SENATE
STATE OF MINNESOTA
EIGHTY-SEVENTH LEGISLATURE S.F. No. 1804

(SENATE AUTHORS: HANN)

DATE	D-PG	OFFICIAL STATUS
02/13/2012	3797	Introduction and first reading Referred to Health and Human Services
03/01/2012		Comm report: To pass as amended and re-refer to Judiciary and Public Safety

1.1 A bill for an act
1.2 relating to state government; making changes to health and human services
1.3 policy provisions; modifying provisions related to continuing care, the telephone
1.4 equipment program, chemical and mental health, and health care; reforming
1.5 comprehensive assessment and case management services; amending Minnesota
1.6 Statutes 2010, sections 237.50; 237.51; 237.52; 237.53; 237.54; 237.55; 237.56;
1.7 245.461, by adding a subdivision; 245.462, subdivision 20; 245.487, by adding
1.8 a subdivision; 245.4871, subdivision 15; 245.4932, subdivision 1; 245A.11,
1.9 subdivision 2a; 246.53, by adding a subdivision; 256.9657, subdivision 1;
1.10 256B.04, subdivision 14; 256B.056, subdivision 3c; 256B.0595, subdivision
1.11 2; 256B.0625, subdivisions 13, 13d, 42; 256B.0659, subdivisions 1, 2, 3a, 4;
1.12 256B.0911, subdivisions 1, 2b, 2c, 3, 3b, 4c, 6; 256B.0913, subdivisions 7, 8;
1.13 256B.0915, subdivisions 1a, 1b, 3c, 6; 256B.092, subdivisions 1, 1a, 1b, 1e, 1g,
1.14 2, 3, 5, 7, 8, 8a, 9, 11; 256B.19, subdivision 1c; 256B.441, subdivisions 13,
1.15 31, 53; 256B.49, subdivision 13; 256B.69, subdivision 5; 256F.13, subdivision
1.16 1; 256G.02, subdivision 6; 256L.05, subdivision 3; 514.982, subdivision
1.17 1; Minnesota Statutes 2011 Supplement, sections 125A.21, subdivision 7;
1.18 144A.071, subdivisions 3, 4a; 254B.04, subdivision 2a; 256B.056, subdivision
1.19 3; 256B.057, subdivision 9; 256B.0625, subdivisions 13e, 13h, 14; 256B.0631,
1.20 subdivisions 1, 2; 256B.0911, subdivisions 1a, 3a, 4a; 256B.0915, subdivision
1.21 10; 256B.49, subdivisions 14, 15; 256B.69, subdivisions 5a, 28; 256L.15,
1.22 subdivision 1; 626.557, subdivision 9; repealing Minnesota Statutes 2010,
1.23 sections 256.01, subdivision 18b; 256B.431, subdivisions 2c, 2g, 2i, 2j, 2k, 2l,
1.24 2o, 3c, 11, 14, 17b, 17f, 19, 20, 25, 27, 29; 256B.434, subdivisions 4a, 4b, 4c,
1.25 4d, 4e, 4g, 4h, 7, 8; 256B.435; 256B.436; Minnesota Statutes 2011 Supplement,
1.26 section 256B.431, subdivision 26; Minnesota Rules, part 9555.7700.

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

1.28 **ARTICLE 1**

1.29 **CONTINUING CARE**

1.30 Section 1. Minnesota Statutes 2011 Supplement, section 144A.071, subdivision 3,
1.31 is amended to read:

2.1 Subd. 3. **Exceptions authorizing increase in beds; hardship areas.** (a) The
2.2 commissioner of health, in coordination with the commissioner of human services, may
2.3 approve the addition of new licensed and Medicare and Medicaid certified nursing home
2.4 beds, using the criteria and process set forth in this subdivision.
2.5 (b) The commissioner, in cooperation with the commissioner of human services,
2.6 shall consider the following criteria when determining that an area of the state is a
2.7 hardship area with regard to access to nursing facility services:
2.8 (1) a low number of beds per thousand in a specified area using as a standard the
2.9 beds per thousand people age 65 and older, in five year age groups, using data from the
2.10 most recent census and population projections, weighted by each group's most recent
2.11 nursing home utilization, of the county at the 20th percentile, as determined by the
2.12 commissioner of human services;
2.13 (2) a high level of out-migration for nursing facility services associated with a
2.14 described area from the county or counties of residence to other Minnesota counties, as
2.15 determined by the commissioner of human services, using as a standard an amount greater
2.16 than the out-migration of the county ranked at the 50th percentile;
2.17 (3) an adequate level of availability of noninstitutional long-term care services
2.18 measured as public spending for home and community-based long-term care services per
2.19 individual age 65 and older, in five year age groups, using data from the most recent
2.20 census and population projections, weighted by each group's most recent nursing home
2.21 utilization, as determined by the commissioner of human services using as a standard an
2.22 amount greater than the 50th percentile of counties;
2.23 (4) there must be a declaration of hardship resulting from insufficient access to
2.24 nursing home beds by local county agencies and area agencies on aging; and
2.25 (5) other factors that may demonstrate the need to add new nursing facility beds.
2.26 (c) On August 15 of odd-numbered years, the commissioner, in cooperation with
2.27 the commissioner of human services, may publish in the State Register a request for
2.28 information in which interested parties, using the data provided under section 144A.351,
2.29 along with any other relevant data, demonstrate that a specified area is a hardship area
2.30 with regard to access to nursing facility services. For a response to be considered, the
2.31 commissioner must receive it by November 15. The commissioner shall make responses
2.32 to the request for information available to the public and shall allow 30 days for comment.
2.33 The commissioner shall review responses and comments and determine if any areas of
2.34 the state are to be declared hardship areas.
2.35 (d) For each designated hardship area determined in paragraph (c), the commissioner
2.36 shall publish a request for proposals in accordance with section 144A.073 and Minnesota

3.1 Rules, parts 4655.1070 to 4655.1098. The request for proposals must be published in the
3.2 State Register by March 15 following receipt of responses to the request for information.
3.3 The request for proposals must specify the number of new beds which may be added
3.4 in the designated hardship area, which must not exceed the number which, if added to
3.5 the existing number of beds in the area, including beds in layaway status, would have
3.6 prevented it from being determined to be a hardship area under paragraph (b), clause
3.7 (1). Beginning July 1, 2011, the number of new beds approved must not exceed 200
3.8 beds statewide per biennium. After June 30, 2019, the number of new beds that may be
3.9 approved in a biennium must not exceed 300 statewide. For a proposal to be considered,
3.10 the commissioner must receive it within six months of the publication of the request for
3.11 proposals. The commissioner shall review responses to the request for proposals and
3.12 shall approve or disapprove each proposal by the following July 15, in accordance with
3.13 section 144A.073 and Minnesota Rules, parts 4655.1070 to 4655.1098. The commissioner
3.14 shall base approvals or disapprovals on a comparison and ranking of proposals using
3.15 only the criteria in subdivision 4a. Approval of a proposal expires after 18 months
3.16 unless the facility has added the new beds using existing space, subject to approval
3.17 by the commissioner, or has commenced construction as defined in section 144A.071,
3.18 subdivision 1a, paragraph (d). ~~Operating~~ If, after the approved beds have been added,
3.19 fewer than 50 percent of the beds in a facility are newly licensed, the operating payment
3.20 rates previously in effect shall remain. If, after the approved beds have been added, 50
3.21 percent or more of the beds in a facility are newly licensed, operating payment rates shall
3.22 be determined according to Minnesota Rules, part 9549.0057, using the limits under
3.23 section 256B.441. External fixed payment rates must be determined according to section
3.24 256B.441, subdivision 53. Property payment rates for facilities with beds added under this
3.25 subdivision must be determined in the same manner as rate determinations resulting from
3.26 projects approved and completed under section 144A.073.
3.27 (e) The commissioner may:
3.28 (1) certify or license new beds in a new facility that is to be operated by the
3.29 commissioner of veterans affairs or when the costs of constructing and operating the new
3.30 beds are to be reimbursed by the commissioner of veterans affairs or the United States
3.31 Veterans Administration; and
3.32 (2) license or certify beds in a facility that has been involuntarily delicensed or
3.33 decertified for participation in the medical assistance program, provided that an application
3.34 for relicensure or recertification is submitted to the commissioner by an organization that
3.35 is not a related organization as defined in section 256B.441, subdivision 34, to the prior
3.36 licensee within 120 days after delicensure or decertification.

4.1 Sec. 2. Minnesota Statutes 2011 Supplement, section 144A.071, subdivision 4a,
4.2 is amended to read:

4.3 Subd. 4a. **Exceptions for replacement beds.** It is in the best interest of the state
4.4 to ensure that nursing homes and boarding care homes continue to meet the physical
4.5 plant licensing and certification requirements by permitting certain construction projects.
4.6 Facilities should be maintained in condition to satisfy the physical and emotional needs
4.7 of residents while allowing the state to maintain control over nursing home expenditure
4.8 growth.

4.9 The commissioner of health in coordination with the commissioner of human
4.10 services, may approve the renovation, replacement, upgrading, or relocation of a nursing
4.11 home or boarding care home, under the following conditions:

4.12 (a) to license or certify beds in a new facility constructed to replace a facility or to
4.13 make repairs in an existing facility that was destroyed or damaged after June 30, 1987, by
4.14 fire, lightning, or other hazard provided:

4.15 (i) destruction was not caused by the intentional act of or at the direction of a
4.16 controlling person of the facility;

4.17 (ii) at the time the facility was destroyed or damaged the controlling persons of the
4.18 facility maintained insurance coverage for the type of hazard that occurred in an amount
4.19 that a reasonable person would conclude was adequate;

4.20 (iii) the net proceeds from an insurance settlement for the damages caused by the
4.21 hazard are applied to the cost of the new facility or repairs;

4.22 (iv) the number of licensed and certified beds in the new facility does not exceed the
4.23 number of licensed and certified beds in the destroyed facility; and

4.24 (v) the commissioner determines that the replacement beds are needed to prevent an
4.25 inadequate supply of beds.

4.26 Project construction costs incurred for repairs authorized under this clause shall not be
4.27 considered in the dollar threshold amount defined in subdivision 2;

4.28 (b) to license or certify beds that are moved from one location to another within a
4.29 nursing home facility, provided the total costs of remodeling performed in conjunction
4.30 with the relocation of beds does not exceed $1,000,000;

4.31 (c) to license or certify beds in a project recommended for approval under section
4.32 144A.073;

4.33 (d) to license or certify beds that are moved from an existing state nursing home to
4.34 a different state facility, provided there is no net increase in the number of state nursing
4.35 home beds;

5.1 (e) to certify and license as nursing home beds boarding care beds in a certified
5.2 boarding care facility if the beds meet the standards for nursing home licensure, or in a
5.3 facility that was granted an exception to the moratorium under section 144A.073, and if
5.4 the cost of any remodeling of the facility does not exceed $1,000,000. If boarding care
5.5 beds are licensed as nursing home beds, the number of boarding care beds in the facility
5.6 must not increase beyond the number remaining at the time of the upgrade in licensure.
5.7 The provisions contained in section 144A.073 regarding the upgrading of the facilities
5.8 do not apply to facilities that satisfy these requirements;

5.9 (f) to license and certify up to 40 beds transferred from an existing facility owned and
5.10 operated by the Amherst H. Wilder Foundation in the city of St. Paul to a new unit at the
5.11 same location as the existing facility that will serve persons with Alzheimer's disease and
5.12 other related disorders. The transfer of beds may occur gradually or in stages, provided
5.13 the total number of beds transferred does not exceed 40. At the time of licensure and
5.14 certification of a bed or beds in the new unit, the commissioner of health shall delicense
5.15 and decertify the same number of beds in the existing facility. As a condition of receiving
5.16 a license or certification under this clause, the facility must make a written commitment
5.17 to the commissioner of human services that it will not seek to receive an increase in its
5.18 property-related payment rate as a result of the transfers allowed under this paragraph;

5.19 (g) to license and certify nursing home beds to replace currently licensed and certified
5.20 boarding care beds which may be located either in a remodeled or renovated boarding care
5.21 or nursing home facility or in a remodeled, renovated, newly constructed, or replacement
5.22 nursing home facility within the identifiable complex of health care facilities in which the
5.23 currently licensed boarding care beds are presently located, provided that the number of
5.24 boarding care beds in the facility or complex are decreased by the number to be licensed
5.25 as nursing home beds and further provided that, if the total costs of new construction,
5.26 replacement, remodeling, or renovation exceed ten percent of the appraised value of
5.27 the facility or $200,000, whichever is less, the facility makes a written commitment to
5.28 the commissioner of human services that it will not seek to receive an increase in its
5.29 property-related payment rate by reason of the new construction, replacement, remodeling,
5.30 or renovation. The provisions contained in section 144A.073 regarding the upgrading of
5.31 facilities do not apply to facilities that satisfy these requirements;

5.32 (h) to license as a nursing home and certify as a nursing facility a facility that is
5.33 licensed as a boarding care facility but not certified under the medical assistance program,
5.34 but only if the commissioner of human services certifies to the commissioner of health that
5.35 licensing the facility as a nursing home and certifying the facility as a nursing facility will
5.36 result in a net annual savings to the state general fund of $200,000 or more;

6.1 (i) to certify, after September 30, 1992, and prior to July 1, 1993, existing nursing
6.2 home beds in a facility that was licensed and in operation prior to January 1, 1992;
6.3 (j) to license and certify new nursing home beds to replace beds in a facility acquired
6.4 by the Minneapolis Community Development Agency as part of redevelopment activities
6.5 in a city of the first class, provided the new facility is located within three miles of the site
6.6 of the old facility. Operating and property costs for the new facility must be determined
6.7 and allowed under section 256B.431 or 256B.434;
6.8 (k) to license and certify up to 20 new nursing home beds in a community-operated
6.9 hospital and attached convalescent and nursing care facility with 40 beds on April 21,
6.10 1991, that suspended operation of the hospital in April 1986. The commissioner of human
6.11 services shall provide the facility with the same per diem property-related payment rate
6.12 for each additional licensed and certified bed as it will receive for its existing 40 beds;
6.13 (l) to license or certify beds in renovation, replacement, or upgrading projects as
6.14 defined in section 144A.073, subdivision 1, so long as the cumulative total costs of the
6.15 facility's remodeling projects do not exceed $1,000,000;
6.16 (m) to license and certify beds that are moved from one location to another for the
6.17 purposes of converting up to five four-bed wards to single or double occupancy rooms
6.18 in a nursing home that, as of January 1, 1993, was county-owned and had a licensed
6.19 capacity of 115 beds;
6.20 (n) to allow a facility that on April 16, 1993, was a 106-bed licensed and certified
6.21 nursing facility located in Minneapolis to layaway all of its licensed and certified nursing
6.22 home beds. These beds may be relicensed and recertified in a newly constructed teaching
6.23 nursing home facility affiliated with a teaching hospital upon approval by the legislature.
6.24 The proposal must be developed in consultation with the interagency committee on
6.25 long-term care planning. The beds on layaway status shall have the same status as
6.26 voluntarily delicensed and decertified beds, except that beds on layaway status remain
6.27 subject to the surcharge in section 256.9657. This layaway provision expires July 1, 1998;
6.28 (o) to allow a project which will be completed in conjunction with an approved
6.29 moratorium exception project for a nursing home in southern Cass County and which is
6.30 directly related to that portion of the facility that must be repaired, renovated, or replaced,
6.31 to correct an emergency plumbing problem for which a state correction order has been
6.32 issued and which must be corrected by August 31, 1993;
6.33 (p) to allow a facility that on April 16, 1993, was a 368-bed licensed and certified
6.34 nursing facility located in Minneapolis to layaway, upon 30 days prior written notice to
6.35 the commissioner, up to 30 of the facility's licensed and certified beds by converting
6.36 three-bed wards to single or double occupancy. Beds on layaway status shall have the

7.1 same status as voluntarily delicensed and decertified beds except that beds on layaway
7.2 status remain subject to the surcharge in section 256.9657, remain subject to the license
7.3 application and renewal fees under section 144A.07 and shall be subject to a $100 per bed
7.4 reactivation fee. In addition, at any time within three years of the effective date of the
7.5 layaway, the beds on layaway status may be:

7.6 (1) relicensed and recertified upon relocation and reactivation of some or all of
7.7 the beds to an existing licensed and certified facility or facilities located in Pine River,
7.8 Brainerd, or International Falls; provided that the total project construction costs related to
7.9 the relocation of beds from layaway status for any facility receiving relocated beds may
7.10 not exceed the dollar threshold provided in subdivision 2 unless the construction project
7.11 has been approved through the moratorium exception process under section 144A.073;

7.12 (2) relicensed and recertified, upon reactivation of some or all of the beds within the
7.13 facility which placed the beds in layaway status, if the commissioner has determined a
7.14 need for the reactivation of the beds on layaway status.

7.15 The property-related payment rate of a facility placing beds on layaway status
7.16 must be adjusted by the incremental change in its rental per diem after recalculating the
7.17 rental per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The
7.18 property-related payment rate for a facility relicensing and recertifying beds from layaway
7.19 status must be adjusted by the incremental change in its rental per diem after recalculating
7.20 its rental per diem using the number of beds after the relicensing to establish the facility's
7.21 capacity day divisor, which shall be effective the first day of the month following the
7.22 month in which the relicensing and recertification became effective. Any beds remaining
7.23 on layaway status more than three years after the date the layaway status became effective
7.24 must be removed from layaway status and immediately delicensed and decertified;

7.25 (q) to license and certify beds in a renovation and remodeling project to convert 12
7.26 four-bed wards into 24 two-bed rooms, expand space, and add improvements in a nursing
7.27 home that, as of January 1, 1994, met the following conditions: the nursing home was
7.28 located in Ramsey County; had a licensed capacity of 154 beds; and had been ranked
7.29 among the top 15 applicants by the 1993 moratorium exceptions advisory review panel.
7.30 The total project construction cost estimate for this project must not exceed the cost
7.31 estimate submitted in connection with the 1993 moratorium exception process;

7.32 (r) to license and certify up to 117 beds that are relocated from a licensed and
7.33 certified 138-bed nursing facility located in St. Paul to a hospital with 130 licensed
7.34 hospital beds located in South St. Paul, provided that the nursing facility and hospital are
7.35 owned by the same or a related organization and that prior to the date the relocation is
7.36 completed the hospital ceases operation of its inpatient hospital services at that hospital.

8.1 After relocation, the nursing facility's status ~~under section 256B.431, subdivision 2j,~~ shall
8.2 be the same as it was prior to relocation. The nursing facility's property-related payment
8.3 rate resulting from the project authorized in this paragraph shall become effective no
8.4 earlier than April 1, 1996. For purposes of calculating the incremental change in the
8.5 facility's rental per diem resulting from this project, the allowable appraised value of
8.6 the nursing facility portion of the existing health care facility physical plant prior to the
8.7 renovation and relocation may not exceed $2,490,000;

8.8 (s) to license and certify two beds in a facility to replace beds that were voluntarily
8.9 delicensed and decertified on June 28, 1991;

8.10 (t) to allow 16 licensed and certified beds located on July 1, 1994, in a 142-bed
8.11 nursing home and 21-bed boarding care home facility in Minneapolis, notwithstanding
8.12 the licensure and certification after July 1, 1995, of the Minneapolis facility as a 147-bed
8.13 nursing home facility after completion of a construction project approved in 1993 under
8.14 section 144A.073, to be laid away upon 30 days' prior written notice to the commissioner.
8.15 Beds on layaway status shall have the same status as voluntarily delicensed or decertified
8.16 beds except that they shall remain subject to the surcharge in section 256.9657. The
8.17 16 beds on layaway status may be relicensed as nursing home beds and recertified at
8.18 any time within five years of the effective date of the layaway upon relocation of some
8.19 or all of the beds to a licensed and certified facility located in Watertown, provided that
8.20 the total project construction costs related to the relocation of beds from layaway status
8.21 for the Watertown facility may not exceed the dollar threshold provided in subdivision
8.22 2 unless the construction project has been approved through the moratorium exception
8.23 process under section 144A.073.

8.24 The property-related payment rate of the facility placing beds on layaway status
8.25 must be adjusted by the incremental change in its rental per diem after recalculating the
8.26 rental per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The
8.27 property-related payment rate for the facility relicensing and recertifying beds from
8.28 layaway status must be adjusted by the incremental change in its rental per diem after
8.29 recalculating its rental per diem using the number of beds after the relicensing to establish
8.30 the facility's capacity day divisor, which shall be effective the first day of the month
8.31 following the month in which the relicensing and recertification became effective. Any
8.32 beds remaining on layaway status more than five years after the date the layaway status
8.33 became effective must be removed from layaway status and immediately delicensed
8.34 and decertified;

8.35 (u) to license and certify beds that are moved within an existing area of a facility or
8.36 to a newly constructed addition which is built for the purpose of eliminating three- and

9.1 four-bed rooms and adding space for dining, lounge areas, bathing rooms, and ancillary
9.2 service areas in a nursing home that, as of January 1, 1995, was located in Fridley and had
9.3 a licensed capacity of 129 beds;

9.4 (v) to relocate 36 beds in Crow Wing County and four beds from Hennepin County
9.5 to a 160-bed facility in Crow Wing County, provided all the affected beds are under
9.6 common ownership;

9.7 (w) to license and certify a total replacement project of up to 49 beds located in
9.8 Norman County that are relocated from a nursing home destroyed by flood and whose
9.9 residents were relocated to other nursing homes. The operating cost payment rates for
9.10 the new nursing facility shall be determined based on the interim and settle-up payment
9.11 provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of
9.12 section 256B.431~~, except that subdivision 26, paragraphs (a) and (b), shall not apply until~~
9.13 ~~the second rate year after the settle-up cost report is filed~~. Property-related reimbursement
9.14 rates shall be determined under section 256B.431, taking into account any federal or state
9.15 flood-related loans or grants provided to the facility;

9.16 (x) to license and certify a total replacement project of up to 129 beds located
9.17 in Polk County that are relocated from a nursing home destroyed by flood and whose
9.18 residents were relocated to other nursing homes. The operating cost payment rates for
9.19 the new nursing facility shall be determined based on the interim and settle-up payment
9.20 provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of
9.21 section 256B.431, except that subdivision 26, paragraphs (a) and (b), shall not apply until
9.22 the second rate year after the settle-up cost report is filed. Property-related reimbursement
9.23 rates shall be determined under section 256B.431, taking into account any federal or state
9.24 flood-related loans or grants provided to the facility;

9.25 (y) to license and certify beds in a renovation and remodeling project to convert 13
9.26 three-bed wards into 13 two-bed rooms and 13 single-bed rooms, expand space, and
9.27 add improvements in a nursing home that, as of January 1, 1994, met the following
9.28 conditions: the nursing home was located in Ramsey County, was not owned by a hospital
9.29 corporation, had a licensed capacity of 64 beds, and had been ranked among the top 15
9.30 applicants by the 1993 moratorium exceptions advisory review panel. The total project
9.31 construction cost estimate for this project must not exceed the cost estimate submitted in
9.32 connection with the 1993 moratorium exception process;

9.33 (z) to license and certify up to 150 nursing home beds to replace an existing 285
9.34 bed nursing facility located in St. Paul. The replacement project shall include both the
9.35 renovation of existing buildings and the construction of new facilities at the existing
9.36 site. The reduction in the licensed capacity of the existing facility shall occur during the

10.1 construction project as beds are taken out of service due to the construction process. Prior
10.2 to the start of the construction process, the facility shall provide written information to the
10.3 commissioner of health describing the process for bed reduction, plans for the relocation
10.4 of residents, and the estimated construction schedule. The relocation of residents shall be
10.5 in accordance with the provisions of law and rule;

10.6 (aa) to allow the commissioner of human services to license an additional 36 beds
10.7 to provide residential services for the physically disabled under Minnesota Rules, parts
10.8 9570.2000 to 9570.3400, in a 198-bed nursing home located in Red Wing, provided that
10.9 the total number of licensed and certified beds at the facility does not increase;

10.10 (bb) to license and certify a new facility in St. Louis County with 44 beds
10.11 constructed to replace an existing facility in St. Louis County with 31 beds, which has
10.12 resident rooms on two separate floors and an antiquated elevator that creates safety
10.13 concerns for residents and prevents nonambulatory residents from residing on the second
10.14 floor. The project shall include the elimination of three- and four-bed rooms;

10.15 (cc) to license and certify four beds in a 16-bed certified boarding care home in
10.16 Minneapolis to replace beds that were voluntarily delicensed and decertified on or
10.17 before March 31, 1992. The licensure and certification is conditional upon the facility
10.18 periodically assessing and adjusting its resident mix and other factors which may
10.19 contribute to a potential institution for mental disease declaration. The commissioner of
10.20 human services shall retain the authority to audit the facility at any time and shall require
10.21 the facility to comply with any requirements necessary to prevent an institution for mental
10.22 disease declaration, including delicensure and decertification of beds, if necessary;

10.23 (dd) to license and certify 72 beds in an existing facility in Mille Lacs County with
10.24 80 beds as part of a renovation project. The renovation must include construction of
10.25 an addition to accommodate ten residents with beginning and midstage dementia in a
10.26 self-contained living unit; creation of three resident households where dining, activities,
10.27 and support spaces are located near resident living quarters; designation of four beds
10.28 for rehabilitation in a self-contained area; designation of 30 private rooms; and other
10.29 improvements;

10.30 (ee) to license and certify beds in a facility that has undergone replacement or
10.31 remodeling as part of a planned closure under section 256B.437;

10.32 (ff) to license and certify a total replacement project of up to 124 beds located
10.33 in Wilkin County that are in need of relocation from a nursing home significantly
10.34 damaged by flood. The operating cost payment rates for the new nursing facility shall
10.35 be determined based on the interim and settle-up payment provisions of Minnesota
10.36 Rules, part 9549.0057, and the reimbursement provisions of section 256B.431~~, except~~

11.1 ~~that section 256B.431, subdivision 26, paragraphs (a) and (b), shall not apply until the~~
11.2 ~~second rate year after the settle-up cost report is filed~~. Property-related reimbursement
11.3 rates shall be determined under section 256B.431, taking into account any federal or state
11.4 flood-related loans or grants provided to the facility;

11.5 (gg) to allow the commissioner of human services to license an additional nine beds
11.6 to provide residential services for the physically disabled under Minnesota Rules, parts
11.7 9570.2000 to 9570.3400, in a 240-bed nursing home located in Duluth, provided that the
11.8 total number of licensed and certified beds at the facility does not increase;

11.9 (hh) to license and certify up to 120 new nursing facility beds to replace beds in a
11.10 facility in Anoka County, which was licensed for 98 beds as of July 1, 2000, provided the
11.11 new facility is located within four miles of the existing facility and is in Anoka County.
11.12 Operating and property rates shall be determined and allowed under section 256B.431
11.13 and Minnesota Rules, parts 9549.0010 to 9549.0080, or section 256B.434 or ~~256B.435.~~
11.14 ~~The provisions of section 256B.431, subdivision 26, paragraphs (a) and (b), do not apply~~
11.15 ~~until the second rate year following settle-up~~ 256B.441; or

11.16 (ii) to transfer up to 98 beds of a 129-licensed bed facility located in Anoka County
11.17 that, as of March 25, 2001, is in the active process of closing, to a 122-licensed bed
11.18 nonprofit nursing facility located in the city of Columbia Heights or its affiliate. The
11.19 transfer is effective when the receiving facility notifies the commissioner in writing of the
11.20 number of beds accepted. The commissioner shall place all transferred beds on layaway
11.21 status held in the name of the receiving facility. The layaway adjustment provisions of
11.22 section 256B.431, subdivision 30, do not apply to this layaway. The receiving facility
11.23 may only remove the beds from layaway for recertification and relicensure at the receiving
11.24 facility's current site, or at a newly constructed facility located in Anoka County. The
11.25 receiving facility must receive statutory authorization before removing these beds from
11.26 layaway status, or may remove these beds from layaway status if removal from layaway
11.27 status is part of a moratorium exception project approved by the commissioner under
11.28 section 144A.073.

11.29 Sec. 3. Minnesota Statutes 2010, section 245A.11, subdivision 2a, is amended to read:

11.30 Subd. 2a. **Adult foster care license capacity.** (a) The commissioner shall issue
11.31 adult foster care licenses with a maximum licensed capacity of four beds, including
11.32 nonstaff roomers and boarders, except that the commissioner may issue a license with a
11.33 capacity of five beds, including roomers and boarders, according to paragraphs (b) to (f).

12.1 (b) An adult foster care license holder may have a maximum license capacity of five
12.2 if all persons in care are age 55 or over and do not have a serious and persistent mental
12.3 illness or a developmental disability.
12.4 (c) The commissioner may grant variances to paragraph (b) to allow a foster care
12.5 provider with a licensed capacity of five persons to admit an individual under the age of 55
12.6 if the variance complies with section 245A.04, subdivision 9, and approval of the variance
12.7 is recommended by the county in which the licensed foster care provider is located.
12.8 (d) The commissioner may grant variances to paragraph (b) to allow the use of a fifth
12.9 bed for emergency crisis services for a person with serious and persistent mental illness
12.10 or a developmental disability, regardless of age, if the variance complies with section
12.11 245A.04, subdivision 9, and approval of the variance is recommended by the county in
12.12 which the licensed foster care provider is located.
12.13 (e) If the 2009 legislature adopts a rate reduction that impacts providers of adult
12.14 foster care services, the commissioner may issue an adult foster care license with a
12.15 capacity of five adults if the fifth bed does not increase the overall statewide capacity of
12.16 licensed adult foster care beds in homes that are not the primary residence of the license
12.17 holder, over the licensed capacity in such homes on July 1, 2009, as identified in a plan
12.18 submitted to the commissioner by the county, when the capacity is recommended by
12.19 the county licensing agency of the county in which the facility is located and if the
12.20 recommendation verifies that:
12.21 (1) the facility meets the physical environment requirements in the adult foster
12.22 care licensing rule;
12.23 (2) the five-bed living arrangement is specified for each resident in the resident's:
12.24 (i) individualized plan of care;
12.25 (ii) individual service plan under section 256B.092, subdivision 1b, if required; or
12.26 (iii) individual resident placement agreement under Minnesota Rules, part
12.27 9555.5105, subpart 19, if required;
12.28 (3) the license holder obtains written and signed informed consent from each
12.29 resident or resident's legal representative documenting the resident's informed choice to
12.30 living in the home and that the resident's refusal to consent would not have resulted in
12.31 service termination; and
12.32 (4) the facility was licensed for adult foster care before March 1, 2009.
12.33 (f) The commissioner shall not issue a new adult foster care license under paragraph
12.34 (e) after June 30, ~~2011~~ 2014. The commissioner shall allow a facility with an adult foster
12.35 care license issued under paragraph (e) before June 30, ~~2011~~ 2014, to continue with a

13.1 capacity of five adults if the license holder continues to comply with the requirements in
13.2 paragraph (e).

13.3 Sec. 4. Minnesota Statutes 2010, section 256.9657, subdivision 1, is amended to read:
13.4 Subdivision 1. **Nursing home license surcharge.** (a) Effective July 1, 1993,
13.5 each non-state-operated nursing home licensed under chapter 144A shall pay to the
13.6 commissioner an annual surcharge according to the schedule in subdivision 4. The
13.7 surcharge shall be calculated as $620 per licensed bed. If the number of licensed beds
13.8 is reduced, the surcharge shall be based on the number of remaining licensed beds the
13.9 second month following the receipt of timely notice by the commissioner of human
13.10 services that beds have been delicensed. The nursing home must notify the commissioner
13.11 of health in writing when beds are delicensed. The commissioner of health must notify
13.12 the commissioner of human services within ten working days after receiving written
13.13 notification. If the notification is received by the commissioner of human services by
13.14 the 15th of the month, the invoice for the second following month must be reduced
13.15 to recognize the delicensing of beds. Beds on layaway status continue to be subject to
13.16 the surcharge. The commissioner of human services must acknowledge a medical care
13.17 surcharge appeal within 30 days of receipt of the written appeal from the provider.
13.18 (b) Effective July 1, 1994, the surcharge in paragraph (a) shall be increased to $625.
13.19 (c) Effective August 15, 2002, the surcharge under paragraph (b) shall be increased
13.20 to $990.
13.21 (d) Effective July 15, 2003, the surcharge under paragraph (c) shall be increased
13.22 to $2,815.
13.23 (e) The commissioner may reduce, and may subsequently restore, the surcharge
13.24 under paragraph (d) based on the commissioner's determination of a permissible surcharge.
13.25 (f) Between April 1, 2002, and August 15, 2004, a facility governed by this
13.26 subdivision may elect to assume full participation in the medical assistance program
13.27 by agreeing to comply with all of the requirements of the medical assistance program,
13.28 including the rate equalization law in section 256B.48, subdivision 1, paragraph (a), and
13.29 all other requirements established in law or rule, and to begin intake of new medical
13.30 assistance recipients. Rates will be determined under Minnesota Rules, parts 9549.0010
13.31 to 9549.0080. ~~Notwithstanding section 256B.431, subdivision 27, paragraph (i),~~ Rate
13.32 calculations will be subject to limits as prescribed in rule and law. Other than the
13.33 adjustments in sections 256B.431, subdivisions 30 and 32; 256B.437, subdivision 3,
13.34 paragraph (b), Minnesota Rules, part 9549.0057, and any other applicable legislation
13.35 enacted prior to the finalization of rates, facilities assuming full participation in medical

14.1 assistance under this paragraph are not eligible for any rate adjustments until the July 1
14.2 following their settle-up period.

14.3 Sec. 5. Minnesota Statutes 2010, section 256B.441, subdivision 13, is amended to read:
14.4 Subd. 13. **External fixed costs.** "External fixed costs" means costs related to the
14.5 nursing home surcharge under section 256.9657, subdivision 1; licensure fees under
14.6 section 144.122; long-term care consultation fees under section 256B.0911, subdivision 6;
14.7 family advisory council fee under section 144A.33; scholarships under section 256B.431,
14.8 subdivision 36; planned closure rate adjustments under section ~~256B.436 or~~ 256B.437; or
14.9 single bed room incentives under section 256B.431, subdivision 42; property taxes and
14.10 property insurance; and PERA.

14.11 Sec. 6. Minnesota Statutes 2010, section 256B.441, subdivision 31, is amended to read:
14.12 Subd. 31. **Prior system operating cost payment rate.** "Prior system operating
14.13 cost payment rate" means the operating cost payment rate in effect on September 30,
14.14 2008, under Minnesota Rules and Minnesota Statutes, not including planned closure rate
14.15 adjustments under section ~~256B.436 or~~ 256B.437, or single bed room incentives under
14.16 section 256B.431, subdivision 42.

14.17 Sec. 7. Minnesota Statutes 2010, section 256B.441, subdivision 53, is amended to read:
14.18 Subd. 53. **Calculation of payment rate for external fixed costs.** The commissioner
14.19 shall calculate a payment rate for external fixed costs.
14.20 (a) For a facility licensed as a nursing home, the portion related to section 256.9657
14.21 shall be equal to $8.86. For a facility licensed as both a nursing home and a boarding care
14.22 home, the portion related to section 256.9657 shall be equal to $8.86 multiplied by the
14.23 result of its number of nursing home beds divided by its total number of licensed beds.
14.24 (b) The portion related to the licensure fee under section 144.122, paragraph (d),
14.25 shall be the amount of the fee divided by actual resident days.
14.26 (c) The portion related to scholarships shall be determined under section 256B.431,
14.27 subdivision 36.
14.28 (d) The portion related to long-term care consultation shall be determined according
14.29 to section 256B.0911, subdivision 6.
14.30 (e) The portion related to development and education of resident and family advisory
14.31 councils under section 144A.33 shall be $5 divided by 365.
14.32 (f) The portion related to planned closure rate adjustments shall be as determined
14.33 under ~~sections 256B.436 and~~ section 256B.437, subdivision 6, and Minnesota Statutes

15.1 2010, section 256B.436. Planned closure rate adjustments that take effect before October
15.2 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning
15.3 October 1, 2016. Planned closure rate adjustments that take effect on or after October 1,
15.4 2014, shall no longer be included in the payment rate for external fixed costs beginning on
15.5 October 1 of the first year not less than two years after their effective date.

15.6 (g) The portions related to property insurance, real estate taxes, special assessments,
15.7 and payments made in lieu of real estate taxes directly identified or allocated to the nursing
15.8 facility shall be the actual amounts divided by actual resident days.

15.9 (h) The portion related to the Public Employees Retirement Association shall be
15.10 actual costs divided by resident days.

15.11 (i) The single bed room incentives shall be as determined under section 256B.431,
15.12 subdivision 42. Single bed room incentives that take effect before October 1, 2014, shall
15.13 no longer be included in the payment rate for external fixed costs beginning October 1,
15.14 2016. Single bed room incentives that take effect on or after October 1, 2014, shall no
15.15 longer be included in the payment rate for external fixed costs beginning on October 1 of
15.16 the first year not less than two years after their effective date.

15.17 (j) The payment rate for external fixed costs shall be the sum of the amounts in
15.18 paragraphs (a) to (i).

15.19 Sec. 8. Minnesota Statutes 2011 Supplement, section 626.557, subdivision 9, is
15.20 amended to read:

15.21 Subd. 9. **Common entry point designation.** (a) Each county board shall designate
15.22 a common entry point for reports of suspected maltreatment. Two or more county boards
15.23 may jointly designate a single common entry point. The common entry point is the unit
15.24 responsible for receiving the report of suspected maltreatment under this section.

15.25 (b) The common entry point must be available 24 hours per day to take calls from
15.26 reporters of suspected maltreatment. The common entry point shall use a standard intake
15.27 form that includes:

15.28 (1) the time and date of the report;

15.29 (2) the name, address, and telephone number of the person reporting;

15.30 (3) the time, date, and location of the incident;

15.31 (4) the names of the persons involved, including but not limited to, perpetrators,
15.32 alleged victims, and witnesses;

15.33 (5) whether there was a risk of imminent danger to the alleged victim;

15.34 (6) a description of the suspected maltreatment;

15.35 (7) the disability, if any, of the alleged victim;

16.1 (8) the relationship of the alleged perpetrator to the alleged victim;
16.2 (9) whether a facility was involved and, if so, which agency licenses the facility;
16.3 (10) any action taken by the common entry point;
16.4 (11) whether law enforcement has been notified;
16.5 (12) whether the reporter wishes to receive notification of the initial and final
16.6 reports; and
16.7 (13) if the report is from a facility with an internal reporting procedure, the name,
16.8 mailing address, and telephone number of the person who initiated the report internally.
16.9 (c) The common entry point is not required to complete each item on the form prior
16.10 to dispatching the report to the appropriate lead investigative agency.
16.11 (d) The common entry point shall immediately report to a law enforcement agency
16.12 any incident in which there is reason to believe a crime has been committed.
16.13 (e) If a report is initially made to a law enforcement agency or a lead investigative
16.14 agency, those agencies shall take the report on the appropriate common entry point intake
16.15 forms and immediately forward a copy to the common entry point.
16.16 (f) The common entry point staff must receive training on how to screen and
16.17 dispatch reports efficiently and in accordance with this section.
16.18 (g) ~~When a centralized database is available, the common entry point has access to~~
16.19 ~~the centralized database and must log the reports into the database.~~ The commissioner of
16.20 human services shall maintain a centralized database for the collection of common entry
16.21 point data, lead investigative agency data including maltreatment report disposition, and
16.22 appeals data.

16.23 Sec. 9. **DISABILITY HOME AND COMMUNITY-BASED WAIVER REQUEST.**
16.24 By December 1, 2012, the commissioner shall request all federal approvals and
16.25 waiver amendments to the disability home and community-based waivers to allow properly
16.26 licensed adult foster care homes to provide residential services for up to five individuals.

16.27 **EFFECTIVE DATE.** This section is effective July 1, 2012.

16.28 Sec. 10. **HOURLY NURSING DETERMINATION MATRIX.**
16.29 A service provider applying for medical assistance payments for private duty nursing
16.30 services under Minnesota Statutes, section 256B.0654, must complete and submit to the
16.31 commissioner of human services an hourly nursing determination matrix for each recipient
16.32 of private duty nursing services. The commissioner of human services will collect and
16.33 analyze data from the hourly nursing determination matrix.

17.1 Sec. 11. **REPEALER.**
17.2 (a) Minnesota Statutes 2010, sections 256B.431, subdivisions 2c, 2g, 2i, 2j, 2k, 2l,
17.3 2o, 3c, 11, 14, 17b, 17f, 19, 20, 25, 27, and 29; 256B.434, subdivisions 4a, 4b, 4c, 4d, 4e,
17.4 4g, 4h, 7, and 8; 256B.435; and 256B.436, are repealed.
17.5 (b) Minnesota Statutes 2011 Supplement, section 256B.431, subdivision 26, is
17.6 repealed.
17.7 (c) Minnesota Rules, part 9555.7700, is repealed.

17.8 **ARTICLE 2**

17.9 **TELEPHONE EQUIPMENT PROGRAM**

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

17.11 **237.50 DEFINITIONS.**
17.12 Subdivision 1. **Scope.** The terms used in sections 237.50 to 237.56 have the
17.13 meanings given them in this section.
17.14 Subd. 3. **Communication ~~impaired~~ disability.** "Communication ~~impaired~~
17.15 disability" means certified as ~~deaf, severely hearing impaired, hard-of-hearing~~ having
17.16 a hearing loss, speech ~~impaired, deaf and blind~~ disability, or ~~mobility impaired if the~~
17.17 ~~mobility impairment significantly impedes the ability~~ physical disability that makes it
17.18 difficult or impossible to use ~~standard customer premises~~ telecommunications services
17.19 and equipment.
17.20 ~~Subd. 4. **Communication device.** "Communication device" means a device that~~
17.21 ~~when connected to a telephone enables a communication-impaired person to communicate~~
17.22 ~~with another person utilizing the telephone system. A "communication device" includes a~~
17.23 ~~ring signaler, an amplification device, a telephone device for the deaf, a Brailling device~~
17.24 ~~for use with a telephone, and any other device the Department of Human Services deems~~
17.25 ~~necessary.~~
17.26 Subd. 4a. **Deaf.** "Deaf" means a hearing ~~impairment~~ loss of such severity that the
17.27 individual must depend primarily upon visual communication such as writing, lip reading,
17.28 ~~manual communication~~ sign language, and gestures.
17.29 Subd. 4b. **Deafblind.** "Deafblind" means any combination of vision and hearing
17.30 loss which interferes with acquiring information from the environment to the extent that
17.31 compensatory strategies and skills are necessary to access that or other information.
17.32 ~~Subd. 5. **Exchange.** "Exchange" means a unit area established and described by the~~
17.33 ~~tariff of a telephone company for the administration of telephone service in a specified~~
17.34 ~~geographical area, usually embracing a city, town, or village and its environs, and served~~

~~by one or more central offices, together with associated facilities used in providing service within that area.~~

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

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

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

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

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

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

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

Subd. 11. **~~Telecommunication~~ Telecommunications Relay ~~service~~ Services.** "~~Telecommunication~~ Telecommunications Relay ~~service~~ Services" or "TRS" means ~~a central statewide service through which a communication-impaired person, using a communication device, may send and receive messages to and from a non-communication-impaired person whose telephone is not equipped with a communication device and through which a non-communication-impaired person may, by using voice communication, send and receive messages to and from a communication-impaired person~~ the telecommunications transmission services required under Federal Communications Commission (FCC) regulations at Code of Federal

19.1 Regulations, title 47, sections 64.604 to 64.606. TRS allows an individual who has
19.2 a communication disability to use telecommunications services in a manner that is
19.3 functionally equivalent to the ability of an individual who does not have a communication
19.4 disability.

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

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

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

19.12 **237.51 TELECOMMUNICATIONS ACCESS MINNESOTA PROGRAM**
19.13 **ADMINISTRATION.**

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

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

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

19.21 For purposes of sections 237.51 to 237.56, the Department of Commerce and any
19.22 organization with which it contracts pursuant to this section or section 237.54, subdivision
19.23 2, are not telephone companies or telecommunications carriers as defined in section
19.24 237.01.

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

19.27 (1) prepare the reports required by section 237.55;

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

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

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

19.34 (1) define economic hardship, special needs, and household criteria so as to
19.35 determine the priority of eligible applicants for initial distribution of devices and to

determine circumstances necessitating provision of more than one ~~communication~~ telecommunications device per household;

(2) establish a method to verify eligibility requirements;

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

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

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

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

(1) at least one member who is deaf;

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

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

(4) at least one member who is hard-of-hearing.

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

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

237.52 TELECOMMUNICATIONS ACCESS MINNESOTA FUND.

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

Subd. 2. **Assessment.** (a) The commissioner of commerce, the commissioner of employment and economic development, and the commissioner of human services shall annually recommend to the Public Utilities Commission (PUC) an adequate and appropriate surcharge and budget to implement sections 237.50 to 237.56, 248.062, and 256C.30, respectively. The maximum annual budget for section 248.062 must not exceed $100,000 and for section 256C.30 must not exceed $300,000. The Public Utilities Commission shall review the budgets for reasonableness and may modify the budget to the extent it is unreasonable. The commission shall annually determine the funding mechanism to be used within 60 days of receipt of the recommendation of the departments and shall order the imposition of surcharges effective on the earliest practicable date. The

commission shall establish a monthly charge no greater than 20 cents for each customer access line, including trunk equivalents as designated by the commission pursuant to section 403.11, subdivision 1.

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

Subd. 3. **Collection.** Every ~~telephone company or communications carrier that provides service~~ <u>provider of services</u> capable of originating a ~~telecommunications relay~~ <u>TRS</u> call, including cellular communications and other nonwire access services, in this state shall collect the charges established by the commission under subdivision 2 and transfer amounts collected to the commissioner of public safety in the same manner as provided in section 403.11, subdivision 1, paragraph (d). The commissioner of public safety must deposit the receipts in the fund established in subdivision 1.

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

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

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

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

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

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

(b) All costs directly associated with the establishment of the program, the purchase and distribution of ~~communication~~ <u>telecommunications</u> devices, and the ~~establishment and operation of the telecommunication relay service~~ <u>provision of TRS</u> are either reimbursable or directly payable from the fund after authorization by the commissioner of commerce. The commissioner of commerce shall contract with ~~the message relay service operator~~ <u>one or more TRS providers</u> to indemnify the ~~local exchange carriers of~~

22.1 ~~the relay~~ telecommunications service providers for any fines imposed by the Federal
22.2 Communications Commission related to the failure of the relay service to comply with
22.3 federal service standards. Notwithstanding section 16A.41, the commissioner may
22.4 advance money to the ~~contractor of the telecommunication relay service~~ TRS providers if
22.5 the ~~contractor establishes~~ providers establish to the commissioner's satisfaction that the
22.6 advance payment is necessary for the ~~operation~~ provision of the service. The advance
22.7 payment may be used only for working capital reserve for the operation of the service.
22.8 The advance payment must be offset or repaid by the end of the contract fiscal year
22.9 together with interest accrued from the date of payment.

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

22.11 **237.53 ~~COMMUNICATION~~ TELECOMMUNICATIONS DEVICE.**

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

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

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

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

22.19 (3) be a resident of the state;

22.20 (4) be a resident in a household that has a median income at or below the applicable
22.21 median household income in the state, except a ~~deaf and blind~~ person who is deafblind
22.22 applying for a ~~telebraille unit~~ Braille device may reside in a household that has a median
22.23 income no more than 150 percent of the applicable median household income in the
22.24 state; and

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

22.29 Subd. 3. **Distribution.** The commissioner of human services shall purchase and
22.30 distribute a sufficient number of ~~communication~~ telecommunications devices so that each
22.31 eligible household receives ~~an~~ appropriate ~~device~~ devices as determined under section
22.32 237.51, subdivision 5a. The commissioner of human services shall distribute the devices
22.33 to eligible households ~~in each service area~~ free of charge ~~as determined under section~~
22.34 ~~237.51, subdivision 5a~~.

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

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

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

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

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

237.54 ~~TELECOMMUNICATION~~ TELECOMMUNICATIONS RELAY ~~SERVICE~~ SERVICES (TRS).

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

(b) The ~~telecommunication relay service provider~~ TRS providers shall operate the relay service within the state of Minnesota. The ~~operator of the system~~ TRS providers shall ~~keep all messages confidential, shall train personnel in the unique needs of communication-impaired people, and shall inform communication-impaired persons and the public of the availability and use of the system. Except in the case of a speech- or mobility-impaired person, the operator shall not relay a message unless it originates or terminates through a communication device for the deaf or a Brailling device for use~~

~~with a telephone~~ comply with all current and subsequent FCC regulations at Code of Federal Regulations, title 47, sections 64.601 to 64.606, and shall inform persons who have communication disabilities and the public of the availability and use of TRS.

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

237.55 ANNUAL REPORT ON ~~COMMUNICATION~~ TELECOMMUNICATIONS ACCESS.

The commissioner of commerce must prepare a report for presentation to the Public Utilities Commission by January 31 of each year. Each report must review the accessibility of ~~the telephone system to communication-impaired persons, review the ability of non-communication-impaired persons to communicate with communication-impaired persons via the telephone system~~ telecommunications services to persons who have communication disabilities, describe services provided, account for ~~money received and disbursed annually~~ annual revenues and expenditures for each aspect of the ~~program~~ fund to date, and include predicted program future operation.

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

237.56 ADEQUATE SERVICE ENFORCEMENT.

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

ARTICLE 3

COMPREHENSIVE ASSESSMENT AND CASE MANAGEMENT REFORM

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

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

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

(c) "Behavior," effective January 1, 2010, means a category to determine the home care rating and is based on the criteria found in this section. "Level I behavior" means

25.1 physical aggression towards self, others, or destruction of property that requires the
25.2 immediate response of another person.

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

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

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

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

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

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

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

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

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

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

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

26.1 (m) "Personal care assistant" or "PCA" means an individual employed by a personal
26.2 care assistance agency who provides personal care assistance services.
26.3 (n) "Personal care assistance care plan" means a written description of personal
26.4 care assistance services developed by the personal care assistance provider according
26.5 to the service plan.
26.6 (o) "Responsible party" means an individual who is capable of providing the support
26.7 necessary to assist the recipient to live in the community.
26.8 (p) "Self-administered medication" means medication taken orally, by injection,
26.9 nebulizer, or insertion, or applied topically without the need for assistance.
26.10 (q) "Service plan" means a written summary of the assessment and description of the
26.11 services needed by the recipient.
26.12 (r) "Wages and benefits" means wages and salaries, the employer's share of FICA
26.13 taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation,
26.14 mileage reimbursement, health and dental insurance, life insurance, disability insurance,
26.15 long-term care insurance, uniform allowance, and contributions to employee retirement
26.16 accounts.

26.17 Sec. 2. Minnesota Statutes 2010, section 256B.0659, subdivision 2, is amended to read:
26.18 Subd. 2. **Personal care assistance services; covered services.** (a) The personal
26.19 care assistance services eligible for payment include services and supports furnished
26.20 to an individual, as needed, to assist in:
26.21 (1) activities of daily living;
26.22 (2) health-related procedures and tasks;
26.23 (3) observation and redirection of behaviors; and
26.24 (4) instrumental activities of daily living.
26.25 (b) Activities of daily living include the following covered services:
26.26 (1) dressing, including assistance with choosing, application, and changing of
26.27 clothing and application of special appliances, wraps, or clothing;
26.28 (2) grooming, including assistance with basic hair care, oral care, shaving, applying
26.29 cosmetics and deodorant, and care of eyeglasses and hearing aids. Nail care is included,
26.30 except for recipients who are diabetic or have poor circulation;
26.31 (3) bathing, including assistance with basic personal hygiene and skin care;
26.32 (4) eating, including assistance with hand washing and application of orthotics
26.33 required for eating, transfers, and feeding;
26.34 (5) transfers, including assistance with transferring the recipient from one seating or
26.35 reclining area to another;

27.1 (6) mobility, including assistance with ambulation, including use of a wheelchair.
27.2 Mobility does not include providing transportation for a recipient;

27.3 (7) positioning, including assistance with positioning or turning a recipient for
27.4 necessary care and comfort; and

27.5 (8) toileting, including assistance with helping recipient with bowel or bladder
27.6 elimination and care including transfers, mobility, positioning, feminine hygiene, use of
27.7 toileting equipment or supplies, cleansing the perineal area, inspection of the skin, and
27.8 adjusting clothing.

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

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

27.12 (2) assistance with self-administered medication as defined by this section, including
27.13 reminders to take medication, bringing medication to the recipient, and assistance with
27.14 opening medication under the direction of the recipient or responsible party, including
27.15 medications given through a nebulizer;

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

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

27.19 (d) A personal care assistant may provide health-related procedures and tasks
27.20 associated with the complex health-related needs of a recipient if the procedures and
27.21 tasks meet the definition of health-related procedures and tasks under this section and the
27.22 personal care assistant is trained by a qualified professional and demonstrates competency
27.23 to safely complete the procedures and tasks. Delegation of health-related procedures and
27.24 tasks and all training must be documented in the personal care assistance care plan and the
27.25 recipient's and personal care assistant's files. A personal care assistant must not determine
27.26 the medication dose or time for medication.

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

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

27.32 (2) utilization of clean rather than sterile procedure;

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

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

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

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

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

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

28.8 Subd. 3a. **Assessment; defined.** (a) "Assessment" means a review and evaluation
28.9 of a recipient's need for ~~home~~ personal care assistance services conducted in person.
28.10 Assessments for personal care assistance services shall be conducted by the county public
28.11 health nurse or a certified public health nurse under contract with the county except when a
28.12 long-term care consultation assessment is being conducted for the purposes of determining
28.13 a person's eligibility for home and community-based waiver services including personal
28.14 care assistance services according to section 256B.0911. An in-person assessment
28.15 must include: documentation of health status, determination of need, evaluation of
28.16 service effectiveness, identification of appropriate services, service plan development
28.17 or modification, coordination of services, referrals and follow-up to appropriate payers
28.18 and community resources, completion of required reports, recommendation of service
28.19 authorization, and consumer education. Once the need for personal care assistance
28.20 services is determined under this section ~~or sections 256B.0651, 256B.0653, 256B.0654,~~
28.21 ~~and 256B.0656~~, the county public health nurse or certified public health nurse under
28.22 contract with the county is responsible for communicating this recommendation to the
28.23 commissioner and the recipient. An in-person assessment must occur at least annually or
28.24 when there is a significant change in the recipient's condition or when there is a change
28.25 in the need for personal care assistance services. A service update may substitute for
28.26 the annual face-to-face assessment when there is not a significant change in recipient
28.27 condition or a change in the need for personal care assistance service. A service update
28.28 may be completed by telephone, used when there is no need for an increase in personal
28.29 care assistance services, and used for two consecutive assessments if followed by a
28.30 face-to-face assessment. A service update must be completed on a form approved by the
28.31 commissioner. A service update or review for temporary increase includes a review of
28.32 initial baseline data, evaluation of service effectiveness, redetermination of service need,
28.33 modification of service plan and appropriate referrals, update of initial forms, obtaining
28.34 service authorization, and on going consumer education. Assessments or reassessments

29.1 must be completed on forms provided by the commissioner within 30 days of a request for
29.2 home care services by a recipient or responsible party ~~or personal care provider agency~~.
29.3 (b) This subdivision expires when notification is given by the commissioner as
29.4 described in section 256B.0911, subdivision 3a.

29.5 Sec. 4. Minnesota Statutes 2010, section 256B.0659, subdivision 4, is amended to read:
29.6 Subd. 4. **~~Assessment~~ Criteria for personal care assistance ~~services~~ service**
29.7 **eligibility; limitations.** (a) An assessment as defined in subdivision 3a must be completed
29.8 for personal care assistance services.
29.9 (b) The following limitations apply to the assessment:
29.10 (1) a person must be assessed as dependent in an activity of daily living based on the
29.11 person's daily need or need on the days during the week the activity is completed for:
29.12 (i) cuing and constant supervision to complete the task; or
29.13 (ii) hands-on assistance to complete the task; and
29.14 (2) a child may not be found to be dependent in an activity of daily living if because
29.15 of the child's age an adult would either perform the activity for the child or assist the child
29.16 with the activity. Assistance needed is the assistance appropriate for a typical child of
29.17 the same age.
29.18 (c) Assessment for complex health-related needs must meet the criteria in this
29.19 paragraph. ~~During the assessment process,~~ A recipient qualifies as having complex
29.20 health-related needs if the recipient has one or more of the interventions that are ordered
29.21 by a physician, specified in a personal care assistance care plan or community support
29.22 plan developed under section 256B.0911, and found in the following:
29.23 (1) tube feedings requiring:
29.24 (i) a gastrojejunostomy tube; or
29.25 (ii) continuous tube feeding lasting longer than 12 hours per day;
29.26 (2) wounds described as:
29.27 (i) stage III or stage IV;
29.28 (ii) multiple wounds;
29.29 (iii) requiring sterile or clean dressing changes or a wound vac; or
29.30 (iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require
29.31 specialized care;
29.32 (3) parenteral therapy described as:
29.33 (i) IV therapy more than two times per week lasting longer than four hours for
29.34 each treatment; or
29.35 (ii) total parenteral nutrition (TPN) daily;

30.1 (4) respiratory interventions, including:
30.2 (i) oxygen required more than eight hours per day;
30.3 (ii) respiratory vest more than one time per day;
30.4 (iii) bronchial drainage treatments more than two times per day;
30.5 (iv) sterile or clean suctioning more than six times per day;
30.6 (v) dependence on another to apply respiratory ventilation augmentation devices
30.7 such as BiPAP and CPAP; and
30.8 (vi) ventilator dependence under section 256B.0652;
30.9 (5) insertion and maintenance of catheter, including:
30.10 (i) sterile catheter changes more than one time per month;
30.11 (ii) clean intermittent catheterization, and including self-catheterization more than
30.12 six times per day; or
30.13 (iii) bladder irrigations;
30.14 (6) bowel program more than two times per week requiring more than 30 minutes to
30.15 perform each time;
30.16 (7) neurological intervention, including:
30.17 (i) seizures more than two times per week and requiring significant physical
30.18 assistance to maintain safety; or
30.19 (ii) swallowing disorders diagnosed by a physician and requiring specialized
30.20 assistance from another on a daily basis; and
30.21 (8) other congenital or acquired diseases creating a need for significantly increased
30.22 direct hands-on assistance and interventions in six to eight activities of daily living.
30.23 (d) An assessment of behaviors must meet the criteria in this paragraph. A recipient
30.24 qualifies as having a need for assistance due to behaviors if the recipient's behavior requires
30.25 assistance at least four times per week and shows one or more of the following behaviors:
30.26 (1) physical aggression towards self or others, or destruction of property that requires
30.27 the immediate response of another person;
30.28 (2) increased vulnerability due to cognitive deficits or socially inappropriate
30.29 behavior; or
30.30 (3) increased need for assistance for recipients who are verbally aggressive ~~and~~ or
30.31 resistive to care so that the time needed to perform activities of daily living is increased.

30.32 Sec. 5. Minnesota Statutes 2010, section 256B.0911, subdivision 1, is amended to read:
30.33 Subdivision 1. **Purpose and goal.** (a) The purpose of long-term care consultation
30.34 services is to assist persons with long-term or chronic care needs in making ~~long-term~~ care
30.35 decisions and selecting support and service options that meet their needs and reflect their

31.1 preferences. The availability of, and access to, information and other types of assistance,
31.2 including assessment and support planning, is also intended to prevent or delay ~~certified~~
31.3 ~~nursing facility~~ institutional placements and to provide access to transition assistance
31.4 after admission. Further, the goal of these services is to contain costs associated with
31.5 unnecessary ~~certified nursing facility~~ institutional admissions. Long-term consultation
31.6 services must be available to any person regardless of public program eligibility. The
31.7 commissioner of human services shall seek to maximize use of available federal and state
31.8 funds and establish the broadest program possible within the funding available.

31.9 (b) These services must be coordinated with long-term care options counseling
31.10 provided under section 256.975, subdivision 7, and section 256.01, subdivision 24~~, for~~
31.11 ~~telephone assistance and follow up and to offer a variety of cost-effective alternatives~~
31.12 ~~to persons with disabilities and elderly persons~~. The ~~county or tribal~~ lead agency ~~or~~
31.13 ~~managed care plan~~ providing long-term care consultation services shall encourage the use
31.14 of volunteers from families, religious organizations, social clubs, and similar civic and
31.15 service organizations to provide community-based services.

31.16 Sec. 6. Minnesota Statutes 2011 Supplement, section 256B.0911, subdivision 1a,
31.17 is amended to read:

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

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

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

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

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

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

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

31.31 (6) federally mandated preadmission screening ~~to determine the need for an~~
31.32 ~~institutional level of care under subdivision 4a~~ activities described under subdivisions
31.33 4a and 4b;

31.34 (7) determination of home and community-based waiver and other service eligibility
31.35 as required under sections 256B.0913, 256B.0915, and 256B.49, including level of

32.1 care determination for individuals who need an institutional level of care as determined
32.2 under section 256B.0911, subdivision 4a, paragraph (d), ~~or 256B.092, service eligibility~~
32.3 ~~including state plan home care services identified in sections 256B.0625, subdivisions 6,~~
32.4 ~~7, and 19, paragraphs (a) and (c), and 256B.0657,~~ based on assessment and community
32.5 support plan development ~~with~~, appropriate referrals to obtain necessary diagnostic
32.6 information, and including ~~the option~~ an eligibility determination for consumer-directed
32.7 community supports;

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

32.10 (9) providing access to assistance to transition people back to community settings
32.11 after ~~facility~~ institutional admission.

32.12 (b) Upon statewide implementation of lead agency requirements in subdivisions 2b,
32.13 2c, and 3a, "long-term care consultation services" also means:

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

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

32.16 (ii) section 256B.0657; or

32.17 (iii) consumer support grants under section 256.476;

32.18 (2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024,
32.19 determination of eligibility for case management services available under sections
32.20 256B.0621, subdivision 2, paragraph (4), and 256B.0924 and Minnesota Rules, part
32.21 9525.0016;

32.22 (3) determination of institutional level of care, home and community-based service
32.23 waiver, and other service eligibility as required under section 256B.092, determination
32.24 of eligibility for family support grants under section 252.32, semi-independent living
32.25 services under section 252.275, and day training and habilitation services under section
32.26 256B.092; and

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

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

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

33.1 ~~(d)~~ (e) "Lead agencies" means counties administering or ~~a collaboration of counties,~~
33.2 tribes~~,~~ and health plans ~~administering~~ under contract with the commissioner to administer
33.3 long-term care consultation assessment and support planning services.

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

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

33.17 (b) Certified assessors are persons with a minimum of a bachelor's degree in social
33.18 work, nursing with a public health nursing certificate, or other closely related field with at
33.19 least one year of home and community-based experience, or a ~~two-year~~ registered ~~nursing~~
33.20 ~~degree~~ nurse without public health certification with at least ~~three~~ two years of home and
33.21 community-based experience that ~~have~~ has received training and certification specific to
33.22 assessment and consultation for long-term care services in the state.

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

33.25 Subd. 2c. **Assessor training and certification.** The commissioner shall develop
33.26 and implement a curriculum and an assessor certification process ~~to begin no later than~~
33.27 ~~January 1, 2010~~. All existing lead agency staff designated to provide the services defined
33.28 in subdivision 1a must be certified ~~by December 30, 2010.~~ within timelines specified by
33.29 the commissioner, but no sooner than six months after statewide availability of the training
33.30 and certification process. The commissioner must establish the timelines for training and
33.31 certification in a manner that allows lead agencies to most efficiently adopt the automated
33.32 process established in subdivision 5. Each lead agency is required to ensure that they have
33.33 sufficient numbers of certified assessors to provide long-term consultation assessment and

34.1 support planning within the timelines and parameters of the service ~~by January 1, 2011~~.
34.2 Certified assessors are required to be recertified every three years.

34.3 Sec. 9. Minnesota Statutes 2010, section 256B.0911, subdivision 3, is amended to read:
34.4 Subd. 3. **Long-term care consultation team.** (a) ~~Until January 1, 2011,~~ A long-term
34.5 care consultation team shall be established by the county board of commissioners. Each
34.6 local consultation team shall consist of at least one social worker and at least one public
34.7 health nurse from their respective county agencies. ~~The board may designate public~~
34.8 ~~health or social services as the lead agency for long-term care consultation services. If a~~
34.9 ~~county does not have a public health nurse available, it may request approval from the~~
34.10 ~~commissioner to assign a county registered nurse with at least one year experience in~~
34.11 ~~home care to participate on the team.~~ Two or more counties may collaborate to establish
34.12 a joint local consultation team or teams.
34.13 (b) Certified assessors must be part of a multidisciplinary long-term care consultation
34.14 team of professionals that includes public health nurses, social workers, and other
34.15 professionals as defined in subdivision 2b, paragraph (b). The team is responsible for
34.16 providing long-term care consultation services to all persons located in the county who
34.17 request the services, regardless of eligibility for Minnesota health care programs.
34.18 (c) The commissioner shall allow arrangements and make recommendations that
34.19 encourage counties and tribes to collaborate to establish joint local long-term care
34.20 consultation teams to ensure that long-term care consultations are done within the
34.21 timelines and parameters of the service. This includes integrated service models as
34.22 required in subdivision 1, paragraph (b).
34.23 (d) Tribes and health plans under contract with the commissioner must provide
34.24 long-term care consultation services as specified in the contract.
34.25 (e) The lead agency must provide the commissioner with (......)

34.26 Sec. 10. Minnesota Statutes 2011 Supplement, section 256B.0911, subdivision 3a,
34.27 is amended to read:
34.28 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment,
34.29 services planning, or other assistance intended to support community-based living,
34.30 including persons who need assessment in order to determine waiver or alternative care
34.31 program eligibility, must be visited by a long-term care consultation team within ~~15~~ 20
34.32 calendar days after the date on which an assessment was requested or recommended.
34.33 ~~After January 1, 2011, these requirements also apply to~~ Upon statewide implementation
34.34 of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person

35.1 requesting personal care assistance services~~,~~ and private duty nursing~~, and home health~~
35.2 ~~agency services, on timelines established in subdivision 5~~. The commissioner shall provide
35.3 at least a 90-day notice to lead agencies prior to the effective date of this requirement.
35.4 Face-to-face assessments must be conducted according to paragraphs (b) to (i).

35.5 (b) The ~~county~~ lead agency may utilize a team of either the social worker or public
35.6 health nurse, or both. ~~After January 1, 2011~~ Upon implementation of subdivisions 2b, 2c,
35.7 and 5, lead agencies shall use certified assessors to conduct the ~~assessment in a face-to-face~~
35.8 ~~interview~~ assessment. The consultation team members must confer regarding the most
35.9 appropriate care for each individual screened or assessed. For a person with complex
35.10 health care needs, a public health or registered nurse from the team must be consulted.

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

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

35.21 ~~(e) The person, or the person's legal representative, must be provided with written~~
35.22 ~~recommendations for community-based services, including consumer-directed options,~~
35.23 ~~or institutional care that include documentation that the most cost-effective alternatives~~
35.24 ~~available were offered to the individual, and alternatives to residential settings, including,~~
35.25 ~~but not limited to, foster care settings that are not the primary residence of the license~~
35.26 ~~holder. For purposes of this requirement, "cost-effective alternatives" means community~~
35.27 ~~services and living arrangements that cost the same as or less than institutional care.~~

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

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

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

36.1 (3) identification of health and safety risks and how those risks will be addressed,
36.2 including personal risk management strategies;
36.3 (4) referral information; and
36.4 (5) informal caregiver supports, if applicable.
36.5 For a person determined eligible for services defined under subdivision 1a,
36.6 paragraphs (a), clause (7), and (b), the community support plan must also include the
36.7 estimated annual and monthly budget amount for those services. In addition, for a person
36.8 determined eligible for state plan home care under subdivision 1a, paragraph (b), clause
36.9 (1), the person or person's representative must also receive a copy of the home care service
36.10 plan developed by the certified assessor.
36.11 (f) A person may request assistance in identifying community supports without
36.12 participating in a complete assessment. Upon a request for assistance identifying
36.13 community support, the person must be transferred or referred to ~~the~~ long-term care
36.14 options counseling services available under sections 256.975, subdivision 7, and 256.01,
36.15 subdivision 24, for telephone assistance and follow up.
36.16 (g) The person has the right to make the final decision between institutional
36.17 placement and community placement after the recommendations have been provided,
36.18 except as provided in subdivision 4a, paragraph (c).
36.19 (h) The ~~team~~ lead agency must give the person receiving assessment or support
36.20 planning, or the person's legal representative, materials, and forms supplied by the
36.21 commissioner containing the following information:
36.22 (1) written recommendations for community-based services and consumer-directed
36.23 options;
36.24 (2) documentation that the most cost-effective alternatives available were offered to
36.25 the individual. For purposes of this clause, "cost-effective" means community services and
36.26 living arrangements that cost the same as or less than institutional care. For an individual
36.27 found to meet eligibility criteria for home and community-based service programs under
36.28 section 256B.0915 or 256B.49, "cost effectiveness" has the meaning found in the federally
36.29 approved waiver plan for each program;
36.30 (3) the need for and purpose of preadmission screening if the person selects nursing
36.31 facility placement;
36.32 ~~(2)~~ (4) the role of ~~the~~ long-term care consultation assessment and support planning
36.33 in ~~waiver and alternative care program~~ eligibility determination for waiver and alternative
36.34 care programs, and state plan home care, case management, and other services as defined
36.35 in subdivision 1a, paragraphs (a), clause (7), and (b);
36.36 ~~(3)~~ (5) information about Minnesota health care programs;

37.1 ~~(4)~~ (6) the person's freedom to accept or reject the recommendations of the team;
37.2 ~~(5)~~ (7) the person's right to confidentiality under the Minnesota Government Data
37.3 Practices Act, chapter 13;
37.4 ~~(6)~~ (8) the ~~long-term care consultant's~~ certified assessor's decision regarding the
37.5 person's need for institutional level of care as determined under criteria established in
37.6 section ~~144.0724, subdivision 11, or 256B.092~~ 256B.0911, subdivision 4a, paragraph (d),
37.7 and the certified assessor's decision regarding eligibility for all services and programs as
37.8 defined in subdivision 1a, paragraphs (a), clause (7), and (b); and
37.9 ~~(7)~~ (9) the person's right to appeal the certified assessor's decision regarding
37.10 eligibility for all services and programs as defined in subdivision 1a, paragraphs (a),
37.11 clause (7), and (b), and incorporating the decision regarding the need for ~~nursing facility~~
37.12 institutional level of care or the ~~county's~~ lead agency's final decisions regarding public
37.13 programs eligibility according to section 256.045, subdivision 3.
37.14 (i) Face-to-face assessment completed as part of eligibility determination for
37.15 the alternative care, elderly waiver, community alternatives for disabled individuals,
37.16 community alternative care, and ~~traumatic~~ brain injury waiver programs under sections
37.17 256B.0913, 256B.0915, ~~256B.0917,~~ and 256B.49 is valid to establish service eligibility
37.18 for no more than 60 calendar days after the date of assessment.
37.19 (j) The effective eligibility start date for ~~these~~ programs in paragraph (i) can never
37.20 be prior to the date of assessment. If an assessment was completed more than 60 days
37.21 before the effective waiver or alternative care program eligibility start date, assessment
37.22 and support plan information must be updated in a face-to-face visit and documented in
37.23 the department's Medicaid Management Information System (MMIS). Notwithstanding
37.24 retroactive medical assistance coverage of state plan services, the effective date of
37.25 ~~program~~ eligibility ~~in this case~~ for programs included in paragraph (i) cannot be prior to
37.26 the date the most recent updated assessment is completed.

37.27 Sec. 11. Minnesota Statutes 2010, section 256B.0911, subdivision 3b, is amended to
37.28 read:
37.29 Subd. 3b. **Transition assistance.** (a) ~~A long-term care consultation team~~ Lead
37.30 agency certified assessors shall provide assistance to persons residing in a nursing
37.31 facility, hospital, regional treatment center, or intermediate care facility for persons with
37.32 developmental disabilities who request or are referred for assistance. Transition assistance
37.33 must include assessment, community support plan development, referrals to long-term
37.34 care options counseling under section ~~256B.975~~ 256.975, subdivision ~~10~~ 7, for community
37.35 support plan implementation and to Minnesota health care programs, including home and

38.1 community-based waiver services and consumer-directed options through the waivers,
38.2 and referrals to programs that provide assistance with housing. Transition assistance
38.3 must also include information about the Centers for Independent Living ~~and the Senior~~
38.4 ~~LinkAge Line~~, Disability Linkage Line, and about other organizations that can provide
38.5 assistance with relocation efforts, and information about contacting these organizations to
38.6 obtain their assistance and support.

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

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

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

38.13 ~~(2)~~ (3) the assessment is completed for persons within ~~ten working~~ 20 calendar days
38.14 of the date of request or recommendation for assessment; ~~and~~

38.15 ~~(3)~~ (4) there is a plan for transition and follow-up for the individual's return to the
38.16 community~~. The plan must require~~, including notification of other local agencies when a
38.17 person ~~who~~ may require assistance ~~is screened by one county for admission to a facility~~
38.18 from agencies located in another county~~.~~; and

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

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

38.24 Sec. 12. Minnesota Statutes 2011 Supplement, section 256B.0911, subdivision 4a,
38.25 is amended to read:

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

38.33 (b) A person who has a diagnosis or possible diagnosis of mental illness or
38.34 developmental disability must receive a preadmission screening before admission
38.35 regardless of the exemptions outlined in subdivision 4b, paragraph (b), to identify the need

39.1 for further evaluation and specialized services, unless the admission prior to screening is
39.2 authorized by the local mental health authority or the local developmental disabilities case
39.3 manager, or unless authorized by the county agency according to Public Law 101-508.

39.4 The following criteria apply to the preadmission screening:

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

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

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

39.12 (ii) a qualified developmental disability professional, for persons with a primary or
39.13 secondary diagnosis of developmental disability. For purposes of this requirement, a
39.14 qualified developmental disability professional must meet the standards for a qualified
39.15 developmental disability professional under Code of Federal Regulations, title 42, section
39.16 483.430.

39.17 (c) The local county mental health authority or the state developmental disability
39.18 authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a
39.19 nursing facility if the individual does not meet the nursing facility level of care criteria or
39.20 needs specialized services as defined in Public Law Numbers 100-203 and 101-508. For
39.21 purposes of this section, "specialized services" for a person with developmental disability
39.22 means active treatment as that term is defined under Code of Federal Regulations, title
39.23 42, section 483.440 (a)(1).

39.24 (d) The determination of the need for nursing facility level of care must be made
39.25 according to criteria developed by the commissioner, and in section 256B.092, using
39.26 forms developed by the commissioner. Effective no sooner than on or after July 1, 2012,
39.27 for individuals age 21 and older, and on or after October 1, 2019, for individuals under
39.28 age 21, the determination of need for nursing facility level of care shall be based on
39.29 criteria in section 144.0724, subdivision 11. In assessing a person's needs, consultation
39.30 team members shall have a physician available for consultation and shall consider the
39.31 assessment of the individual's attending physician, if any. The individual's physician must
39.32 be included if the physician chooses to participate. Other personnel may be included on
39.33 the team as deemed appropriate by the ~~county~~ lead agency.

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

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

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

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

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

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

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

Sec. 14. Minnesota Statutes 2010, section 256B.0911, subdivision 6, is amended to read:

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

(b) The commissioner shall include the total annual payment determined under paragraph (a) for each nursing facility reimbursed under section 256B.431 ~~or~~, 256B.434 ~~according to section 256B.431, subdivision 2b, paragraph (g)~~, or 256B.441.

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

shall be on or after the first day of the month following the effective date of the layaway, delicensure and decertification, or removal from layaway.

(d) Payments for long-term care consultation services are available to the county or counties to cover staff salaries and expenses to provide the services described in subdivision 1a. The county shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide long-term care consultation services while meeting the state's long-term care outcomes and objectives as defined in ~~section 256B.0917,~~ subdivision 1. The county shall be accountable for meeting local objectives as approved by the commissioner in the biennial home and community-based services quality assurance plan on a form provided by the commissioner.

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

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

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

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

Sec. 15. Minnesota Statutes 2010, section 256B.0913, subdivision 7, is amended to read:

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

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

(c) The case manager is responsible for the cost-effectiveness of the alternative care individual ~~care~~ coordinated service and support plan and must not approve any ~~care~~ plan

42.1 in which the cost of services funded by alternative care and client contributions exceeds
42.2 the limit specified in section 256B.0915, subdivision 3, paragraph (b).
42.3 (d) Case manager responsibilities include those in section 256B.0915, subdivision
42.4 1a, paragraph (g).

42.5 Sec. 16. Minnesota Statutes 2010, section 256B.0913, subdivision 8, is amended to
42.6 read:
42.7 Subd. 8. **Requirements for individual ~~care~~ coordinated service and support**
42.8 **plan.** (a) The case manager shall implement the coordinated service and support plan ~~of~~
42.9 ~~care~~ for each alternative care client and ensure that a client's service needs and eligibility
42.10 are reassessed at least every 12 months. The coordinated service and support plan must
42.11 meet the requirements in section 256B.0915, subdivision 6. The plan shall include any
42.12 services prescribed by the individual's attending physician as necessary to allow the
42.13 individual to remain in a community setting. In developing the individual's care plan, the
42.14 case manager should include the use of volunteers from families and neighbors, religious
42.15 organizations, social clubs, and civic and service organizations to support the formal home
42.16 care services. The lead agency shall be held harmless for damages or injuries sustained
42.17 through the use of volunteers under this subdivision including workers' compensation
42.18 liability. The case manager shall provide documentation in each individual's plan ~~of care~~
42.19 and, if requested, to the commissioner that the most cost-effective alternatives available
42.20 have been offered to the individual and that the individual was free to choose among
42.21 available qualified providers, both public and private, including qualified case management
42.22 or service coordination providers other than those employed by any county; however, the
42.23 county or tribe maintains responsibility for prior authorizing services in accordance with
42.24 statutory and administrative requirements. The case manager must give the individual a
42.25 ten-day written notice of any denial, termination, or reduction of alternative care services.
42.26 (b) The county of service or tribe must provide access to and arrange for case
42.27 management services, including assuring implementation of the coordinated service
42.28 and support plan. "County of service" has the meaning given it in Minnesota Rules,
42.29 part 9505.0015, subpart 11. The county of service must notify the county of financial
42.30 responsibility of the approved care plan and the amount of encumbered funds.

42.31 Sec. 17. Minnesota Statutes 2010, section 256B.0915, subdivision 1a, is amended to
42.32 read:
42.33 Subd. 1a. **Elderly waiver case management services.** (a) ~~Elderly~~ Except
42.34 as provided to individuals under prepaid medical assistance programs as described

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

(b) Case management services assist individuals who receive waiver services in gaining access to needed waiver and other state plan services~~,~~ and assist individuals in appeals under section 256.045, as well as needed medical, social, educational, and other services regardless of the funding source for the services to which access is gained. Case managers shall collaborate with consumers, families, legal representatives, and relevant medical experts and service providers in the development and periodic review of the coordinated service and support plan.

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

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

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

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

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

(1) development of the coordinated service and support plan under subdivision 6;

(2) informing the individual or the individual's legal guardian or conservator of service options, and options for case management services and providers;

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

44.1 (4) assisting the person in the identification of potential providers;
44.2 (5) assisting the person to access services;
44.3 (6) coordination of services; and
44.4 (7) evaluation and monitoring of the services identified in the plan, which must
44.5 incorporate at least one annual face-to-face visit by the case manager with each person.
44.6 (h) For individuals enrolled in prepaid medical assistance programs under section
44.7 256B.69, subdivisions 6b and 23, the health plan shall provide or arrange to provide
44.8 elderly waiver case management services in paragraph (g), as part of an integrated delivery
44.9 system in accordance with contract requirements established by the commissioner.

44.10 Sec. 18. Minnesota Statutes 2010, section 256B.0915, subdivision 1b, is amended to
44.11 read:
44.12 Subd. 1b. **Provider qualifications and standards.** (a) The commissioner must
44.13 enroll qualified providers of ~~elderly~~ case management services under the home and
44.14 community-based waiver for the elderly under section 1915(c) of the Social Security
44.15 Act. The enrollment process shall ensure the provider's ability to meet the qualification
44.16 requirements and standards in this subdivision and other federal and state requirements
44.17 of this service. ~~An elderly~~ A case management provider is an enrolled medical
44.18 assistance provider who is determined by the commissioner to have all of the following
44.19 characteristics:
44.20 (1) the demonstrated capacity and experience to provide the components of
44.21 case management to coordinate and link community resources needed by the eligible
44.22 population;
44.23 (2) administrative capacity and experience in serving the target population for
44.24 whom it will provide services and in ensuring quality of services under state and federal
44.25 requirements;
44.26 (3) a financial management system that provides accurate documentation of services
44.27 and costs under state and federal requirements;
44.28 (4) the capacity to document and maintain individual case records under state and
44.29 federal requirements; and
44.30 (5) the lead agency may allow a case manager employed by the lead agency to
44.31 delegate certain aspects of the case management activity to another individual employed
44.32 by the lead agency provided there is oversight of the individual by the case manager.
44.33 The case manager may not delegate those aspects which require professional judgment
44.34 including assessments, reassessments, and ~~care~~ coordinated service and support plan

development. Lead agencies include counties, health plans, and federally recognized tribes who authorize services under this section.

(b) A health plan shall provide or arrange to provide elderly waiver case management services in subdivision 1a, paragraph (g), as part of an integrated delivery system in accordance with contract requirements established by the commissioner related to provider standards and qualifications.

Sec. 19. Minnesota Statutes 2010, section 256B.0915, subdivision 3c, is amended to read:

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

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

Sec. 20. Minnesota Statutes 2010, section 256B.0915, subdivision 6, is amended to read:

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

(1) is developed and signed by the recipient within ten working days after the case manager receives the assessment information and written community support plan as described in section 256B.0911, subdivision 3a, from the certified assessor;

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

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

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

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

46.1 (6) identifies long and short-range goals for the person;
46.2 (7) identifies specific services and the amount, frequency, duration, and cost of the
46.3 services to be provided to the person based on assessed needs, preferences, and available
46.4 resources; and
46.5 (8) includes information about the right to appeal decisions under section 256.045;
46.6 (b) In developing the coordinated service and support plan, the case manager should
46.7 also include the use of volunteers, religious organizations, social clubs, and civic and
46.8 service organizations to support the individual in the community. The lead agency must be
46.9 held harmless for damages or injuries sustained through the use of volunteers and agencies
46.10 under this paragraph, including workers' compensation liability.

46.11 Sec. 21. Minnesota Statutes 2011 Supplement, section 256B.0915, subdivision 10,
46.12 is amended to read:
46.13 Subd. 10. **Waiver payment rates; managed care organizations.** The
46.14 commissioner shall adjust the elderly waiver capitation payment rates for managed
46.15 care organizations paid under section 256B.69, subdivisions ~~6a~~ 6b and 23, to reflect the
46.16 maximum service rate limits for customized living services and 24-hour customized
46.17 living services under subdivisions 3e and 3h. Medical assistance rates paid to customized
46.18 living providers by managed care organizations under this section shall not exceed the
46.19 maximum service rate limits and component rates as determined by the commissioner
46.20 under subdivisions 3e and 3h.

46.21 Sec. 22. Minnesota Statutes 2010, section 256B.092, subdivision 1, is amended to read:
46.22 Subdivision 1. **County of financial responsibility; duties.** Before any services
46.23 shall be rendered to persons with developmental disabilities who are in need of social
46.24 service and medical assistance, the county of financial responsibility shall conduct or
46.25 arrange for a diagnostic evaluation in order to determine whether the person has or may
46.26 have a developmental disability or has or may have a related condition. If the county
46.27 of financial responsibility determines that the person has a developmental disability,
46.28 the county shall inform the person of case management services available under this
46.29 section. Except as provided in subdivision 1g or 4b, if a person is diagnosed as having a
46.30 developmental disability, the county of financial responsibility shall conduct or arrange for
46.31 a needs assessment by a certified assessor, and develop ~~or arrange for an individual service~~
46.32 a community support plan according to section 256B.0911, ~~provide or arrange for ongoing~~
46.33 ~~case management services at the level identified in the individual service plan, provide~~
46.34 ~~or arrange for case management administration,~~ and authorize services identified in the

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

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

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

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

~~(2) screening;~~

~~(3) intake;~~

~~(4) diagnosis;~~

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

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

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

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

48.1 (2) informing the individual or the individual's legal guardian or conservator, or
48.2 parent if the person is a minor, of service options;
48.3 (3) consulting with relevant medical experts or service providers;
48.4 (4) assisting the person in the identification of potential providers;
48.5 (5) assisting the person to access services and assisting in appeals under section
48.6 256.045;
48.7 (6) coordination of services, if coordination is not provided by another service
48.8 provider;
48.9 (7) evaluation and monitoring of the services identified in the coordinated service
48.10 and support plan, which must incorporate at least one annual face-to-face visit by the case
48.11 manager with each person; and
48.12 (8) ~~annual reviews of service plans and services provided~~ reviewing coordinated
48.13 service and support plans and providing the lead agency with recommendations for service
48.14 authorization based upon the individual's needs identified in the coordinated service and
48.15 support plan.
48.16 (c) Case management ~~administration and~~ service activities that are provided to the
48.17 person with a developmental disability shall be provided directly by county agencies or
48.18 under contract. Case management services must be provided by a public or private agency
48.19 that is enrolled as a medical assistance provider determined by the commissioner to meet
48.20 all of the requirements in the approved federal waiver plans. Case management services
48.21 must not be provided to a recipient by a private agency that has a financial interest in the
48.22 provision of any other services included in the recipient's coordinated service and support
48.23 plan. For purposes of this section, "private agency" means any agency that is not identified
48.24 as a lead agency under section 256B.0911, subdivision 1a, paragraph (e).
48.25 (d) Case managers are responsible for ~~the administrative duties and~~ service
48.26 provisions listed in paragraphs (a) and (b). Case managers shall collaborate with
48.27 consumers, families, legal representatives, and relevant medical experts and service
48.28 providers in the development and annual review of the ~~individualized service~~ coordinated
48.29 service and support plan and habilitation ~~plans~~ plan.
48.30 (e) The Department of Human Services shall offer ongoing education in case
48.31 management to case managers. Case managers shall receive no less than ten hours of case
48.32 management education and disability-related training each year.

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

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

(1) is developed and signed by the recipient within ten working days after the case manager receives the assessment information and written community support plan as described in section 256B.0911, subdivision 3a, from the certified assessor;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) provide consultation on the case management process;

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

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

(4) provide training and technical assistance to county case managers; and

(5) authorize payment for medical assistance services according to this chapter and rules implementing it.

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

Subd. 3. **Authorization and termination of services.** County agency case managers, under rules of the commissioner, shall authorize and terminate services of community and regional treatment center providers according to ~~individual service~~

52.1 support plans. Services provided to persons with developmental disabilities may only be
52.2 authorized and terminated by case managers or certified assessors according to (1) rules of
52.3 the commissioner and (2) the ~~individual service~~ coordinated service and support plan as
52.4 defined in subdivision 1b. Medical assistance services not needed shall not be authorized
52.5 by county agencies or funded by the commissioner. When purchasing or arranging for
52.6 unlicensed respite care services for persons with overriding health needs, the county
52.7 agency shall seek the advice of a health care professional in assessing provider staff
52.8 training needs and skills necessary to meet the medical needs of the person.

52.9 Sec. 29. Minnesota Statutes 2010, section 256B.092, subdivision 5, is amended to read:
52.10 Subd. 5. **Federal waivers.** (a) The commissioner shall apply for any federal
52.11 waivers necessary to secure, to the extent allowed by law, federal financial participation
52.12 under United States Code, title 42, sections 1396 et seq., as amended, for the provision
52.13 of services to persons who, in the absence of the services, would need the level of care
52.14 provided in a regional treatment center or a community intermediate care facility for
52.15 persons with developmental disabilities. The commissioner may seek amendments to the
52.16 waivers or apply for additional waivers under United States Code, title 42, sections 1396
52.17 et seq., as amended, to contain costs. The commissioner shall ensure that payment for
52.18 the cost of providing home and community-based alternative services under the federal
52.19 waiver plan shall not exceed the cost of intermediate care services including day training
52.20 and habilitation services that would have been provided without the waivered services.
52.21 The commissioner shall seek an amendment to the 1915c home and
52.22 community-based waiver to allow properly licensed adult foster care homes to provide
52.23 residential services to up to five individuals with developmental disabilities. If the
52.24 amendment to the waiver is approved, adult foster care providers that can accommodate
52.25 five individuals shall increase their capacity to five beds, provided the providers continue
52.26 to meet all applicable licensing requirements.
52.27 (b) The commissioner, in administering home and community-based waivers for
52.28 persons with developmental disabilities, shall ensure that day services for eligible persons
52.29 are not provided by the person's residential service provider, unless the person or the
52.30 person's legal representative is offered a choice of providers and agrees in writing to
52.31 provision of day services by the residential service provider. The ~~individual service~~
52.32 coordinated service and support plan for individuals who choose to have their residential
52.33 service provider provide their day services must describe how health, safety, protection,
52.34 and habilitation needs will be met, including how frequent and regular contact with
52.35 persons other than the residential service provider will occur. The ~~individualized service~~

53.1 coordinated service and support plan must address the provision of services during the
53.2 day outside the residence on weekdays.

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

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

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

53.15 (b) For persons with developmental disabilities, ~~screening teams shall be established~~
53.16 ~~which~~ a certified assessor shall evaluate the need for ~~the~~ an institutional level of care.
53.17 ~~provided by residential-based habilitation services, residential services, training and~~
53.18 ~~habilitation services, and nursing facility services.~~ The ~~evaluation~~ assessment shall
53.19 address whether home and community-based services are appropriate for persons who
53.20 are at risk of placement in an intermediate care facility for persons with developmental
53.21 disabilities, or for whom there is reasonable indication that they might require this level of
53.22 care. The ~~screening team~~ certified assessor shall make an evaluation of need ~~within 60~~
53.23 ~~working days of a request for service by a person with a developmental disability, and~~
53.24 within five working days of an emergency admission of a person to an intermediate care
53.25 facility for persons with developmental disabilities. ~~The screening team shall consist of~~
53.26 ~~the case manager for persons with developmental disabilities, the person, the person's~~
53.27 ~~legal guardian or conservator, or the parent if the person is a minor, and a qualified~~
53.28 ~~developmental disability professional, as defined in the Code of Federal Regulations,~~
53.29 ~~title 42, section 483.430, as amended through June 3, 1988. The case manager may also~~
53.30 ~~act as the qualified developmental disability professional if the case manager meets~~
53.31 ~~the federal definition. County social service agencies may contract with a public or~~
53.32 ~~private agency or individual who is not a service provider for the person for the public~~
53.33 ~~guardianship representation required by the screening or individual service planning~~
53.34 ~~process. The contract shall be limited to public guardianship representation for the~~
53.35 ~~screening and individual service planning activities. The contract shall require compliance~~

~~with the commissioner's instructions and may be for paid or voluntary services. For persons determined to have overriding health care needs and are seeking admission to a nursing facility or an ICF/MR, or seeking access to home and community-based waivered services, a registered nurse must be designated as either the case manager or the qualified developmental disability professional. For persons under the jurisdiction of a correctional agency, the case manager must consult with the corrections administrator regarding additional health, safety, and supervision needs. The case manager, with the concurrence of the person, the person's legal guardian or conservator, or the parent if the person is a minor, may invite other individuals to attend meetings of the screening team. No member of the screening team shall have any direct or indirect service provider interest in the case. Nothing in this section shall be construed as requiring the screening team meeting to be separate from the service planning meeting.~~

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

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

~~(1) review diagnostic data;~~

~~(2) review health, social, and developmental assessment data using a uniform screening tool specified by the commissioner;~~

~~(3) identify the level of services appropriate to maintain the person in the most normal and least restrictive setting that is consistent with the person's treatment needs;~~

~~(4)~~ (1) identify other noninstitutional public assistance or social service that may prevent or delay long-term residential placement;

~~(5)~~ (2) assess whether a person is in need of long-term residential care;

~~(6)~~ (3) make recommendations regarding placement and payment for:

(i) social service or public assistance support, or both, to maintain a person in the person's own home or other place of residence;

(ii) training and habilitation service, vocational rehabilitation, and employment training activities;

(iii) community residential service placement;

(iv) regional treatment center placement; or

(v) a home and community-based service alternative to community residential ~~placement~~ service or regional treatment center placement;

~~(7)~~ (4) evaluate the availability, location, and quality of the services listed in clause ~~(6)~~ (3), including the impact of placement alternatives on the person's ability to maintain

55.1 or improve existing patterns of contact and involvement with parents and other family
55.2 members;

55.3 ~~(8)~~ (5) identify the cost implications of recommendations in clause ~~(6)~~ (3); and

55.4 ~~(9)~~ (6) make recommendations to a court as may be needed to assist the court in
55.5 making decisions regarding commitment of persons with developmental disabilities~~; and~~.

55.6 ~~(10) inform the person and the person's legal guardian or conservator, or the parent if~~
55.7 ~~the person is a minor, that appeal may be made to the commissioner pursuant to section~~
55.8 ~~256.045.~~

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

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

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

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

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

55.33 (c) The county of service shall notify the county of financial responsibility of
55.34 ~~concurrence or refusal to concur~~ any concerns about the chosen provider's capacity to
55.35 meet the needs of the person seeking to move to residential services in another county no

56.1 later than 20 working days following receipt of the written ~~request~~ notification. Unless
56.2 other mutually acceptable arrangements are made by the involved county agencies, the
56.3 county of financial responsibility is responsible for costs of social services and the costs
56.4 associated with the development and maintenance of the placement. The county of
56.5 service may request that the county of financial responsibility purchase case management
56.6 services from the county of service or from a contracted provider of case management
56.7 when the county of financial responsibility is not providing case management as defined
56.8 in this section and rules adopted under this section, unless other mutually acceptable
56.9 arrangements are made by the involved county agencies. Standards for payment limits
56.10 under this section may be established by the commissioner. Financial disputes between
56.11 counties shall be resolved as provided in section 256G.09. This subdivision also applies to
56.12 home and community-based waiver services provided under section 256B.49.

56.13 Sec. 33. Minnesota Statutes 2010, section 256B.092, subdivision 9, is amended to read:
56.14 Subd. 9. **Reimbursement.** Payment for services shall not be provided to a
56.15 service provider for any person placed in an intermediate care facility for persons with
56.16 developmental disabilities prior to the person ~~being screened by the screening team~~
56.17 receiving an assessment by a certified assessor. The commissioner shall not deny
56.18 reimbursement for: (1) a person admitted to an intermediate care facility for persons
56.19 with developmental disabilities who is assessed to need long-term supportive services,
56.20 if long-term supportive services other than intermediate care are not available in that
56.21 community; (2) any person admitted to an intermediate care facility for persons with
56.22 developmental disabilities under emergency circumstances; (3) any eligible person placed
56.23 in the intermediate care facility for persons with developmental disabilities pending an
56.24 appeal of the ~~screening team's~~ certified assessor's decision; or (4) any medical assistance
56.25 recipient when, after full discussion of all appropriate alternatives including those that
56.26 are expected to be less costly than intermediate care for persons with developmental
56.27 disabilities, the person or the person's legal guardian or conservator, or the parent if the
56.28 person is a minor, insists on intermediate care placement. The ~~screening team~~ certified
56.29 assessor shall provide documentation that the most cost-effective alternatives available
56.30 were offered to this individual or the individual's legal guardian or conservator.

56.31 Sec. 34. Minnesota Statutes 2010, section 256B.092, subdivision 11, is amended to
56.32 read:
56.33 Subd. 11. **Residential support services.** (a) Upon federal approval, there is
56.34 established a new service called residential support that is available on the community

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

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

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

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

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

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

57.14 (5) the provider of residential support services must meet the requirements of
57.15 licensure and additional requirements of the person's ~~community~~ coordinated service and
57.16 support plan.

57.17 (c) Providers of residential support services that meet the definition in paragraph
57.18 (a) must be registered using a process determined by the commissioner beginning July
57.19 1, 2009.

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

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

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

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

57.30 ~~(3)~~ (2) informing the recipient or the recipient's legal guardian or conservator
57.31 of service options;

57.32 ~~(4)~~ (3) assisting the recipient in the identification of potential service providers and
57.33 available options for case management service and providers;

57.34 ~~(5)~~ (4) assisting the recipient to access services and assisting with appeals under
57.35 section 256.045; and

58.1 ~~(6)~~ (5) coordinating, evaluating, and monitoring of the services identified in the
58.2 service plan~~;~~.
58.3 ~~(7) completing the annual reviews of the service plan; and~~
58.4 ~~(8) informing the recipient or legal representative of the right to have assessments~~
58.5 ~~completed and service plans developed within specified time periods, and to appeal county~~
58.6 ~~action or inaction under section 256.045, subdivision 3, including the determination of~~
58.7 ~~nursing facility level of care.~~
58.8 (b) The case manager may delegate certain aspects of the case management service
58.9 activities to another individual provided there is oversight by the case manager. The case
58.10 manager may not delegate those aspects which require professional judgment including
58.11 ~~assessments, reassessments, and care plan development.~~:
58.12 (1) finalizing the coordinated service and support plan;
58.13 (2) ongoing assessment and monitoring of the person's needs and adequacy of the
58.14 approved coordinated service and support plan; and
58.15 (3) adjustments to the coordinated service and support plan.
58.16 (c) Case management services must be provided by a public or private agency that is
58.17 enrolled as a medical assistance provider determined by the commissioner to meet all of
58.18 the requirements in the approved federal waiver plans. Case management services must
58.19 not be provided to a recipient by a private agency that has any financial interest in the
58.20 provision of any other services included in the recipient's coordinated service and support
58.21 plan. For purposes of this section, "private agency" means any agency that is not identified
58.22 as a lead agency under section 256B.0911, subdivision 1a, paragraph (e).

58.23 Sec. 36. Minnesota Statutes 2011 Supplement, section 256B.49, subdivision 14,
58.24 is amended to read:
58.25 Subd. 14. **Assessment and reassessment.** (a) Assessments ~~of each recipient's~~
58.26 ~~strengths, informal support systems, and need for services shall be completed within 20~~
58.27 ~~working days of the recipient's request as provided in section 256B.0911. Reassessment~~
58.28 ~~of each recipient's strengths, support systems, and need for services shall be conducted~~
58.29 ~~at least every 12 months and at other times when there has been a significant change in~~
58.30 ~~the recipient's functioning~~ and reassessments shall be conducted by certified assessors
58.31 according to section 256B.0911, subdivision 2b.
58.32 (b) There must be a determination that the client requires a hospital level of care or a
58.33 nursing facility level of care as defined in section 256B.0911, subdivision 4a, paragraph
58.34 (d), at initial and subsequent assessments to initiate and maintain participation in the
58.35 waiver program.

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

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

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

59.13 ~~(f)~~ (e) The commissioner shall develop criteria to identify recipients whose level of
59.14 functioning is reasonably expected to improve and reassess these recipients to establish
59.15 a baseline assessment. Recipients who meet these criteria must have a comprehensive
59.16 transitional service plan developed under subdivision 15, paragraphs (b) and (c), and be
59.17 reassessed every six months until there has been no significant change in the recipient's
59.18 functioning for at least 12 months. After there has been no significant change in the
59.19 recipient's functioning for at least 12 months, reassessments of the recipient's strengths,
59.20 informal support systems, and need for services shall be conducted at least every 12
59.21 months and at other times when there has been a significant change in the recipient's
59.22 functioning. Counties, case managers, and service providers are responsible for
59.23 conducting these reassessments and shall complete the reassessments out of existing funds.

59.24 Sec. 37. Minnesota Statutes 2011 Supplement, section 256B.49, subdivision 15,
59.25 is amended to read:

59.26 Subd. 15. **Individualized service plan; comprehensive transitional service plan;**
59.27 **maintenance service plan.** (a) Each recipient of home and community-based waivered
59.28 services shall be provided a copy of the written coordinated service and support plan
59.29 which~~:~~ meets the requirements in section 256B.092, subdivision 1b.

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

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

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

59.34 ~~(4) promotes independence;~~

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

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

60.3 (b) In developing the comprehensive transitional service plan, the individual
60.4 receiving services, the case manager, and the guardian, if applicable, will identify
60.5 the transitional service plan fundamental service outcome and anticipated timeline to
60.6 achieve this outcome. Within the first 20 days following a recipient's request for an
60.7 assessment or reassessment, the transitional service planning team must be identified. A
60.8 team leader must be identified who will be responsible for assigning responsibility and
60.9 communicating with team members to ensure implementation of the transition plan and
60.10 ongoing assessment and communication process. The team leader should be an individual,
60.11 such as the case manager or guardian, who has the opportunity to follow the recipient to
60.12 the next level of service.

60.13 Within ten days following an assessment, a comprehensive transitional service plan
60.14 must be developed incorporating elements of a comprehensive functional assessment and
60.15 including short-term measurable outcomes and timelines for achievement of and reporting
60.16 on these outcomes. Functional milestones must also be identified and reported according
60.17 to the timelines agreed upon by the transitional service planning team. In addition, the
60.18 comprehensive transitional service plan must identify additional supports that may assist
60.19 in the achievement of the fundamental service outcome such as the development of greater
60.20 natural community support, increased collaboration among agencies, and technological
60.21 supports.

60.22 The timelines for reporting on functional milestones will prompt a reassessment of
60.23 services provided, the units of services, rates, and appropriate service providers. It is
60.24 the responsibility of the transitional service planning team leader to review functional
60.25 milestone reporting to determine if the milestones are consistent with observable skills
60.26 and that milestone achievement prompts any needed changes to the comprehensive
60.27 transitional service plan.

60.28 For those whose fundamental transitional service outcome involves the need to
60.29 procure housing, a plan for the recipient to seek the resources necessary to secure the least
60.30 restrictive housing possible should be incorporated into the plan, including employment
60.31 and public supports such as housing access and shelter needy funding.

60.32 (c) Counties and other agencies responsible for funding community placement and
60.33 ongoing community supportive services are responsible for the implementation of the
60.34 comprehensive transitional service plans. Oversight responsibilities include both ensuring
60.35 effective transitional service delivery and efficient utilization of funding resources.

(d) Following one year of transitional services, the transitional services planning team will make a determination as to whether or not the individual receiving services requires the current level of continuous and consistent support in order to maintain the recipient's current level of functioning. Recipients who are determined to have not had a significant change in functioning for 12 months must move from a transitional to a maintenance service plan. Recipients on a maintenance service plan must be reassessed to determine if the recipient would benefit from a transitional service plan at least every 12 months and at other times when there has been a significant change in the recipient's functioning. This assessment should consider any changes to technological or natural community supports.

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

(f) At the time of reassessment, local agency case managers shall assess each recipient of community alternatives for disabled individuals or traumatic brain injury waivered services currently residing in a licensed adult foster home that is not the primary residence of the license holder, or in which the license holder is not the primary caregiver, to determine if that recipient could appropriately be served in a community-living setting. If appropriate for the recipient, the case manager shall offer the recipient, through a person-centered planning process, the option to receive alternative housing and service options. In the event that the recipient chooses to transfer from the adult foster home, the vacated bed shall not be filled with another recipient of waiver services and group residential housing, unless provided under section 245A.03, subdivision 7, paragraph (a), clauses (3) and (4), and the licensed capacity shall be reduced accordingly. If the adult foster home becomes no longer viable due to these transfers, the county agency, with the assistance of the department, shall facilitate a consolidation of settings or closure. This reassessment process shall be completed by June 30, 2012.

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

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

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

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

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

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

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

(1) definitions of service and consolidation of standards and rates to the extent appropriate for all types of medical assistance case management service services, including targeted case management under Minnesota Statutes, sections 256B.0621, 256B.0924, and 256B.094, and all types of home and community-based waiver case management and case management under Minnesota Rules, parts 9525.0004 to 9525.0036. This work must be completed in collaboration with efforts under Minnesota Statutes, section 256B.4912;

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

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

ARTICLE 4

CHEMICAL AND MENTAL HEALTH

Section 1. Minnesota Statutes 2010, section 245.461, is amended by adding a subdivision to read:

63.1 Subd. 6. **Diagnostic codes manual.** By July 1, 2013, the commissioner of
63.2 human services shall develop a manual of diagnostic codes to be used in definition
63.3 of emotional disturbance and mental illness for the statewide mental health system.
63.4 The commissioner may use the Internal Classification of Diseases (ICD); the American
63.5 Psychiatric Association's Diagnostic and Statistical Manual (DSM); or a combination of
63.6 both to develop the manual. The commissioner shall establish a time-limited advisory
63.7 committee, comprising mental health professional associations, counties, tribes, managed
63.8 care organizations, state agencies, and consumer organizations that shall advise the
63.9 commissioner regarding development of the diagnostic codes manual. The commissioner
63.10 shall annually notify providers of changes to the manual.

63.11 Sec. 2. Minnesota Statutes 2010, section 245.462, subdivision 20, is amended to read:
63.12 Subd. 20. **Mental illness.** (a) "Mental illness" means an organic disorder of the
63.13 brain or a clinically significant disorder of thought, mood, perception, orientation,
63.14 memory, or behavior that is ~~listed in the clinical manual of the International Classification~~
63.15 ~~of Diseases (ICD-9-CM), current edition, code range 290.0 to 302.99 or 306.0 to 316.0~~
63.16 ~~or the corresponding code in the American Psychiatric Association's Diagnostic and~~
63.17 ~~Statistical Manual of Mental Disorders (DSM-MD), current edition, Axes I, II, or III~~
63.18 detailed in a diagnostic codes manual published by the commissioner, and that seriously
63.19 limits a person's capacity to function in primary aspects of daily living such as personal
63.20 relations, living arrangements, work, and recreation.
63.21 (b) An "adult with acute mental illness" means an adult who has a mental illness that
63.22 is serious enough to require prompt intervention.
63.23 (c) For purposes of case management and community support services, a "person
63.24 with serious and persistent mental illness" means an adult who has a mental illness and
63.25 meets at least one of the following criteria:
63.26 (1) the adult has undergone two or more episodes of inpatient care for a mental
63.27 illness within the preceding 24 months;
63.28 (2) the adult has experienced a continuous psychiatric hospitalization or residential
63.29 treatment exceeding six months' duration within the preceding 12 months;
63.30 (3) the adult has been treated by a crisis team two or more times within the preceding
63.31 24 months;
63.32 (4) the adult:
63.33 (i) has a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline
63.34 personality disorder;
63.35 (ii) indicates a significant impairment in functioning; and

64.1 (iii) has a written opinion from a mental health professional, in the last three years,
64.2 stating that the adult is reasonably likely to have future episodes requiring inpatient or
64.3 residential treatment, of a frequency described in clause (1) or (2), unless ongoing case
64.4 management or community support services are provided;
64.5 (5) the adult has, in the last three years, been committed by a court as a person
64.6 who is mentally ill under chapter 253B, or the adult's commitment has been stayed or
64.7 continued; or
64.8 (6) the adult (i) was eligible under clauses (1) to (5), but the specified time period
64.9 has expired or the adult was eligible as a child under section 245.4871, subdivision 6; and
64.10 (ii) has a written opinion from a mental health professional, in the last three years, stating
64.11 that the adult is reasonably likely to have future episodes requiring inpatient or residential
64.12 treatment, of a frequency described in clause (1) or (2), unless ongoing case management
64.13 or community support services are provided.

64.14 Sec. 3. Minnesota Statutes 2010, section 245.487, is amended by adding a subdivision
64.15 to read:
64.16 Subd. 7. **Diagnostic codes manual.** By July 1, 2013, the commissioner of
64.17 human services shall develop a manual of diagnostic codes to be used in definition
64.18 of emotional disturbance and mental illness for the statewide mental health system.
64.19 The commissioner may use the Internal Classification of Diseases (ICD); the American
64.20 Psychiatric Association's Diagnostic and Statistical Manual (DSM); or a combination of
64.21 both to develop the manual. The commissioner shall establish a time-limited advisory
64.22 committee, comprising mental health professional associations, counties, tribes, managed
64.23 care organizations, state agencies, and consumer organizations that shall advise the
64.24 commissioner regarding development of the diagnostic codes manual. The commissioner
64.25 shall annually notify providers of changes to the manual.

64.26 Sec. 4. Minnesota Statutes 2010, section 245.4871, subdivision 15, is amended to read:
64.27 Subd. 15. **Emotional disturbance.** "Emotional disturbance" means an organic
64.28 disorder of the brain or a clinically significant disorder of thought, mood, perception,
64.29 orientation, memory, or behavior that:
64.30 (1) is ~~listed in the clinical manual of the International Classification of Diseases~~
64.31 ~~(ICD-9-CM), current edition, code range 290.0 to 302.99 or 306.0 to 316.0 or the~~
64.32 ~~corresponding code in the American Psychiatric Association's Diagnostic and Statistical~~
64.33 ~~Manual of Mental Disorders (DSM-MD), current edition, Axes I, II, or III~~ detailed in a
64.34 diagnostic codes manual published by the commissioner; and

(2) seriously limits a child's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, school, and recreation.

"Emotional disturbance" is a generic term and is intended to reflect all categories of disorder described in ~~DSM-MD, current edition~~ the clinical code manual published by the commissioner as "usually first evident in childhood or adolescence."

Sec. 5. Minnesota Statutes 2010, section 245.4932, subdivision 1, is amended to read:

Subdivision 1. **Collaborative responsibilities.** The children's mental health collaborative shall have the following authority and responsibilities regarding federal revenue enhancement:

(1) the collaborative must establish an integrated fund;

(2) the collaborative shall designate a lead county or other qualified entity as the fiscal agency for reporting, claiming, and receiving payments;

(3) the collaborative or lead county may enter into subcontracts with other counties, school districts, special education cooperatives, municipalities, and other public and nonprofit entities for purposes of identifying and claiming eligible expenditures to enhance federal reimbursement;

(4) the collaborative shall use any enhanced revenue attributable to the activities of the collaborative, including administrative and service revenue, solely to provide mental health services or to expand the operational target population. The lead county or other qualified entity may not use enhanced federal revenue for any other purpose;

~~(5) the members of the collaborative must continue the base level of expenditures, as defined in section 245.492, subdivision 2, for services for children with emotional or behavioral disturbances and their families from any state, county, federal, or other public or private funding source which, in the absence of the new federal reimbursement earned under sections 245.491 to 245.495, would have been available for those services. The base year for purposes of this subdivision shall be the accounting period closest to state fiscal year 1993;~~

~~(6)~~ (5) the collaborative or lead county must develop and maintain an accounting and financial management system adequate to support all claims for federal reimbursement, including a clear audit trail and any provisions specified in the contract with the commissioner of human services;

~~(7)~~ (6) the collaborative or its members may elect to pay the nonfederal share of the medical assistance costs for services designated by the collaborative; and

66.1 ~~(8)~~ (7) the lead county or other qualified entity may not use federal funds or local
66.2 funds designated as matching for other federal funds to provide the nonfederal share of
66.3 medical assistance.

66.4 Sec. 6. Minnesota Statutes 2010, section 246.53, is amended by adding a subdivision
66.5 to read:
66.6 Subd. 4. **Exception from statute of limitations.** Any statute of limitations that
66.7 limits the commissioner in recovering the cost of care obligation incurred by a client or
66.8 former client shall not apply to any claim against an estate made under this section to
66.9 recover the cost of care.

66.10 Sec. 7. Minnesota Statutes 2011 Supplement, section 254B.04, subdivision 2a, is
66.11 amended to read:
66.12 Subd. 2a. **Eligibility for treatment in residential settings.** Notwithstanding
66.13 provisions of Minnesota Rules, part 9530.6622, subparts 5 and 6, related to an assessor's
66.14 discretion in making placements to residential treatment settings, a person eligible for
66.15 services under this section must score at level 4 on assessment dimensions related to
66.16 relapse, continued use, ~~and~~ or recovery environment in order to be assigned to services
66.17 with a room and board component reimbursed under this section.

66.18 Sec. 8. Minnesota Statutes 2010, section 256B.0625, subdivision 42, is amended to
66.19 read:
66.20 Subd. 42. **Mental health professional.** Notwithstanding Minnesota Rules, part
66.21 9505.0175, subpart 28, the definition of a mental health professional shall include a person
66.22 who is qualified as specified in section 245.462, subdivision 18, clauses ~~(5) and~~ (1) to (6);
66.23 or 245.4871, subdivision 27, clauses ~~(5) and~~ (1) to (6), for the purpose of this section and
66.24 Minnesota Rules, parts 9505.0170 to 9505.0475.

66.25 Sec. 9. Minnesota Statutes 2010, section 256F.13, subdivision 1, is amended to read:
66.26 Subdivision 1. **Federal revenue enhancement.** (a) The commissioner of human
66.27 services may enter into an agreement with one or more family services collaboratives
66.28 to enhance federal reimbursement under title IV-E of the Social Security Act and
66.29 federal administrative reimbursement under title XIX of the Social Security Act. The
66.30 commissioner may contract with the Department of Education for purposes of transferring
66.31 the federal reimbursement to the commissioner of education to be distributed to the

collaboratives according to clause (2). The commissioner shall have the following authority and responsibilities regarding family services collaboratives:

(1) the commissioner shall submit amendments to state plans and seek waivers as necessary to implement the provisions of this section;

(2) the commissioner shall pay the federal reimbursement earned under this subdivision to each collaborative based on their earnings. Payments to collaboratives for expenditures under this subdivision will only be made of federal earnings from services provided by the collaborative;

(3) the commissioner shall review expenditures of family services collaboratives using reports specified in the agreement with the collaborative to ensure ~~that the base level of expenditures is continued and~~ new federal reimbursement is used to expand education, social, health, or health-related services to young children and their families;

~~(4) the commissioner may reduce, suspend, or eliminate a family services collaborative's obligations to continue the base level of expenditures or expansion of services if the commissioner determines that one or more of the following conditions apply:~~

~~(i) imposition of levy limits that significantly reduce available funds for social, health, or health-related services to families and children;~~

~~(ii) reduction in the net tax capacity of the taxable property eligible to be taxed by the lead county or subcontractor that significantly reduces available funds for education, social, health, or health-related services to families and children;~~

~~(iii) reduction in the number of children under age 19 in the county, collaborative service delivery area, subcontractor's district, or catchment area when compared to the number in the base year using the most recent data provided by the State Demographer's Office; or~~

~~(iv) termination of the federal revenue earned under the family services collaborative agreement;~~

~~(5)~~ (4) the commissioner shall not use the federal reimbursement earned under this subdivision in determining the allocation or distribution of other funds to counties or collaboratives;

~~(6)~~ (5) the commissioner may suspend, reduce, or terminate the federal reimbursement to a provider that does not meet the reporting or other requirements of this subdivision;

~~(7)~~ (6) the commissioner shall recover from the family services collaborative any federal fiscal disallowances or sanctions for audit exceptions directly attributable to the

68.1 family services collaborative's actions in the integrated fund, or the proportional share if
68.2 federal fiscal disallowances or sanctions are based on a statewide random sample; and

68.3 ~~(8)~~ <u>(7)</u> the commissioner shall establish criteria for the family services collaborative
68.4 for the accounting and financial management system that will support claims for federal
68.5 reimbursement.

68.6 (b) The family services collaborative shall have the following authority and
68.7 responsibilities regarding federal revenue enhancement:

68.8 (1) the family services collaborative shall be the party with which the commissioner
68.9 contracts. A lead county shall be designated as the fiscal agency for reporting, claiming,
68.10 and receiving payments;

68.11 (2) the family services collaboratives may enter into subcontracts with other
68.12 counties, school districts, special education cooperatives, municipalities, and other public
68.13 and nonprofit entities for purposes of identifying and claiming eligible expenditures to
68.14 enhance federal reimbursement, or to expand education, social, health, or health-related
68.15 services to families and children;

68.16 (3) the family services collaborative must use all new federal reimbursement
68.17 resulting from federal revenue enhancement to expand expenditures for education, social,
68.18 health, or health-related services to families and children beyond the base level~~, except~~
68.19 ~~as provided in paragraph (a), clause (4)~~;

68.20 (4) the family services collaborative must ensure that expenditures submitted for
68.21 federal reimbursement are not made from federal funds or funds used to match other
68.22 federal funds. Notwithstanding section 256B.19, subdivision 1, for the purposes of family
68.23 services collaborative expenditures under agreement with the department, the nonfederal
68.24 share of costs shall be provided by the family services collaborative from sources other
68.25 than federal funds or funds used to match other federal funds;

68.26 (5) the family services collaborative must develop and maintain an accounting and
68.27 financial management system adequate to support all claims for federal reimbursement,
68.28 including a clear audit trail and any provisions specified in the agreement; and

68.29 (6) the family services collaborative shall submit an annual report to the
68.30 commissioner as specified in the agreement.

68.31 **ARTICLE 5**

68.32 **HEALTH CARE**

68.33 Section 1. Minnesota Statutes 2011 Supplement, section 125A.21, subdivision 7,
68.34 is amended to read:

Subd. 7. **District disclosure of information.** A school district may disclose information contained in a student's individualized education program, consistent with section 13.32, subdivision 3, paragraph (a), and Code of Federal Regulations, title 34, parts 99 and 300; including records of the student's diagnosis and treatment, to a health plan company only with the signed and dated consent of the student's parent, or other legally authorized individual~~, including consent that the parent or legal representative gave as part of the application process for MinnesotaCare or medical assistance under section 256B.08, subdivision 1~~. The school district shall disclose only that information necessary for the health plan company to decide matters of coverage and payment. A health plan company may use the information only for making decisions regarding coverage and payment, and for any other use permitted by law.

Sec. 2. Minnesota Statutes 2010, section 256B.04, subdivision 14, is amended to read:

Subd. 14. **Competitive bidding.** (a) When determined to be effective, economical, and feasible, the commissioner may utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C, to provide items under the medical assistance program including but not limited to the following:

(1) eyeglasses;

(2) oxygen. The commissioner shall provide for oxygen needed in an emergency situation on a short-term basis, until the vendor can obtain the necessary supply from the contract dealer;

(3) hearing aids and supplies; and

(4) durable medical equipment, including but not limited to:

(i) hospital beds;

(ii) commodes;

(iii) glide-about chairs;

(iv) patient lift apparatus;

(v) wheelchairs and accessories;

(vi) oxygen administration equipment;

(vii) respiratory therapy equipment;

(viii) electronic diagnostic, therapeutic and life-support systems;

(5) nonemergency medical transportation level of need determinations, disbursement of public transportation passes and tokens, and volunteer and recipient mileage and parking reimbursements; and

(6) drugs.

70.1 (b) Rate changes and recipient cost-sharing under this chapter and chapters 256D and
70.2 256L do not affect contract payments under this subdivision unless specifically identified.
70.3 (c) The commissioner may not utilize volume purchase through competitive bidding
70.4 and negotiation for special transportation services under the provisions of chapter 16C.

70.5 Sec. 3. Minnesota Statutes 2011 Supplement, section 256B.056, subdivision 3, is
70.6 amended to read:
70.7 Subd. 3. **Asset limitations for individuals and families.** (a) To be eligible for
70.8 medical assistance, a person must not individually own more than $3,000 in assets, or if a
70.9 member of a household with two family members, husband and wife, or parent and child,
70.10 the household must not own more than $6,000 in assets, plus $200 for each additional
70.11 legal dependent. In addition to these maximum amounts, an eligible individual or family
70.12 may accrue interest on these amounts, but they must be reduced to the maximum at the
70.13 time of an eligibility redetermination. The accumulation of the clothing and personal
70.14 needs allowance according to section 256B.35 must also be reduced to the maximum at
70.15 the time of the eligibility redetermination. The value of assets that are not considered in
70.16 determining eligibility for medical assistance is the value of those assets excluded under
70.17 the supplemental security income program for aged, blind, and disabled persons, with
70.18 the following exceptions:
70.19 (1) household goods and personal effects are not considered;
70.20 (2) capital and operating assets of a trade or business that the local agency determines
70.21 are necessary to the person's ability to earn an income are not considered;
70.22 (3) motor vehicles are excluded to the same extent excluded by the supplemental
70.23 security income program;
70.24 (4) assets designated as burial expenses are excluded to the same extent excluded by
70.25 the supplemental security income program. Burial expenses funded by annuity contracts
70.26 or life insurance policies must irrevocably designate the individual's estate as contingent
70.27 beneficiary to the extent proceeds are not used for payment of selected burial expenses; ~~and~~
70.28 (5) for a person who no longer qualifies as an employed person with a disability due
70.29 to loss of earnings, assets allowed while eligible for medical assistance under section
70.30 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month
70.31 of ineligibility as an employed person with a disability, to the extent that the person's total
70.32 assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph
70.33 (d)~~.~~; and
70.34 (6) effective July 1, 2009, certain assets owned by American Indians are excluded as
70.35 required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public

71.1 Law 111-5. For purposes of this clause, an American Indian is any person who meets the
71.2 definition of Indian according to Code of Federal Regulations, title 42, section 447.50.
71.3 (b) No asset limit shall apply to persons eligible under section 256B.055, subdivision
71.4 15.

71.5 **EFFECTIVE DATE.** This section is effective retroactively from July 1, 2009.

71.6 Sec. 4. Minnesota Statutes 2010, section 256B.056, subdivision 3c, is amended to read:
71.7 Subd. 3c. **Asset limitations for families and children.** A household of two or more
71.8 persons must not own more than $20,000 in total net assets, and a household of one
71.9 person must not own more than $10,000 in total net assets. In addition to these maximum
71.10 amounts, an eligible individual or family may accrue interest on these amounts, but they
71.11 must be reduced to the maximum at the time of an eligibility redetermination. The value of
71.12 assets that are not considered in determining eligibility for medical assistance for families
71.13 and children is the value of those assets excluded under the AFDC state plan as of July 16,
71.14 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation
71.15 Act of 1996 (PRWORA), Public Law 104-193, with the following exceptions:
71.16 (1) household goods and personal effects are not considered;
71.17 (2) capital and operating assets of a trade or business up to $200,000 are not
71.18 considered, except that a bank account that contains personal income or assets, or is used to
71.19 pay personal expenses, is not considered a capital or operating asset of a trade or business;
71.20 (3) one motor vehicle is excluded for each person of legal driving age who is
71.21 employed or seeking employment;
71.22 (4) assets designated as burial expenses are excluded to the same extent they are
71.23 excluded by the Supplemental Security Income program;
71.24 (5) court-ordered settlements up to $10,000 are not considered;
71.25 (6) individual retirement accounts and funds are not considered; ~~and~~
71.26 (7) assets owned by children are not considered~~.~~; and
71.27 (8) effective July 1, 2009, certain assets owned by American Indians are excluded, as
71.28 required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public
71.29 Law 111-5. For purposes of this clause, an American Indian is any person who meets the
71.30 definition of Indian according to Code of Federal Regulations, title 42, section 447.50.
71.31 The assets specified in clause (2) must be disclosed to the local agency at the time of
71.32 application and at the time of an eligibility redetermination, and must be verified upon
71.33 request of the local agency.

71.34 **EFFECTIVE DATE.** This section is effective retroactively from July 1, 2009.

72.1 Sec. 5. Minnesota Statutes 2011 Supplement, section 256B.057, subdivision 9, is
72.2 amended to read:
72.3 Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid
72.4 for a person who is employed and who:
72.5 (1) but for excess earnings or assets, meets the definition of disabled under the
72.6 Supplemental Security Income program;
72.7 (2) is at least 16 but less than 65 years of age;
72.8 (3) meets the asset limits in paragraph (d); and
72.9 (4) pays a premium and other obligations under paragraph (e).
72.10 (b) For purposes of eligibility, there is a $65 earned income disregard. To be eligible
72.11 for medical assistance under this subdivision, a person must have more than $65 of earned
72.12 income. Earned income must have Medicare, Social Security, and applicable state and
72.13 federal taxes withheld. The person must document earned income tax withholding. Any
72.14 spousal income or assets shall be disregarded for purposes of eligibility and premium
72.15 determinations.
72.16 (c) After the month of enrollment, a person enrolled in medical assistance under
72.17 this subdivision who:
72.18 (1) is temporarily unable to work and without receipt of earned income due to a
72.19 medical condition, as verified by a physician; or
72.20 (2) loses employment for reasons not attributable to the enrollee, and is without
72.21 receipt of earned income may retain eligibility for up to four consecutive months after the
72.22 month of job loss. To receive a four-month extension, enrollees must verify the medical
72.23 condition or provide notification of job loss. All other eligibility requirements must be met
72.24 and the enrollee must pay all calculated premium costs for continued eligibility.
72.25 (d) For purposes of determining eligibility under this subdivision, a person's assets
72.26 must not exceed $20,000, excluding:
72.27 (1) all assets excluded under section 256B.056;
72.28 (2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans,
72.29 Keogh plans, and pension plans;
72.30 (3) medical expense accounts set up through the person's employer; and
72.31 (4) spousal assets, including spouse's share of jointly held assets.
72.32 (e) All enrollees must pay a premium to be eligible for medical assistance under this
72.33 subdivision, except as provided under ~~section 256.01, subdivision 18b~~ clause (5).
72.34 (1) An enrollee must pay the greater of a $65 premium or the premium calculated
72.35 based on the person's gross earned and unearned income and the applicable family size
72.36 using a sliding fee scale established by the commissioner, which begins at one percent of

73.1 income at 100 percent of the federal poverty guidelines and increases to 7.5 percent of
73.2 income for those with incomes at or above 300 percent of the federal poverty guidelines.
73.3 (2) Annual adjustments in the premium schedule based upon changes in the federal
73.4 poverty guidelines shall be effective for premiums due in July of each year.
73.5 (3) All enrollees who receive unearned income must pay five percent of unearned
73.6 income in addition to the premium amount, except as provided under ~~section 256.01,~~
73.7 ~~subdivision 18b~~ clause (5).
73.8 (4) Increases in benefits under title II of the Social Security Act shall not be counted
73.9 as income for purposes of this subdivision until July 1 of each year.
73.10 (5) Effective July 1, 2009, American Indians are exempt from paying premiums as
73.11 required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public
73.12 Law 111-5. For purposes of this clause, an American Indian is any person who meets the
73.13 definition of Indian according to Code of Federal Regulations, title 42, section 447.50.
73.14 (f) A person's eligibility and premium shall be determined by the local county
73.15 agency. Premiums must be paid to the commissioner. All premiums are dedicated to
73.16 the commissioner.
73.17 (g) Any required premium shall be determined at application and redetermined at
73.18 the enrollee's six-month income review or when a change in income or household size is
73.19 reported. Enrollees must report any change in income or household size within ten days
73.20 of when the change occurs. A decreased premium resulting from a reported change in
73.21 income or household size shall be effective the first day of the next available billing month
73.22 after the change is reported. Except for changes occurring from annual cost-of-living
73.23 increases, a change resulting in an increased premium shall not affect the premium amount
73.24 until the next six-month review.
73.25 (h) Premium payment is due upon notification from the commissioner of the
73.26 premium amount required. Premiums may be paid in installments at the discretion of
73.27 the commissioner.
73.28 (i) Nonpayment of the premium shall result in denial or termination of medical
73.29 assistance unless the person demonstrates good cause for nonpayment. Good cause exists
73.30 if the requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to
73.31 D, are met. Except when an installment agreement is accepted by the commissioner,
73.32 all persons disenrolled for nonpayment of a premium must pay any past due premiums
73.33 as well as current premiums due prior to being reenrolled. Nonpayment shall include
73.34 payment with a returned, refused, or dishonored instrument. The commissioner may
73.35 require a guaranteed form of payment as the only means to replace a returned, refused,
73.36 or dishonored instrument.

74.1 (j) The commissioner shall notify enrollees annually beginning at least 24 months
74.2 before the person's 65th birthday of the medical assistance eligibility rules affecting
74.3 income, assets, and treatment of a spouse's income and assets that will be applied upon
74.4 reaching age 65.

74.5 (k) For enrollees whose income does not exceed 200 percent of the federal poverty
74.6 guidelines and who are also enrolled in Medicare, the commissioner shall reimburse
74.7 the enrollee for Medicare part B premiums under section 256B.0625, subdivision 15,
74.8 paragraph (a).

74.9 **EFFECTIVE DATE.** This section is effective retroactively from July 1, 2009.

74.10 Sec. 6. Minnesota Statutes 2010, section 256B.0595, subdivision 2, is amended to read:

74.11 Subd. 2. **Period of ineligibility for long-term care services.** (a) For any
74.12 uncompensated transfer occurring on or before August 10, 1993, the number of months
74.13 of ineligibility for long-term care services shall be the lesser of 30 months, or the
74.14 uncompensated transfer amount divided by the average medical assistance rate for nursing
74.15 facility services in the state in effect on the date of application. The amount used to
74.16 calculate the average medical assistance payment rate shall be adjusted each July 1 to
74.17 reflect payment rates for the previous calendar year. The period of ineligibility begins
74.18 with the month in which the assets were transferred. If the transfer was not reported to
74.19 the local agency at the time of application, and the applicant received long-term care
74.20 services during what would have been the period of ineligibility if the transfer had been
74.21 reported, a cause of action exists against the transferee for the cost of long-term care
74.22 services provided during the period of ineligibility, or for the uncompensated amount of
74.23 the transfer, whichever is less. The uncompensated transfer amount is the fair market
74.24 value of the asset at the time it was given away, sold, or disposed of, less the amount of
74.25 compensation received.

74.26 (b) For uncompensated transfers made after August 10, 1993, the number of months
74.27 of ineligibility for long-term care services shall be the total uncompensated value of the
74.28 resources transferred divided by the average medical assistance rate for nursing facility
74.29 services in the state in effect on the date of application. The amount used to calculate
74.30 the average medical assistance payment rate shall be adjusted each July 1 to reflect
74.31 payment rates for the previous calendar year. The period of ineligibility begins with the
74.32 first day of the month after the month in which the assets were transferred except that
74.33 if one or more uncompensated transfers are made during a period of ineligibility, the
74.34 total assets transferred during the ineligibility period shall be combined and a penalty
74.35 period calculated to begin on the first day of the month after the month in which the first

75.1 uncompensated transfer was made. If the transfer was reported to the local agency after
75.2 the date that advance notice of a period of ineligibility that affects the next month could
75.3 be provided to the recipient and the recipient received medical assistance services or the
75.4 transfer was not reported to the local agency, and the applicant or recipient received
75.5 medical assistance services during what would have been the period of ineligibility if
75.6 the transfer had been reported, a cause of action exists against the transferee for that
75.7 portion of long-term care services provided during the period of ineligibility, or for the
75.8 uncompensated amount of the transfer, whichever is less. The uncompensated transfer
75.9 amount is the fair market value of the asset at the time it was given away, sold, or disposed
75.10 of, less the amount of compensation received. Effective for transfers made on or after
75.11 March 1, 1996, involving persons who apply for medical assistance on or after April 13,
75.12 1996, no cause of action exists for a transfer unless:

75.13 (1) the transferee knew or should have known that the transfer was being made by a
75.14 person who was a resident of a long-term care facility or was receiving that level of care in
75.15 the community at the time of the transfer;

75.16 (2) the transferee knew or should have known that the transfer was being made to
75.17 assist the person to qualify for or retain medical assistance eligibility; or

75.18 (3) the transferee actively solicited the transfer with intent to assist the person to
75.19 qualify for or retain eligibility for medical assistance.

75.20 (c) For uncompensated transfers made on or after February 8, 2006, the period
75.21 of ineligibility:

75.22 (1) for uncompensated transfers by or on behalf of individuals receiving medical
75.23 assistance payment of long-term care services, begins the first day of the month following
75.24 advance notice of the period of ineligibility, but no later than the first day of the month
75.25 that follows three full calendar months from the date of the report or discovery of the
75.26 transfer; or

75.27 (2) for uncompensated transfers by individuals requesting medical assistance
75.28 payment of long-term care services, begins the date on which the individual is eligible
75.29 for medical assistance under the Medicaid state plan and would otherwise be receiving
75.30 long-term care services based on an approved application for such care but for the period
75.31 of ineligibility resulting from the uncompensated transfer; and

75.32 (3) cannot begin during any other period of ineligibility.

75.33 (d) If a calculation of a period of ineligibility results in a partial month, payments for
75.34 long-term care services shall be reduced in an amount equal to the fraction.

75.35 (e) In the case of multiple fractional transfers of assets in more than one month for
75.36 less than fair market value on or after February 8, 2006, the period of ineligibility is

76.1 calculated by treating the total, cumulative, uncompensated value of all assets transferred
76.2 during all months on or after February 8, 2006, as one transfer.
76.3 (f) A period of ineligibility established under paragraph (c) may be eliminated if
76.4 all of the assets transferred for less than fair market value used to calculate the period of
76.5 ineligibility, or cash equal to the value of the assets at the time of the transfer, are returned
76.6 ~~within 12 months after the date the period of ineligibility began~~. A period of ineligibility
76.7 must not be adjusted if less than the full amount of the transferred assets or the full cash
76.8 value of the transferred assets are returned.

76.9 Sec. 7. Minnesota Statutes 2010, section 256B.0625, subdivision 13, is amended to
76.10 read:
76.11 Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs
76.12 when specifically used to enhance fertility, if prescribed by a licensed practitioner and
76.13 dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance
76.14 program as a dispensing physician, or by a physician, physician assistant, or a nurse
76.15 practitioner employed by or under contract with a community health board as defined in
76.16 section 145A.02, subdivision 5, for the purposes of communicable disease control.
76.17 (b) The dispensed quantity of a prescription drug must not exceed a 34-day supply,
76.18 unless authorized by the commissioner.
76.19 (c) For the purpose of this subdivision and subdivision 13d, an "active
76.20 pharmaceutical ingredient" is defined as a substance that is represented for use in a drug
76.21 and when used in the manufacturing, processing, or packaging of a drug, becomes an
76.22 active ingredient of the drug product. An "excipient" is defined as an inert substance
76.23 used as a diluent or vehicle for a drug. The commissioner shall establish a list of active
76.24 pharmaceutical ingredients and excipients which are included in the medical assistance
76.25 formulary. Medical assistance covers selected active pharmaceutical ingredients and
76.26 excipients used in compounded prescriptions when the compounded combination is
76.27 specifically approved by the commissioner or when a commercially available product:
76.28 (1) is not a therapeutic option for the patient;
76.29 (2) does not exist in the same combination of active ingredients in the same strengths
76.30 as the compounded prescription; and
76.31 (3) cannot be used in place of the active pharmaceutical ingredient in the
76.32 compounded prescription.
76.33 ~~(c)~~ (d) Medical assistance covers the following over-the-counter drugs when
76.34 prescribed by a licensed practitioner or by a licensed pharmacist who meets standards
76.35 established by the commissioner, in consultation with the board of pharmacy: antacids,

77.1 acetaminophen, family planning products, aspirin, insulin, products for the treatment of
77.2 lice, vitamins for adults with documented vitamin deficiencies, vitamins for children
77.3 under the age of seven and pregnant or nursing women, and any other over-the-counter
77.4 drug identified by the commissioner, in consultation with the formulary committee, as
77.5 necessary, appropriate, and cost-effective for the treatment of certain specified chronic
77.6 diseases, conditions, or disorders, and this determination shall not be subject to the
77.7 requirements of chapter 14. A pharmacist may prescribe over-the-counter medications as
77.8 provided under this paragraph for purposes of receiving reimbursement under Medicaid.
77.9 When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must
77.10 consult with the recipient to determine necessity, provide drug counseling, review drug
77.11 therapy for potential adverse interactions, and make referrals as needed to other health care
77.12 professionals. Over-the-counter medications must be dispensed in a quantity that is the
77.13 lower of: (1) the number of dosage units contained in the manufacturer's original package;
77.14 and (2) the number of dosage units required to complete the patient's course of therapy.

77.15 ~~(d)~~ (e) Effective January 1, 2006, medical assistance shall not cover drugs that
77.16 are coverable under Medicare Part D as defined in the Medicare Prescription Drug,
77.17 Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e),
77.18 for individuals eligible for drug coverage as defined in the Medicare Prescription
77.19 Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section
77.20 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the
77.21 drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this
77.22 subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code,
77.23 title 42, section 1396r-8(d)(2)(E), shall not be covered.

77.24 Sec. 8. Minnesota Statutes 2010, section 256B.0625, subdivision 13d, is amended to
77.25 read:

77.26 Subd. 13d. **Drug formulary.** (a) The commissioner shall establish a drug
77.27 formulary. Its establishment and publication shall not be subject to the requirements of the
77.28 Administrative Procedure Act, but the Formulary Committee shall review and comment
77.29 on the formulary contents.

77.30 (b) The formulary shall not include:

77.31 (1) drugs, active pharmaceutical ingredients, or products for which there is no
77.32 federal funding;

77.33 (2) over-the-counter drugs, except as provided in subdivision 13;

77.34 (3) drugs or active pharmaceutical ingredients used for weight loss, except that
77.35 medically necessary lipase inhibitors may be covered for a recipient with type II diabetes;

78.1 (4) drugs or active pharmaceutical ingredients when used for the treatment of
78.2 impotence or erectile dysfunction;
78.3 (5) drugs or active pharmaceutical ingredients for which medical value has not
78.4 been established; and
78.5 (6) drugs from manufacturers who have not signed a rebate agreement with the
78.6 Department of Health and Human Services pursuant to section 1927 of title XIX of the
78.7 Social Security Act.
78.8 (c) If a single-source drug used by at least two percent of the fee-for-service
78.9 medical assistance recipients is removed from the formulary due to the failure of the
78.10 manufacturer to sign a rebate agreement with the Department of Health and Human
78.11 Services, the commissioner shall notify prescribing practitioners within 30 days of
78.12 receiving notification from the Centers for Medicare and Medicaid Services (CMS) that a
78.13 rebate agreement was not signed.

78.14 Sec. 9. Minnesota Statutes 2011 Supplement, section 256B.0625, subdivision 13e,
78.15 is amended to read:
78.16 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment
78.17 shall be the lower of the actual acquisition costs of the drugs or the maximum allowable
78.18 cost by the commissioner plus the fixed dispensing fee; or the usual and customary price
78.19 charged to the public. The amount of payment basis must be reduced to reflect all discount
78.20 amounts applied to the charge by any provider/insurer agreement or contract for submitted
78.21 charges to medical assistance programs. The net submitted charge may not be greater
78.22 than the patient liability for the service. The pharmacy dispensing fee shall be $3.65,
78.23 except that the dispensing fee for intravenous solutions which must be compounded by the
78.24 pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30
78.25 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per
78.26 bag for total parenteral nutritional products dispensed in quantities greater than one liter.
78.27 Actual acquisition cost includes quantity and other special discounts except time and cash
78.28 discounts. The actual acquisition cost of a drug shall be estimated by the commissioner at
78.29 wholesale acquisition cost plus four percent for independently owned pharmacies located
78.30 in a designated rural area within Minnesota, and at wholesale acquisition cost plus two
78.31 percent for all other pharmacies. A pharmacy is "independently owned" if it is one
78.32 of four or fewer pharmacies under the same ownership nationally. A "designated rural
78.33 area" means an area defined as a small rural area or isolated rural area according to the
78.34 four-category classification of the Rural Urban Commuting Area system developed for the
78.35 United States Health Resources and Services Administration. Wholesale acquisition cost

79.1 is defined as the manufacturer's list price for a drug or biological to wholesalers or direct
79.2 purchasers in the United States, not including prompt pay or other discounts, rebates, or
79.3 reductions in price, for the most recent month for which information is available, as
79.4 reported in wholesale price guides or other publications of drug or biological pricing data.
79.5 The maximum allowable cost of a multisource drug may be set by the commissioner and it
79.6 shall be comparable to, but no higher than, the maximum amount paid by other third-party
79.7 payors in this state who have maximum allowable cost programs. Establishment of the
79.8 amount of payment for drugs shall not be subject to the requirements of the Administrative
79.9 Procedure Act.

79.10 (b) An additional dispensing fee of $.30 may be added to the dispensing fee paid
79.11 to pharmacists for legend drug prescriptions dispensed to residents of long-term care
79.12 facilities when a unit dose blister card system, approved by the department, is used. Under
79.13 this type of dispensing system, the pharmacist must dispense a 30-day supply of drug.
79.14 The National Drug Code (NDC) from the drug container used to fill the blister card must
79.15 be identified on the claim to the department. The unit dose blister card containing the
79.16 drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700,
79.17 that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider
79.18 will be required to credit the department for the actual acquisition cost of all unused
79.19 drugs that are eligible for reuse. ~~Over-the-counter medications must be dispensed in the~~
79.20 ~~manufacturer's unopened package.~~ The commissioner may permit the drug clozapine to be
79.21 dispensed in a quantity that is less than a 30-day supply.

79.22 (c) Whenever a maximum allowable cost has been set for a multisource drug,
79.23 payment shall be the lower of the usual and customary price charged to the public or the
79.24 maximum allowable cost established by the commissioner unless prior authorization
79.25 for the brand name product has been granted according to the criteria established by
79.26 the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the
79.27 prescriber has indicated "dispense as written" on the prescription in a manner consistent
79.28 with section 151.21, subdivision 2.

79.29 (d) The basis for determining the amount of payment for drugs administered in an
79.30 outpatient setting shall be the lower of the usual and customary cost submitted by the
79.31 provider or 106 percent of the average sales price as determined by the United States
79.32 Department of Health and Human Services pursuant to title XVIII, section 1847a of the
79.33 federal Social Security Act. If average sales price is unavailable, the amount of payment
79.34 must be lower of the usual and customary cost submitted by the provider or the wholesale
79.35 acquisition cost.

80.1 (e) The commissioner may negotiate lower reimbursement rates for specialty
80.2 pharmacy products than the rates specified in paragraph (a). The commissioner may
80.3 require individuals enrolled in the health care programs administered by the department
80.4 to obtain specialty pharmacy products from providers with whom the commissioner has
80.5 negotiated lower reimbursement rates. Specialty pharmacy products are defined as those
80.6 used by a small number of recipients or recipients with complex and chronic diseases
80.7 that require expensive and challenging drug regimens. Examples of these conditions
80.8 include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis
80.9 C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms
80.10 of cancer. Specialty pharmaceutical products include injectable and infusion therapies,
80.11 biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies
80.12 that require complex care. The commissioner shall consult with the formulary committee
80.13 to develop a list of specialty pharmacy products subject to this paragraph. In consulting
80.14 with the formulary committee in developing this list, the commissioner shall take into
80.15 consideration the population served by specialty pharmacy products, the current delivery
80.16 system and standard of care in the state, and access to care issues. The commissioner shall
80.17 have the discretion to adjust the reimbursement rate to prevent access to care issues.
80.18 (f) Home infusion therapy services provided by home infusion therapy pharmacies
80.19 must be paid at rates according to subdivision 8d.

80.20 Sec. 10. Minnesota Statutes 2011 Supplement, section 256B.0625, subdivision 13h,
80.21 is amended to read:
80.22 Subd. 13h. **Medication therapy management services.** (a) Medical assistance
80.23 and general assistance medical care cover medication therapy management services for
80.24 a recipient taking three or more prescriptions to treat or prevent one or more chronic
80.25 medical conditions; a recipient with a drug therapy problem that is identified by the
80.26 commissioner or identified by a pharmacist and approved by the commissioner; or prior
80.27 authorized by the commissioner that has resulted or is likely to result in significant
80.28 nondrug program costs. The commissioner may cover medical therapy management
80.29 services under MinnesotaCare if the commissioner determines this is cost-effective. For
80.30 purposes of this subdivision, "medication therapy management" means the provision
80.31 of the following pharmaceutical care services by a licensed pharmacist to optimize the
80.32 therapeutic outcomes of the patient's medications:
80.33 (1) performing or obtaining necessary assessments of the patient's health status;
80.34 (2) formulating a medication treatment plan;

(3) monitoring and evaluating the patient's response to therapy, including safety and effectiveness;

(4) performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;

(5) documenting the care delivered and communicating essential information to the patient's other primary care providers;

(6) providing verbal education and training designed to enhance patient understanding and appropriate use of the patient's medications;

(7) providing information, support services, and resources designed to enhance patient adherence with the patient's therapeutic regimens; and

(8) coordinating and integrating medication therapy management services within the broader health care management services being provided to the patient.

Nothing in this subdivision shall be construed to expand or modify the scope of practice of the pharmacist as defined in section 151.01, subdivision 27.

(b) To be eligible for reimbursement for services under this subdivision, a pharmacist must meet the following requirements:

(1) have a valid license issued ~~under chapter 151~~ by the Board of Pharmacy of the state in which the medication therapy management service is being performed;

(2) have graduated from an accredited college of pharmacy on or after May 1996, or completed a structured and comprehensive education program approved by the Board of Pharmacy and the American Council of Pharmaceutical Education for the provision and documentation of pharmaceutical care management services that has both clinical and didactic elements;

(3) be practicing in an ambulatory care setting as part of a multidisciplinary team or have developed a structured patient care process that is offered in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting, or in home settings, including long-term care settings, group homes, and facilities providing assisted living services, but excluding skilled nursing facilities; and

(4) make use of an electronic patient record system that meets state standards.

(c) For purposes of reimbursement for medication therapy management services, the commissioner may enroll individual pharmacists as medical assistance and general assistance medical care providers. The commissioner may also establish contact requirements between the pharmacist and recipient, including limiting the number of reimbursable consultations per recipient.

(d) If there are no pharmacists who meet the requirements of paragraph (b) practicing within a reasonable geographic distance of the patient, a pharmacist who meets the

82.1 requirements may provide the services via two-way interactive video. Reimbursement
82.2 shall be at the same rates and under the same conditions that would otherwise apply to
82.3 the services provided. To qualify for reimbursement under this paragraph, the pharmacist
82.4 providing the services must meet the requirements of paragraph (b), and must be located
82.5 within an ambulatory care setting approved by the commissioner. The patient must also
82.6 be located within an ambulatory care setting approved by the commissioner. Services
82.7 provided under this paragraph may not be transmitted into the patient's residence.

82.8 (e) The commissioner shall establish a pilot project for an intensive medication
82.9 therapy management program for patients identified by the commissioner with multiple
82.10 chronic conditions and a high number of medications who are at high risk of preventable
82.11 hospitalizations, emergency room use, medication complications, and suboptimal
82.12 treatment outcomes due to medication-related problems. For purposes of the pilot
82.13 project, medication therapy management services may be provided in a patient's home
82.14 or community setting, in addition to other authorized settings. The commissioner may
82.15 waive existing payment policies and establish special payment rates for the pilot project.
82.16 The pilot project must be designed to produce a net savings to the state compared to the
82.17 estimated costs that would otherwise be incurred for similar patients without the program.
82.18 The pilot project must begin by January 1, 2010, and end June 30, 2012.

82.19 Sec. 11. Minnesota Statutes 2011 Supplement, section 256B.0625, subdivision 14,
82.20 is amended to read:

82.21 Subd. 14. **Diagnostic, screening, and preventive services.** (a) Medical assistance
82.22 covers diagnostic, screening, and preventive services.

82.23 (b) "Preventive services" include services related to pregnancy, including:

82.24 (1) services for those conditions which may complicate a pregnancy and which may
82.25 be available to a pregnant woman determined to be at risk of poor pregnancy outcome;

82.26 (2) prenatal HIV risk assessment, education, counseling, and testing; and

82.27 (3) alcohol abuse assessment, education, and counseling on the effects of alcohol
82.28 usage while pregnant. Preventive services available to a woman at risk of poor pregnancy
82.29 outcome may differ in an amount, duration, or scope from those available to other
82.30 individuals eligible for medical assistance.

82.31 (c) "Screening services" include, but are not limited to, blood lead tests.

82.32 (d) The commissioner shall encourage, at the time of the child and teen checkup or
82.33 at an episodic care visit, the primary care health care provider to perform primary caries
82.34 preventive services. Primary caries preventive services include, at a minimum:

83.1 (1) a general visual examination of the child's mouth without using probes or other
83.2 dental equipment or taking radiographs;
83.3 (2) a risk assessment using the factors established by the American Academies
83.4 of Pediatrics and Pediatric Dentistry; and
83.5 (3) the application of a fluoride varnish beginning at age one to those children
83.6 assessed by the provider as being high risk in accordance with best practices as defined by
83.7 the Department of Human Services. The provider must obtain parental or legal guardian
83.8 consent before a fluoride ~~treatment~~ varnish is applied to a minor child's teeth.

83.9 At each checkup, if primary caries preventive services are provided, the provider must
83.10 provide to the child's parent or legal guardian: information on caries etiology and
83.11 prevention; and information on the importance of finding a dental home for their child
83.12 by the age of one. The provider must also advise the parent or legal guardian to contact
83.13 the child's managed care plan or the Department of Human Services in order to secure a
83.14 dental appointment with a dentist. The provider must indicate in the child's medical record
83.15 that the parent or legal guardian was provided with this information and document any
83.16 primary caries prevention services provided to the child.

83.17 Sec. 12. Minnesota Statutes 2011 Supplement, section 256B.0631, subdivision 1,
83.18 is amended to read:

83.19 Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical
83.20 assistance benefit plan shall include the following cost-sharing for all recipients, effective
83.21 for services provided on or after September 1, 2011:
83.22 (1) $3 per nonpreventive visit, except as provided in paragraph (b). For purposes
83.23 of this subdivision, a visit means an episode of service which is required because of
83.24 a recipient's symptoms, diagnosis, or established illness, and which is delivered in an
83.25 ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse
83.26 midwife, advanced practice nurse, audiologist, optician, or optometrist;
83.27 ~~(2) $3 for eyeglasses;~~
83.28 ~~(3)~~ (2) $3.50 for nonemergency visits to a hospital-based emergency room, except
83.29 that this co-payment shall be increased to $20 upon federal approval;
83.30 ~~(4)~~ (3) $3 per brand-name drug prescription and $1 per generic drug prescription,
83.31 subject to a $12 per month maximum for prescription drug co-payments. No co-payments
83.32 shall apply to antipsychotic drugs when used for the treatment of mental illness;
83.33 ~~(5)~~ (4) effective January 1, 2012, a family deductible equal to the maximum amount
83.34 allowed under Code of Federal Regulations, title 42, part 447.54; and

84.1 ~~(6)~~ (5) for individuals identified by the commissioner with income at or below 100
84.2 percent of the federal poverty guidelines, total monthly cost-sharing must not exceed five
84.3 percent of family income. For purposes of this paragraph, family income is the total
84.4 earned and unearned income of the individual and the individual's spouse, if the spouse is
84.5 enrolled in medical assistance and also subject to the five percent limit on cost-sharing.
84.6 (b) Recipients of medical assistance are responsible for all co-payments and
84.7 deductibles in this subdivision.

84.8 Sec. 13. Minnesota Statutes 2011 Supplement, section 256B.0631, subdivision 2,
84.9 is amended to read:
84.10 Subd. 2. **Exceptions.** Co-payments and deductibles shall be subject to the following
84.11 exceptions:
84.12 (1) children under the age of 21;
84.13 (2) pregnant women for services that relate to the pregnancy or any other medical
84.14 condition that may complicate the pregnancy;
84.15 (3) recipients expected to reside for at least 30 days in a hospital, nursing home, or
84.16 intermediate care facility for the developmentally disabled;
84.17 (4) recipients receiving hospice care;
84.18 (5) 100 percent federally funded services provided by an Indian health service;
84.19 (6) emergency services;
84.20 (7) family planning services;
84.21 (8) services that are paid by Medicare, resulting in the medical assistance program
84.22 paying for the coinsurance and deductible; ~~and~~
84.23 (9) co-payments that exceed one per day per provider for nonpreventive visits,
84.24 eyeglasses, and nonemergency visits to a hospital-based emergency room~~.~~; and
84.25 (10) services, fee-for-service payments subject to volume purchase through
84.26 competitive bidding.

84.27 Sec. 14. Minnesota Statutes 2010, section 256B.19, subdivision 1c, is amended to read:
84.28 Subd. 1c. **Additional portion of nonfederal share.** (a) Hennepin County shall
84.29 be responsible for a monthly transfer payment of $1,500,000, due before noon on the
84.30 15th of each month and the University of Minnesota shall be responsible for a monthly
84.31 transfer payment of $500,000 due before noon on the 15th of each month, beginning July
84.32 15, 1995. These sums shall be part of the designated governmental unit's portion of the
84.33 nonfederal share of medical assistance costs.

85.1 (b) Beginning July 1, 2001, Hennepin County's payment under paragraph (a) shall
85.2 be $2,066,000 each month.

85.3 (c) Beginning July 1, 2001, the commissioner shall increase annual capitation
85.4 payments to ~~the metropolitan health plan~~ a demonstration provider serving eligible
85.5 individuals in Hennepin County under section 256B.69 for the prepaid medical assistance
85.6 program by approximately $6,800,000 to recognize higher than average medical education
85.7 costs.

85.8 (d) Effective August 1, 2005, Hennepin County's payment under paragraphs (a)
85.9 and (b) shall be reduced to $566,000, and the University of Minnesota's payment under
85.10 paragraph (a) shall be reduced to zero. Effective October 1, 2008, to December 31, 2010,
85.11 Hennepin County's payment under paragraphs (a) and (b) shall be $434,688. Effective
85.12 January 1, 2011, Hennepin County's payment under paragraphs (a) and (b) shall be
85.13 $566,000.

85.14 (e) Notwithstanding paragraph (d), upon federal enactment of an extension to June
85.15 30, 2011, of the enhanced federal medical assistance percentage (FMAP) originally
85.16 provided under Public Law 111-5, for the six-month period from January 1, 2011, to June
85.17 30, 2011, Hennepin County's payment under paragraphs (a) and (b) shall be $434,688.

85.18 Sec. 15. Minnesota Statutes 2010, section 256B.69, subdivision 5, is amended to read:

85.19 Subd. 5. **Prospective per capita payment.** The commissioner shall establish the
85.20 method and amount of payments for services. The commissioner shall annually contract
85.21 with demonstration providers to provide services consistent with these established
85.22 methods and amounts for payment.

85.23 If allowed by the commissioner, a demonstration provider may contract with
85.24 an insurer, health care provider, nonprofit health service plan corporation, or the
85.25 commissioner, to provide insurance or similar protection against the cost of care provided
85.26 by the demonstration provider or to provide coverage against the risks incurred by
85.27 demonstration providers under this section. The recipients enrolled with a demonstration
85.28 provider are a permissible group under group insurance laws and chapter 62C, the
85.29 Nonprofit Health Service Plan Corporations Act. Under this type of contract, the insurer
85.30 or corporation may make benefit payments to a demonstration provider for services
85.31 rendered or to be rendered to a recipient. Any insurer or nonprofit health service plan
85.32 corporation licensed to do business in this state is authorized to provide this insurance or
85.33 similar protection.

85.34 Payments to providers participating in the project are exempt from the requirements
85.35 of sections 256.966 and 256B.03, subdivision 2. The commissioner shall complete

86.1 development of capitation rates for payments before delivery of services under this section
86.2 is begun. For payments made during calendar year 1990 and later years, the commissioner
86.3 shall contract with an independent actuary to establish prepayment rates.

86.4 By January 15, 1996, the commissioner shall report to the legislature on the
86.5 methodology used to allocate to participating counties available administrative
86.6 reimbursement for advocacy and enrollment costs. The report shall reflect the
86.7 commissioner's judgment as to the adequacy of the funds made available and of the
86.8 methodology for equitable distribution of the funds. The commissioner must involve
86.9 participating counties in the development of the report.

86.10 Beginning July 1, 2004, the commissioner may include payments for elderly waiver
86.11 services and 180 days of nursing home care in capitation payments for the prepaid medical
86.12 assistance program for recipients age 65 and older. ~~Payments for elderly waiver services~~
86.13 ~~shall be made no earlier than the month following the month in which services were~~
86.14 ~~received.~~

86.15 Sec. 16. Minnesota Statutes 2011 Supplement, section 256B.69, subdivision 5a,
86.16 is amended to read:

86.17 Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section
86.18 and section 256L.12 shall be entered into or renewed on a calendar year basis beginning
86.19 January 1, 1996. Managed care contracts which were in effect on June 30, 1995, and set to
86.20 renew on July 1, 1995, shall be renewed for the period July 1, 1995 through December
86.21 31, 1995 at the same terms that were in effect on June 30, 1995. The commissioner may
86.22 issue separate contracts with requirements specific to services to medical assistance
86.23 recipients age 65 and older.

86.24 (b) A prepaid health plan providing covered health services for eligible persons
86.25 pursuant to chapters 256B and 256L is responsible for complying with the terms of its
86.26 contract with the commissioner. Requirements applicable to managed care programs
86.27 under chapters 256B and 256L established after the effective date of a contract with the
86.28 commissioner take effect when the contract is next issued or renewed.

86.29 (c) Effective for services rendered on or after January 1, 2003, the commissioner
86.30 shall withhold five percent of managed care plan payments under this section and
86.31 county-based purchasing plan payments under section 256B.692 for the prepaid medical
86.32 assistance program pending completion of performance targets. Each performance target
86.33 must be quantifiable, objective, measurable, and reasonably attainable, except in the case
86.34 of a performance target based on a federal or state law or rule. Criteria for assessment
86.35 of each performance target must be outlined in writing prior to the contract effective

87.1 date. The managed care plan must demonstrate, to the commissioner's satisfaction,
87.2 that the data submitted regarding attainment of the performance target is accurate. The
87.3 commissioner shall periodically change the administrative measures used as performance
87.4 targets in order to improve plan performance across a broader range of administrative
87.5 services. The performance targets must include measurement of plan efforts to contain
87.6 spending on health care services and administrative activities. The commissioner may
87.7 adopt plan-specific performance targets that take into account factors affecting only one
87.8 plan, including characteristics of the plan's enrollee population. The withheld funds
87.9 must be returned no sooner than July of the following year if performance targets in the
87.10 contract are achieved. The commissioner may exclude special demonstration projects
87.11 under subdivision 23.

87.12 (d) Effective for services rendered on or after January 1, 2009, through December
87.13 31, 2009, the commissioner shall withhold three percent of managed care plan payments
87.14 under this section and county-based purchasing plan payments under section 256B.692
87.15 for the prepaid medical assistance program. The withheld funds must be returned no
87.16 sooner than July 1 and no later than July 31 of the following year. The commissioner may
87.17 exclude special demonstration projects under subdivision 23.

87.18 (e) Effective for services provided on or after January 1, 2010, the commissioner
87.19 shall require that managed care plans use the assessment and authorization processes,
87.20 forms, timelines, standards, documentation, and data reporting requirements, protocols,
87.21 billing processes, and policies consistent with medical assistance fee-for-service or the
87.22 Department of Human Services contract requirements consistent with medical assistance
87.23 fee-for-service or the Department of Human Services contract requirements for all
87.24 personal care assistance services under section 256B.0659.

87.25 (f) Effective for services rendered on or after January 1, 2010, through December
87.26 31, 2010, the commissioner shall withhold 4.5 percent of managed care plan payments
87.27 under this section and county-based purchasing plan payments under section 256B.692
87.28 for the prepaid medical assistance program. The withheld funds must be returned no
87.29 sooner than July 1 and no later than July 31 of the following year. The commissioner may
87.30 exclude special demonstration projects under subdivision 23.

87.31 (g) Effective for services rendered on or after January 1, 2011, through December
87.32 31, 2011, the commissioner shall include as part of the performance targets described
87.33 in paragraph (c) a reduction in the health plan's emergency room utilization rate for
87.34 state health care program enrollees by a measurable rate of five percent from the plan's
87.35 utilization rate for state health care program enrollees for the previous calendar year.
87.36 Effective for services rendered on or after January 1, 2012, the commissioner shall include

88.1 as part of the performance targets described in paragraph (c) a reduction in the health
88.2 plan's emergency department utilization rate for medical assistance and MinnesotaCare
88.3 enrollees, as determined by the commissioner. To earn the return of the withhold each
88.4 year, the managed care plan or county-based purchasing plan must achieve a qualifying
88.5 reduction of no less than ten percent of the plan's emergency department utilization rate for
88.6 medical assistance and MinnesotaCare enrollees, excluding Medicare enrollees, compared
88.7 to the previous calendar year until the final performance target is reached.

88.8 The withheld funds must be returned no sooner than July 1 and no later than July
88.9 31 of the following calendar year if the managed care plan or county-based purchasing
88.10 plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization
88.11 rate was achieved.

88.12 The withhold described in this paragraph shall continue for each consecutive
88.13 contract period until the plan's emergency room utilization rate for state health care
88.14 program enrollees is reduced by 25 percent of the plan's emergency room utilization
88.15 rate for medical assistance and MinnesotaCare enrollees for calendar year ~~2011~~ 2009.
88.16 Hospitals shall cooperate with the health plans in meeting this performance target and
88.17 shall accept payment withholds that may be returned to the hospitals if the performance
88.18 target is achieved.

88.19 (h) Effective for services rendered on or after January 1, 2012, the commissioner
88.20 shall include as part of the performance targets described in paragraph (c) a reduction
88.21 in the plan's hospitalization admission rate for medical assistance and MinnesotaCare
88.22 enrollees, as determined by the commissioner. To earn the return of the withhold each
88.23 year, the managed care plan or county-based purchasing plan must achieve a qualifying
88.24 reduction of no less than five percent of the plan's hospital admission rate for medical
88.25 assistance and MinnesotaCare enrollees, excluding Medicare enrollees, compared to the
88.26 previous calendar year until the final performance target is reached.

88.27 The withheld funds must be returned no sooner than July 1 and no later than July
88.28 31 of the following calendar year if the managed care plan or county-based purchasing
88.29 plan demonstrates to the satisfaction of the commissioner that this reduction in the
88.30 hospitalization rate was achieved.

88.31 The withhold described in this paragraph shall continue until there is a 25 percent
88.32 reduction in the hospital admission rate compared to the hospital admission rates in
88.33 calendar year 2011, as determined by the commissioner. The hospital admissions in this
88.34 performance target do not include the admissions applicable to the subsequent hospital
88.35 admission performance target under paragraph (i). Hospitals shall cooperate with the

89.1 plans in meeting this performance target and shall accept payment withholds that may be
89.2 returned to the hospitals if the performance target is achieved.

89.3 (i) Effective for services rendered on or after January 1, 2012, the commissioner
89.4 shall include as part of the performance targets described in paragraph (c) a reduction in
89.5 the plan's hospitalization admission rates for subsequent hospitalizations within 30 days
89.6 of a previous hospitalization of a patient regardless of the reason, for medical assistance
89.7 and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of
89.8 the withhold each year, the managed care plan or county-based purchasing plan must
89.9 achieve a qualifying reduction of the subsequent hospitalization rate for medical assistance
89.10 and MinnesotaCare enrollees, excluding Medicare enrollees, of no less than five percent
89.11 compared to the previous calendar year until the final performance target is reached.

89.12 The withheld funds must be returned no sooner than July 1 and no later than July 31
89.13 of the following calendar year if the managed care plan or county-based purchasing plan
89.14 demonstrates to the satisfaction of the commissioner that a qualifying reduction in the
89.15 subsequent hospitalization rate was achieved.

89.16 The withhold described in this paragraph must continue for each consecutive
89.17 contract period until the plan's subsequent hospitalization rate for medical assistance and
89.18 MinnesotaCare enrollees, excluding Medicare enrollees, is reduced by 25 percent of the
89.19 plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate
89.20 with the plans in meeting this performance target and shall accept payment withholds that
89.21 must be returned to the hospitals if the performance target is achieved.

89.22 (j) Effective for services rendered on or after January 1, 2011, through December 31,
89.23 2011, the commissioner shall withhold 4.5 percent of managed care plan payments under
89.24 this section and county-based purchasing plan payments under section 256B.692 for the
89.25 prepaid medical assistance program. The withheld funds must be returned no sooner than
89.26 July 1 and no later than July 31 of the following year. The commissioner may exclude
89.27 special demonstration projects under subdivision 23.

89.28 (k) Effective for services rendered on or after January 1, 2012, through December
89.29 31, 2012, the commissioner shall withhold 4.5 percent of managed care plan payments
89.30 under this section and county-based purchasing plan payments under section 256B.692
89.31 for the prepaid medical assistance program. The withheld funds must be returned no
89.32 sooner than July 1 and no later than July 31 of the following year. The commissioner may
89.33 exclude special demonstration projects under subdivision 23.

89.34 (l) Effective for services rendered on or after January 1, 2013, through December 31,
89.35 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under
89.36 this section and county-based purchasing plan payments under section 256B.692 for the

90.1 prepaid medical assistance program. The withheld funds must be returned no sooner than
90.2 July 1 and no later than July 31 of the following year. The commissioner may exclude
90.3 special demonstration projects under subdivision 23.

90.4 (m) Effective for services rendered on or after January 1, 2014, the commissioner
90.5 shall withhold three percent of managed care plan payments under this section and
90.6 county-based purchasing plan payments under section 256B.692 for the prepaid medical
90.7 assistance program. The withheld funds must be returned no sooner than July 1 and
90.8 no later than July 31 of the following year. The commissioner may exclude special
90.9 demonstration projects under subdivision 23.

90.10 (n) A managed care plan or a county-based purchasing plan under section 256B.692
90.11 may include as admitted assets under section 62D.044 any amount withheld under this
90.12 section that is reasonably expected to be returned.

90.13 (o) Contracts between the commissioner and a prepaid health plan are exempt from
90.14 the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph
90.15 (a), and 7.

90.16 (p) The return of the withhold under paragraphs (d), (f), and (j) to (m) is not subject
90.17 to the requirements of paragraph (c).

90.18 Sec. 17. Minnesota Statutes 2011 Supplement, section 256B.69, subdivision 28,
90.19 is amended to read:

90.20 Subd. 28. **Medicare special needs plans; medical assistance basic health**
90.21 **care.** (a) The commissioner may contract with demonstration providers and current or
90.22 former sponsors of qualified Medicare-approved special needs plans, to provide medical
90.23 assistance basic health care services to persons with disabilities, including those with
90.24 developmental disabilities. Basic health care services include:

90.25 (1) those services covered by the medical assistance state plan except for ICF/MR
90.26 services, home and community-based waiver services, case management for persons with
90.27 developmental disabilities under section 256B.0625, subdivision 20a, and personal care
90.28 and certain home care services defined by the commissioner in consultation with the
90.29 stakeholder group established under paragraph (d); and

90.30 (2) basic health care services may also include risk for up to 100 days of nursing
90.31 facility services for persons who reside in a noninstitutional setting and home health
90.32 services related to rehabilitation as defined by the commissioner after consultation with
90.33 the stakeholder group.

91.1 The commissioner may exclude other medical assistance services from the basic
91.2 health care benefit set. Enrollees in these plans can access any excluded services on the
91.3 same basis as other medical assistance recipients who have not enrolled.

91.4 (b) Beginning January 1, 2007, the commissioner may contract with demonstration
91.5 providers and sponsors of qualified Medicare special needs plans, to provide basic
91.6 health care services under medical assistance to persons who are dually eligible for both
91.7 Medicare and Medicaid and those Social Security beneficiaries eligible for Medicaid but
91.8 in the waiting period for Medicare. The commissioner shall consult with the stakeholder
91.9 group under paragraph (d) in developing program specifications for these services.
91.10 The commissioner shall report to the chairs of the house of representatives and senate
91.11 committees with jurisdiction over health and human services policy and finance by
91.12 February 1, 2007, on implementation of these programs and the need for increased funding
91.13 for the ombudsman for managed care and other consumer assistance and protections
91.14 needed due to enrollment in managed care of persons with disabilities. Payment for
91.15 Medicaid services provided under this subdivision for the months of May and June will
91.16 be made no earlier than July 1 of the same calendar year.

91.17 (c) Notwithstanding subdivision 4, beginning January 1, 2012, the commissioner
91.18 shall enroll persons with disabilities in managed care under this section, unless the
91.19 individual chooses to opt out of enrollment. The commissioner shall establish enrollment
91.20 and opt out procedures consistent with applicable enrollment procedures under this
91.21 subdivision.

91.22 (d) The commissioner shall establish a state-level stakeholder group to provide
91.23 advice on managed care programs for persons with disabilities, including both MnDHO
91.24 and contracts with special needs plans that provide basic health care services as described
91.25 in paragraphs (a) and (b). The stakeholder group shall provide advice on program
91.26 expansions under this subdivision and subdivision 23, including:

91.27 (1) implementation efforts;

91.28 (2) consumer protections; and

91.29 (3) program specifications such as quality assurance measures, data collection and
91.30 reporting, and evaluation of costs, quality, and results.

91.31 (e) Each plan under contract to provide medical assistance basic health care services
91.32 shall establish a local or regional stakeholder group, including representatives of the
91.33 counties covered by the plan, members, consumer advocates, and providers, for advice on
91.34 issues that arise in the local or regional area.

91.35 (f) The commissioner is prohibited from providing the names of potential enrollees
91.36 to health plans for marketing purposes. The commissioner shall mail no more than

two sets of marketing materials per contract year to potential enrollees on behalf of health plans, at the health plan's request. The marketing materials shall be mailed by the commissioner within 30 days of receipt of these materials from the health plan. The health plans shall cover any costs incurred by the commissioner for mailing marketing materials.

Sec. 18. Minnesota Statutes 2010, section 256L.05, subdivision 3, is amended to read:

Subd. 3. **Effective date of coverage.** (a) The effective date of coverage is the first day of the month following the month in which eligibility is approved and the first premium payment has been received. As provided in section 256B.057, coverage for newborns is automatic from the date of birth and must be coordinated with other health coverage. The effective date of coverage for eligible newly adoptive children added to a family receiving covered health services is the month of placement. The effective date of coverage for other new members added to the family is the first day of the month following the month in which the change is reported. All eligibility criteria must be met by the family at the time the new family member is added. The income of the new family member is included with the family's gross income and the adjusted premium begins in the month the new family member is added.

(b) The initial premium must be received by the last working day of the month for coverage to begin the first day of the following month.

(c) Benefits are not available until the day following discharge if an enrollee is hospitalized on the first day of coverage.

(d) Notwithstanding any other law to the contrary, benefits under sections 256L.01 to 256L.18 are secondary to a plan of insurance or benefit program under which an eligible person may have coverage and the commissioner shall use cost avoidance techniques to ensure coordination of any other health coverage for eligible persons. The commissioner shall identify eligible persons who may have coverage or benefits under other plans of insurance or who become eligible for medical assistance.

(e) The effective date of coverage for individuals or families who are exempt from paying premiums under section 256L.15, subdivision 1, paragraph (d), is the first day of the month following the month in which verification of American Indian status is received or eligibility is approved, whichever is later.

Sec. 19. Minnesota Statutes 2011 Supplement, section 256L.15, subdivision 1, is amended to read:

Subdivision 1. **Premium determination.** (a) Families with children and individuals shall pay a premium determined according to subdivision 2.

93.1 (b) Pregnant women and children under age two are exempt from the provisions
93.2 of section 256L.06, subdivision 3, paragraph (b), clause (3), requiring disenrollment
93.3 for failure to pay premiums. For pregnant women, this exemption continues until the
93.4 first day of the month following the 60th day postpartum. Women who remain enrolled
93.5 during pregnancy or the postpartum period, despite nonpayment of premiums, shall be
93.6 disenrolled on the first of the month following the 60th day postpartum for the penalty
93.7 period that otherwise applies under section 256L.06, unless they begin paying premiums.

93.8 (c) Members of the military and their families who meet the eligibility criteria
93.9 for MinnesotaCare upon eligibility approval made within 24 months following the end
93.10 of the member's tour of active duty shall have their premiums paid by the commissioner.
93.11 The effective date of coverage for an individual or family who meets the criteria of this
93.12 paragraph shall be the first day of the month following the month in which eligibility is
93.13 approved. This exemption applies for 12 months.

93.14 (d) Beginning July 1, 2009, American Indians enrolled in MinnesotaCare and their
93.15 families shall have their premiums waived by the commissioner in accordance with
93.16 section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5.
93.17 An individual must document status as an American Indian, as defined under Code of
93.18 Federal Regulations, title 42, section 447.50, to qualify for the waiver of premiums.

93.19 **EFFECTIVE DATE.** This section is effective retroactively from July 1, 2009.

93.20 Sec. 20. Minnesota Statutes 2010, section 514.982, subdivision 1, is amended to read:

93.21 Subdivision 1. **Contents.** A medical assistance lien notice must be dated and
93.22 must contain:

93.23 (1) the full name, last known address, and last four digits of the Social Security
93.24 number of the medical assistance recipient;

93.25 (2) a statement that medical assistance payments have been made to or for the
93.26 benefit of the medical assistance recipient named in the notice, specifying the first date
93.27 of eligibility for benefits;

93.28 (3) a statement that all interests in real property owned by the persons named in the
93.29 notice may be subject to or affected by the rights of the agency to be reimbursed for
93.30 medical assistance benefits; and

93.31 (4) the legal description of the real property upon which the lien attaches, and
93.32 whether the property is registered property.

93.33 Sec. 21. **HEALTH SERVICES ADVISORY COUNCIL.**

94.1 The Health Services Advisory Council shall review currently available literature
94.2 regarding the efficacy of various treatments for autism spectrum disorder, including
94.3 an evaluation of age-based variation in the appropriateness of existing medical and
94.4 behavioral interventions. The council shall recommend to the commissioner of human
94.5 services authorization criteria for services based on existing evidence. The council may
94.6 recommend coverage with ongoing collection of outcomes evidence in circumstances
94.7 where evidence is currently unavailable, or where the strength of the evidence is low. The
94.8 council shall make this recommendation by December 31, 2012.

94.9 Sec. 22. **REPEALER.**

94.10 Minnesota Statutes 2010, section 256.01, subdivision 18b, is repealed.

APPENDIX
Article locations in 12-3993

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ARTICLE 3	COMPREHENSIVE ASSESSMENT AND CASE MANAGEMENT REFORM	Page.Ln 24.23
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