SENATE
STATE OF MINNESOTA
EIGHTY-SEVENTH LEGISLATURE

S.F. No. 2140

(SENATE AUTHORS: HANN)

DATE	D-PG	OFFICIAL STATUS
03/01/2012	4069	Introduction and first reading Referred to Health and Human Services

A bill for an act

relating to human services; establishing new payment rate-setting methodologies for home and community-based waiver services; providing rulemaking authority; amending Minnesota Statutes 2010, sections 245A.11, subdivision 8; 256B.0911, by adding a subdivision; 256B.0916, subdivision 2; 256B.092, subdivision 4; 256B.49, subdivision 17; 256B.4912; proposing coding for new law in Minnesota Statutes, chapter 256B.

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

Section 1. Minnesota Statutes 2010, section 245A.11, subdivision 8, is amended to read:

Subd. 8. **Community residential setting license.** (a) The commissioner shall establish provider standards for residential support services that integrate service standards and the residential setting under one license. The commissioner shall propose statutory language and an implementation plan for licensing requirements for residential support services to the legislature by January 15, 2011.

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

(c) Individuals receiving services under the community residential setting license shall have a team to support them in making decisions regarding services. These teams shall be called "support teams" and be composed of the person; the case manager or services coordinator; the person's legal representative; the person's advocate, if any; other people chosen by the person receiving services; and the representatives of providers of

service areas relevant to the needs of the person as described in the coordinated service and support plan.

(d) The support team shall have access to information or data included in the assessment conducted under section 256B.0911, subdivision 10, that is needed to complete treatment and risk assessment plans.

(e) Support teams shall have the final decision regarding plans to mitigate vulnerabilities identified for an individual. Based on an assessment, the individual and support team can choose not to create a plan for identified vulnerabilities that do not rise to the level of self neglect, maltreatment, or violations of the law, if the team accepts the vulnerability as part of a person's qualify of life. Any licensing review or other oversight shall review that the team has gone through the process of an assessment and has come to an agreement on whether a plan will be developed for any individual vulnerability. The licensing review shall not include authority to challenge the decision of the team.

(f) Support teams shall be included in any formal or informal evaluation of the quality of services provided to an individual.

(g) Region 10 staff shall be consulted regarding establishing a system for evaluating the quality of services provided under the community residential setting license.

Sec. 2. Minnesota Statutes 2010, section 256B.0911, is amended by adding a subdivision to read:

Subd. 10. **Disability waivered services assessment requirements.** The commissioner of human services shall establish an assessment methodology to determine reimbursement classifications based upon each individual's assessed needs for services reimbursed under section 256B.4913.

(a) For purposes of this subdivision, the following terms have the meanings given them:

(1) "high medical needs" means complex health-related needs that require on-site medical attention and are specified in the coordinated service and support plan;

(2) "high behavioral needs" means a history of observable behavior that deviates from social norms as defined and counted in the assessment that require comprehensive training in behavior management, behavior programming, de-escalation techniques, or medication management training for behavior medications. Examples of participant needs include, but are not limited to, a participant at risk of or with a history of:

(i) elopement, defined as when a patient or resident who is cognitively, physically, mentally, emotionally, or chemically impaired wanders away, walks away, runs away,

escapes, or otherwise leaves a caregiving facility or environment unsupervised, unnoticed, or prior to their scheduled discharge; or

(ii) serious harm to self or others;

(3) "high mental health needs" means a history of a mental disorder, diagnosed by a physician and confirmed in the assessment, that requires constant staff oversight without which the consequences of the participant's behaviors are severe. The management of these needs requires comprehensive training in mental health issues, dual diagnosis, and medication management training. This means a current diagnosis of severe and persistent mental illness or severe emotional disturbance that manifests itself through one of the following:

(i) serious harm to self or others; or

(ii) other extreme behaviors that interfere with major life activities; and

(4) "deaf or hard-of-hearing" means a loss of hearing diagnosed by a physician and confirmed in the assessment that requires staff proficient in one or more of the following to communicate:

(i) American sign language;

(ii) tactile interpretation; or

(iii) other sign language.

(b) The commissioner shall ensure that:

(1) the assessment includes a full and accurate accounting of each individual's need for supports;

(2) the results of the methodology for each individual are statistically valid and reliable, and for each individual's result, there is a statistically significant level of interrated reliability; and

(3) the assessment determines if an individual fits the definitions of high medical needs, high behavioral needs, high mental health needs, or deaf or hard-of-hearing.

(c) The assessment methodology must be completed prior to the implementation of any changes to rates determined under section 246B.4913.

(d) Any individual may appeal the results of the individual's assessment as outlined in section 256.045.

(e) The commissioner shall adopt rules under section 14.05 to implement this methodology.

Sec. 3. Minnesota Statutes 2010, section 256B.0916, subdivision 2, is amended to read:

Subd. 2. **Distribution of funds; partnerships.** (a) Beginning with fiscal year 2000, the commissioner shall distribute all funding available for home and community-based

waiver services for persons with developmental disabilities to individual counties or to groups of counties that form partnerships to jointly plan, administer, and authorize funding for eligible individuals. The commissioner shall encourage counties to form partnerships that have a sufficient number of recipients and funding to adequately manage the risk and maximize use of available resources.

(b) Counties must submit a request for funds and a plan for administering the program as required by the commissioner. The plan must identify the number of clients to be served, their ages, and their priority listing based on:

(1) requirements in Minnesota Rules, part 9525.1880; and

(2) statewide priorities identified in section 256B.092, subdivision 12.

The plan must also identify changes made to improve services to eligible persons and to improve program management.

(c) In allocating resources to counties, priority must be given to groups of counties that form partnerships to jointly plan, administer, and authorize funding for eligible individuals and to counties determined by the commissioner to have sufficient waiver capacity to maximize resource use.

(d) Within 30 days after receiving the county request for funds and plans, the commissioner shall provide a written response to the plan that includes the level of resources available to serve additional persons.

(e) Counties are eligible to receive medical assistance administrative reimbursement for administrative costs under criteria established by the commissioner.

(f) Upon implementation of rate methodologies developed under section 256B.4913, the commissioner shall adjust allocations to local agencies for home and community-based waivered service allocations to reflect the total amount of spending for all recipients with disabilities in their respective counties in need of the level of care provided in an intermediate care facility for individuals with developmental disabilities, a nursing facility, or a hospital as determined by the methodology in section 256B.4913.

Sec. 4. Minnesota Statutes 2010, section 256B.092, subdivision 4, is amended to read:

Subd. 4. **Home and community-based services for developmental disabilities.** (a) The commissioner shall make payments to approved vendors participating in the medical assistance program to pay costs of providing home and community-based services, including case management service activities provided as an approved home and community-based service, to medical assistance eligible persons with developmental disabilities who have been screened under subdivision 7 and according to federal requirements. Federal requirements include those services and limitations included in the

federally approved application for home and community-based services for persons with developmental disabilities and subsequent amendments.

(b) Effective July 1, 1995, contingent upon federal approval and state appropriations made available for this purpose, and in conjunction with Laws 1995, chapter 207, article 8, section 40, the commissioner of human services shall allocate resources to county agencies for home and community-based waivered services for persons with developmental disabilities authorized but not receiving those services as of June 30, 1995, based upon the average resource need of persons with similar functional characteristics. To ensure service continuity for service recipients receiving home and community-based waivered services for persons with developmental disabilities prior to July 1, 1995, the commissioner shall make available to the county of financial responsibility home and community-based waivered services resources based upon fiscal year 1995 authorized levels.

(c) Home and community-based resources for all recipients shall be managed by ~~the county of financial responsibility within an allowable reimbursement average established for~~ each county. Payments for home and community-based services provided to individual recipients shall not exceed amounts authorized by the county of financial responsibility. For specifically identified former residents of nursing facilities, the commissioner shall be responsible for authorizing payments and payment limits under the appropriate home and community-based service program. Payment is available under this subdivision only for persons who, if not provided these services, would require the level of care provided in an intermediate care facility for persons with developmental disabilities.

(d) Resources and payment rates for all recipients of home and community-based services shall remain as negotiated by each county of fiscal responsibility as of January 1, 2012.

(e) Resources and payment rates for recipients of home and community-based services enrolled prior to January 1, 2012, may be adjusted for changes in needs using processes by county agencies established as of January 1, 2012.

(f) Any new recipients of home and community-based services after January 1, 2012, shall have resources managed by the county using the process in place in each county as of January 1, 2012.

(g) Counties may not implement changes to resources for individuals under section 256B.4913, until the implementation of a statistically valid and reliable process for assessing each individual's needs under section 256B.0911, subdivision 10.

Sec. 5. Minnesota Statutes 2010, section 256B.49, subdivision 17, is amended to read:

Subd. 17. **Cost of services and supports.** (a) The commissioner shall ensure that the average per capita expenditures estimated in any fiscal year for home and community-based waiver recipients does not exceed the average per capita expenditures that would have been made to provide institutional services for recipients in the absence of the waiver.

(b) ~~The commissioner shall implement on January 1, 2002, one or more aggregate, need-based methods for allocating to local agencies the home and community-based waivered service resources available to support recipients with disabilities in need of the level of care provided in a nursing facility or a hospital.~~ Upon implementation of rate methodologies developed under section 256B.4913, the commissioner shall adjust allocations to local agencies for home and community-based waivered service allocations to reflect the total amount of spending for all recipients with disabilities in their respective counties in need of the level of care provided in an intermediate care facility for individuals with developmental disabilities, a nursing facility, or a hospital as determined by the methodology in section 256B.4913:

(1) the commissioner shall set each county's allocation to include resources for the total amount of spending for each respective county based on the total number of individuals estimated to be served multiplied by each individual's service rate determined under section 256B.4913; and

(2) if an individual relocates from one county to another within a calendar year, the commissioner shall adjust county allocations to reflect where the individual is receiving services.

(c) Until the allocation method described in paragraph (b) is implemented, the commissioner shall allocate resources to single counties and county partnerships in a manner that reflects consideration of:

(1) an incentive-based payment process for achieving outcomes;

(2) the need for a state-level risk pool;

(3) the need for retention of management responsibility at the state agency level; and

(4) a phase-in strategy as appropriate.

~~(c) Until the allocation methods described in paragraph (b) are implemented, the annual allowable reimbursement level of home and community-based waiver services shall be the greater of:~~

~~(1) the statewide average payment amount which the recipient is assigned under the waiver reimbursement system in place on June 30, 2001, modified by the percentage of any provider rate increase appropriated for home and community-based services; or~~

~~(2) an amount approved by the commissioner based on the recipient's extraordinary needs that cannot be met within the current allowable reimbursement level. The increased reimbursement level must be necessary to allow the recipient to be discharged from an institution or to prevent imminent placement in an institution. The additional reimbursement may be used to secure environmental modifications; assistive technology and equipment; and increased costs for supervision, training, and support services necessary to address the recipient's extraordinary needs. The commissioner may approve an increased reimbursement level for up to one year of the recipient's relocation from an institution or up to six months of a determination that a current waiver recipient is at imminent risk of being placed in an institution.~~

(d) Beginning July 1, 2001, medically necessary private duty nursing services will be authorized under this section as complex and regular care according to sections 256B.0651 to 256B.0656 and 256B.0659. The rate established by the commissioner for registered nurse or licensed practical nurse services under any home and community-based waiver as of January 1, 2001, shall not be reduced.

(e) Notwithstanding section 252.28, subdivision 3, paragraph (d), if the 2009 legislature adopts a rate reduction that impacts payment to providers of adult foster care services, the commissioner may issue adult foster care licenses that permit a capacity of five adults. The application for a five-bed license must meet the requirements of section 245A.11, subdivision 2a. Prior to admission of the fifth recipient of adult foster care services, the county must negotiate a revised per diem rate for room and board and waiver services that reflects the legislated rate reduction and results in an overall average per diem reduction for all foster care recipients in that home. The revised per diem must allow the provider to maintain, as much as possible, the level of services or enhanced services provided in the residence, while mitigating the losses of the legislated rate reduction.

Sec. 6. Minnesota Statutes 2010, section 256B.4912, is amended to read:

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

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

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

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

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

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

(c) Upon enactment of section 256B.4913, providers of waiver services must reenroll with the state. County and tribal agency contracts existing prior to January 1, 2013, are not effective beginning January 1, 2013.

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

(b) No changes in existing provider rates are effective until the development and implementation of an assessment methodology for individuals assessed under section 256B.0911, subdivision 10, that provides a statistically reliable and valid means for assessing each individual's support needs.

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

(b) Payment rates shall be determined according to reasonable, ordinary, and necessary costs that accurately reflect the actual cost of service delivery.

(c) Payment rates shall be sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that care and services are available to the general population in the geographic area as required by section 1902(a)(30)(A) of the Social Security Act.

(d) The commissioner must not reimburse:

(1) unauthorized service delivery;

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

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

(4) extended employment services under Minnesota Rules, parts 3300.2005 to 3300.3100; or vocational rehabilitation services provided under the federal Rehabilitation

Act, United States Code, title I, section 110, as amended; or United States Code, title VI, part C, and not through use of medical assistance or county social service funds; or

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

(e) Payment rates are set prospectively and may not be enforced retroactively.

Sec. 7. **[256B.4913] HOME AND COMMUNITY-BASED WAIVERS; RATE-SETTING METHODOLOGIES.**

Subdivision 1. **Applicable services.** "Applicable services" are those authorized under the state's home and community-based waivers under sections 256B.092 and 256B.49, including those defined in the federally approved home and community-based services plan, as follows:

(1) adult day care;

(2) family adult day services;

(3) day training and habilitation;

(4) prevocational services;

(5) structured day services;

(6) supported employment services;

(7) behavioral programming;

(8) housing access coordination;

(9) independent living services;

(10) in-home family supports;

(11) night supervision;

(12) personal support;

(13) supported living services;

(14) transportation services;

(15) respite services;

(16) residential services; or

(17) any other services approved as part of the state's home and community-based services plan.

Subd. 2. **Base wage index.** (a) The base wage index is established to determine staffing costs associated with providing services to individuals receiving home and community-based services.

(b) The base wage shall be calculated using a composite of wages taken from job descriptions and standard occupational classification (SOC) codes from the Bureau

of Labor Statistics, as defined in the most recent edition of the Occupational Outlook Handbook. The base wage index shall be calculated as follows:

(1) for day services, 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services workers (SOC code 21-1093);

(2) for residential direct care staff, 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(3) for residential awake overnight staff, 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(4) for residential asleep overnight staff, the wage will be $7.66 per hour, adjusted annually by the Consumer Price Index for urban wage earners;

(5) for supported living services hourly staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(6) for behavior programming aide staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(7) for behavioral programming professional staff, 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(8) for supported employment job coach staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(9) for supported employment job developer staff, 50 percent of the median wage for rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for social and human services aide (SOC code 21-1093);

(10) for in-home family support, 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(11) for housing access coordination staff, 50 percent of the median wage for community and social services specialist (SOC code 21-1099); and 50 percent of the median wage for social and human services aide (SOC code 21-1093);

(12) for night supervision staff, 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(13) for respite staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides, orderlies, and attendants (SOC code 31-1012);

(14) for personal support staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides, orderlies, and attendants (SOC code 31-1012);

(15) for transportation staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(16) for independent living skills staff, ten percent of the median wage for nursing aides, orderlies, and attendants (SOC code 31-1012); 30 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093); and

(17) for supervisory staff, 55 percent of the median wage for medical and health services managers (SOC code 11-9111).

(c) The commissioner shall update the base wage index on an annual basis upon the release of the December 31 data of the most recent year from the Bureau of Labor Statistics and publish the base wage index on July 1 of the beginning of the next fiscal year.

(d) The commissioner shall adjust payment rates for changes in the base wage index on an annual basis for each individual receiving waivered services.

(e) The commissioner shall determine the staffing component of each individual's payment rate receiving services under sections 256B.092 and 256B.49 using the base wage index.

Subd. 3. **Payments for residential services.** (a) Payments for services in residential settings include supported living services, foster care, residential care, customized living, and 24-hour customized living.

(b) The separate components of each individual's payment rate for residential services shall be calculated as follows:

(1) for direct supervision, the commissioner shall determine the number of units of service to be used utilizing the assessment process in section 256B.0911, subdivision 10. The support team in section 245A.11, subdivision 8, shall determine the number of hours of direct supervision to be comprised of direct staff and supervision technology:

(i) for direct staff cost:

(A) the commissioner shall determine staff wages for shared staff, individual staffing, and supervision staffing using the base wage index in subdivision 2. The direct care cost is the staff wage multiplied by the number of direct staff hours specified by each individual's support team;

(B) for individuals that qualify for a customization under subdivision 6, add the customization rate provided in subdivision 6 to the base wage amount determined in the direct care cost;

(C) multiply the number of direct staff hours by the staff wage; and

(D) multiply the result of the previous calculation by one plus 9.4 percent;

(ii) for supervision technology cost:

(A) the commissioner shall determine supervision technology wages using the base wage index in subdivision 2. The supervision technology cost is the staff wage multiplied by the number of supervision technology hours specified by each individual's support team;

(B) for individuals that qualify for a customization under subdivision 6, add the customization rate provided in subdivision 6 to the base wage amount determined in the supervision technology cost;

(C) multiply the number of supervision technology hours by the staff wage; and

(D) add the amounts under subitems (B) and (C) to obtain the direct staffing cost;

(iii) add the amounts from items (i) and (ii) to obtain the direct supervision cost;

(2) for employee-related expenses:

(i) the commissioner shall include an adjustment of 10.3 percent for the cost of taxes and workers' compensation;

(ii) the commissioner shall include an adjustment of 16.2 percent for the cost of other benefits, including health insurance, dental insurance, life insurance, short-term disability insurance, long-term disability insurance, vision insurance, retirement, and tuition reimbursement; and

(iii) the total of the two percentages under items (i) and (ii) is the total percentage for employee-related expenses;

(3) for transportation:

(i) the commissioner shall include an amount for the costs of acquiring and maintaining vehicles for the transportation of individuals, as follows: $1,875 for a standard vehicle; $3,803 for a full-size adapted van; and $2,208 for a minivan;

(ii) for individuals requiring individualized customization, the commissioner shall include the number of miles multiplied by $0.51 per mile for a standard vehicle, $1.43 for a full-size adapted van, and $0.61 for a minivan. The amount of miles for customization shall be determined by each individual's support team under section 245A.11, subdivision 8; and

(iii) the total under items (i) and (ii) is the total for transportation;

(4) for client programming and supports:

(i) the commissioner shall add $2,179 for the cost of client programming and supports; and

(ii) for individuals that had previously received an adjustment to rates under section 256B.501, subdivision 4, the commissioner shall add an amount to reflect the costs of providing services allowable under title XIX of the Social Security Act to obtain the total for client programming and supports;

(5) for support costs:

(i) the commissioner shall include an adjustment of 16.5 percent for standard and general administrative support;

(ii) the commissioner shall include an adjustment of 2.65 percent for program support; and

(iii) the total of the adjustments under items (i) and (ii) is the total percentage for support costs; and

(6) for administrative overhead:

(i) the commissioner shall include an adjustment of 6.58 percent for costs associated with absence overhead;

(ii) the commissioner shall include an adjustment of 3.8 percent for utilization overhead; and

(iii) the total of the adjustments under items (i) and (ii) is the total percentage for administrative overhead.

(c) The total rate shall be calculated using the following steps:

(1) the direct supervision cost multiplied by one plus the total percentage for employee-related expenses;

(2) plus the total for transportation;

(3) plus the total for client programming and supports;

(4) the subtotal of clauses (1) to (3), multiplied by one plus the total percentage for support costs;

(5) the subtotal of clauses (1) to (4), multiplied by one plus the total percentage for administrative overhead; and

(6) divide the total of clause (5) by 365 to obtain the daily rate.

Subd. 4. **Payment for day program services.** (a) Payments for services with day programs include adult day care, family adult day care, day training and habilitation, prevocational services, and structured day services.

(b) The separate components of each individual's payment rate for day program services shall be calculated as follows:

(1) for direct staffing:

(i) the commissioner shall determine the number of units of service to be used and each individual's support ratio utilizing the assessment process in section 256B.0911, subdivision 10;

(ii) the commissioner shall determine staff wages using the base wage index in subdivision 2. The direct care cost is the staff wage multiplied by the number of units of service. The commissioner shall include 4.5 supervisory hours per week for each individual at a staffing ratio of 1:1. Supervisory hours will reduce as ratios increase, but shall not be less than 2.5 hours per week. The number of hours shall be prorated for less than full-day participation;

(iii) for individuals that qualify for a customization under subdivision 6, add the customization rate provided in subdivision 6 to the base wage amount determined in the direct care cost;

(iv) multiply the units of service by the staff wage;

(v) multiply the result of the calculation in item (iv) by 9.4 percent; and

(vi) add the amounts under items (iv) and (v) to obtain the direct staffing cost;

(2) for employee-related expenses:

(i) the commissioner shall include an adjustment of 10.3 percent for the cost of taxes and workers' compensation;

(ii) the commissioner shall include an adjustment of 16.2 percent for the cost of other benefits, including health insurance, dental insurance, life insurance, short-term disability insurance, long-term disability insurance, vision insurance, retirement, and tuition reimbursement; and

(iii) the total of the two percentages under items (i) and (ii) is the total percentage for employee-related expenses;

(3) for transportation:

(i) the commissioner shall determine the number of trips required, as determined under the assessment process in section 256B.0911, subdivision 10;

(ii) the commissioner shall determine the total distance transported from the person's residence to the initial day service destination and whether an individual requires the use of a lift;

(iii) for each trip to and from each individual's residence, the commissioner shall add a value of:

(A) for distances of zero to ten miles, the commissioner shall pay $7.77 per trip for individuals transported in a vehicle equipped with a wheelchair lift, and $7.00 for those who are transported in other vehicles;

(B) for individuals who are transported 11 to 20 miles, the commissioner shall pay $10.27 per trip for individuals transported in a vehicle equipped with a wheelchair lift, and $7.87 for those who are transported in other vehicles;

(C) for individuals who are transported 21 to 50 miles, the commissioner shall pay $15.04 per trip for individuals transported in a vehicle equipped with a wheelchair lift, and $9.53 for those who are transported in other vehicles; and

(D) for individuals transported 51 or more miles, the commissioner shall pay $18.74 per trip for individuals transported in a vehicle equipped with a wheelchair lift, and $10.80 for those who are transported in other vehicles;

(iv) these rates shall apply regardless of whether the person is being transported alone or with others;

(v) the rates identified in paragraph (c) shall be adjusted within 30 days by the commissioner using the same percentage as used by the Internal Revenue Service when adjusting standard mileage rates for business purposes; and

(vi) the rates determined in this clause are the total for transportation;

(4) for program plan and supports, the commissioner shall add 16.6 percent for the cost of program plan and supports;

(5) the commissioner shall include an adjustment of ten percent for the cost of client programming and supports;

(6) for support costs:

(i) the commissioner shall include an adjustment of 16.5 percent for standard and general administrative support;

(ii) the commissioner shall include an adjustment of 2.65 percent for program support;

(iii) the commissioner shall add $31.69 per week for the facility reasonable-use rate; and

(iv) the total of the adjustments under items (i) to (iii) is the total percentage for support costs; and

(7) for administrative overhead:

(i) the commissioner shall include an adjustment of 6.58 percent for costs associated with absence overhead;

(ii) the commissioner shall include an adjustment of 3.8 percent for utilization overhead; and

(iii) the total of the adjustments under items (i) and (ii) is the total percentage for administrative overhead.

(c) The total rate shall be calculated using the following steps:

(1) the direct staffing cost multiplied by one plus the total percentage for employee-related expenses;

(2) plus the total for transportation;

(3) plus the cost for program plan and supports;

(4) plus the cost for client programming and supports;

(5) the subtotal of clauses (1) to (4), multiplied by one plus the total percentage for support costs;

(6) the subtotal of clauses (1) to (5), multiplied by one plus the total percentage for administrative overhead; and

(7) divide the total in clause (6) by 365 to obtain the daily rate.

Subd. 5. **Payment for individualized services.** (a) Payments for individualized services include supported employment, behavioral programming, housing access coordination, independent living services, in-home family supports, night supervision, personal support, and respite services.

(b) The separate components of each individual's payment rate for individualized services shall be calculated as follows:

(1) for direct staffing:

(i) the commissioner shall determine the number of units of service to be used utilizing the assessment process in section 256B.0911, subdivision 10;

(ii) the commissioner shall determine staff wages for shared staff, individual staffing, and supervision staffing using the base wage index in subdivision 2. The direct care cost is the staff wage multiplied by the number of units of service;

(iii) for individuals that qualify for a customization under subdivision 6, add the customization rate provided in subdivision 6 to the base wage amount determined in the direct care cost;

(iv) multiply the units of service by the staff wage;

(v) multiply the result of the calculation in item (iv) by 9.4 percent; and

(vi) add the amounts under items (iv) and (v) to obtain the direct staffing cost;

(2) for employee-related expenses:

(i) the commissioner shall include an adjustment of 10.3 percent for the cost of taxes and workers' compensation;

(ii) the commissioner shall include an adjustment of 16.2 percent for the cost of other benefits, including health insurance, dental insurance, life insurance, short-term disability insurance, long-term disability insurance, vision insurance, retirement, and tuition reimbursement; and

(iii) the total of the percentages under items (i) and (ii) is the total percentage for employee-related expenses;

(3) for program plan and supports, the commissioner shall add 16.6 percent for the cost of program plan supports;

(4) for client programming and supports, the commissioner shall include an adjustment of ten percent for the cost of client programming and supports; and

(5) for support costs:

(i) the commissioner shall include an adjustment of 16.5 percent for standard and general administrative support;

(ii) the commissioner shall include an adjustment of 2.65 percent for program support; and

(iii) the total of the adjustments under the two previous items is the total percentage for support costs; and

(6) for administrative overhead:

(i) the commissioner shall include an adjustment of 6.58 percent for costs associated with absence overhead;

(ii) the commissioner shall include an adjustment of 3.8 percent for utilization overhead; and

(iii) the total of the adjustments under items (i) and (ii) is the total percentage for administrative overhead.

(c) The total rate shall be calculated using the following steps:

(1) the direct staffing cost multiplied by one plus the total percentage for employee-related expenses;

(2) plus the cost for program plan supports;

(3) plus the cost for client programming and supports;

(4) the subtotal of clauses (1) to (3), multiplied by one plus the total percentage for support costs;

(5) the subtotal of clauses (1) to (4), multiplied by one plus the total percentage for administrative overhead; and

(6) adjust the total in clause (5) to reflect the hourly units of service that will be provided to the individual per year, and divide by four to obtain the 15-minute rate.

Subd. 6. **Customization of rates for individuals.** For persons determined to have higher needs based on their assessed needs, as determined by the process in section 256B.0911, subdivision 10, those individuals will receive an increase in staffing wages. The customization add-on shall be:

(1) for individuals assessed as having high medical needs, $1.79 per authorized hour;

(2) for individuals assessed as having high behavioral needs, $2.01 per authorized hour;

(3) for individuals assessed as having high mental health needs, $2.01 per authorized hour; and

(4) for individuals assessed as being deaf or hard-of-hearing, $1.79 per authorized hour.

Subd. 7. **Rate exception process.** (a) A variance from rates determined in subdivisions 3, 4, and 5 may be granted by the lead agency when:

(1) an individual is set to be discharged; and

(2) the rate determined is inadequate to meet the health and safety needs of that individual.

(b) The lead agency shall have 30 calendar days from the date of the receipt of the complete request from the vendor for a rate variance to accept or reject it, or the request shall be deemed to have been granted. The lead agency shall state in writing the specific objections to the request and the reasons for its rejection.

(c) If the lead agency rejects the request from the vendor for a rate variance, the vendor may appeal the decision to the commissioner of human services. The commissioner shall have 30 calendar days to consider the appeal. The commissioner shall state in writing the specific objections to the request and the reasons for its rejection of the appeal.

(d) The commissioner shall collect information annually and report on the number of exceptions granted under this subdivision.

Subd. 8. **Cost neutrality adjustment.** (a) The commissioner shall calculate the spending for all long-term care waivered services under the payments as defined in subdivisions 3, 4, and 5 for each group of service. These groups are defined as:

(1) residential services, including corporate foster care, family foster care, residential care, supported living services, customized living, and 24-hour customized living;

(2) day program services, including adult day care, day training and habilitation, prevocational services, and structured day services;

(3) hourly services with programming, including in-home family support, independent living services, supported living services, supported employment, behavior programming, and housing access coordination;

(4) hourly services without programming, including respite, personal support, and night supervision; and

(5) individualized services, including 24-hour emergency assistance, assistive technology, caregiver training and education, consumer education and training, crisis respite, family counseling and training, independent living service therapies, live-in caregiver expenses, modification and adaptations, specialist services, specialized supplies and equipment, transitional, and transportation services.

(b) If spending for each group of service does not equal the total spending under current law, the commissioner shall apply an across-the-board adjustment to payment rates to align the levels of overall spending under current law.

Subd. 9. **Budget neutrality adjustment.** (a) The commissioner shall calculate the total spending for all long-term care waivered services under the payments as defined in subdivisions 3, 4, and 5, and total spending under current law for the fiscal year beginning July 1, 2013. If total spending under subdivisions 3, 4, and 5 is projected to be higher than under current law, the commissioner shall adjust the rate by whatever percentage is needed to reduce aggregate spending to the same level as projected under current law.

(b) The commissioner shall make any future across-the-board adjustment to provider rates in this portion of the rate calculation.

Subd. 10. **Individual rate notification.** Upon request, the commissioner shall make available the rate calculation for each individual to any member of the individual's support team under sections 245A.11, subdivision 8, and 256B.4913, subdivisions 3, 4, and 5, prior to any cost or budget neutrality adjustments.

Subd. 11. **Rulemaking authority.** The commissioner shall adopt rules under section 14.05 to address the implementation of the payment methodology system. These

rules will address processes for detailing the implementation of this payment methodology system, including the roles and responsibilities of the department, lead agencies, and service providers.

Subd. 12. **Rate review and adjustments.** (a) If an individual's needs change, the commissioner shall reassess that individual's needs under the process as outlined in section 256B.0911, subdivision 10.

(b) If there is a material change to an individual's existing services, the commissioner shall reassess that individual's needs under the assessment process outlined in section 256B.0911, subdivision 10.

Subd. 13. **Reports and data.** Twelve months prior to final implementation, the commissioner shall:

(1) generate and publish provider rates calculated under this section;

(2) provide an analysis of the impact of the rate methodology system to the legislature that includes:

(i) the average individual rate for residential services and day training and habilitation services under the new and previous methodologies; and

(ii) the projected supply of service providers prior to and after implementation.

Sec. 8. **EFFECTIVE DATE; APPLICATION.**

Sections 1 to 7 are effective the day following final enactment. The rate-setting methodologies in section 7 apply on January 1, 2013, following the implementation of the assessment methodology under Minnesota Statutes, section 256B.0911, subdivision 10.