) The following costs must be included in determining the total monthly costs for the waiver client:

(1) cost of all waived services, including specialized supplies and equipment and environmental accessibility adaptations; and

(2) cost of skilled nursing, home health aide, and personal care services reimbursable by medical assistance.

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

Subd. 3d. **Adult foster care rate.** The adult foster care rate shall not include room and board. The elderly waiver payment for the foster care service in combination with the payment for all other elderly waiver services, including case management, must not exceed the limit specified in subdivision 3a, paragraph (a).

Subd. 3e. **Customized living service rate.** (a) Payment for customized living services shall be a monthly rate authorized by the lead agency within the parameters established by the commissioner. The payment agreement must delineate the amount of each component service included in the recipient's customized living service plan. The lead agency, with input from the provider of customized living services, shall ensure that there is a documented need within the parameters established by the commissioner for all component customized living services authorized.

(b) The payment rate must be based on the amount of component services to be provided utilizing component rates established by the commissioner. Counties and tribes shall use tools issued by the commissioner to develop and document customized living service plans and rates.

(c) Component service rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale. Customized living services must not include rent or raw food costs.

(d) With the exception of individuals described in subdivision 3a, paragraph (b), the individualized monthly authorized payment for the customized living service plan shall not exceed 50 percent of the statewide weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver eligible client would be assigned under Minnesota Rules, parts 9549.0051 to 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph (a). On July 1 of each year, the individualized monthly authorized payment for the services described in this clause shall not exceed the limit which was in effect on June 30 of the previous state fiscal year updated annually based on legislatively adopted changes to all service rate maximums for home and community-based service providers.

(e) The individualized monthly payment for the customized living service plan for individuals described in subdivision 3a, paragraph (b), must be the monthly authorized payment limit for customized living for individuals classified as case mix A, reduced by 25 percent. This rate limit must be applied to all new participants enrolled in the program on or after July 1, 2011, who meet the criteria described in subdivision 3a, paragraph (b). This monthly limit also applies to all other participants who meet the criteria described in subdivision 3a, paragraph (b), at reassessment.

(f) Customized living services are delivered by a provider licensed by the Department of Health as a class A or class F home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D. Licensed home care providers are subject to section 256B.0651, subdivision 14.

(g) A provider may not bill or otherwise charge an elderly waiver participant or their family for additional units of any allowable component service beyond those available under the service rate limits described in paragraph (e), nor for additional units of any allowable component service beyond those approved in the service plan by the lead agency.

(h) Effective January 1, 2018, and each January 1 thereafter, individualized service rate limits for customized living services under this subdivision shall be increased by the difference between any legislatively adopted home and community-based provider rate increases effective on January 1 or since the previous January 1 and the average statewide percentage increase in nursing facility operating payment rates under chapter 256R, effective the previous January 1. This paragraph shall only apply if the average statewide percentage increase in nursing facility operating payment rates is greater than any legislatively adopted home and community-based provider rate increases effective on January 1, or occurring since the previous January 1.

Subd. 3f. **Payments for services; expenditure forecasts.** (a) Lead agencies shall authorize payments for services in accordance with the payment rates and limits published annually by the commissioner.

(b) Reimbursement for the medical assistance recipients under the approved waiver shall be made from the medical assistance account through the invoice processing procedures of the department's Medicaid Management Information System (MMIS), only with the approval of the

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client's case manager. The budget for the state share of the Medicaid expenditures shall be forecasted with the medical assistance budget, and shall be consistent with the approved waiver.

Subd. 3g. **Service rate limits; state assumption of costs.** (a) To improve access to community services and eliminate payment disparities between the alternative care program and the elderly waiver, the commissioner shall establish statewide service rate limits and eliminate lead agency-specific service rate limits.

(b) Effective July 1, 2001, for statewide service rate limits, except those described or defined in subdivisions 3d, 3e, and 3h, the statewide service rate limit for each service shall be the greater of the alternative care statewide rate or the elderly waiver statewide rate.

Subd. 3h. **Service rate limits; 24-hour customized living services.** (a) The payment rate for 24-hour customized living services is a monthly rate authorized by the lead agency within the parameters established by the commissioner of human services. The payment agreement must delineate the amount of each component service included in each recipient's customized living service plan. The lead agency, with input from the provider of customized living services, shall ensure that there is a documented need within the parameters established by the commissioner for all component customized living services authorized. The lead agency shall not authorize 24-hour customized living services unless there is a documented need for 24-hour supervision.

(b) For purposes of this section, "24-hour supervision" means that the recipient requires assistance due to needs related to one or more of the following:

- (1) intermittent assistance with toileting, positioning, or transferring;
- (2) cognitive or behavioral issues;
- (3) a medical condition that requires clinical monitoring; or

(4) for all new participants enrolled in the program on or after July 1, 2011, and all other participants at their first reassessment after July 1, 2011, dependency in at least three of the following activities of daily living as determined by assessment under section 256B.0911: bathing; dressing; grooming; walking; or eating when the dependency score in eating is three or greater; and needs medication management and at least 50 hours of service per month. The lead agency shall ensure that the frequency and mode of supervision of the recipient and the qualifications of staff providing supervision are described and meet the needs of the recipient.

(c) The payment rate for 24-hour customized living services must be based on the amount of component services to be provided utilizing component rates established by the commissioner. Counties and tribes will use tools issued by the commissioner to develop and document customized living plans and authorize rates.

(d) Component service rates must not exceed payment rates for comparable elderly waiver or medical assistance services and must reflect economies of scale.

(e) The individually authorized 24-hour customized living payments, in combination with the payment for other elderly waiver services, including case management, must not exceed the recipient's community budget cap specified in subdivision 3a. Customized living services must not include rent or raw food costs.

(f) The individually authorized 24-hour customized living payment rates shall not exceed the 95 percentile of statewide monthly authorizations for 24-hour customized living services in effect and in the Medicaid management information systems on March 31, 2009, for each case mix resident class under Minnesota Rules, parts 9549.0051 to 9549.0059, to which elderly waiver service clients are assigned. When there are fewer than 50 authorizations in effect in the case mix resident class, the commissioner shall multiply the calculated service payment rate maximum for the A classification by the standard weight for that classification under Minnesota Rules, parts 9549.0051 to 9549.0059, to determine the applicable payment rate maximum. Service payment rate maximums shall be updated annually based on legislatively adopted changes to all service rates for home and community-based service providers.

(g) Notwithstanding the requirements of paragraphs (d) and (f), the commissioner may establish alternative payment rate systems for 24-hour customized living services in housing with services establishments which are freestanding buildings with a capacity of 16 or fewer, by applying a single hourly rate for covered component services provided in either:

- (1) licensed corporate adult foster homes; or

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(2) specialized dementia care units which meet the requirements of section 144D.065 and in which:

(i) each resident is offered the option of having their own apartment; or

(ii) the units are licensed as board and lodge establishments with maximum capacity of eight residents, and which meet the requirements of Minnesota Rules, part 9555.6205, subparts 1, 2, 3, and 4, item A.

(h) Twenty-four-hour customized living services are delivered by a provider licensed by the Department of Health as a class A or class F home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D. Licensed home care providers are subject to section 256B.0651, subdivision 14.

(i) A provider may not bill or otherwise charge an elderly waiver participant or their family for additional units of any allowable component service beyond those available under the service rate limits described in paragraph (e), nor for additional units of any allowable component service beyond those approved in the service plan by the lead agency.

(j) Effective January 1, 2018, and each January 1 thereafter, individualized service rate limits for 24-hour customized living services under this subdivision shall be increased by the difference between any legislatively adopted home and community-based provider rate increases effective on January 1 or since the previous January 1 and the average statewide percentage increase in nursing facility operating payment rates under chapter 256R, effective the previous January 1. This paragraph shall only apply if the average statewide percentage increase in nursing facility operating payment rates is greater than any legislatively adopted home and community-based provider rate increases effective on January 1, or occurring since the previous January 1.

Subd. 3i. Rate reduction for customized living and 24-hour customized living services. (a) Effective July 1, 2010, the commissioner shall reduce service component rates and service rate limits for customized living services and 24-hour customized living services, from the rates in effect on June 30, 2010, by five percent.

(b) To implement the rate reductions in this subdivision, capitation rates paid by the commissioner to managed care organizations under section 256B.69 shall reflect a ten percent reduction for the specified services for the period January 1, 2011, to June 30, 2011, and a five percent reduction for those services on and after July 1, 2011.

Subd. 3j. Individual community living support. Upon federal approval, there is established a new service called individual community living support (ICLS) that is available on the elderly waiver. ICLS providers may not be the landlord of recipients, nor have any interest in the recipient's housing. ICLS must be delivered in a single-family home or apartment where the service recipient or their family owns or rents, as demonstrated by a lease agreement, and maintains control over the individual unit. Case managers or care coordinators must develop individual ICLS plans in consultation with the client using a tool developed by the commissioner. The commissioner shall establish payment rates and mechanisms to align payments with the type and amount of service provided, assure statewide uniformity for payment rates, and assure cost-effectiveness. Licensing standards for ICLS shall be reviewed jointly by the Departments of Health and Human Services to avoid conflict with provider regulatory standards pursuant to section 144A.43 and chapter 245D.

Subd. 4. Termination notice. The case manager must give the individual a ten-day written notice of any denial, reduction, or termination of waived services.

Subd. 5. Assessments and reassessments for waiver clients. (a) Each client shall receive an initial assessment of strengths, informal supports, and need for services in accordance with section 256B.0911, subdivisions 3, 3a, and 3b. A reassessment of a client served under the elderly waiver must be conducted at least every 12 months. There must be a determination that the client requires nursing facility level of care as defined in section 256B.0911, subdivision 4e, at initial and subsequent assessments to initiate and maintain participation in the waiver program.

(b) 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 and 3b, that result in a nursing facility level of care determination will be accepted for purposes of initial and ongoing access to waiver service payment.

(c) The lead agency shall conduct a change-in-condition reassessment before the annual reassessment in cases where a client's condition changed due to a major health event, an emerging

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need or risk, worsening health condition, or cases where the current services do not meet the client's needs. A change-in-condition reassessment may be initiated by the lead agency, or it may be requested by the client or requested on the client's behalf by another party, such as a provider of services. The lead agency shall complete a change-in-condition reassessment no later than 20 calendar days from the request. The lead agency shall conduct these assessments in a timely manner and expedite urgent requests. The lead agency shall evaluate urgent requests based on the client's needs and risk to the client if a reassessment is not completed.

Subd. 6. Implementation of coordinated service and support plan. (a) Each elderly waiver client shall be provided a copy of a written coordinated service and support plan which:

(1) is developed and signed by the recipient within ten working days after the case manager receives the assessment information and written community support plan as described in section 256B.0911, subdivision 3a, from the certified assessor;

(2) includes 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 welfare 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-range 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;

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

(9) includes the authorized annual and estimated monthly amounts for the services.

(b) In developing the coordinated service 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.

Subd. 7. Prepaid elderly waiver services. An individual for whom a prepaid health plan is liable for nursing home services or elderly waiver services according to section 256B.69, subdivision 6a, is not eligible to also receive county-administered elderly waiver services.

Subd. 8. Services and supports. (a) Services and supports shall meet the requirements set out in United States Code, title 42, section 1396n.

(b) Services and supports shall promote consumer choice and be arranged and provided consistent with individualized, written care plans.

(c) The state of Minnesota, county, managed care organization, or tribal government under contract to administer the elderly waiver shall not be liable for damages, injuries, or liabilities sustained through the purchase of direct supports or goods by the person, the person's family, or the authorized representatives with funds received through consumer-directed community support services under the federally approved waiver plan. Liabilities include, but are not limited to, workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA).

Subd. 9. Tribal management of elderly waiver. Notwithstanding contrary provisions of this section, or those in other state laws or rules, the commissioner may develop a model for tribal management of the elderly waiver program and implement this model through a contract between the state and any of the state's federally recognized tribal governments. The model shall include the provision of tribal waiver case management, assessment for personal care assistance, and administrative requirements otherwise carried out by lead agencies but shall not include tribal financial eligibility determination for medical assistance.

Subd. 10. Waiver payment rates; managed care organizations. The commissioner shall adjust the elderly waiver capitation payment rates for managed care organizations paid under section

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256B.69, subdivisions 6b and 23, to reflect the maximum service rate limits for customized living services and 24-hour customized living services under subdivisions 3e and 3h. Medical assistance rates paid to customized living providers by managed care organizations under this section shall not exceed the maximum service rate limits and component rates as determined by the commissioner under subdivisions 3e and 3h.

Subd. 11. **Payment rates; application.** The payment methodologies in subdivisions 12 to 16 apply to elderly waiver and elderly waiver customized living under this section, alternative care under section 256B.0913, essential community supports under section 256B.0922, and community access for disability inclusion customized living, brain injury customized living, and elderly waiver foster care and residential care.

Subd. 12. **Payment rates; phase-in.** Effective January 1, 2019, all rates and rate components for services under subdivision 11 shall be the sum of ten percent of the rates calculated under subdivisions 13 to 16 and 90 percent of the rates calculated using the rate methodology in effect as of June 30, 2017.

Subd. 13. **Payment rates; establishment.** (a) When establishing the base wages according to subdivision 14, the commissioner shall use standard occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in the edition of the Occupational Handbook published immediately prior to January 1, 2019, using Minnesota-specific wages taken from job descriptions.

(b) Beginning January 1, 2019, and every January 1 thereafter, the commissioner shall establish factors, component rates, and rates according to subdivisions 15 and 16, using base wages established according to paragraph (a) and subdivision 14.

Subd. 14. **Payment rates; base wage index.** (a) Base wages are calculated for customized living, foster care, and residential care component services as follows:

(1) the home management and support services base wage equals 33.33 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home care aide (SOC code 39-9021); 33.33 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for food preparation workers (SOC code 35-2021); and 33.34 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012);

(2) the home care aide base wage equals 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for home health aides (SOC code 31-1011); and 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014);

(3) the home health aide base wage equals 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed vocational nurses (SOC code 29-2061); and 80 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014); and

(4) the medication setups by licensed practical nurse base wage equals ten percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed vocational nurses (SOC code 29-2061); and 90 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code 29-1141).

(b) Base wages are calculated for the following services as follows:

(1) the chore services base wage equals 100 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for landscaping and groundskeeping workers (SOC code 37-3011);

(2) the companion services base wage equals 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home care aides (SOC code 39-9021); and 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012);

(3) the homemaker services and assistance with personal care base wage equals 60 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home care aide (SOC code 39-9021); 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014); and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012);

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(4) the homemaker services and cleaning base wage equals 60 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home care aide (SOC code 39-9021); 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014); and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012);

(5) the homemaker services and home management base wage equals 60 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home care aide (SOC code 39-9021); 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014); and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and housekeeping cleaners (SOC code 37-2012);

(6) the in-home respite care services base wage equals five percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code 29-1141); 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014); and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed vocational nurses (SOC code 29-2061);

(7) the out-of-home respite care services base wage equals five percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code 29-1141); 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014); and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed vocational nurses (SOC code 29-2061); and

(8) the individual community living support base wage equals 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed vocational nurses (SOC code 29-2061); and 80 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code 31-1014).

(c) Base wages are calculated for the following values as follows:

(1) the registered nurse base wage equals 100 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code 29-1141); and

(2) the social worker base wage equals 100 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for medical and public health social workers (SOC code 21-1022).

(d) If any of the SOC codes and positions are no longer available, the commissioner shall, in consultation with stakeholders, select a new SOC code and position that is the closest match to the previously used SOC position.

Subd. 15. **Payment rates; factors.** The commissioner shall use the following factors:

(1) the payroll taxes and benefits factor is the sum of net payroll taxes and benefits divided by the sum of all salaries for all nursing facilities on the most recent and available cost report;

(2) the general and administrative factor is the sum of net general and administrative expenses minus administrative salaries divided by total operating expenses for all nursing facilities on the most recent and available cost report;

(3) the program plan support factor is 12.8 percent to cover the cost of direct service staff needed to provide support for the home and community-based service when not engaged in direct contact with clients;

(4) the registered nurse management and supervision factor equals 15 percent of the product of the position's base wage and the sum of the factors in clauses (1) to (3); and

(5) the social worker supervision factor equals 15 percent of the product of the position's base wage and the sum of the factors in clauses (1) to (3).

Subd. 16. **Payment rates; component rates.** (a) For the purposes of this subdivision, the "adjusted base wage" for a position equals the position's base wage plus:

(1) the position's base wage multiplied by the payroll taxes and benefits factor;

(2) the position's base wage multiplied by the general and administrative factor; and

(3) the position's base wage multiplied by the program plan support factor.

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(b) For medication setups by licensed nurse, registered nurse, and social worker services, the component rate for each service equals the respective position's adjusted base wage.

(c) For home management and support services, home care aide, and home health aide services, the component rate for each service equals the respective position's adjusted base wage plus the registered nurse management and supervision factor.

(d) The home management and support services component rate shall be used for payment for socialization and transportation component rates under elderly waiver customized living.

(e) The 15-minute unit rates for chore services and companion services are calculated as follows:

- (1) sum the adjusted base wage for the respective position and the social worker factor; and
- (2) divide the result of clause (1) by four.

(f) The 15-minute unit rates for homemaker services and assistance with personal care, homemaker services and cleaning, and homemaker services and home management are calculated as follows:

- (1) sum the adjusted base wage for the respective position and the registered nurse management and supervision factor; and
- (2) divide the result of clause (1) by four.

(g) The 15-minute unit rate for in-home respite care services is calculated as follows:

- (1) sum the adjusted base wage for in-home respite care services and the registered nurse management and supervision factor; and
- (2) divide the result of clause (1) by four.

(h) The in-home respite care services daily rate equals the in-home respite care services 15-minute unit rate multiplied by 18.

(i) The 15-minute unit rate for out-of-home respite care is calculated as follows:

- (1) sum the out-of-home respite care services adjusted base wage and the registered nurse management and supervision factor; and
- (2) divide the result of clause (1) by four.

(j) The out-of-home respite care services daily rate equals the out-of-home respite care services 15-minute unit rate multiplied by 18.

(k) The individual community living support rate is calculated as follows:

- (1) sum the adjusted base wage for the home care aide rate in subdivision 14, paragraph (a), clause (2), and the social worker factor; and
- (2) divide the result of clause (1) by four.

(l) The home delivered meals rate equals \$9.30. Beginning July 1, 2018, the commissioner shall increase the home delivered meals rate every July 1 by the percent increase in the nursing facility dietary per diem using the two most recent and available nursing facility cost reports.

(m) The adult day services rate is based on the home care aide rate in subdivision 14, paragraph (a), clause (2), plus the additional factors from subdivision 15, except that the general and administrative factor used shall be 20 percent. The nonregistered nurse portion of the rate shall be multiplied by 0.25, to reflect an assumed-ratio staffing of one caregiver to four clients, and divided by four to determine the 15-minute unit rate. The registered nurse portion is divided by four to determine the 15-minute unit rate and \$0.63 per 15-minute unit is added to cover the cost of meals.

(n) The adult day services bath 15-minute unit rate is the same as the calculation of the adult day services 15-minute unit rate without the adjustment for staffing ratio.

(o) If a bath is authorized for an adult day services client, at least two 15-minute units must be authorized to allow for adequate time to meet client needs. Adult day services may be authorized for up to 48 units, or 12 hours, per day based on client and family caregiver needs.

Subd. 17. **Evaluation of rate methodology.** The commissioner, in consultation with stakeholders, shall conduct a study to evaluate the following:

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(1) base wages in subdivision 14, to determine if the standard occupational classification codes for each rate and component rate are an appropriate representation of staff who deliver the services; and

(2) factors in subdivision 15, and adjusted base wage calculation in subdivision 16, to determine if the factors and calculations appropriately address nonwage provider costs.

By January 1, 2019, the commissioner shall submit a report to the legislature on the changes to the rate methodology in this statute, based on the results of the evaluation. Where feasible, the report shall address the impact of the new rates on the workforce situation and client access to services. The report should include any changes to the rate calculations methods that the commissioner recommends.