State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-SEVENTH SESSION

H. F. No. 2456

02/22/2012 Authored by Abeler and Loeffler
The bill was read for the first time and referred to the Committee on Health and Human Services Reform
03/08/2012 Adoption of Report: Pass as Amended and re-referred to the Committee on Civil Law
03/22/2012 Adoption of Report: Pass as Amended and re-referred to the Committee on Health and Human Services Finance

A bill for an act

relating to human services; amending continuing care policy provisions; making changes to disability services and licensing provisions; establishing home and community-based services standards; establishing payment methodologies; requiring a report; providing rulemaking authority; amending Minnesota Statutes 2010, sections 245A.03, subdivision 2; 245A.041, by adding subdivisions; 245A.085; 245B.02, subdivision 10, by adding a subdivision; 245B.04, subdivisions 1, 2, 3; 245B.05, subdivision 1; 245B.07, subdivisions 5, 9, 10, by adding a subdivision; 252.40; 252.41, subdivision 3; 252.42; 252.43; 252.44; 252.45; 252.451, subdivisions 2, 5; 252.46, subdivision 1a; 256B.0911, by adding a subdivision; 256B.0916, subdivision 2; 256B.092, subdivision 4; 256B.49, subdivision 17; 256B.4912; 256B.501, subdivision 4b; 256B.5013, subdivision 1; Minnesota Statutes 2011 Supplement, section 256B.49, subdivision 16a; proposing coding for new law in Minnesota Statutes, chapters 245A; 256B; proposing coding for new law as Minnesota Statutes, chapter 245D.

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

ARTICLE 1

STATEWIDE PROVIDER ENROLLMENT, PERFORMANCE STANDARDS, AND RATE-SETTING METHODOLOGY

Section 1. Minnesota Statutes 2010, section 245A.03, subdivision 2, is amended to read:

Subd. 2. **Exclusion from licensure.** (a) This chapter does not apply to:

(1) residential or nonresidential programs that are provided to a person by an individual who is related unless the residential program is a child foster care placement made by a local social services agency or a licensed child-placing agency, except as provided in subdivision 2a;

(2) nonresidential programs that are provided by an unrelated individual to persons from a single related family;

(3) residential or nonresidential programs that are provided to adults who do not abuse chemicals or who do not have a chemical dependency, a mental illness, a developmental disability, a functional impairment, or a physical disability;

(4) sheltered workshops or work activity programs that are certified by the commissioner of employment and economic development;

(5) programs operated by a public school for children 33 months or older;

(6) nonresidential programs primarily for children that provide care or supervision for periods of less than three hours a day while the child's parent or legal guardian is in the same building as the nonresidential program or present within another building that is directly contiguous to the building in which the nonresidential program is located;

(7) nursing homes or hospitals licensed by the commissioner of health except as specified under section 245A.02;

(8) board and lodge facilities licensed by the commissioner of health that do not provide children's residential services under Minnesota Rules, chapter 2960, mental health or chemical dependency treatment;

(9) homes providing programs for persons placed by a county or a licensed agency for legal adoption, unless the adoption is not completed within two years;

(10) programs licensed by the commissioner of corrections;

(11) recreation programs for children or adults that are operated or approved by a park and recreation board whose primary purpose is to provide social and recreational activities;

(12) programs operated by a school as defined in section 120A.22, subdivision 4; YMCA as defined in section 315.44; YWCA as defined in section 315.44; or JCC as defined in section 315.51, whose primary purpose is to provide child care or services to school-age children;

(13) Head Start nonresidential programs which operate for less than 45 days in each calendar year;

(14) noncertified boarding care homes unless they provide services for five or more persons whose primary diagnosis is mental illness or a developmental disability;

(15) programs for children such as scouting, boys clubs, girls clubs, and sports and art programs, and nonresidential programs for children provided for a cumulative total of less than 30 days in any 12-month period;

(16) residential programs for persons with mental illness, that are located in hospitals;

(17) the religious instruction of school-age children; Sabbath or Sunday schools; or the congregate care of children by a church, congregation, or religious society during the period used by the church, congregation, or religious society for its regular worship;

(18) camps licensed by the commissioner of health under Minnesota Rules, chapter 4630;

(19) mental health outpatient services for adults with mental illness or children with emotional disturbance;

(20) residential programs serving school-age children whose sole purpose is cultural or educational exchange, until the commissioner adopts appropriate rules;

~~(21) unrelated individuals who provide out-of-home respite care services to persons with developmental disabilities from a single related family for no more than 90 days in a 12-month period and the respite care services are for the temporary relief of the person's family or legal representative;~~

~~(22) respite care services provided as a home and community-based service to a person with a developmental disability, in the person's primary residence;~~

~~(23)~~ (21) community support services programs as defined in section 245.462, subdivision 6, and family community support services as defined in section 245.4871, subdivision 17;

~~(24)~~ (22) the placement of a child by a birth parent or legal guardian in a preadoptive home for purposes of adoption as authorized by section 259.47;

~~(25)~~ (23) settings registered under chapter 144D which provide home care services licensed by the commissioner of health to fewer than seven adults;

~~(26)~~ (24) chemical dependency or substance abuse treatment activities of licensed professionals in private practice as defined in Minnesota Rules, part 9530.6405, subpart 15, when the treatment activities are not paid for by the consolidated chemical dependency treatment fund;

~~(27)~~ (25) consumer-directed community support service funded under the Medicaid waiver for persons with developmental disabilities when the individual who provided the service is:

(i) the same individual who is the direct payee of these specific waiver funds or paid by a fiscal agent, fiscal intermediary, or employer of record; and

(ii) not otherwise under the control of a residential or nonresidential program that is required to be licensed under this chapter when providing the service; or

~~(28)~~ (26) a program serving only children who are age 33 months or older, that is operated by a nonpublic school, for no more than four hours per day per child, with no more than 20 children at any one time, and that is accredited by:

(i) an accrediting agency that is formally recognized by the commissioner of education as a nonpublic school accrediting organization; or

(ii) an accrediting agency that requires background studies and that receives and investigates complaints about the services provided.

A program that asserts its exemption from licensure under item (ii) shall, upon request from the commissioner, provide the commissioner with documentation from the accrediting agency that verifies: that the accreditation is current; that the accrediting agency investigates complaints about services; and that the accrediting agency's standards require background studies on all people providing direct contact services.

(b) For purposes of paragraph (a), clause (6), a building is directly contiguous to a building in which a nonresidential program is located if it shares a common wall with the building in which the nonresidential program is located or is attached to that building by skyway, tunnel, atrium, or common roof.

(c) Except for the home and community-based services identified in section 245D.03, subdivision 1, nothing in this chapter shall be construed to require licensure for any services provided and funded according to an approved federal waiver plan where licensure is specifically identified as not being a condition for the services and funding.

Sec. 2. Minnesota Statutes 2010, section 245A.041, is amended by adding a subdivision to read:

Subd. 3. **Record retention; license holder requirements.** (a) A license holder must maintain and store records in a manner that will allow for review by the commissioner as identified in section 245A.04, subdivision 5. The following records must be maintained as specified and in accordance with applicable state or federal law, regulation, or rule:

(1) service recipient records, including verification of service delivery, must be maintained for a minimum of five years following discharge or termination of service;

(2) personnel records must be maintained for a minimum of five years following termination of employment; and

(3) program administration and financial records must be maintained for a minimum of five years from the date the program closes.

(b) A license holder who ceases to provide services must maintain all records related to the licensed program for five years from the date the program closes. The license holder must notify the commissioner of the location where the licensing records will be stored and the name of the person responsible for maintaining the stored records.

(c) If the ownership of a licensed program or service changes, the transferor, unless otherwise provided by law or written agreement with the transferee, is responsible for maintaining, preserving, and making available to the commissioner on demand the license records generated before the date of the transfer.

(d) In the event of a contested case, the license holder must retain records as required in paragraph (a) or until the final agency decision is issued and the conclusion of any related appeal, whichever period is longer.

Sec. 3. Minnesota Statutes 2010, section 245A.041, is amended by adding a subdivision to read:

Subd. 4. **Electronic records; license holder use.** A license holder's use of electronic record keeping or electronic signatures must meet the following requirements:

(1) use of electronic record keeping or electronic signatures does not alter the license holder's obligations under state or federal law, regulation, or rule;

(2) the license holder must ensure that the use of electronic record keeping does not limit the commissioner's access to records as specified under section 245A.04, subdivision 5;

(3) upon request, the license holder must assist the commissioner in accessing and copying all records, including encrypted records and electronic signatures; and

(4) the license holder must establish a mechanism or procedure to ensure that:

(i) the act of creating the electronic record or signature is attributable to the license holder, according to section 325L.09;

(ii) the electronic records and signatures are maintained in a form capable of being retained and accurately reproduced;

(iii) the commissioner has access to information that establishes the date and time that data and signatures were entered into the electronic record; and

(iv) the license holder's use of electronic record keeping or electronic signatures does not compromise the security of the records.

Sec. 4. **[245A.042] HOME AND COMMUNITY-BASED SERVICES; ADDITIONAL STANDARDS AND PROCEDURES.**

Subdivision 1. **Standards governing the provision of home and community-based services.** Residential and nonresidential programs for persons with disabilities or age 65 and older must obtain a license according to this chapter to provide home and community-based services defined in the federal waiver plans governed by United States Code, title 42, sections 1396 et seq., or the state's alternative care program according to section 256B.0913, and identified in section 245D.03, subdivision 1. As a condition of licensure, an applicant or license holder must demonstrate and maintain verification of compliance with:

(1) licensing requirements under this chapter and chapter 245D;

(2) applicable health care program requirements under Minnesota Rules, parts 9505.0170 to 9505.0475 and 9505.2160 to 9505.2245; and

(3) provider standards and qualifications identified in the federal waiver plans or the alternative care program.

Subd. 2. **Implementation.** Licensure of home and community-based services according to this section will be implemented upon authorization for the commissioner to collect fees according to section 245A.10, subdivisions 3 and 4, necessary to support licensing functions. License applications will be received on a phased in schedule as determined by the commissioner. Licenses will be issued on or after January 1, 2013, according to section 245A.04.

Sec. 5. Minnesota Statutes 2010, section 245A.085, is amended to read:

245A.085 CONSOLIDATION OF HEARINGS; RECONSIDERATION.

Hearings authorized under this chapter, chapter 245C, and sections 256.045, 256B.04, 626.556, and 626.557, shall be consolidated if feasible and in accordance with other applicable statutes and rules. Reconsideration under sections 245C.28; 626.556, subdivision 10i; and 626.557, subdivision 9d, shall also be consolidated if feasible.

Sec. 6. Minnesota Statutes 2010, section 245B.02, is amended by adding a subdivision to read:

Subd. 8a. **Emergency.** "Emergency" means any fires, severe weather, natural disasters, power failures, or any event that affects the ordinary daily operation of the program, including, but not limited to, events that threaten the immediate health and safety of a person receiving services and that require calling 911, emergency evacuation, moving to an emergency shelter, or temporary closure or relocation of the program to another facility or service site.

Sec. 7. Minnesota Statutes 2010, section 245B.02, subdivision 10, is amended to read:

Subd. 10. **Incident.** "Incident" means an occurrence that affects the ordinary provision of services to a person and includes any of the following:

(1) serious injury as determined by section 245.91, subdivision 6;

(2) a consumer's death;

(3) any medical ~~emergencies~~ emergency, unexpected serious ~~illnesses~~ illness, or ~~accidents~~ significant unexpected changes in an illness or medical condition, or the mental health status of a person that ~~require~~ requires calling 911 or a mental health mobile crisis intervention team, physician treatment, or hospitalization;

(4) a consumer's unauthorized or unexplained absence;

~~(5) any fires or other events that require the relocation of services for more than 24 hours, or circumstances involving a law enforcement agency or fire department related to the health, safety, or supervision of a consumer;~~

~~(6)~~ (5) physical aggression by a consumer against another consumer that causes physical pain, injury, or persistent emotional distress, including, but not limited to, hitting, slapping, kicking, scratching, pinching, biting, pushing, and spitting;

~~(7)~~ (6) any sexual activity between consumers involving force or coercion as defined under section 609.341, subdivisions 3 and 14; or

~~(8)~~ (7) a report of child or vulnerable adult maltreatment under section 626.556 or 626.557.

Sec. 8. Minnesota Statutes 2010, section 245B.04, subdivision 1, is amended to read:

Subdivision 1. **License holder's responsibility for consumers' rights.** The license holder must:

(1) provide the consumer or the consumer's legal representative a copy of the consumer's rights on the day that services are initiated and an explanation of the rights in subdivisions 2 and 3 within five working days of service initiation and annually thereafter. Reasonable accommodations shall be made by the license holder to provide this information in other formats as needed to facilitate understanding of the rights by the consumer and the consumer's legal representative, if any;

(2) document the consumer's or the consumer's legal representative's receipt of a copy of the rights and an explanation of the rights; and

(3) ensure the exercise and protection of the consumer's rights in the services provided by the license holder and authorized in the individual service plan.

Sec. 9. Minnesota Statutes 2010, section 245B.04, subdivision 2, is amended to read:

Subd. 2. **Service-related rights.** A consumer's service-related rights include the right to:

(1) refuse or terminate services and be informed of the consequences of refusing or terminating services;

(2) know, in advance, limits to the services available from the license holder;

(3) know conditions and terms governing the provision of services, including ~~those~~ the license holder's policies and procedures related to initiation and termination;

(4) know what the charges are for services, regardless of who will be paying for the services, and be notified upon request of changes in those charges;

(5) know, in advance, whether services are covered by insurance, government funding, or other sources, and be told of any charges the consumer or other private party may have to pay; and

(6) receive licensed services from individuals who are competent and trained, who have professional certification or licensure, as required, and who meet additional qualifications identified in the individual service plan.

Sec. 10. Minnesota Statutes 2010, section 245B.04, subdivision 3, is amended to read:

Subd. 3. **Protection-related rights.** (a) The consumer's protection-related rights include the right to:

(1) have personal, financial, services, and medical information kept private, and be advised of the license holder's policies and procedures regarding disclosure of such information;

(2) access records and recorded information about the person in accordance with applicable state and federal law, regulation, or rule;

(3) be free from maltreatment;

(4) be treated with courtesy and respect for the consumer's individuality, mode of communication, and culture, and receive respectful treatment of the consumer's property;

(5) reasonable observance of cultural and ethnic practice and religion;

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

(7) be informed of and use the license holder's grievance policy and procedures, including knowing how to contact persons responsible for addressing problems and to appeal under section 256.045;

(8) know the name, telephone number, and the Web site, e-mail, and street addresses of protection and advocacy services, including the appropriate state-appointed ombudsman, and a brief description of how to file a complaint with these offices;

~~(5)~~ (9) voice grievances, know the contact persons responsible for addressing problems and how to contact those persons;

~~(6)~~ (10) any procedures for grievance or complaint resolution and the right to appeal under section 256.045;

~~(7)~~ (11) know the name and address of the state, county, or advocacy agency to contact for additional information or assistance;

~~(8)~~ (12) assert these rights personally, or have them asserted by the consumer's family or legal representative, without retaliation;

~~(9)~~ (13) give or withhold written informed consent to participate in any research or experimental treatment;

~~(10)~~ (14) have daily, private access to and use of a non-coin-operated telephone for local calls and long-distance calls made collect or paid for by the resident;

~~(11)~~ (15) receive and send, without interference, uncensored, unopened mail or electronic correspondence or communication;

~~(12)~~ (16) marital privacy for visits with the consumer's spouse and, if both are residents of the site, the right to share a bedroom and bed;

~~(13)~~ (17) associate with other persons of the consumer's choice;

~~(14)~~ (18) personal privacy; and

~~(15)~~ (19) engage in chosen activities.

(b) Restriction of a person's rights under paragraph (a), clauses (13) to (15), or this paragraph is allowed only if determined necessary to ensure the health, safety, and well-being of the person. Any restriction of these rights must be documented in the service plan for the person and must include the following information:

(1) the justification for the restriction based on an assessment of the person's vulnerability related to exercising the right without restriction;

(2) the objective measures set as conditions for ending the restriction;

(3) a schedule for reviewing the need for the restriction based on the conditions for ending the restriction to occur, at a minimum, every three months for persons who do not have a legal representative and annually for persons who do have a legal representative from the date of initial approval; and

(4) signed and dated approval for the restriction from the person, or the person's legal representative, if any. A restriction may be implemented only when the required approval has been obtained. Approval may be withdrawn at any time. If approval is withdrawn, the right must be immediately and fully restored.

Sec. 11. Minnesota Statutes 2010, section 245B.05, subdivision 1, is amended to read:

Subdivision 1. **Environment.** The license holder must:

(1) ensure that services are provided in a safe and hazard-free environment when the license holder is the owner, lessor, or tenant of the service site. All other license holders shall inform the consumer or the consumer's legal representative and case manager about any environmental safety concerns in writing;

(2) ~~lock doors~~ ensure that doors are locked or toxic substances or dangerous items normally accessible to persons served by the program are stored in locked cabinets, drawers, or containers only to protect the safety of consumers and not as a substitute for

staff supervision or interactions with consumers. If doors are locked or toxic substances or dangerous items normally accessible to persons served by the program are stored in locked cabinets, drawers, or containers, the license holder must justify and document how this determination was made in consultation with the person or the person's legal representative and how access will otherwise be provided to the person and all other affected persons receiving services;

(3) follow procedures that minimize the consumer's health risk from communicable diseases; and

(4) maintain equipment, vehicles, supplies, and materials owned or leased by the license holder in good condition.

Sec. 12. Minnesota Statutes 2010, section 245B.07, subdivision 5, is amended to read:

Subd. 5. **Staff orientation.** (a) Within 60 days of hiring staff who provide direct service, the license holder must provide 30 hours of staff orientation. Direct care staff must complete 15 of the 30 hours orientation before providing any unsupervised direct service to a consumer. If the staff person has received orientation training from a license holder licensed under this chapter, or provides semi-independent living services only, the 15-hour requirement may be reduced to eight hours. The total orientation of 30 hours may be reduced to 15 hours if the staff person has previously received orientation training from a license holder licensed under this chapter.

(b) The 30 hours of orientation must combine supervised on-the-job training with ~~coverage~~ review of and instruction on the following material:

(1) review of the consumer's service plans and risk management plan to achieve an understanding of the consumer as a unique individual and staff responsibilities related to implementation of those plans;

(2) review and instruction on implementation of the license holder's policies and procedures, including their location and access;

(3) staff responsibilities related to emergency procedures;

(4) explanation of specific job functions, including implementing objectives from the consumer's individual service plan;

(5) explanation of responsibilities related to section 245A.65; sections 626.556 and 626.557, governing maltreatment reporting and service planning for children and vulnerable adults; and section 245.825, governing use of aversive and deprivation procedures;

(6) medication administration as it applies to the individual consumer, from a training curriculum developed by a health services professional described in section

245B.05, subdivision 5, and when the consumer meets the criteria of having overriding health care needs, then medication administration taught by a health services professional. Staff may administer medications only after they demonstrate the ability, as defined in the license holder's medication administration policy and procedures. Once a consumer with overriding health care needs is admitted, staff will be provided with remedial training as deemed necessary by the license holder and the health professional to meet the needs of that consumer.

For purposes of this section, overriding health care needs means a health care condition that affects the service options available to the consumer because the condition requires:

(i) specialized or intensive medical or nursing supervision; and

(ii) nonmedical service providers to adapt their services to accommodate the health and safety needs of the consumer;

(7) consumer rights and staff responsibilities related to protecting and ensuring the exercise of the consumer rights; and

(8) other topics necessary as determined by the consumer's individual service plan or other areas identified by the license holder.

(c) The license holder must document each employee's orientation received.

Sec. 13. Minnesota Statutes 2010, section 245B.07, is amended by adding a subdivision to read:

Subd. 7a. **Subcontractors.** If the license holder uses a subcontractor to perform services licensed under this chapter on the license holder's behalf, the license holder must ensure that the subcontractor meets and maintains compliance with all requirements under this chapter that apply to the services to be provided.

Sec. 14. Minnesota Statutes 2010, section 245B.07, subdivision 9, is amended to read:

Subd. 9. **Availability of current written policies and procedures.** The license holder shall:

(1) review and update, as needed, the written policies and procedures in this chapter;

(2) inform consumers or the consumer's legal representatives of the written policies and procedures in this chapter upon service initiation. Copies of policies and procedures affecting a consumer's rights under section 245D.04 must be provided upon service initiation. Copies of all other policies and procedures must be available to consumers or the consumer's legal representatives, case managers, the county where services are located, and the commissioner upon request;

(3) provide all consumers or the consumers' legal representatives and case managers a copy of the revised policies and procedures and explanation of the revisions ~~to policies and procedures~~ that affect consumers' service-related or protection-related rights under section 245B.04 and maltreatment reporting policies and procedures. Unless there is reasonable cause, the license holder must provide this notice at least 30 days before implementing the revised policy and procedure. The license holder must document the reason for not providing the notice at least 30 days before implementing the revisions;

(4) annually notify all consumers or the consumers' legal representatives and case managers of any revised policies and procedures under this chapter, other than those in clause (3). Upon request, the license holder must provide the consumer or consumer's legal representative and case manager copies of the revised policies and procedures;

(5) before implementing revisions to policies and procedures under this chapter, inform all employees of the revisions and provide training on implementation of the revised policies and procedures; and

(6) document and maintain relevant information related to the policies and procedures in this chapter.

Sec. 15. Minnesota Statutes 2010, section 245B.07, subdivision 10, is amended to read:

Subd. 10. **Consumer funds.** (a) The license holder must ensure that consumers retain the use and availability of personal funds or property unless restrictions are justified in the consumer's individual service plan.

(b) The license holder must ensure separation of consumer funds from funds of the license holder, the program, or program staff.

(c) Whenever the license holder assists a consumer with the safekeeping of funds or other property, the license holder must have written authorization to do so by the consumer or the consumer's legal representative, and the case manager. In addition, the license holder must:

(1) document receipt and disbursement of the consumer's funds or the property;

(2) annually survey, document, and implement the preferences of the consumer, consumer's legal representative, and the case manager for frequency of receiving a statement that itemizes receipts and disbursements of consumer funds or other property; and

(3) return to the consumer upon the consumer's request, funds and property in the license holder's possession subject to restrictions in the consumer's individual service plan, as soon as possible, but no later than three working days after the date of the request.

(d) License holders and program staff must not:

(1) borrow money from a consumer;

(2) purchase personal items from a consumer;

(3) sell merchandise or personal services to a consumer;

(4) require a consumer to purchase items for which the license holder is eligible for reimbursement; ~~or~~

(5) use consumer funds in a manner that would violate section 256B.04, or any rules promulgated under that section~~.~~; or

(6) accept powers-of-attorney from a person receiving services from the license holder for any purpose, and may not accept an appointment as guardian or conservator of a person receiving services from the license holder. This does not apply to license holders that are Minnesota counties or other units of government.

Sec. 16. **[245D.01] CITATION.**

This chapter may be cited as the "Home and Community-Based Services Standards" or "HCBS Standards."

Sec. 17. **[245D.02] DEFINITIONS.**

Subdivision 1. **Scope.** The terms used in this chapter have the meanings given them in this section.

Subd. 2. **Annual and annually.** "Annual" and "annually" have the meaning given in section 245A.02, subdivision 2b.

Subd. 3. **Case manager.** "Case manager" means the individual designated to provide waiver case management services, care coordination, or long-term care consultation, as specified in sections 256B.0913, 256B.0915, 256B.092, and 256B.49, or successor provisions.

Subd. 4. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or the commissioner's designated representative.

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

Subd. 6. **Direct contact.** "Direct contact" has the meaning given in section 245C.02, subdivision 11, and is used interchangeably with the term "direct service."

Subd. 7. **Drug.** "Drug" has the meaning given in section 151.01, subdivision 5.

Subd. 8. **Emergency.** "Emergency" means any event that affects the ordinary daily operation of the program including, but not limited to, fires, severe weather, natural disasters, power failures, or other events that threaten the immediate health and safety of a person receiving services and that require calling 911, emergency evacuation, moving

to an emergency shelter, or temporary closure or relocation of the program to another facility or service site.

Subd. 9. **Health services.** "Health services" means any service or treatment consistent with the physical and mental health needs of the person, such as medication administration and monitoring, medical, dental, nutritional, health monitoring, wellness education, and exercise.

Subd. 10. **Home and community-based services.** "Home and community-based services" means the services subject to the provisions of this chapter and defined in the federal waiver plans governed by United States Code, title 42, sections 1396 et seq., or the state's alternative care program according to section 256B.0913, including the brain injury (BI) waiver, the community alternative care (CAC) waiver, the community alternatives for disabled individuals (CADI) waiver, the developmental disability (DD) waiver, the elderly waiver (EW), and the alternative care (AC) program.

Subd. 11. **Incident.** "Incident" means an occurrence that affects the ordinary provision of services to a person and includes any of the following:

(1) serious injury as determined by section 245.91, subdivision 6;

(2) a person's death;

(3) any medical emergency, unexpected serious illness, or significant unexpected change in an illness or medical condition, or the mental health status of a person that requires calling 911 or a mental health crisis intervention team, physician treatment, or hospitalization;

(4) a person's unauthorized or unexplained absence from a program;

(5) physical aggression by a person receiving services against another person receiving services that causes physical pain, injury, or persistent emotional distress, including, but not limited to, hitting, slapping, kicking, scratching, pinching, biting, pushing, and spitting;

(6) any sexual activity between persons receiving services involving force or coercion as defined under section 609.341, subdivisions 3 and 14; or

(7) a report of alleged or suspected child or vulnerable adult maltreatment under section 626.556 or 626.557.

Subd. 12. **Legal representative.** "Legal representative" means the parent of a person who is under 18 years of age, a court-appointed guardian, or other representative with legal authority to make decisions about services for a person.

Subd. 13. **License.** "License" has the meaning given in section 245A.02, subdivision 8.

Subd. 14. **Licensed health professional.** "Licensed health professional" means a person licensed in Minnesota to practice those professions described in section 214.01, subdivision 2.

Subd. 15. **License holder.** "License holder" has the meaning given in section 245A.02, subdivision 9.

Subd. 16. **Medication.** "Medication" means a prescription drug or over-the-counter drug. For purposes of this chapter, "medication" includes dietary supplements.

Subd. 17. **Medication administration.** "Medication administration" means performing the following set of tasks to ensure a person takes both prescription and over-the-counter medications and treatments according to orders issued by appropriately licensed professionals, and includes the following:

(1) checking the person's medication record;

(2) preparing the medication for administration;

(3) administering the medication to the person;

(4) documenting the administration of the medication or the reason for not administering the medication; and

(5) reporting to the prescriber or a nurse any concerns about the medication, including side effects, adverse reactions, effectiveness, or the person's refusal to take the medication or the person's self-administration of the medication.

Subd. 18. **Medication assistance.** "Medication assistance" means providing verbal or visual reminders to take regularly scheduled medication, which includes either of the following:

(1) bringing to the person and opening a container of previously set up medications and emptying the container into the person's hand or opening and giving the medications in the original container to the person, or bringing to the person liquids or food to accompany the medication; or

(2) providing verbal or visual reminders to perform regularly scheduled treatments and exercises.

Subd. 19. **Medication management.** "Medication management" means the provision of any of the following:

(1) medication-related services to a person;

(2) medication setup;

(3) medication administration;

(4) medication storage and security;

(5) medication documentation and charting;

(6) verification and monitoring of effectiveness of systems to ensure safe medication handling and administration;

(7) coordination of medication refills;

(8) handling changes to prescriptions and implementation of those changes;

(9) communicating with the pharmacy; or

(10) coordination and communication with prescriber.

For the purposes of this chapter, medication management does not mean "medication therapy management services" as identified in section 256B.0625, subdivision 13h.

Subd. 20. **Mental health crisis intervention team.** "Mental health crisis intervention team" means mental health crisis response providers as identified in section 256B.0624, subdivision 2, paragraph (d), for adults, and in section 256B.0944, subdivision 1, paragraph (d), for children.

Subd. 21. **Over-the-counter drug.** "Over-the-counter drug" means a drug that is not required by federal law to bear the statement "Caution: Federal law prohibits dispensing without prescription."

Subd. 22. **Person.** "Person" has the meaning given in section 245A.02, subdivision 11.

Subd. 23. **Person with a disability.** "Person with a disability" means a person determined to have a disability by the commissioner's state medical review team as identified in section 256B.055, subdivision 7, the Social Security Administration, or the person is determined to have a developmental disability as defined in Minnesota Rules, part 9525.0016, subpart 2, item B, or a related condition as defined in section 252.27, subdivision 1a.

Subd. 24. **Prescriber.** "Prescriber" means a licensed practitioner as defined in section 151.01, subdivision 23, who is authorized under section 151.37 to prescribe drugs. For the purposes of this chapter, the term "prescriber" is used interchangeably with "physician."

Subd. 25. **Prescription drug.** "Prescription drug" has the meaning given in section 151.01, subdivision 17.

Subd. 26. **Program.** "Program" means either the nonresidential or residential program as defined in section 245A.02, subdivisions 10 and 14.

Subd. 27. **Psychotropic medication.** "Psychotropic medication" means any medication prescribed to treat the symptoms of mental illness that affect thought processes, mood, sleep, or behavior. The major classes of psychotropic medication are antipsychotic (neuroleptic), antidepressant, antianxiety, mood stabilizers, anticonvulsants, and stimulants and nonstimulants for the treatment of attention deficit/hyperactivity disorder.

Other miscellaneous medications are considered to be a psychotropic medication when they are specifically prescribed to treat a mental illness or to control or alter behavior.

Subd. 28. **Restraint.** "Restraint" means physical or mechanical limiting of the free and normal movement of body or limbs.

Subd. 29. **Seclusion.** "Seclusion" means separating a person from others in a way that prevents social contact and prevents the person from leaving the situation if he or she chooses.

Subd. 30. **Service.** "Service" means care, training, supervision, counseling, consultation, or medication assistance assigned to the license holder in the service plan.

Subd. 31. **Service plan.** "Service plan" means the individual service plan or individual care plan identified in sections 256B.0913, 256B.0915, 256B.092, and 256B.49, or successor provisions, and includes any support plans or service needs identified as a result of long-term care consultation, or a support team meeting that includes the participation of the person, the person's legal representative, and case manager, or assigned to a license holder through an authorized service agreement.

Subd. 32. **Service site.** "Service site" means the location where the service is provided to the person, including but not limited to, a facility licensed according to chapter 245A; a location where the license holder is the owner, lessor, or tenant; a person's own home; or a community-based location.

Subd. 33. **Staff.** "Staff" means an employee who will have direct contact with a person served by the facility, agency, or program.

Subd. 34. **Support team.** "Support team" means the service planning team identified in section 256B.49, subdivision 15, or the interdisciplinary team identified in Minnesota Rules, part 9525.0004, subpart 14.

Subd. 35. **Unit of government.** "Unit of government" means every city, county, town, school district, other political subdivisions of the state, and any agency of the state or the United States, and includes any instrumentality of a unit of government.

Subd. 36. **Volunteer.** "Volunteer" means an individual who, under the direction of the license holder, provides direct services without pay to a person served by the license holder.

Sec. 18. **[245D.03] APPLICABILITY AND EFFECT.**

Subdivision 1. **Applicability.** The commissioner shall regulate the provision of home and community-based services to persons with disabilities and persons age 65 and older pursuant to this chapter. The licensing standards in this chapter govern the provision of the following services:

(1) housing access coordination as defined under the current BI, CADI, and DD waiver plans or successor plans;

(2) respite services as defined under the current CADI, BI, CAC, DD, and EW waiver plans or successor plans when the provider is an individual who is not an employee of a residential or nonresidential program licensed by the Department of Human Services or the Department of Health that is otherwise providing the respite service;

(3) behavioral programming as defined under the current BI and CADI waiver plans or successor plans;

(4) specialist services as defined under the current DD waiver plan or successor plans;

(5) companion services as defined under the current BI, CADI, and EW waiver plans or successor plans, excluding companion services provided under the Corporation for National and Community Services Senior Companion Program established under the Domestic Volunteer Service Act of 1973, Public Law 98-288;

(6) personal support as defined under the current DD waiver plan or successor plans;

(7) 24-hour emergency assistance, on-call and personal emergency response as defined under the current CADI and DD waiver plans or successor plans;

(8) night supervision services as defined under the current BI waiver plan or successor plans;

(9) homemaker services as defined under the current CADI, BI, CAC, DD, and EW waiver plans or successor plans, excluding providers licensed by the Department of Health under chapter 144A and those providers providing cleaning services only;

(10) independent living skills training as defined under the current BI and CADI waiver plans or successor plans;

(11) prevocational services as defined under the current BI and CADI waiver plans or successor plans;

(12) structured day services as defined under the current BI waiver plan or successor plans; or

(13) supported employment as defined under the current BI and CADI waiver plans or successor plans.

Subd. 2. **Relationship to other standards governing home and community-based services.** (a) A license holder governed by this chapter is also subject to the licensure requirements under chapter 245A.

(b) A license holder concurrently providing child foster care services licensed according to Minnesota Rules, chapter 2960, to the same person receiving a service licensed under this chapter is exempt from section 245D.04, as it applies to the person.

(c) A license holder concurrently providing home care services registered according to sections 144A.43 to 144A.49 to the same person receiving home management services licensed under this chapter is exempt from section 245D.04, as it applies to the person.

(d) A license holder identified in subdivision 1, clauses (1), (5), and (9), is exempt from compliance with sections 245A.65, subdivision 2, paragraph (a), and 626.557, subdivision 14, paragraph (b).

(e) Notwithstanding section 245D.06, subdivision 5, a license holder providing structured day, prevocational, or supported employment services under this chapter and day training and habilitation or supported employment services licensed under chapter 245B within the same program is exempt from compliance with this chapter, when the license holder notifies the commissioner in writing that the requirements under chapter 245B will be met for all persons receiving these services from the program. For the purposes of this paragraph, if the license holder has obtained approval from the commissioner for an alternative inspection status according to section 245B.031, that approval will apply to all persons receiving services in the program.

Subd. 3. **Variance.** If the conditions in section 245A.04, subdivision 9, are met, the commissioner may grant a variance to any of the requirements in this chapter, except sections 245D.04, and 245D.10, subdivision 4, paragraph (b), or provisions governing data practices and information rights of persons.

Subd. 4. **License holders with multiple 245D licenses.** (a) When a person changes service from one license to a different license held by the same license holder, the license holder is exempt from the requirements in section 245D.10, subdivision 4, paragraph (b).

(b) When a staff person begins providing direct service under one or more licenses held by the same license holder, other than the license for which staff orientation was initially provided according to section 245D.09, subdivision 4, the license holder is exempt from those staff orientation requirements; except the staff person must review each person's service plan and medication administration procedures in accordance with section 245D.09, subdivision 4, paragraph (c), if not previously reviewed by the staff person.

Sec. 19. **[245D.04] SERVICE RECIPIENT RIGHTS.**

Subdivision 1. **License holder responsibility for individual rights of persons served by the program.** The license holder must:

(1) provide each person or each person's legal representative with a written notice that identifies the service recipient rights in subdivisions 2 and 3, and an explanation of those rights within five working days of service initiation and annually thereafter;

(2) make reasonable accommodations to provide this information in other formats or languages as needed to facilitate understanding of the rights by the person and the person's legal representative, if any;

(3) maintain documentation of the person's or the person's legal representative's receipt of a copy and an explanation of the rights; and

(4) ensure the exercise and protection of the person's rights in the services provided by the license holder and as authorized in the service plan.

Subd. 2. **Service-related rights.** A person's service-related rights include the right to:

(1) participate in the development and evaluation of the services provided to the person;

(2) have services identified in the service plan provided in a manner that respects and takes into consideration the person's preferences;

(3) refuse or terminate services and be informed of the consequences of refusing or terminating services;

(4) know, in advance, limits to the services available from the license holder;

(5) know conditions and terms governing the provision of services, including the license holder's policies and procedures related to temporary service suspension and service termination;

(6) know what the charges are for services, regardless of who will be paying for the services, and be notified of changes in those charges;

(7) know, in advance, whether services are covered by insurance, government funding, or other sources, and be told of any charges the person or other private party may have to pay; and

(8) receive services from an individual who is competent and trained, who has professional certification or licensure, as required, and who meets additional qualifications identified in the person's service plan.

Subd. 3. **Protection-related rights.** (a) A person's protection-related rights include the right to:

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

(2) access records and recorded information about the person in accordance with applicable state and federal law, regulation, or rule;

(3) be free from maltreatment;

(4) be free from restraint or seclusion used for a purpose other than to protect the person from imminent danger to self or others;

(5) receive services in a clean and safe environment when the license holder is the owner, lessor, or tenant of the service site;

(6) be treated with courtesy and respect and receive respectful treatment of the person's property;

(7) reasonable observance of cultural and ethnic practice and religion;

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

(9) be informed of and use the license holder's grievance policy and procedures, including knowing how to contact persons responsible for addressing problems and to appeal under section 256.045;

(10) know the name, telephone number, and the Web site, e-mail, and street addresses of protection and advocacy services, including the appropriate state-appointed ombudsman, and a brief description of how to file a complaint with these offices;

(11) assert these rights personally, or have them asserted by the person's family, authorized representative, or legal representative, without retaliation;

(12) give or withhold written informed consent to participate in any research or experimental treatment;

(13) associate with other persons of the person's choice;

(14) personal privacy; and

(15) engage in chosen activities.

(b) For a person residing in a residential site licensed according to chapter 245A, or where the license holder is the owner, lessor, or tenant of the residential service site, protection-related rights also include the right to:

(1) have daily, private access to and use of a non-coin-operated telephone for local calls and long-distance calls made collect or paid for by the person;

(2) receive and send, without interference, uncensored, unopened mail or electronic correspondence or communication; and

(3) privacy for visits with the person's spouse, next of kin, legal counsel, religious advisor, or others, in accordance with section 363A.09 of the Human Rights Act, including privacy in the person's bedroom.

(c) Restriction of a person's rights under paragraph (a), clauses (13) to (15), or paragraph (b) is allowed only if determined necessary to ensure the health, safety, and well-being of the person. Any restriction of those rights must be documented in the service plan for the person and must include the following information:

(1) the justification for the restriction based on an assessment of the person's vulnerability related to exercising the right without restriction;

(2) the objective measures set as conditions for ending the restriction;

(3) a schedule for reviewing the need for the restriction based on the conditions for ending the restriction to occur, at a minimum, every three months for persons who do not have a legal representative and annually for persons who do have a legal representative from the date of initial approval; and

(4) signed and dated approval for the restriction from the person, or the person's legal representative, if any. A restriction may be implemented only when the required approval has been obtained. Approval may be withdrawn at any time. If approval is withdrawn, the right must be immediately and fully restored.

Sec. 20. **[245D.05] HEALTH SERVICES.**

Subdivision 1. **Health needs.** (a) The license holder is responsible for providing health services assigned in the service plan and consistent with the person's health needs. The license holder is responsible for promptly notifying the person or the person's legal representative and the case manager of changes in a person's physical and mental health needs affecting assigned health services, when discovered by the license holder, unless the license holder has reason to know the change has already been reported. The license holder must document when the notice is provided.

(b) When assigned in the service plan, the license holder is required to maintain documentation on how the person's health needs will be met, including a description of the procedures the license holder will follow in order to:

(1) provide medication administration, medication assistance, or medication management according to this chapter;

(2) monitor health conditions according to written instructions from the person's physician or a licensed health professional;

(3) assist with or coordinate medical, dental, and other health service appointments; or

(4) use medical equipment, devices, or adaptive aides or technology safely and correctly according to written instructions from the person's physician or a licensed health professional.

Subd. 2. **Medication administration.** (a) The license holder must ensure that the following criteria have been met before staff that is not a licensed health professional administers medication or treatment:

(1) written authorization has been obtained from the person or the person's legal representative to administer medication or treatment orders;

(2) the staff person has completed medication administration training according to section 245D.09, subdivision 4, paragraph (c), clause (2); and

(3) the medication or treatment will be administered under administration procedures established for the person in consultation with a licensed health professional. Written instruction from the person's physician may constitute the medication administration procedures. A prescription label or the prescriber's order for the prescription is sufficient to constitute written instructions from the prescriber. A licensed health professional may delegate medication administration procedures.

(b) The license holder must ensure the following information is documented in the person's medication administration record:

(1) the information on the prescription label or the prescriber's order that includes directions for safely and correctly administering the medication to ensure effectiveness;

(2) information on any discomforts, risks, or other side effects that are reasonable to expect, and any contraindications to its use;

(3) the possible consequences if the medication or treatment is not taken or administered as directed;

(4) instruction from the prescriber on when and to whom to report the following:

(i) if the medication or treatment is not administered as prescribed, whether by error by the staff or the person or by refusal by the person; and

(ii) the occurrence of possible adverse reactions to the medication or treatment;

(5) notation of any occurrence of medication not being administered as prescribed or of adverse reactions, and when and to whom the report was made; and

(6) notation of when a medication or treatment is started, changed, or discontinued.

(c) The license holder must ensure that the information maintained in the medication administration record is current and is regularly reviewed with the person or the person's legal representative and the staff administering the medication to identify medication administration issues or errors. At a minimum, the review must be conducted every three months or more often if requested by the person or the person's legal representative. Based on the review, the license holder must develop and implement a plan to correct medication administration issues or errors. If issues or concerns are identified related to the medication itself, the license holder must report those as required under subdivision 4.

Subd. 3. **Medication assistance.** The license holder must ensure that the requirements of subdivision 2, paragraph (a), have been met when staff provides assistance to enable a person to self-administer medication when the person is capable of directing the person's own care, or when the person's legal representative is present and able to direct care for the person.

Subd. 4. **Reporting medication and treatment issues.** The following medication administration issues must be reported to the person or the person's legal representative and case manager as they occur or following timelines established in the person's service plan or as requested in writing by the person or the person's legal representative, or the case manager:

(1) any reports made to the person's physician or prescriber required under subdivision 2, paragraph (b), clause (4);

(2) a person's refusal or failure to take medication or treatment as prescribed; or

(3) concerns about a person's self-administration of medication.

Subd. 5. **Injectable medications.** Injectable medications may be administered according to a prescriber's order and written instructions when one of the following conditions has been met:

(1) a registered nurse or licensed practical nurse will administer the subcutaneous or intramuscular injection;

(2) a supervising registered nurse with a physician's order has delegated the administration of subcutaneous injectable medication to an unlicensed staff member and has provided the necessary training; or

(3) there is an agreement signed by the license holder, the prescriber, and the person or the person's legal representative, specifying what subcutaneous injections may be given, when, how, and that the prescriber must retain responsibility for the license holder's giving the injections. A copy of the agreement must be placed in the person's service recipient record.

Only licensed health professionals are allowed to administer psychotropic medications by injection.

Sec. 21. **[245D.06] PROTECTION STANDARDS.**

Subdivision 1. **Incident response and reporting.** (a) The license holder must respond to all incidents under section 245D.02, subdivision 11, that occur while providing services to protect the health and safety of and minimize risk of harm to the person.

(b) The license holder must maintain information about and report incidents to the person's legal representative or designated emergency contact and case manager within 24 hours of an incident occurring while services are being provided, or within 24 hours of discovery or receipt of information that an incident occurred, unless the license holder has reason to know that the incident has already been reported. An incident of suspected or alleged maltreatment must be reported as required under paragraph (d), and an incident of serious injury or death must be reported as required under paragraph (e).

(c) When the incident involves more than one person, the license holder must not disclose personally identifiable information about any other person when making the report to each person and case manager unless the license holder has the consent of the person.

(d) Within 24 hours of reporting maltreatment as required under section 626.556 or 626.557, the license holder must inform the case manager of the report unless there is reason to believe that the case manager is involved in the suspected maltreatment. The license holder must disclose the nature of the activity or occurrence reported and the agency that received the report.

(e) Within 24 hours of the occurrence, or within 24 hours of receipt of the information, the license holder must report the death or serious injury of the person to the legal representative, if any, and case manager, the Department of Human Services Licensing Division, and the Office of Ombudsman for Mental Health and Developmental Disabilities as required under section 245.94, subdivision 2a.

(f) The license holder must conduct a review of incident reports, for identification of incident patterns, and implementation of corrective action as necessary to reduce occurrences.

Subd. 2. **Environment and safety.** The license holder must:

(1) ensure the following when the license holder is the owner, lessor, or tenant of the service site:

(i) the service site is a safe and hazard-free environment;

(ii) doors are locked or toxic substances or dangerous items normally accessible to persons served by the program are stored in locked cabinets, drawers, or containers only to protect the safety of a person receiving services and not as a substitute for staff supervision or interactions with a person who is receiving services. If doors are locked or toxic substances or dangerous items normally accessible to persons served by the program are stored in locked cabinets, drawers, or containers, the license holder must justify and document how this determination was made in consultation with the person or person's legal representative, and how access will otherwise be provided to the person and all other affected persons receiving services; and

(iii) a staff person is available on site who is trained in basic first aid whenever persons are present and staff are required to be at the site to provide direct service;

(2) maintain equipment, vehicles, supplies, and materials owned or leased by the license holder in good condition when used to provide services;

(3) follow procedures to ensure safe transportation, handling, and transfers of the person and any equipment used by the person, when the license holder is responsible for transportation of a person or a person's equipment;

(4) be prepared for emergencies and follow emergency response procedures to ensure the person's safety in an emergency; and

(5) follow sanitary practices for infection control and to prevent communicable diseases.

Subd. 3. **Compliance with fire and safety codes.** When services are provided at a service site licensed according to chapter 245A or where the license holder is the owner, lessor, or tenant of the service site, the license holder must document compliance with applicable building codes, fire and safety codes, health rules, and zoning ordinances, or document that an appropriate waiver has been granted.

Subd. 4. **Funds and property.** (a) Whenever the license holder assists a person with the safekeeping of funds or other property according to section 245A.04, subdivision 13, the license holder must have written authorization to do so from the person and the case manager.

(b) A license holder or staff person may not accept powers-of-attorney from a person receiving services from the license holder for any purpose, and may not accept an appointment as guardian or conservator of a person receiving services from the license holder. This does not apply to license holders that are Minnesota counties or other units of government.

Subd. 5. **Prohibitions.** The license holder is prohibited from using psychotropic medication as a substitute for adequate staffing, as punishment, for staff convenience, or for any reason other than as prescribed.

Sec. 22. **[245D.07] SERVICE NEEDS.**

Subdivision 1. **Provision of services.** The license holder must provide services as specified in the service plan and assigned to the license holder. The provision of services must comply with the requirements of this chapter and the federal waiver plans.

Subd. 2. **Service planning.** The license holder must participate in support team meetings related to the person following stated timelines established in the person's service plan or as requested by the support team, the person, or the person's legal representative.

Subd. 3. **Reports.** The license holder must provide written reports regarding the person's progress or status as requested by the person, the person's legal representative, the case manager, or the team.

Sec. 23. **[245D.08] RECORD REQUIREMENTS.**

Subdivision 1. **Record-keeping systems.** The license holder must ensure that the content and format of service recipient, personnel, and program records are uniform, legible, and in compliance with the requirements of this chapter.

Subd. 2. **Service recipient record.** (a) The license holder must:

(1) maintain a record of current services provided to each person on the premises where the services are provided or coordinated; and

(2) protect service recipient records against loss, tampering, or unauthorized disclosure in compliance with sections 13.01 to 13.10 and 13.46.

(b) The license holder must maintain the following information for each person:

(1) identifying information, including the person's name, date of birth, address, and telephone number;

(2) the name, address, and telephone number of the person's legal representative, if any, an emergency contact, the case manager, and family members or others as identified by the person or case manager;

(3) service information, including service initiation information, verification of the person's eligibility for services, and documentation verifying that services have been provided as identified in the service plan according to paragraph (a);

(4) health information, including medical history and allergies; and when the license holder is assigned responsibility for meeting the person's health needs according to section 245D.05:

(i) current orders for medication, treatments, or medical equipment;

(ii) medication administration procedures;

(iii) a medication administration record documenting the implementation of the medication administration procedures, including any agreements for administration of injectable medications by the license holder; and

(iv) a medical appointment schedule;

(5) the person's current service plan or that portion of the plan assigned to the license holder. When a person's case manager does not provide a current service plan, the license holder must make a written request to the case manager to provide a copy of the service plan and inform the person of the right to a current service plan and the right to appeal under section 256.045;

(6) a record of other service providers serving the person when the person's service plan identifies the need for coordination between the service providers, that includes a contact person and telephone numbers, services being provided, and names of staff responsible for coordination;

(7) documentation of orientation to the service recipient rights according to section 245D.04, subdivision 1, and maltreatment reporting policies and procedures according to section 245A.65, subdivision 1, paragraph (c);

(8) copies of authorizations to handle a person's funds, according to section 245D.06, subdivision 4, paragraph (a);

(9) documentation of complaints received and grievance resolution;

(10) incident reports required under section 245D.06, subdivision 1;

(11) copies of written reports regarding the person's status when requested according to section 245D.07, subdivision 3; and

(12) discharge summary, including service termination notice and related documentation, when applicable.

Subd. 3. **Access to service recipient records.** The license holder must ensure that the following people have access to the information in subdivision 1 in accordance with applicable state and federal law, regulation, or rule:

(1) the person, the person's legal representative, and anyone properly authorized by the person;

(2) the person's case manager;

(3) staff providing services to the person unless the information is not relevant to carrying out the service plan; and

(4) the county adult foster care licensor, when services are also licensed as adult foster care.

Subd. 4. **Personnel records.** The license holder must maintain a personnel record of each employee, direct service volunteer, and subcontractor to document and verify staff qualifications, orientation, and training. For the purposes of this subdivision, the terms "staff" or "staff person" mean paid employee, direct service volunteer, or subcontractor. The personnel record must include:

(1) the staff person's date of hire, completed application, a position description signed by the staff person, documentation that the staff person meets the position requirements as determined by the license holder, the date of first supervised direct contact with a person served by the program, and the date of first unsupervised direct contact with a person served by the program;

(2) documentation of staff qualifications, orientation, training, and performance evaluations as required under section 245D.09, subdivisions 3, 4, and 5, including the date the training was completed, the number of hours per subject area, and the name and qualifications of the trainer or instructor; and

(3) a completed background study as required under chapter 245C.

Sec. 24. **[245D.09] STAFFING STANDARDS.**

Subdivision 1. **Staffing requirements.** The license holder must provide direct service staff sufficient to ensure the health, safety, and protection of rights of each person and to be able to implement the responsibilities assigned to the license holder in each person's service plan.

Subd. 2. **Supervision of staff having direct contact.** Except for a license holder who are the sole direct service staff, the license holder must provide adequate supervision of staff providing direct service to ensure the health, safety, and protection of rights of each person and implementation of the responsibilities assigned to the license holder in each person's service plan.

Subd. 3. **Staff qualifications.** (a) The license holder must ensure that staff is competent through training, experience, and education to meet the person's needs and additional requirements as written in the service plan, or when otherwise required by the case manager or the federal waiver plan. The license holder must verify and maintain evidence of staff competency, including documentation of:

(1) education and experience qualifications, including a valid degree and transcript, or a current license, registration, or certification, when a degree or licensure, registration, or certification is required;

(2) completion of required orientation and training, including completion of continuing education required to maintain professional licensure, registration, or certification requirements; and

(3) except for a license holder who is the sole direct service staff, performance evaluations completed by the license holder of the direct service staff person's ability to perform the job functions based on direct observation.

(b) Staff under 18 years of age may not perform overnight duties or administer medication.

Subd. 4. **Orientation.** (a) Except for a license holder who does not supervise any direct service staff, within 90 days of hiring direct service staff, the license holder must provide and ensure completion of orientation that combines supervised on-the-job training with review of and instruction on the following:

(1) the job description and how to complete specific job functions, including:

(i) responding to and reporting incidents as required under section 245D.06, subdivision 1; and

(ii) following safety practices established by the license holder and as required in section 245D.06, subdivision 2;

(2) the license holder's current policies and procedures required under this chapter, including their location and access, and staff responsibilities related to implementation of those policies and procedures;

(3) data privacy requirements according to sections 13.01 to 13.10 and 13.46, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), and staff responsibilities related to complying with data privacy practices;

(4) the service recipient rights under section 245D.04, and staff responsibilities related to ensuring the exercise and protection of those rights;

(5) sections 245A.65; 245A.66, 626.556, and 626.557, governing maltreatment reporting and service planning for children and vulnerable adults, and staff responsibilities related to protecting persons from maltreatment and reporting maltreatment;

(6) what constitutes use of restraints, seclusion, and psychotropic medications, and staff responsibilities related to the prohibitions of their use; and

(7) other topics as determined necessary in the person's service plan by the case manager or other areas identified by the license holder.

(b) License holders who provide direct service themselves must complete the orientation required in paragraph (a), clauses (3) to (7).

(c) Before providing unsupervised direct service to a person served by the program, or for whom the staff person has not previously provided direct service, or any time the plans or procedures identified in clauses (1) and (2) are revised, the staff person must review and receive instruction on the following as it relates to the staff person's job functions for that person:

(1) the person's service plan as it relates to the responsibilities assigned to the license holder, and when applicable, the person's individual abuse prevention plan according to section 245A.65, to achieve an understanding of the person as a unique individual, and how to implement those plans; and

(2) medication administration procedures established for the person when assigned to the license holder according to section 245D.05, subdivision 1, paragraph (b). Unlicensed staff may administer medications only after successful completion of a medication administration training, from a training curriculum developed by a registered nurse, clinical nurse specialist in psychiatric and mental health nursing, certified nurse practitioner, physician's assistant, or physician incorporating an observed skill assessment conducted by the trainer to ensure staff demonstrate the ability to safely and correctly follow medication procedures. Medication administration must be taught by a registered nurse, clinical nurse specialist, certified nurse practitioner, physician's assistant, or physician, if at the time of service initiation or any time thereafter, the person has or

develops a health care condition that affects the service options available to the person because the condition requires:

(i) specialized or intensive medical or nursing supervision;

(ii) nonmedical service providers to adapt their services to accommodate the health and safety needs of the person; and

(iii) necessary training in order to meet the health service needs of the person as determined by the person's physician.

Subd. 5. **Training.** (a) A license holder must provide annual training to direct service staff on the topics identified in subdivision 4, paragraph (a), clauses (3) to (6).

(b) A license holder providing behavioral programming, specialist services, personal support, 24-hour emergency assistance, night supervision, independent living skills, structured day, prevocational, or supported employment services must provide a minimum of eight hours of annual training to direct service staff that addresses:

(1) topics related to the general health, safety, and service needs of the population served by the license holder; and

(2) other areas identified by the license holder or in the person's current service plan.

Training on relevant topics received from sources other than the license holder may count toward training requirements.

(c) When the license holder is the owner, lessor, or tenant of the service site and whenever a person receiving services is present at the site, the license holder must have a staff person available on site who is trained in basic first aid and, when required in a person's service plan, cardiopulmonary resuscitation.

Subd. 6. **Subcontractors.** If the license holder uses a subcontractor to perform services licensed under this chapter on their behalf, the license holder must ensure that the subcontractor meets and maintains compliance with all requirements under this chapter that apply to the services to be provided.

Subd. 7. **Volunteers.** The license holder must ensure that volunteers who provide direct services to persons served by the program receive the training, orientation, and supervision necessary to fulfill their responsibilities.

Sec. 25. **[245D.10] POLICIES AND PROCEDURES.**

Subdivision 1. **Policy and procedure requirements.** The license holder must establish, enforce, and maintain policies and procedures as required in this chapter.

Subd. 2. **Grievances.** The license holder must establish policies and procedures that provide a simple complaint process for persons served by the program and their authorized representatives to bring a grievance that:

(1) provides staff assistance with the complaint process when requested, and the addresses and telephone numbers of outside agencies to assist the person;

(2) allows the person to bring the complaint to the highest level of authority in the program if the grievance cannot be resolved by other staff members, and that provides the name, address, and telephone number of that person;

(3) requires the license holder to promptly respond to all complaints affecting a person's health and safety. For all other complaints the license holder must provide an initial response within 14 calendar days of receipt of the complaint. All complaints must be resolved within 30 calendar days of receipt or the license holder must document the reason for the delay and a plan for resolution;

(4) requires a complaint review that includes an evaluation of whether:

(i) related policies and procedures were followed and adequate;

(ii) there is a need for additional staff training;

(iii) the complaint is similar to past complaints with the persons, staff, or services involved; and

(iv) there is a need for corrective action by the license holder to protect the health and safety of persons receiving services;

(5) based on the review in clause (4), requires the license holder to develop, document, and implement a corrective action plan, designed to correct current lapses and prevent future lapses in performance by staff or the license holder, if any;

(6) provides a written summary of the complaint and a notice of the complaint resolution to the person and case manager, that:

(i) identifies the nature of the complaint and the date it was received;

(ii) includes the results of the complaint review;

(iii) identifies the complaint resolution, including any corrective action; and

(7) requires that the complaint summary and resolution notice be maintained in the service recipient record.

Subd. 3. **Service suspension and service termination.** (a) The license holder must establish policies and procedures for temporary service suspension and service termination that promote continuity of care and service coordination with the person and the case manager, and with other licensed caregivers, if any, who also provide support to the person.

(b) The policy must include the following requirements:

(1) the license holder must notify the person and case manager in writing of the intended termination or temporary service suspension, and the person's right to seek a temporary order staying the termination of service according to the procedures in section 256.045, subdivision 4a, or 6, paragraph (c);

(2) notice of the proposed termination of services, including those situations that began with a temporary service suspension, must be given at least 60 days before the proposed termination is to become effective when a license holder is providing independent living skills training, structured day, prevocational or supported employment services to the person, and 30 days prior to termination for all other services licensed under this chapter;

(3) the license holder must provide information requested by the person or case manager when services are temporarily suspended or upon notice of termination;

(4) prior to giving notice of service termination or temporary service suspension, the license holder must document actions taken to minimize or eliminate the need for service suspension or termination;

(5) during the temporary service suspension or service termination notice period, the license holder will work with the appropriate county agency to develop reasonable alternatives to protect the person and others;

(6) the license holder must maintain information about the service suspension or termination, including the written termination notice, in the service recipient record; and

(7) the license holder must restrict temporary service suspension to situations in which the person's behavior causes immediate and serious danger to the health and safety of the person or others.

Subd. 4. **Availability of current written policies and procedures.** (a) The license holder must review and update, as needed, the written policies and procedures required under this chapter.

(b) The license holder must inform the person and case manager of the policies and procedures affecting a person's rights under section 245D.04, and provide copies of those policies and procedures, within five working days of service initiation.

(c) The license holder must provide a written notice at least 30 days before implementing any revised policies and procedures affecting a person's rights under section 245D.04. The notice must explain the revision that was made and include a copy of the revised policy and procedure. The license holder must document the reason for not providing the notice at least 30 days before implementing the revisions.

(d) Before implementing revisions to required policies and procedures the license holder must inform all employees of the revisions and provide training on implementation of the revised policies and procedures.

Sec. 26. Minnesota Statutes 2010, section 252.40, is amended to read:

252.40 SERVICE PRINCIPLES AND RATE-SETTING PROCEDURES.

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

(b) This section expires January 1, 2013.

Sec. 27. Minnesota Statutes 2010, section 252.41, subdivision 3, is amended to read:

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

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

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

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

EFFECTIVE DATE. This section is effective January 1, 2013.

Sec. 28. Minnesota Statutes 2010, section 252.42, is amended to read:

252.42 SERVICE PRINCIPLES.

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

(1) services must suit a person's chronological age and be provided in the least restrictive environment possible, consistent with the needs identified in the person's

individual service and individual habilitation plans under Minnesota Rules, parts 9525.0015 to 9525.0165;

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

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

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

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

EFFECTIVE DATE. This section is effective January 1, 2013.

Sec. 29. Minnesota Statutes 2010, section 252.43, is amended to read:

252.43 COMMISSIONER'S DUTIES.

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

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

(2) ~~approve payment rates established by a county under section 252.46, subdivision 1~~ implement the payment rates under section 256B.4913. The payment rates will supersede rates established in county contracts for recipients receiving day training and habilitation funded through Medicaid;

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

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

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

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

EFFECTIVE DATE. This section is effective January 1, 2013.

Sec. 30. Minnesota Statutes 2010, section 252.44, is amended to read:

252.44 COUNTY BOARD RESPONSIBILITIES.

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

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

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

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

(4) ~~set~~ apply payment rates under section ~~252.46~~ 256B.4913;

(5) monitor and evaluate the cost and effectiveness of the services; and

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

(b) With all vendors ~~except regional centers~~, the contract must include the approved payment rates under section 256B.4913, the projected budget for the contract period, and any actual expenditures of previous and current contract periods. ~~With all vendors, including regional centers,~~ The contract must also include the amount, availability, and components of day training and habilitation services to be provided, the performance standards governing service provision and evaluation, and the time period in which the contract is effective.

EFFECTIVE DATE. This section is effective January 1, 2013.

Sec. 31. Minnesota Statutes 2010, section 252.45, is amended to read:

252.45 VENDOR'S DUTIES.

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective January 1, 2013.

Sec. 32. Minnesota Statutes 2010, section 252.451, subdivision 2, is amended to read:

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

EFFECTIVE DATE. This section is effective January 1, 2013.

Sec. 33. Minnesota Statutes 2010, section 252.451, subdivision 5, is amended to read:

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

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

~~(2) the client for whom a rate will be billed will receive full-day or partial-day services from the vendor and the rate to be paid the vendor will allow the client to work~~

~~with this support and supervision at the qualified business instead of receiving these services from the vendor.~~ vendors of day training and habilitation services that enter into agreements with qualified businesses shall reimburse the qualified business according to the terms of their written agreement as defined in subdivision 3, clause (5), items (i) and (ii).

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

EFFECTIVE DATE. This section is effective January 1, 2013.

Sec. 34. Minnesota Statutes 2010, section 252.46, subdivision 1a, is amended to read:

Subd. 1a. **Day training and habilitation rates.** The commissioner shall establish a statewide rate-setting methodology for all day training and habilitation services as defined in section 256B.4913. The ~~rate-setting~~ payment methodology must abide by the principles of transparency and equitability across the state. The methodology must involve a uniform process of structuring rates for each service and must promote quality and participant choice under section 256B.4913.

EFFECTIVE DATE. This section is effective January 1, 2013.

Sec. 35. 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) Beginning January 1, 2013, the commissioner shall implement, within the allocation methodologies for each home and community-based waiver under this section, a procedure to adjust for the impact on waiver allocations of changes in payment and waiver service usage under section 256B.4913. In the aggregate, the procedure may not increase or decrease the amount of waiver funds available for allocation to counties or tribes under this section.

Sec. 36. Minnesota Statutes 2011 Supplement, section 256B.49, subdivision 16a, is amended to read:

Subd. 16a. **Medical assistance reimbursement.** ~~(a) The commissioner shall seek federal approval for medical assistance reimbursement of independent living skills services, foster care waiver service, supported employment, prevocational service, and structured day service under the home and community-based waiver for persons with a traumatic brain injury, the community alternatives for disabled individuals waivers, and the community alternative care waivers.~~

~~(b) Medical reimbursement shall be made only when the provider demonstrates evidence of its capacity to meet basic health, safety, and protection standards through the following methods:~~

~~(1) for independent living skills services, supported employment, prevocational service, and structured day service through one of the methods in paragraphs (c) and (d); and~~

~~(2) for foster care waiver services through the method in paragraph (c).~~

~~(c) The provider is licensed to provide services under chapter 245B and agrees to apply these standards to services funded through the traumatic brain injury, community alternatives for disabled persons, or community alternative care home and community-based waivers.~~

~~(d) The commissioner shall certify that the provider has policies and procedures governing the following:~~

~~(1) protection of the consumer's rights and privacy;~~

~~(2) risk assessment and planning;~~

~~(3) record keeping and reporting of incidents and emergencies with documentation of corrective action if needed;~~

~~(4) service outcomes, regular reviews of progress, and periodic reports;~~

~~(5) complaint and grievance procedures;~~

~~(6) service termination or suspension;~~

~~(7) necessary training and supervision of direct care staff that includes:~~

~~(i) documentation in personnel files of 20 hours of orientation training in providing training related to service provision;~~

~~(ii) training in recognizing the symptoms and effects of certain disabilities, health conditions, and positive behavioral supports and interventions;~~

~~(iii) a minimum of five hours of related training annually; and~~

~~(iv) when applicable:~~

~~(A) safe medication administration;~~

~~(B) proper handling of consumer funds; and~~

~~(C) compliance with prohibitions and standards developed by the commissioner to satisfy federal requirements regarding the use of restraints and restrictive interventions.~~ ~~The commissioner shall review at least biennially that each service provider's policies and procedures governing basic health, safety, and protection of rights continue to meet minimum standards.~~

~~(e) The commissioner shall seek federal approval for Medicaid reimbursement of foster care services under the home and community-based waiver for persons with a traumatic brain injury, the community alternatives for disabled individuals waiver, and community alternative care waiver when the provider demonstrates evidence of its capacity to meet basic health, safety, and protection standards. The commissioner shall verify that the adult foster care provider is licensed under Minnesota Rules, parts 9555.5105 to 9555.6265; that the child foster care provider is licensed as a family foster care or a foster care residence under Minnesota Rules, parts 2960.3000 to 2960.3340, and certify that the provider has policies and procedures that govern:~~

~~(1) compliance with prohibitions and standards developed by the commissioner to meet federal requirements regarding the use of restraints and restrictive interventions;~~

~~(2) documentation of service needs and outcomes, regular reviews of progress, and periodic reports; and~~

~~(3) safe medication management and administration.~~

~~The commissioner shall review at least biennially that each service provider's policies and procedures governing basic health, safety, and protection of rights standards continue to meet minimum standards.~~

~~(f)~~ The commissioner shall seek federal waiver approval for Medicaid reimbursement of family adult day services under all disability waivers. After the waiver is granted, the commissioner shall include family adult day services in the common services menu that is currently under development.

Sec. 37. 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. 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.

(f) Beginning January 1, 2013, the commissioner shall implement, within the allocation methodologies for each home and community-based waiver under this section, a procedure to adjust for the impact on waiver allocations of changes in payment and waiver service usage under section 256B.4913. In the aggregate, the procedure may not increase or decrease the amount of waiver funds available for allocation to counties or tribes under this section.

Sec. 38. Minnesota Statutes 2010, section 256B.4912, is amended to read:

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

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

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

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

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

~~By July 2010,~~ Beginning July 2012, 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.

Subd. 2. **~~Rate-setting~~ Payment methodologies.** The commissioner shall establish statewide ~~rate-setting~~ payment methodologies that meet federal waiver requirements for home and community-based waiver services for individuals with disabilities. The ~~rate-setting~~ payment 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.

Subd. 3. **Payment requirements.** The payment-setting methodologies established under this section shall accommodate:

(1) direct care staffing wages;

(2) staffing patterns;

(3) program-related expenses;

(4) general and administrative expenses; and

(5) consideration of recipient intensity.

Subd. 4. **Payment rate criteria.** (a) The payment structures and methodologies under this section shall reflect the payment rate criteria in paragraphs (b) and (c).

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

(c) The commissioner must not reimburse:

(1) unauthorized service delivery;

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

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

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

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

Subd. 5. **County and tribal provider contract elimination.** County and tribal contracts with providers of home and community-based waiver services provided under sections 256B.0913, 256B.0915, 256B.092, and 256B.49 are eliminated effective January 1, 2013, or when the commissioner receives authority for the collection of fees for home and community-based waiver services under section 245A.10, subdivisions 3, paragraph (b), and 4, paragraph (g), whichever is later.

Subd. 6. **Program standards.** The commissioner of human services must establish uniform program standards for services identified in chapter 245D for persons with disabilities and people age 65 and older that reflect the service needs of the populations served. The commissioner must grant licenses according to the provisions of chapter 245A.

Subd. 7. **Applicant and license holder training.** An applicant or license holder that is not enrolled as a Minnesota health care program home and community-based services waiver provider at the time of application must ensure that at least one controlling individual completes a onetime training on the requirements for providing home and community-based services from a qualified source as determined by the commissioner, before a provider is enrolled or license is issued.

EFFECTIVE DATE. This section is effective July 1, 2012, except that subdivision 6 is effective January 1, 2013, or when the commissioner receives an appropriation or authorization for the collection of fees under section 245A.10, subdivisions 3, paragraph (b), and 4, paragraph (g), whichever is later.

Sec. 39. **[256B.4913] PAYMENT METHODOLOGIES.**

Subdivision 1. **Application.** The payment methodologies in this section apply to home and community-based services waivers under sections 256B.092 and 256B.49, except that where the particular waiver limits the type, scope, or extent of service provided, the commissioner may not provide that service to an individual subject to that service restriction under this methodology.

Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them, unless the context clearly indicates otherwise.

(b) "Commissioner" means the commissioner of human services.

(c) "Payment" means reimbursement to an eligible provider for services provided to a qualified individual based on an approved service authorization.

Subd. 3. **Applicable services.** Applicable services are those authorized under the state's home and community-based services waivers under sections 256B.092 and 256B.49 including as defined in the federally approved home and community-based services plan:

(1) adult day care or family adult day services;

(2) behavioral programming;

(3) customized living or 24-hour customized living;

(4) day training and habilitation;

(5) housing access coordination;

(6) independent living services;

(7) in-home family supports;

(8) night supervision;

(9) personal support;

(10) prevocational services;

(11) residential care services;

(12) respite services;

(13) structured day services;

(14) supported employment services;

(15) supported living services;

(16) transportation services; and

(17) other services as approved by the federal government in the state home and community-based services plan.

Subd. 4. **Uniform payment methodology.** The commissioner shall determine representative personnel and program-related components to meet the individualized service plan for individuals with disabilities as funded under the state plan for home and community-based services under sections 256B.092 and 256B.49. The commissioner shall use those representative components, along with individualized assessment information, to determine the amount payable to a provider under this section.

Subd. 5. **Payments for individualized unit-based services.** (a) Payments for services priced on a partial hour or hourly unit basis and provided to an individual outside of any day or residential service plan must be calculated as follows unless the services are authorized separately under subdivisions 6 and 7:

(1) Determine the number of units of service used.

(2) Determine the direct staff wages. The personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in paragraph (b). This is the direct care rate except for customizations for certain individuals.

(3) For an individual requiring customization under subdivision 8, add the customization rate provided in subdivision 8 to the result of step (2). This is the customized direct care rate.

(4) Take the direct care rate under step (2) or step (3) and increase this amount by the employee and program-related expense factor of 102.7 percent.

(5) Take the rate under step (4) and add $20 per day for daily respite room and board as authorized and provided. This is the payment rate.

(6) Multiply the result of step (5) by step (1) to establish the payment amount.

(b) If the commissioner derives rates for personnel hourly wages under this paragraph, the commissioner must use the following Direct Care Job Classifications with the Bureau of Labor Statistics job classes. These classes must be aligned with services provided under the home and community-based waiver:

(1) adult companion;

(2) behavior program analyst;

(3) behavior program professional;

(4) behavior program specialist;

(5) housing access coordinator;

(6) in-home family support;

(7) independent living skills direct service;

(8) independent living skills professional;

(9) night supervision;

(10) personal support;

(11) respite hourly;

(12) supported employment job coach;

(13) supported employment job developer;

(14) supportive living services;

(15) extra transportation attendant;

(16) registered nurse;

(17) licensed practical nurse;

(18) direct primary care;

(19) asleep overnight; and

(20) supervisor.

(c) The commissioner shall revise the wage rates under paragraph (a), clause (2), in the manner provided in subdivision 10.

Subd. 6. **Payments for day programs.** (a) Payments for services with day programs including adult day care, day treatment and habilitation, prevocational services, and

structured day services must be calculated as follows unless the services are authorized separately under subdivisions 5 and 7:

(1) Determine the number of units of service used.

(2) Determine the direct staff wages. The personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in paragraph (b). This is the direct care rate except for customizations for certain individuals.

(3) For an individual requiring customization under subdivision 8, add the customization rate provided in subdivision 8 to the result of step (2). This is the customized direct care rate.

(4) Take the direct care rate under step (2) or step (3) and increase this amount by the employee and program-related expense factor of 108.8 percent, with consideration of staffing to meet individual needs and utilization.

(5) To the result of step (4) add the facility reasonable use rate of $8.30 per week, with consideration of staffing ratios to meet individual needs and utilization.

(6) To the result of step (5) add reimbursement for meals authorized and provided in conjunction with adult day care services. This is the payment rate. For bathing services provided in conjunction with adult day care services, the payment rate is $7.01 per 15-minute unit per bath.

(7) Multiply the result of step (6) by step (1) to establish the payment amount.

(b) If the commissioner derives rates for personnel hourly wages under this paragraph, the commissioner must use the following Direct Care Job Classification with Bureau of Labor Standards job classes. These classes must be aligned with services provided under the home and community-based services waiver:

(1) registered nurse;

(2) licensed practical nurse; and

(3) direct primary care.

(c) The commissioner shall revise the wage rates under paragraph (a), clause (2), in the manner provided in subdivision 10.

Subd. 7. **Payments for residential services.** (a) Payments for services in residential settings including supported living services, foster care, residential care, customized living, and 24-hour customized living subject to limitation to settings registered or licensed for five or fewer individuals must be calculated as follows unless the services are authorized separately under subdivisions 5 and 6:

(1) Determine the number of units of service used.

(2) Determine the direct staff wages. The personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in paragraph (b). This is the direct care rate except for customizations for certain individuals.

(3) For an individual requiring customization under subdivision 8, add the customization rate provided in subdivision 8 to the result of step (2). This is the customized direct care rate.

(4) Except for a family foster care setting subject to step (5), take the direct care cost under step (2) or step (3) and increase this amount by the employee and program-related expense factor of 61.8 percent.

(5) For family foster care settings, take the direct care cost under step (2) or step (3) and increase this amount by the employee and program-related expense factor of 38.3 percent.

(6) To the result of step (4) or step (5) add a value of $2,179 per year adjusted to a weekly unit.

(7) To the result of step (6) add individual waiver transportation, if provided, at $1,680 or $4,290 annually if customized for full size adapted transportation. This is the payment rate.

(8) Multiply the result of step (7) by step (1) to establish the payment amount.

(b) If the commissioner derives rates for personnel hourly wages under this paragraph, the commissioner must use the following Direct Care Job Classifications with the Bureau of Labor Statistics job classes. These classes must be aligned with services provided under the home and community-based waiver:

(1) licensed practical nurse;

(2) registered nurse;

(3) direct primary care;

(4) asleep overnight; and

(5) supervisor.

(c) The commissioner shall revise the wage rates under paragraph (a), clause (2), in the manner provided in subdivision 10.

(d) For customized living settings registered for six or more, the commissioner shall use service planning results from the customized living tool to determine the customized living payment to be used beginning January 1, 2013. The commissioner shall provide notice of that payment rate under subdivision 10. By January 15, 2014, the commissioner shall provide an evaluation of the implications of the rate on service provision to the legislative committees with jurisdiction over human services.

Subd. 8. **Customization of rates for individuals.** (a) For persons determined to have higher needs based on assessment of medical, mental health, or behavior issues, or as being deaf/hard-of-hearing, the direct care costs in subdivisions 5 to 7 must be increased by an adjustment factor prior to calculating the price under the respective subdivision.

(b) The customization rate with respect to medical, mental health, and behavior issues shall be $2.38 per authorized hour for clients who meet the respective criteria as determined by the commissioner.

(c) The customization rate with respect to deaf/hard-of-hearing persons shall be $9.70 per hour for clients who meet the respective criteria as determined by the commissioner.

Subd. 9. **Payments for transportation.** (a) Transportation payments must be calculated according to clauses (1) to (5).

(1) Determine the number of individual and shared trips authorized.

(2) Determine the distance and whether the individual requires a lift.

(3) For an individual trip payment take the constant trip value of $2.52 and add a distance rate amount of payment of:

(i) 50 cents per mile for five miles for distances within ten miles;

(ii) 50 cents per mile for 15.5 miles for distances more than ten and up to 20 miles;

(iii) 50 cents per mile for 35.5 miles for distances more than 20 and up to 50 miles; and

(iv) 50 cents per mile for 51 miles for distances more than 50 miles.

(4) For shared trip payments, take the constant trip value of $2.52 and add one-sixth of the distance rate payment amounts provided for in paragraph (a), clause (3).

(5) For a trip payment requiring a lift, add 93 cents per mile to the distance rate calculation in paragraph (a), clauses (3) and (4).

(b) The commissioner shall require that the purchase of transportation services be cost-effective and be limited to market rates where the transportation mode is generally available and accessible.

Subd. 10. **Updating or changing payment values.** (a) The commissioner shall develop and implement uniform procedures to refine terms and update or adjust values used to calculate payment rates in this section. For calendar year 2013, the commissioner shall use the values, terms, and procedures provided in this section as revised to reflect the results of staffing and service utilization findings under subdivision 11.

(b) The commissioner must update the factors and values described in this section on January 1 of every second year subsequent to January 1, 2013, and provide notice of the update by October 1 of the prior year.

(c) A commissioner's notice must be made available October 1 of each year starting October 1, 2012, and shall contain information detailing: calculation values including derived wage rates and related employee and administrative factors; service utilization; and, in even-numbered years, information on adjustments to be made to calculation values and the timing of those adjustments.

(d) By November 1, 2012, the commissioner shall report to the legislative committees with jurisdiction over disability waiver policy and budget on the operation and management of the disability waiver rates-setting system, the results of the service utilization research under subdivision 11, paragraph (a), and the implications of those results for providers, provider types and applicable services, counties and tribes, and individuals with disabilities. With respect to the procedure developed under subdivision 11, paragraph (b), the report shall include a description of the procedure and the expected impact of the procedure on payments to providers individually and grouped by the applicable services listed in subdivision 3.

Subd. 11. **Waiver rates management system.** (a) The rates management system tool shall be used to determine the rate for an individual eligible under section 256B.092 or 256B.49. Beginning February 2012, the system shall be used as a guide for research into service utilization in calendar year 2012 to inform factor values for payments to be made in 2013. Effective January 1, 2013, the system must be used to determine payment rates for home and community-based services and shall be the basis for authorizing services except as provided under paragraphs (b) to (e). Paragraphs (b) to (e) apply to payments made in calendar years 2013 and 2014.

(b) By October 1, 2012, the commissioner shall develop a procedure for uniformly adjusting individualized payment rates, subject to accommodation under this section, to allow for higher or lower reimbursements for providers when equivalent individualized rates in effect as of October 1, 2012, with respect to the service, are more than five percent higher or lower than the payments provided under section 256B.4913.

(c) For payment rates in effect for 2013 and 2014, if the payment rates established under section 256B.4913 are within five percent of the historic individual rate for calendar year 2013 and subsequently calendar year 2014, the payment rate shall be the authorization rate.

(d) For payment rates in effect for 2013 and 2014, when a historic rate is above the five percent range of the payment rates established under section 256B.4913, the county or tribe shall increase the payment to providers to five percent below the historic rate.

(e) For payment rates in effect for 2013 and 2014, when a historic rate is below the five percent range of the payment rates established under section 256B.4913, the county or tribe shall decrease the payment to providers to five percent above the historic rate.

(f) For calendar year 2015, all payment rates established under section 256B.4913 shall be the authorization rates.

Subd. 12. **Exceptions.** In a format prescribed by the commissioner, lead agencies must identify individuals with exceptional needs that cannot be met under the disability waiver rate system. The commissioner shall use that information to evaluate and, if necessary, design an alternative payment structure for those individuals.

Subd. 13. **Shared service limits.** The commissioner retains authority to limit the number of people that share waiver and day services. Individualized payment structures and methodologies established by the commissioner under section 256B.4912 must reflect the option to share services within the limits established by the commissioner.

Subd. 14. **Payment implementation.** Upon implementation of the payment methodologies under this section, those payment rates supersede rates established in county contracts for recipients receiving waiver services under sections 256B.092 and 256B.49.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 40. Minnesota Statutes 2010, section 256B.501, subdivision 4b, is amended to read:

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

(b) This subdivision expires January 1, 2013.

Sec. 41. Minnesota Statutes 2010, section 256B.5013, subdivision 1, is amended to read:

Subdivision 1. **Variable rate adjustments.** (a) For rate years beginning on or after October 1, 2000, when there is a documented increase in the needs of a current ICF/MR recipient, the county of financial responsibility may recommend a variable rate to enable the facility to meet the individual's increased needs. ~~Variable rate adjustments made under this subdivision replace payments for persons with special needs under section 256B.501, subdivision 8, and payments for persons with special needs for crisis intervention services under section 256B.501, subdivision 8a.~~ Effective July 1, 2003, facilities with a base rate above the 50th percentile of the statewide average reimbursement rate for a Class A facility or Class B facility, whichever matches the facility licensure, are not eligible for a variable rate adjustment. Variable rate adjustments may not exceed a 12-month period, except when approved for purposes established in paragraph (b), clause (1). Variable rate adjustments approved solely on the basis of changes on a developmental disabilities screening document will end June 30, 2002.

(b) A variable rate may be recommended by the county of financial responsibility for increased needs in the following situations:

(1) a need for resources due to an individual's full or partial retirement from participation in a day training and habilitation service when the individual: (i) has reached the age of 65 or has a change in health condition that makes it difficult for the person to participate in day training and habilitation services over an extended period of time because it is medically contraindicated; and (ii) has expressed a desire for change through the developmental disability screening process under section 256B.092;

(2) a need for additional resources for intensive short-term programming which is necessary prior to an individual's discharge to a less restrictive, more integrated setting;

(3) a demonstrated medical need that significantly impacts the type or amount of services needed by the individual; or

(4) a demonstrated behavioral need that significantly impacts the type or amount of services needed by the individual.

(c) The county of financial responsibility must justify the purpose, the projected length of time, and the additional funding needed for the facility to meet the needs of the individual.

(d) The facility shall provide an annual report to the county case manager on the use of the variable rate funds and the status of the individual on whose behalf the funds were approved. The county case manager will forward the facility's report with a recommendation to the commissioner to approve or disapprove a continuation of the variable rate.

(e) Funds made available through the variable rate process that are not used by the facility to meet the needs of the individual for whom they were approved shall be returned to the state.

Sec. 42. **REVISOR'S INSTRUCTION.**

In Minnesota Statutes, sections 245B.02, 245B.06, 252.40, 252.41, 256B.038, 256B.0918, 256B.5015, 256B.765, and 604A.33, the revisor of statutes shall delete "sections 252.40 to 252.46" and replace it with "sections 252.41 to 252.46."

EFFECTIVE DATE. This section is effective January 1, 2013.

ARTICLE 2

PAYMENT RATE-SETTING METHODOLOGIES

Section 1. 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. 2. 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. 3. 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. 4. 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. 5. 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. 6. **[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 delivered utilizing the assessment process in section 256B.0911, subdivision 10. The provider may deliver services using direct staffing or 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 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 subdivisions 3, 4, and 5, and section 245A.11, subdivision 8, 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. 7. **EFFECTIVE DATE; APPLICATION.**

Sections 1 to 6 are effective the day following final enactment. The rate-setting methodologies in section 6 apply on January 1, 2013, following the implementation of the assessment methodology under Minnesota Statutes, section 256B.0911, subdivision 10.

APPENDIX
Article locations in H2456-2

ARTICLE 1	STATEWIDE PROVIDER ENROLLMENT, PERFORMANCE STANDARDS, AND RATE-SETTING METHODOLOGY	Page.Ln 1.17
ARTICLE 2	PAYMENT RATE-SETTING METHODOLOGIES	Page.Ln 53.9