CHAPTER 256S

MEDICAL ASSISTANCE ELDERLY WAIVER

256S.01 GENERALLY.

Subdivision 1. **Authority.** 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, 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 that is advantageous to the state for funding home care services for the elderly who are eligible for medical assistance. The provision of waiver services to an elderly person receiving medical assistance must comply with the criteria for service definitions and provider standards approved in the elderly waiver.

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

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

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

Subd. 4. **Payment for services.** Reimbursement for the services provided to a participant under this chapter and under the elderly waiver must 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 participant's case manager.

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

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

History: *2019 c 54 art 1 s 1*

256S.02 DEFINITIONS.

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

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

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

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

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

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

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

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

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

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

Subd. 11. **Customized living service rate.** "Customized living service rate" means the rate established for all combined component services based on an individualized customized living service plan approved

by the lead agency, not to exceed the customized living monthly service rate limit based on the participant's case mix classification.

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

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

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

Subd. 15. **Lead agency.** "Lead agency" means a county administering long-term care consultation services as defined in section 256B.0911, subdivision 1a, or a tribe or managed care organization under contract with the commissioner to administer long-term care consultation services as defined in section 256B.0911, subdivision 1a.

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

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

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

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

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

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

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

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

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

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

History: *2019 c 54 art 1 s 2*

256S.03 ADMINISTRATION BY TRIBES.

Notwithstanding any other state laws or rules, the commissioner may develop a model for tribal management of the elderly waiver 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 elderly 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.

History: *2019 c 54 art 1 s 3*

256S.04 LIMITS OF ELDERLY WAIVER CASES.

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

History: *2019 c 54 art 1 s 4*

256S.05 ELIGIBILITY.

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

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

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

Subd. 4. **Spousal impoverishment policies.** For the purposes of eligibility for elderly waiver services, 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 a participant with income at or below the special income standard according to Code of Federal Regulations, title 42, section 435.236, shall receive the maintenance needs allowance in subdivision 3.

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

History: *2019 c 54 art 1 s 5*

256S.06 ASSESSMENTS AND REASSESSMENTS.

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

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

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

(b) A change-in-condition reassessment may be initiated by the lead agency, may be requested by the participant, or may be requested on the participant's behalf by another 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 a change-in-condition reassessment 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.

History: *2019 c 54 art 1 s 6*

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.

History: *2019 c 54 art 1 s 7*

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 must 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 must 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.

History: *2019 c 54 art 1 s 8*

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.

History: *2019 c 54 art 1 s 9*

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 the timelines established by the commissioner and section 256B.0911, subdivision 3a, paragraph (e), the case manager must develop with the participant 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;

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

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

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

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

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

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

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

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

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

History: *2019 c 54 art 1 s 10,33; 1Sp2019 c 9 art 5 s 49*

256S.11 APPROVAL REQUIRED FOR CERTAIN STATE PLAN HOME CARE SERVICES.

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

(1) skilled nursing services;

(2) home care nursing;

(3) home health aide services; and

(4) personal care assistance services.

History: *2019 c 54 art 1 s 11*

256S.12 ADULT DAY SERVICES.

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

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

History: *2019 c 54 art 1 s 12*

256S.13 INDIVIDUAL COMMUNITY LIVING SUPPORTS.

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

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

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

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

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

History: *2019 c 54 art 1 s 13*

256S.14 TERMINATION OF ELDERLY WAIVER SERVICES.

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

History: *2019 c 54 art 1 s 14*

256S.15 ESTABLISHMENT OF ELDERLY WAIVER SERVICE RATES AND SERVICE RATE LIMITS.

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

Subd. 2. **Foster care limit.** 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 monthly case mix budget cap for the participant as specified in sections 256S.18, subdivision 3, and 256S.19, subdivisions 3 and 4.

History: *2019 c 54 art 1 s 15*

256S.16 AUTHORIZATION OF ELDERLY WAIVER SERVICES AND SERVICE RATES.

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

History: *2019 c 54 art 1 s 16*

256S.17 COSTS EXCLUDED FROM ELDERLY WAIVER SERVICE RATES.

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

History: *2019 c 54 art 1 s 17*

256S.18 MONTHLY CASE MIX BUDGET CAPS; GENERALLY.

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

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

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

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

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

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

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

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

Subd. 4. **Monthly case mix budget cap prorating for specialized supplies, equipment, or environmental modifications.** If specialized supplies and equipment or environmental accessibility and adaptations are or will be purchased for a participant, these costs may be prorated for up to 12 consecutive

months beginning with the month of purchase. If the monthly cost of a participant's elderly waiver services exceeds the participant's monthly case mix budget cap established under subdivision 3, 5, or 6, the annual cost of all elderly waiver services shall be determined. In this event, the annual cost of all elderly waiver services shall not exceed 12 times the applicable monthly case mix budget cap under subdivision 3, 5, or 6.

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

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

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

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

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

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

Subd. 7. **Monthly case mix budget cap exception.** The commissioner shall approve an exception to the monthly case mix budget cap in paragraph (a) to account for the additional cost of providing enhanced rate personal care assistance services under section 256B.0659 or 256B.85. The exception shall not exceed 107.5 percent of the budget otherwise available to the individual. The exception must be reapproved on an annual basis at the time of a participant's annual reassessment.

[See Note.]

History: *2019 c 54 art 1 s 18,33; 1Sp2019 c 9 art 5 s 48*

NOTE: The amendment to Minnesota Statutes, section 256B.0915, subdivision 3a, adding paragraph (f), by Laws 2019, First Special Session chapter 9, article 5, section 48, coded as Minnesota Statutes, section 256S.18, subdivision 7, is effective July 1, 2019, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Laws 2019, First Special Session chapter 9, article 5, section 48, the effective date.

256S.19 MONTHLY CASE MIX BUDGET CAPS; NURSING FACILITY RESIDENTS.

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

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

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

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

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

Subd. 4. **Calculation of monthly conversion budget cap with consumer-directed community supports.** For the elderly waiver monthly conversion budget cap for the cost of elderly waiver services with consumer-directed community support services, the nursing facility case mix adjusted total payment rate used under subdivision 3 to calculate the monthly conversion budget cap for elderly waiver services without consumer-directed community supports 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 elderly waiver plan and the corresponding monthly case mix budget cap under this chapter, but not to exceed 50 percent.

History: *2019 c 54 art 1 s 19*

256S.20 CUSTOMIZED LIVING SERVICES; POLICY.

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

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

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

Subd. 4. **24-hour customized living services eligibility.** (a) The lead agency shall not authorize 24-hour customized living services unless the participant receiving customized living services requires assistance, including 24-hour supervision, 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) the need for medication management, at least 50 hours of services per month, and a 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.

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

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

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

History: *2019 c 54 art 1 s 20*

256S.201 CUSTOMIZED LIVING SERVICES; RATES.

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

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

Subd. 3. **Customized living service rates.** The authorized rates for customized living services and 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 shall use tools issued by the commissioner to develop and document customized living service plans and rates.

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

History: *2019 c 54 art 1 s 21*

256S.202 CUSTOMIZED LIVING SERVICES; RATE LIMITS.

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

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

Subd. 2. **24-hour customized living monthly service rate limits.** (a) The 24-hour customized living monthly service rate limit is the 95th 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 participants are assigned, adjusted at least annually in the manner described under section 256S.18, subdivisions 5 and 6.

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

History: *2019 c 54 art 1 s 22*

256S.203 CUSTOMIZED LIVING SERVICES; MANAGED CARE RATES.

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

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

History: *2019 c 54 art 1 s 23*

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.

History: *2019 c 54 art 1 s 24*

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.

History: *2019 c 54 art 1 s 25*

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.

History: *2019 c 54 art 1 s 26*

256S.211 RATE SETTING; RATE ESTABLISHMENT.

Subdivision 1. **Establishing base wages.** When establishing the base wages according to section 256S.212, 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.

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

History: *2019 c 54 art 1 s 27*

256S.212 RATE SETTING; BASE WAGE INDEX.

Subdivision 1. **Updating SOC codes.** If any of the SOC codes and positions used in this section 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. 2. **Home management and support services base wage.** For customized living, foster care, and residential care component services, 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).

Subd. 3. **Home care aide base wage.** For customized living, foster care, and residential care component services, 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).

Subd. 4. **Home health aide base wage.** For customized living, foster care, and residential care component services, 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).

Subd. 5. **Medication setups by licensed nurse base wage.** For customized living, foster care, and residential care component services, the medication setups by licensed 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).

Subd. 6. **Chore services base wage.** 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).

Subd. 7. **Companion services base wage.** 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).

Subd. 8. **Homemaker services and assistance with personal care base wage.** 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).

Subd. 9. **Homemaker services and cleaning base wage.** 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).

Subd. 10. **Homemaker services and home management base wage.** 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).

Subd. 11. **In-home respite care services base wage.** 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).

Subd. 12. **Out-of-home respite care services base wage.** 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).

Subd. 13. **Individual community living support base wage.** 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).

Subd. 14. **Registered nurse base wage.** 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).

Subd. 15. **Social worker base wage.** 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).

History: *2019 c 54 art 1 s 28*

256S.213 RATE SETTING; FACTORS.

Subdivision 1. **Payroll taxes and benefits factor.** 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.

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

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

Subd. 4. **Registered nurse management and supervision factor.** The registered nurse management and supervision factor equals 15 percent of the registered nurse adjusted base wage as defined in section 256S.214.

Subd. 5. **Social worker supervision factor.** The social worker supervision factor equals 15 percent of the social worker adjusted base wage as defined in section 256S.214.

History: *2019 c 54 art 1 s 29*

256S.214 RATE SETTING; ADJUSTED BASE WAGE.

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

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

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

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

History: *2019 c 54 art 1 s 30*

256S.215 RATE SETTING; COMPONENT RATES.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) sum the in-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.

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

Subd. 13. **Out-of-home respite care services rates.** (a) 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

History: *2019 c 54 art 1 s 31*