State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-SEVENTH SESSION

H. F. No. 1994

01/30/2012 Authored by Gottwalt
The bill was read for the first time and referred to the Committee on Health and Human Services Reform
03/08/2012 Adoption of Report: Pass as Amended and re-referred to the Committee on Civil Law
03/13/2012 Adoption of Report: Pass as Amended and Read Second Time

A bill for an act

relating to state government; making changes to health and human services policy provisions; modifying provisions related to continuing care, the telephone equipment program, chemical and mental health, and health care; reforming comprehensive assessment and case management services; making technical changes; requiring reports; amending Minnesota Statutes 2010, sections 144A.071, subdivision 5a; 237.50; 237.51; 237.52; 237.53; 237.54; 237.55; 237.56; 245.461, by adding a subdivision; 245.462, subdivision 20; 245.487, by adding a subdivision; 245.4871, subdivision 15; 245.4932, subdivision 1; 245A.11, subdivisions 2a, 8; 246.53, by adding a subdivision; 252.32, subdivision 1a; 252A.21, subdivision 2; 256.476, subdivision 11; 256.9657, subdivision 1; 256B.04, subdivision 14; 256B.056, subdivision 3c; 256B.0595, subdivision 2; 256B.0625, subdivisions 13, 13d, 19c, 42; 256B.0659, subdivisions 1, 2, 3, 3a, 4, 9, 13, 14, 19, 21, 30; 256B.0911, subdivisions 1, 2b, 2c, 3, 3b, 4c, 6; 256B.0913, subdivisions 7, 8; 256B.0915, subdivisions 1a, 1b, 3c, 6; 256B.0916, subdivision 7; 256B.092, subdivisions 1, 1a, 1b, 1e, 1g, 2, 3, 5, 7, 8, 8a, 9, 11; 256B.096, subdivision 5; 256B.15, subdivisions 1c, 1f; 256B.19, subdivision 1c; 256B.441, subdivisions 13, 31, 53; 256B.49, subdivisions 13, 21; 256B.69, subdivision 5; 256F.13, subdivision 1; 256G.02, subdivision 6; 256L.05, subdivision 3; 514.982, subdivision 1; Minnesota Statutes 2011 Supplement, sections 125A.21, subdivision 7; 144A.071, subdivisions 3, 4a; 245A.03, subdivision 7; 254B.04, subdivision 2a; 256B.056, subdivision 3; 256B.057, subdivision 9; 256B.0625, subdivisions 13e, 13h, 14, 56; 256B.0631, subdivisions 1, 2; 256B.0659, subdivision 11; 256B.0911, subdivisions 1a, 3a, 4a; 256B.0915, subdivision 10; 256B.49, subdivisions 14, 15; 256B.69, subdivisions 5a, 28; 256L.12, subdivision 9; 256L.15, subdivision 1; 626.557, subdivision 9; Laws 2009, chapter 79, article 8, section 81, as amended; proposing coding for new law in Minnesota Statutes, chapter 252; repealing Minnesota Statutes 2010, sections 256.01, subdivision 18b; 256B.431, subdivisions 2c, 2g, 2i, 2j, 2k, 2l, 2o, 3c, 11, 14, 17b, 17f, 19, 20, 25, 27, 29; 256B.434, subdivisions 4a, 4b, 4c, 4d, 4e, 4g, 4h, 7, 8; 256B.435; 256B.436; Minnesota Statutes 2011 Supplement, section 256B.431, subdivision 26; Minnesota Rules, part 9555.7700.

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

ARTICLE 1

CONTINUING CARE

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

Subd. 3. **Exceptions authorizing increase in beds; hardship areas.** (a) The commissioner of health, in coordination with the commissioner of human services, may approve the addition of new licensed and Medicare and Medicaid certified nursing home beds, using the criteria and process set forth in this subdivision.

(b) The commissioner, in cooperation with the commissioner of human services, shall consider the following criteria when determining that an area of the state is a hardship area with regard to access to nursing facility services:

(1) a low number of beds per thousand in a specified area using as a standard the beds per thousand people age 65 and older, in five year age groups, using data from the most recent census and population projections, weighted by each group's most recent nursing home utilization, of the county at the 20th percentile, as determined by the commissioner of human services;

(2) a high level of out-migration for nursing facility services associated with a described area from the county or counties of residence to other Minnesota counties, as determined by the commissioner of human services, using as a standard an amount greater than the out-migration of the county ranked at the 50th percentile;

(3) an adequate level of availability of noninstitutional long-term care services measured as public spending for home and community-based long-term care services per individual age 65 and older, in five year age groups, using data from the most recent census and population projections, weighted by each group's most recent nursing home utilization, as determined by the commissioner of human services using as a standard an amount greater than the 50th percentile of counties;

(4) there must be a declaration of hardship resulting from insufficient access to nursing home beds by local county agencies and area agencies on aging; and

(5) other factors that may demonstrate the need to add new nursing facility beds.

(c) On August 15 of odd-numbered years, the commissioner, in cooperation with the commissioner of human services, may publish in the State Register a request for information in which interested parties, using the data provided under section 144A.351, along with any other relevant data, demonstrate that a specified area is a hardship area with regard to access to nursing facility services. For a response to be considered, the commissioner must receive it by November 15. The commissioner shall make responses

to the request for information available to the public and shall allow 30 days for comment. The commissioner shall review responses and comments and determine if any areas of the state are to be declared hardship areas.

(d) For each designated hardship area determined in paragraph (c), the commissioner shall publish a request for proposals in accordance with section 144A.073 and Minnesota Rules, parts 4655.1070 to 4655.1098. The request for proposals must be published in the State Register by March 15 following receipt of responses to the request for information. The request for proposals must specify the number of new beds which may be added in the designated hardship area, which must not exceed the number which, if added to the existing number of beds in the area, including beds in layaway status, would have prevented it from being determined to be a hardship area under paragraph (b), clause (1). Beginning July 1, 2011, the number of new beds approved must not exceed 200 beds statewide per biennium. After June 30, 2019, the number of new beds that may be approved in a biennium must not exceed 300 statewide. For a proposal to be considered, the commissioner must receive it within six months of the publication of the request for proposals. The commissioner shall review responses to the request for proposals and shall approve or disapprove each proposal by the following July 15, in accordance with section 144A.073 and Minnesota Rules, parts 4655.1070 to 4655.1098. The commissioner shall base approvals or disapprovals on a comparison and ranking of proposals using only the criteria in subdivision 4a. Approval of a proposal expires after 18 months unless the facility has added the new beds using existing space, subject to approval by the commissioner, or has commenced construction as defined in section 144A.071, subdivision 1a, paragraph (d). ~~Operating~~ If, after the approved beds have been added, fewer than 50 percent of the beds in a facility are newly licensed, the operating payment rates previously in effect shall remain. If, after the approved beds have been added, 50 percent or more of the beds in a facility are newly licensed, operating payment rates shall be determined according to Minnesota Rules, part 9549.0057, using the limits under section 256B.441. External fixed payment rates must be determined according to section 256B.441, subdivision 53. Property payment rates for facilities with beds added under this subdivision must be determined in the same manner as rate determinations resulting from projects approved and completed under section 144A.073.

(e) The commissioner may:

(1) certify or license new beds in a new facility that is to be operated by the commissioner of veterans affairs or when the costs of constructing and operating the new beds are to be reimbursed by the commissioner of veterans affairs or the United States Veterans Administration; and

(2) license or certify beds in a facility that has been involuntarily delicensed or decertified for participation in the medical assistance program, provided that an application for relicensure or recertification is submitted to the commissioner by an organization that is not a related organization as defined in section 256B.441, subdivision 34, to the prior licensee within 120 days after delicensure or decertification.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) to certify, after September 30, 1992, and prior to July 1, 1993, existing nursing home beds in a facility that was licensed and in operation prior to January 1, 1992;

(j) to license and certify new nursing home beds to replace beds in a facility acquired by the Minneapolis Community Development Agency as part of redevelopment activities in a city of the first class, provided the new facility is located within three miles of the site of the old facility. Operating and property costs for the new facility must be determined and allowed under section 256B.431 or 256B.434;

(k) to license and certify up to 20 new nursing home beds in a community-operated hospital and attached convalescent and nursing care facility with 40 beds on April 21, 1991, that suspended operation of the hospital in April 1986. The commissioner of human services shall provide the facility with the same per diem property-related payment rate for each additional licensed and certified bed as it will receive for its existing 40 beds;

(l) to license or certify beds in renovation, replacement, or upgrading projects as defined in section 144A.073, subdivision 1, so long as the cumulative total costs of the facility's remodeling projects do not exceed $1,000,000;

(m) to license and certify beds that are moved from one location to another for the purposes of converting up to five four-bed wards to single or double occupancy rooms in a nursing home that, as of January 1, 1993, was county-owned and had a licensed capacity of 115 beds;

(n) to allow a facility that on April 16, 1993, was a 106-bed licensed and certified nursing facility located in Minneapolis to layaway all of its licensed and certified nursing home beds. These beds may be relicensed and recertified in a newly constructed teaching nursing home facility affiliated with a teaching hospital upon approval by the legislature. The proposal must be developed in consultation with the interagency committee on long-term care planning. The beds on layaway status shall have the same status as voluntarily delicensed and decertified beds, except that beds on layaway status remain subject to the surcharge in section 256.9657. This layaway provision expires July 1, 1998;

(o) to allow a project which will be completed in conjunction with an approved moratorium exception project for a nursing home in southern Cass County and which is directly related to that portion of the facility that must be repaired, renovated, or replaced,

to correct an emergency plumbing problem for which a state correction order has been issued and which must be corrected by August 31, 1993;

(p) to allow a facility that on April 16, 1993, was a 368-bed licensed and certified nursing facility located in Minneapolis to layaway, upon 30 days prior written notice to the commissioner, up to 30 of the facility's licensed and certified beds by converting three-bed wards to single or double occupancy. Beds on layaway status shall have the same status as voluntarily delicensed and decertified beds except that beds on layaway status remain subject to the surcharge in section 256.9657, remain subject to the license application and renewal fees under section 144A.07 and shall be subject to a $100 per bed reactivation fee. In addition, at any time within three years of the effective date of the layaway, the beds on layaway status may be:

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

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

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

(q) to license and certify beds in a renovation and remodeling project to convert 12 four-bed wards into 24 two-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey County; had a licensed capacity of 154 beds; and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel.

The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process;

(r) to license and certify up to 117 beds that are relocated from a licensed and certified 138-bed nursing facility located in St. Paul to a hospital with 130 licensed hospital beds located in South St. Paul, provided that the nursing facility and hospital are owned by the same or a related organization and that prior to the date the relocation is completed the hospital ceases operation of its inpatient hospital services at that hospital. After relocation, the nursing facility's status ~~under section 256B.431, subdivision 2j,~~ shall be the same as it was prior to relocation. The nursing facility's property-related payment rate resulting from the project authorized in this paragraph shall become effective no earlier than April 1, 1996. For purposes of calculating the incremental change in the facility's rental per diem resulting from this project, the allowable appraised value of the nursing facility portion of the existing health care facility physical plant prior to the renovation and relocation may not exceed $2,490,000;

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

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

The property-related payment rate of the facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related payment rate for the facility relicensing and recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per diem using the number of beds after the relicensing to establish

the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than five years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified;

(u) to license and certify beds that are moved within an existing area of a facility or to a newly constructed addition which is built for the purpose of eliminating three- and four-bed rooms and adding space for dining, lounge areas, bathing rooms, and ancillary service areas in a nursing home that, as of January 1, 1995, was located in Fridley and had a licensed capacity of 129 beds;

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

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

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

(y) to license and certify beds in a renovation and remodeling project to convert 13 three-bed wards into 13 two-bed rooms and 13 single-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey County, was not owned by a hospital corporation, had a licensed capacity of 64 beds, and had been ranked among the top 15

applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process;

(z) to license and certify up to 150 nursing home beds to replace an existing 285 bed nursing facility located in St. Paul. The replacement project shall include both the renovation of existing buildings and the construction of new facilities at the existing site. The reduction in the licensed capacity of the existing facility shall occur during the construction project as beds are taken out of service due to the construction process. Prior to the start of the construction process, the facility shall provide written information to the commissioner of health describing the process for bed reduction, plans for the relocation of residents, and the estimated construction schedule. The relocation of residents shall be in accordance with the provisions of law and rule;

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

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

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

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

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

(ff) to license and certify a total replacement project of up to 124 beds located in Wilkin County that are in need of relocation from a nursing home significantly damaged by flood. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, part 9549.0057, and the reimbursement provisions of section 256B.431~~, except that section 256B.431, subdivision 26, paragraphs (a) and (b), shall not apply until the second rate year after the settle-up cost report is filed~~. Property-related reimbursement rates shall be determined under section 256B.431, taking into account any federal or state flood-related loans or grants provided to the facility;

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

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

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

Sec. 3. Minnesota Statutes 2011 Supplement, section 245A.03, subdivision 7, is amended to read:

Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter for a physical location that will not be the primary residence of the license holder for the entire period of licensure. If a license is issued during this moratorium, and the license holder changes the license holder's primary residence away from the physical location of the foster care license, the commissioner shall revoke the license according to section 245A.07. Exceptions to the moratorium include:

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

(2) foster care licenses replacing foster care licenses in existence on May 15, 2009, and determined to be needed by the commissioner under paragraph (b);

(3) new foster care licenses determined to be needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/MR, or regional treatment center, or restructuring of state-operated services that limits the capacity of state-operated facilities;

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

(5) new foster care licenses determined to be needed by the commissioner for the transition of people from personal care assistance to the home and community-based services.

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

~~(c) Residential settings that would otherwise be subject to the moratorium established in paragraph (a), that are in the process of receiving an adult or child foster care license as of July 1, 2009, shall be allowed to continue to complete the process of receiving an adult or child foster care license. For this paragraph, all of the following conditions must be met to be considered in the process of receiving an adult or child foster care license:~~

~~(1) participants have made decisions to move into the residential setting, including documentation in each participant's care plan;~~

~~(2) the provider has purchased housing or has made a financial investment in the property;~~

~~(3) the lead agency has approved the plans, including costs for the residential setting for each individual;~~

~~(4) the completion of the licensing process, including all necessary inspections, is the only remaining component prior to being able to provide services; and~~

~~(5) the needs of the individuals cannot be met within the existing capacity in that county.~~

~~To qualify for the process under this paragraph, the lead agency must submit documentation to the commissioner by August 1, 2009, that all of the above criteria are met.~~

~~(d)~~ (c) The commissioner shall study the effects of the license moratorium under this subdivision and shall report back to the legislature by January 15, 2011. This study shall include, but is not limited to the following:

(1) the overall capacity and utilization of foster care beds where the physical location is not the primary residence of the license holder prior to and after implementation of the moratorium;

(2) the overall capacity and utilization of foster care beds where the physical location is the primary residence of the license holder prior to and after implementation of the moratorium; and

(3) the number of licensed and occupied ICF/MR beds prior to and after implementation of the moratorium.

~~(c)~~ (d) When a foster care recipient moves out of a foster home that is not the primary residence of the license holder according to section 256B.49, subdivision 15, paragraph (f), the county shall immediately inform the Department of Human Services Licensing Division, and the department shall immediately decrease the licensed capacity for the home. A decreased licensed capacity according to this paragraph is not subject to appeal under this chapter.

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

(f) License holders of foster care homes identified under paragraph (e) that are not the primary residence of the license holder and that also provide services in the foster care

home that are covered by a federally approved home and community-based services waiver, as authorized under section 256B.0915, 256B.092, or 256B.49 must inform the human services licensing division that the license holder provides or intends to provide these waiver-funded services. These license holders must be considered registered under section 256B.092, subdivision 11, paragraph (c), and this registration status must be identified on their license certificates.

Sec. 4. Minnesota Statutes 2010, section 245A.11, subdivision 2a, is amended to read:

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

(b) An adult foster care license holder may have a maximum license capacity of five if all persons in care are age 55 or over and do not have a serious and persistent mental illness or a developmental disability.

(c) The commissioner may grant variances to paragraph (b) to allow a foster care provider with a licensed capacity of five persons to admit an individual under the age of 55 if the variance complies with section 245A.04, subdivision 9, and approval of the variance is recommended by the county in which the licensed foster care provider is located.

(d) The commissioner may grant variances to paragraph (b) to allow the use of a fifth bed for emergency crisis services for a person with serious and persistent mental illness or a developmental disability, regardless of age, if the variance complies with section 245A.04, subdivision 9, and approval of the variance is recommended by the county in which the licensed foster care provider is located.

(e) If the 2009 legislature adopts a rate reduction that impacts providers of adult foster care services, the commissioner may issue an adult foster care license with a capacity of five adults if the fifth bed does not increase the overall statewide capacity of licensed adult foster care beds in homes that are not the primary residence of the license holder, over the licensed capacity in such homes on July 1, 2009, as identified in a plan submitted to the commissioner by the county, when the capacity is recommended by the county licensing agency of the county in which the facility is located and if the recommendation verifies that:

(1) the facility meets the physical environment requirements in the adult foster care licensing rule;

(2) the five-bed living arrangement is specified for each resident in the resident's:

(i) individualized plan of care;

(ii) individual service plan under section 256B.092, subdivision 1b, if required; or

(iii) individual resident placement agreement under Minnesota Rules, part 9555.5105, subpart 19, if required;

(3) the license holder obtains written and signed informed consent from each resident or resident's legal representative documenting the resident's informed choice to living in the home and that the resident's refusal to consent would not have resulted in service termination; and

(4) the facility was licensed for adult foster care before March 1, 2009.

(f) The commissioner shall not issue a new adult foster care license under paragraph (e) after June 30, ~~2011~~ 2014. The commissioner shall allow a facility with an adult foster care license issued under paragraph (e) before June 30, ~~2011~~ 2014, to continue with a capacity of five adults if the license holder continues to comply with the requirements in paragraph (e).

Sec. 5. Minnesota Statutes 2010, section 245A.11, subdivision 8, is amended to read:

Subd. 8. **Community residential setting license.** (a) The commissioner shall establish provider standards for residential support services that integrate service standards and the residential setting under one license. The commissioner shall propose statutory language and an implementation plan for licensing requirements for residential support services to the legislature by January 15, ~~2011~~ 2012, as a component of the quality outcome standards recommendations required by Laws 2010, chapter 352, article 1, section 24.

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

Sec. 6. Minnesota Statutes 2010, section 252.32, subdivision 1a, is amended to read:

Subd. 1a. **Support grants.** (a) Provision of support grants must be limited to families who require support and whose dependents are under the age of 21 and who have been certified disabled under section 256B.055, subdivision 12, paragraphs (a), (b), (c), (d), and (e). Families who are receiving: home and community-based waivered services for persons with ~~developmental~~ disabilities authorized under section 256B.092 or 256B.49; personal care assistance under section 256B.0652; or a consumer support grant under section 256.476 are not eligible for support grants.

Families whose annual adjusted gross income is $60,000 or more are not eligible for support grants except in cases where extreme hardship is demonstrated. Beginning in state fiscal year 1994, the commissioner shall adjust the income ceiling annually to reflect the projected change in the average value in the United States Department of Labor Bureau of Labor Statistics Consumer Price Index (all urban) for that year.

(b) Support grants may be made available as monthly subsidy grants and lump-sum grants.

(c) Support grants may be issued in the form of cash, voucher, and direct county payment to a vendor.

(d) Applications for the support grant shall be made by the legal guardian to the county social service agency. The application shall specify the needs of the families, the form of the grant requested by the families, and the items and services to be reimbursed.

Sec. 7. **[252.34] REPORT BY COMMISSIONER OF HUMAN SERVICES.**

Beginning January 1, 2013, the commissioner of human services shall provide a biennial report to the chairs of the legislative committees with jurisdiction over health and human services policy and funding. The report must provide a summary of overarching goals and priorities for persons with disabilities, including the status of how each of the following programs administered by the commissioner is supporting the overarching goals and priorities:

(1) home and community-based services waivers for persons with disabilities under sections 256B.092 and 256B.49;

(2) home care services under section 256B.0652; and

(3) other relevant programs and services as determined by the commissioner.

Sec. 8. Minnesota Statutes 2010, section 252A.21, subdivision 2, is amended to read:

Subd. 2. **Rules.** The commissioner shall adopt rules to implement this chapter. The rules must include standards for performance of guardianship or conservatorship duties including, but not limited to: twice a year visits with the ward; ~~quarterly reviews of records from day, residential, and support services;~~ a requirement that the duties of guardianship or conservatorship and case management not be performed by the same person; specific standards for action on "do not resuscitate" orders, sterilization requests, and the use of psychotropic medication and aversive procedures.

Sec. 9. Minnesota Statutes 2010, section 256.476, subdivision 11, is amended to read:

Subd. 11. **Consumer support grant program after July 1, 2001.** Effective July 1, 2001, the commissioner shall allocate consumer support grant resources to serve additional individuals based on a review of Medicaid authorization and payment information of persons eligible for a consumer support grant from the most recent fiscal year. The commissioner shall use the following methodology to calculate maximum allowable monthly consumer support grant levels:

(1) For individuals whose program of origination is medical assistance home care under sections 256B.0651 and 256B.0653 to 256B.0656, the maximum allowable monthly grant levels are calculated by:

(i) determining ~~50 percent of the average~~ the service authorization for each individual based on the individual's home care ~~rating~~ assessment;

(ii) calculating the overall ratio of actual payments to service authorizations by program;

(iii) applying the overall ratio to ~~the average~~ 50 percent of the service authorization level of each home care rating; and

(iv) adjusting the result for any authorized rate ~~increases~~ changes provided by the legislature~~; and~~.

~~(v) adjusting the result for the average monthly utilization per recipient.~~

(2) The commissioner ~~may review and evaluate~~ shall ensure the methodology ~~to reflect changes in~~ is consistent with the home care programs.

Sec. 10. Minnesota Statutes 2010, section 256.9657, subdivision 1, is amended to read:

Subdivision 1. **Nursing home license surcharge.** (a) Effective July 1, 1993, each non-state-operated nursing home licensed under chapter 144A shall pay to the commissioner an annual surcharge according to the schedule in subdivision 4. The surcharge shall be calculated as $620 per licensed bed. If the number of licensed beds is reduced, the surcharge shall be based on the number of remaining licensed beds the second month following the receipt of timely notice by the commissioner of human services that beds have been delicensed. The nursing home must notify the commissioner of health in writing when beds are delicensed. The commissioner of health must notify the commissioner of human services within ten working days after receiving written notification. If the notification is received by the commissioner of human services by the 15th of the month, the invoice for the second following month must be reduced to recognize the delicensing of beds. Beds on layaway status continue to be subject to the surcharge. The commissioner of human services must acknowledge a medical care surcharge appeal within 30 days of receipt of the written appeal from the provider.

(b) Effective July 1, 1994, the surcharge in paragraph (a) shall be increased to $625.

(c) Effective August 15, 2002, the surcharge under paragraph (b) shall be increased to $990.

(d) Effective July 15, 2003, the surcharge under paragraph (c) shall be increased to $2,815.

(e) The commissioner may reduce, and may subsequently restore, the surcharge under paragraph (d) based on the commissioner's determination of a permissible surcharge.

(f) Between April 1, 2002, and August 15, 2004, a facility governed by this subdivision may elect to assume full participation in the medical assistance program by agreeing to comply with all of the requirements of the medical assistance program, including the rate equalization law in section 256B.48, subdivision 1, paragraph (a), and all other requirements established in law or rule, and to begin intake of new medical assistance recipients. Rates will be determined under Minnesota Rules, parts 9549.0010 to 9549.0080. ~~Notwithstanding section 256B.431, subdivision 27, paragraph (i),~~ Rate calculations will be subject to limits as prescribed in rule and law. Other than the adjustments in sections 256B.431, subdivisions 30 and 32; 256B.437, subdivision 3, paragraph (b), Minnesota Rules, part 9549.0057, and any other applicable legislation enacted prior to the finalization of rates, facilities assuming full participation in medical assistance under this paragraph are not eligible for any rate adjustments until the July 1 following their settle-up period.

Sec. 11. Minnesota Statutes 2010, section 256B.0625, subdivision 19c, is amended to read:

Subd. 19c. **Personal care.** Medical assistance covers personal care assistance services provided by an individual who is qualified to provide the services according to subdivision 19a and sections 256B.0651 to 256B.0656, provided in accordance with a plan, and supervised by a qualified professional.

"Qualified professional" means a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6); or a registered nurse as defined in sections 148.171 to 148.285, a licensed social worker as defined in sections 148D.010 and 148D.055, or a qualified developmental disabilities specialist under section 245B.07, subdivision 4. The qualified professional shall perform the duties required in section 256B.0659.

Sec. 12. 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 physical aggression towards self, others, or destruction of property that requires the immediate response of another person.

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

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

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

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

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

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

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

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

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

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

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

(m) "Personal care assistant" or "PCA" means an individual employed by a personal care assistance agency who provides personal care assistance services.

(n) "Personal care assistance care plan" means a written description of personal care assistance services developed by the personal care assistance provider according to the service plan.

(o) "Responsible party" means an individual who is capable of providing the support necessary to assist the recipient to live in the community.

(p) "Self-administered medication" means medication taken orally, by injection or insertion, or applied topically without the need for assistance.

(q) "Service plan" means a written summary of the assessment and description of the services needed by the recipient.

(r) "Wages and benefits" means wages and salaries, the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, mileage reimbursement, health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and contributions to employee retirement accounts.

Sec. 13. Minnesota Statutes 2010, section 256B.0659, subdivision 3, is amended to read:

Subd. 3. **Noncovered personal care assistance services.** (a) Personal care assistance services are not eligible for medical assistance payment under this section when provided:

(1) by the recipient's spouse, parent of a recipient under the age of 18, paid legal guardian, licensed foster provider, except as allowed under section 256B.0652, subdivision 10, or responsible party;

(2) in ~~lieu of other staffing options~~ order to meet staffing or license requirements in a residential or child care setting;

(3) solely as a child care or babysitting service; or

(4) without authorization by the commissioner or the commissioner's designee.

(b) The following personal care services are not eligible for medical assistance payment under this section when provided in residential settings:

(1) ~~effective January 1, 2010,~~ when the provider of home care services who is not related by blood, marriage, or adoption owns or otherwise controls the living arrangement, including licensed or unlicensed services; or

(2) when personal care assistance services are the responsibility of a residential or program license holder under the terms of a service agreement and administrative rules.

(c) Other specific tasks not covered under paragraph (a) or (b) that are not eligible for medical assistance reimbursement for personal care assistance services under this section include:

(1) sterile procedures;

(2) injections of fluids and medications into veins, muscles, or skin;

(3) home maintenance or chore services;

(4) homemaker services not an integral part of assessed personal care assistance services needed by a recipient;

(5) application of restraints or implementation of procedures under section 245.825;

(6) instrumental activities of daily living for children under the age of 18, except when immediate attention is needed for health or hygiene reasons integral to the personal care services and the need is listed in the service plan by the assessor; and

(7) assessments for personal care assistance services by personal care assistance provider agencies or by independently enrolled registered nurses.

Sec. 14. Minnesota Statutes 2010, section 256B.0659, subdivision 9, is amended to read:

Subd. 9. **Responsible party; generally.** (a) "Responsible party" means an individual who is capable of providing the support necessary to assist the recipient to live in the community.

(b) A responsible party must be 18 years of age, actively participate in planning and directing of personal care assistance services, and attend all assessments for the recipient.

(c) A responsible party must not be the:

(1) personal care assistant;

(2) qualified professional;

(3) home care provider agency owner or ~~staff~~ manager; ~~or~~

(4) home care provider agency staff unless staff who are not listed in clauses (1) to (3) are related to the recipient by blood, marriage, or adoption; or

~~(3)~~ (5) county staff acting as part of employment.

(d) A licensed family foster parent who lives with the recipient may be the responsible party as long as the family foster parent meets the other responsible party requirements.

(e) A responsible party is required when:

(1) the person is a minor according to section 524.5-102, subdivision 10;

(2) the person is an incapacitated adult according to section 524.5-102, subdivision 6, resulting in a court-appointed guardian; or

(3) the assessment according to subdivision 3a determines that the recipient is in need of a responsible party to direct the recipient's care.

(f) There may be two persons designated as the responsible party for reasons such as divided households and court-ordered custodies. Each person named as responsible party must meet the program criteria and responsibilities.

(g) The recipient or the recipient's legal representative shall appoint a responsible party if necessary to direct and supervise the care provided to the recipient. The responsible party must be identified at the time of assessment and listed on the recipient's service agreement and personal care assistance care plan.

Sec. 15. Minnesota Statutes 2011 Supplement, section 256B.0659, subdivision 11, is amended to read:

Subd. 11. **Personal care assistant; requirements.** (a) A personal care assistant must meet the following requirements:

(1) be at least 18 years of age with the exception of persons who are 16 or 17 years of age with these additional requirements:

(i) supervision by a qualified professional every 60 days; and

(ii) employment by only one personal care assistance provider agency responsible for compliance with current labor laws;

(2) be employed by a personal care assistance provider agency;

(3) enroll with the department as a personal care assistant after clearing a background study. Except as provided in subdivision 11a, before a personal care assistant provides services, the personal care assistance provider agency must initiate a background study on the personal care assistant under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the personal care assistant is:

(i) not disqualified under section 245C.14; or

(ii) is disqualified, but the personal care assistant has received a set aside of the disqualification under section 245C.22;

(4) be able to effectively communicate with the recipient and personal care assistance provider agency;

(5) be able to provide covered personal care assistance services according to the recipient's personal care assistance care plan, respond appropriately to recipient needs, and report changes in the recipient's condition to the supervising qualified professional or physician;

(6) not be a consumer of personal care assistance services;

(7) maintain daily written records including, but not limited to, time sheets under subdivision 12;

(8) effective January 1, 2010, complete standardized training as determined by the commissioner before completing enrollment. The training must be available in languages other than English and to those who need accommodations due to disabilities. Personal care assistant training must include successful completion of the following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of personal care assistants including information about assistance with lifting and transfers for recipients, emergency preparedness, orientation to positive behavioral practices, fraud issues, and completion of time sheets. Upon completion of the training components, the personal care assistant must demonstrate the competency to provide assistance to recipients;

(9) complete training and orientation on the needs of the recipient ~~within the first seven days after the services begin~~; and

(10) be limited to providing and being paid for up to 275 hours per month~~, except that this limit shall be 275 hours per month for the period July 1, 2009, through June 30, 2011,~~ of personal care assistance services regardless of the number of recipients being served or the number of personal care assistance provider agencies enrolled with. The number of hours worked per day shall not be disallowed by the department unless in violation of the law.

(b) A legal guardian may be a personal care assistant if the guardian is not being paid for the guardian services and meets the criteria for personal care assistants in paragraph (a).

(c) Persons who do not qualify as a personal care assistant include parents ~~and~~, stepparents, and legal guardians of minors~~;~~; spouses~~;~~; paid legal guardians~~;~~ of adults; family foster care providers, except as otherwise allowed in section 256B.0625, subdivision 19a~~, or~~; and staff of a residential setting. When the personal care assistant is a relative of the recipient, the commissioner shall pay 80 percent of the provider rate. For purposes of this section, relative means the parent or adoptive parent of an adult child, a sibling aged 16 years or older, an adult child, a grandparent, or a grandchild.

Sec. 16. Minnesota Statutes 2010, section 256B.0659, subdivision 13, is amended to read:

Subd. 13. **Qualified professional; qualifications.** (a) The qualified professional must work for a personal care assistance provider agency and meet the definition under section 256B.0625, subdivision 19c. Before a qualified professional provides services, the personal care assistance provider agency must initiate a background study on the qualified professional under chapter 245C, and the personal care assistance provider agency must have received a notice from the commissioner that the qualified professional:

(1) is not disqualified under section 245C.14; or

(2) is disqualified, but the qualified professional has received a set aside of the disqualification under section 245C.22.

(b) The qualified professional shall perform the duties of training, supervision, and evaluation of the personal care assistance staff and evaluation of the effectiveness of personal care assistance services. The qualified professional shall:

(1) develop and monitor with the recipient a personal care assistance care plan based on the service plan and individualized needs of the recipient;

(2) develop and monitor with the recipient a monthly plan for the use of personal care assistance services;

(3) review documentation of personal care assistance services provided;

(4) provide training and ensure competency for the personal care assistant in the individual needs of the recipient; and

(5) document all training, communication, evaluations, and needed actions to improve performance of the personal care assistants.

(c) Effective July 1, ~~2010~~ 2011, the qualified professional shall complete the provider training with basic information about the personal care assistance program approved by the commissioner. Newly hired qualified professionals must complete the training within six months of the date hired by a personal care assistance provider agency. Qualified professionals who have completed the required training as a worker from a personal care assistance provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the last three years. The required training ~~shall~~ must be available ~~in languages other than English and to those who need accommodations due to disabilities,~~ with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online~~,~~ or by electronic remote connection~~, and~~. The required training must provide for competency testing to demonstrate an understanding of the content without

attending in-person training. A qualified professional is allowed to be employed and is not subject to the training requirement until the training is offered online or through remote electronic connection. A qualified professional employed by a personal care assistance provider agency certified for participation in Medicare as a home health agency is exempt from the training required in this subdivision. When available, the qualified professional working for a Medicare-certified home health agency must successfully complete the competency test. The commissioner shall ensure there is a mechanism in place to verify the identity of persons completing the competency testing electronically.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2011.

Sec. 17. Minnesota Statutes 2010, section 256B.0659, subdivision 14, is amended to read:

Subd. 14. **Qualified professional; duties.** (a) Effective January 1, 2010, all personal care assistants must be supervised by a qualified professional.

(b) Through direct training, observation, return demonstrations, and consultation with the staff and the recipient, the qualified professional must ensure and document that the personal care assistant is:

(1) capable of providing the required personal care assistance services;

(2) knowledgeable about the plan of personal care assistance services before services are performed; and

(3) able to identify conditions that should be immediately brought to the attention of the qualified professional.

(c) The qualified professional shall evaluate the personal care assistant within the first 14 days of starting to provide regularly scheduled services for a recipient, or sooner as determined by the qualified professional, except for the personal care assistance choice option under subdivision 19, paragraph (a), clause (4). For the initial evaluation, the qualified professional shall evaluate the personal care assistance services for a recipient through direct observation of a personal care assistant's work. The qualified professional may conduct additional training and evaluation visits, based upon the needs of the recipient and the personal care assistant's ability to meet those needs. Subsequent visits to evaluate the personal care assistance services provided to a recipient do not require direct observation of each personal care assistant's work and shall occur:

(1) at least every 90 days thereafter for the first year of a recipient's services;

(2) every 120 days after the first year of a recipient's service or whenever needed for response to a recipient's request for increased supervision of the personal care assistance staff; and

(3) after the first 180 days of a recipient's service, supervisory visits may alternate between unscheduled phone or Internet technology and in-person visits, unless the in-person visits are needed according to the care plan.

(d) Communication with the recipient is a part of the evaluation process of the personal care assistance staff.

(e) At each supervisory visit, the qualified professional shall evaluate personal care assistance services including the following information:

(1) satisfaction level of the recipient with personal care assistance services;

(2) review of the month-to-month plan for use of personal care assistance services;

(3) review of documentation of personal care assistance services provided;

(4) whether the personal care assistance services are meeting the goals of the service as stated in the personal care assistance care plan and service plan;

(5) a written record of the results of the evaluation and actions taken to correct any deficiencies in the work of a personal care assistant; and

(6) revision of the personal care assistance care plan as necessary in consultation with the recipient or responsible party, to meet the needs of the recipient.

(f) The qualified professional shall complete the required documentation in the agency recipient and employee files and the recipient's home, including the following documentation:

(1) the personal care assistance care plan based on the service plan and individualized needs of the recipient;

(2) a month-to-month plan for use of personal care assistance services;

(3) changes in need of the recipient requiring a change to the level of service and the personal care assistance care plan;

(4) evaluation results of supervision visits and identified issues with personal care assistance staff with actions taken;

(5) all communication with the recipient and personal care assistance staff; and

(6) hands-on training or individualized training for the care of the recipient.

(g) The documentation in paragraph (f) must be done on agency ~~forms~~ templates.

(h) The services that are not eligible for payment as qualified professional services include:

(1) direct professional nursing tasks that could be assessed and authorized as skilled nursing tasks;

~~(2) supervision of personal care assistance completed by telephone;~~

~~(3)~~ (2) agency administrative activities;

~~(4)~~ (3) training other than the individualized training required to provide care for a recipient; and

~~(5)~~ (4) any other activity that is not described in this section.

Sec. 18. Minnesota Statutes 2010, section 256B.0659, subdivision 19, is amended to read:

Subd. 19. **Personal care assistance choice option; qualifications; duties.** (a) Under personal care assistance choice, the recipient or responsible party shall:

(1) recruit, hire, schedule, and terminate personal care assistants according to the terms of the written agreement required under subdivision 20, paragraph (a);

(2) develop a personal care assistance care plan based on the assessed needs and addressing the health and safety of the recipient with the assistance of a qualified professional as needed;

(3) orient and train the personal care assistant with assistance as needed from the qualified professional;

(4) effective January 1, 2010, supervise and evaluate the personal care assistant with the qualified professional, who is required to visit the recipient at least every 180 days;

(5) monitor and verify in writing and report to the personal care assistance choice agency the number of hours worked by the personal care assistant and the qualified professional;

(6) engage in an annual face-to-face reassessment to determine continuing eligibility and service authorization; and

(7) use the same personal care assistance choice provider agency if shared personal assistance care is being used.

(b) The personal care assistance choice provider agency shall:

(1) meet all personal care assistance provider agency standards;

(2) enter into a written agreement with the recipient, responsible party, and personal care assistants;

(3) not be related as a parent, child, sibling, or spouse to the recipient~~, qualified professional,~~ or the personal care assistant; and

(4) ensure arm's-length transactions without undue influence or coercion with the recipient and personal care assistant.

(c) The duties of the personal care assistance choice provider agency are to:

(1) be the employer of the personal care assistant and the qualified professional for employment law and related regulations including, but not limited to, purchasing and maintaining workers' compensation, unemployment insurance, surety and fidelity bonds,

and liability insurance, and submit any or all necessary documentation including, but not limited to, workers' compensation and unemployment insurance;

(2) bill the medical assistance program for personal care assistance services and qualified professional services;

(3) request and complete background studies that comply with the requirements for personal care assistants and qualified professionals;

(4) pay the personal care assistant and qualified professional based on actual hours of services provided;

(5) withhold and pay all applicable federal and state taxes;

(6) verify and keep records of hours worked by the personal care assistant and qualified professional;

(7) make the arrangements and pay taxes and other benefits, if any, and comply with any legal requirements for a Minnesota employer;

(8) enroll in the medical assistance program as a personal care assistance choice agency; and

(9) enter into a written agreement as specified in subdivision 20 before services are provided.

Sec. 19. Minnesota Statutes 2010, section 256B.0659, subdivision 21, is amended to read:

Subd. 21. **Requirements for initial enrollment of personal care assistance provider agencies.** (a) All personal care assistance provider agencies must provide, at the time of enrollment as a personal care assistance provider agency in a format determined by the commissioner, information and documentation that includes, but is not limited to, the following:

(1) the personal care assistance provider agency's current contact information including address, telephone number, and e-mail address;

(2) proof of surety bond coverage in the amount of $50,000 or ten percent of the provider's payments from Medicaid in the previous year, whichever is less;

(3) proof of fidelity bond coverage in the amount of $20,000;

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

(6) a description of the personal care assistance provider agency's organization identifying the names of all owners, managing employees, staff, board of directors, and the affiliations of the directors, owners, or staff to other service providers;

(7) a copy of the personal care assistance provider agency's written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety including process for notification and resolution of consumer grievances, identification and prevention of communicable diseases, and employee misconduct;

(8) copies of all other forms the personal care assistance provider agency uses in the course of daily business including, but not limited to:

(i) a copy of the personal care assistance provider agency's time sheet if the time sheet varies from the standard time sheet for personal care assistance services approved by the commissioner, and a letter requesting approval of the personal care assistance provider agency's nonstandard time sheet;

(ii) the personal care assistance provider agency's template for the personal care assistance care plan; and

(iii) the personal care assistance provider agency's template for the written agreement in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

(9) a list of all training and classes that the personal care assistance provider agency requires of its staff providing personal care assistance services;

(10) documentation that the personal care assistance provider agency and staff have successfully completed all the training required by this section;

(11) documentation of the agency's marketing practices;

(12) disclosure of ownership, leasing, or management of all residential properties that is used or could be used for providing home care services;

(13) documentation that the agency will use the following percentages of revenue generated from the medical assistance rate paid for personal care assistance services for employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal care assistance choice option and 72.5 percent of revenue from other personal care assistance providers; and

(14) effective May 15, 2010, documentation that the agency does not burden recipients' free exercise of their right to choose service providers by requiring personal care assistants to sign an agreement not to work with any particular personal care assistance recipient or for another personal care assistance provider agency after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) Personal care assistance provider agencies shall provide the information specified in paragraph (a) to the commissioner at the time the personal care assistance provider

agency enrolls as a vendor or upon request from the commissioner. The commissioner shall collect the information specified in paragraph (a) from all personal care assistance providers beginning July 1, 2009.

(c) All personal care assistance provider agencies shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner before enrollment of the agency as a provider. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a personal care assistance provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the past three years. By September 1, 2010, the required training must be available ~~in languages other than English and to those who need accommodations due to disabilities,~~ with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online~~,~~ or by electronic remote connection~~, and~~. The required training must provide for competency testing. Personal care assistance provider agency billing staff shall complete training about personal care assistance program financial management. This training is effective July 1, 2009. Any personal care assistance provider agency enrolled before that date shall, if it has not already, complete the provider training within 18 months of July 1, 2009. Any new owners or employees in management and supervisory positions involved in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency. Personal care assistance provider agencies certified for participation in Medicare as home health agencies are exempt from the training required in this subdivision. When available, Medicare-certified home health agency owners, supervisors, or managers must successfully complete the competency test.

Sec. 20. Minnesota Statutes 2010, section 256B.0659, subdivision 30, is amended to read:

Subd. 30. **Notice of service changes to recipients.** The commissioner must provide:

(1) by October 31, 2009, information to recipients likely to be affected that (i) describes the changes to the personal care assistance program that may result in the loss of access to personal care assistance services, and (ii) includes resources to obtain further information; and

~~(2) notice of changes in medical assistance personal care assistance services to each affected recipient at least 30 days before the effective date of the change.~~

~~The notice shall include how to get further information on the changes, how to get help to obtain other services, a list of community resources, and appeal rights. Notwithstanding section 256.045, a recipient may request continued services pending appeal within the time period allowed to request an appeal; and~~

~~(3)~~ (2) a service agreement authorizing personal care assistance hours of service at the previously authorized level, throughout the appeal process period, when a recipient requests services pending an appeal.

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

Sec. 21. Minnesota Statutes 2010, section 256B.0916, subdivision 7, is amended to read:

Subd. 7. **Annual report by commissioner.** (a) Beginning November 1, 2001, and each November 1 thereafter, the commissioner shall issue an annual report on county and state use of available resources for the home and community-based waiver for persons with developmental disabilities. For each county or county partnership, the report shall include:

(1) the amount of funds allocated but not used;

(2) the county specific allowed reserve amount approved and used;

(3) the number, ages, and living situations of individuals screened and waiting for services;

(4) the urgency of need for services to begin within one, two, or more than two years for each individual;

(5) the services needed;

(6) the number of additional persons served by approval of increased capacity within existing allocations;

(7) results of action by the commissioner to streamline administrative requirements and improve county resource management; and

(8) additional action that would decrease the number of those eligible and waiting for waivered services.

The commissioner shall specify intended outcomes for the program and the degree to which these specified outcomes are attained.

(b) This subdivision expires January 1, 2013.

Sec. 22. Minnesota Statutes 2010, section 256B.092, subdivision 11, is amended to read:

Subd. 11. **Residential support services.** (a) Upon federal approval, there is established a new service called residential support that is available on the community alternative care, community alternatives for disabled individuals, developmental disabilities, and traumatic brain injury waivers. Existing waiver service descriptions must be modified to the extent necessary to ensure there is no duplication between other services. Residential support services must be provided by vendors licensed as a community residential setting as defined in section 245A.11, subdivision 8.

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

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

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

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

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

(5) the provider of residential support services must meet the requirements of licensure and additional requirements of the person's community support plan.

(c) Providers of residential support services that meet the definition in paragraph (a) must be registered using a process determined by the commissioner beginning July 1, 2009. Providers licensed to provide child foster care under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, and that meet the requirements in section 245A.03, subdivision 7, paragraph (e), are considered registered under this section.

Sec. 23. Minnesota Statutes 2010, section 256B.096, subdivision 5, is amended to read:

Subd. 5. **Biennial report.** (a) The commissioner shall provide a biennial report to the chairs of the legislative committees with jurisdiction over health and human services policy and funding beginning January 15, 2009, on the development and activities of the quality management, assurance, and improvement system designed to meet the federal requirements under the home and community-based services waiver programs for persons with disabilities. By January 15, 2008, the commissioner shall provide a preliminary report on priorities for meeting the federal requirements, progress on development and field testing of the annual survey, appropriations necessary to implement an annual survey of service recipients once field testing is completed, recommendations for improvements

in the incident reporting system, and a plan for incorporating quality assurance efforts under section 256B.095 and other regional efforts into the statewide system.

(b) This subdivision expires January 1, 2013.

Sec. 24. Minnesota Statutes 2010, section 256B.441, subdivision 13, is amended to read:

Subd. 13. **External fixed costs.** "External fixed costs" means costs related to the nursing home surcharge under section 256.9657, subdivision 1; licensure fees under section 144.122; long-term care consultation fees under section 256B.0911, subdivision 6; family advisory council fee under section 144A.33; scholarships under section 256B.431, subdivision 36; planned closure rate adjustments under section ~~256B.436 or~~ 256B.437; or single bed room incentives under section 256B.431, subdivision 42; property taxes and property insurance; and PERA.

Sec. 25. Minnesota Statutes 2010, section 256B.441, subdivision 31, is amended to read:

Subd. 31. **Prior system operating cost payment rate.** "Prior system operating cost payment rate" means the operating cost payment rate in effect on September 30, 2008, under Minnesota Rules and Minnesota Statutes, not including planned closure rate adjustments under section ~~256B.436 or~~ 256B.437, or single bed room incentives under section 256B.431, subdivision 42.

Sec. 26. Minnesota Statutes 2010, section 256B.441, subdivision 53, is amended to read:

Subd. 53. **Calculation of payment rate for external fixed costs.** The commissioner shall calculate a payment rate for external fixed costs.

(a) For a facility licensed as a nursing home, the portion related to section 256.9657 shall be equal to $8.86. For a facility licensed as both a nursing home and a boarding care home, the portion related to section 256.9657 shall be equal to $8.86 multiplied by the result of its number of nursing home beds divided by its total number of licensed beds.

(b) The portion related to the licensure fee under section 144.122, paragraph (d), shall be the amount of the fee divided by actual resident days.

(c) The portion related to scholarships shall be determined under section 256B.431, subdivision 36.

(d) The portion related to long-term care consultation shall be determined according to section 256B.0911, subdivision 6.

(e) The portion related to development and education of resident and family advisory councils under section 144A.33 shall be $5 divided by 365.

(f) The portion related to planned closure rate adjustments shall be as determined under ~~sections 256B.436 and~~ section 256B.437, subdivision 6, and Minnesota Statutes 2010, section 256B.436. Planned closure rate adjustments that take effect before October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning October 1, 2016. Planned closure rate adjustments that take effect on or after October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning on October 1 of the first year not less than two years after their effective date.

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

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

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

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

Sec. 27. Minnesota Statutes 2010, section 256B.49, subdivision 21, is amended to read:

Subd. 21. **Report.** (a) The commissioner shall expand on the annual report required under section 256B.0916, subdivision 7, to include information on the county of residence and financial responsibility, age, and major diagnoses for persons eligible for the home and community-based waivers authorized under subdivision 11 who are:

(1) receiving those services;

(2) screened and waiting for waiver services; and

(3) residing in nursing facilities and are under age 65.

(b) This subdivision expires January 1, 2013.

Sec. 28. Minnesota Statutes 2011 Supplement, section 626.557, subdivision 9, is amended to read:

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

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

(1) the time and date of the report;

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

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

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

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

(6) a description of the suspected maltreatment;

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

(8) the relationship of the alleged perpetrator to the alleged victim;

(9) whether a facility was involved and, if so, which agency licenses the facility;

(10) any action taken by the common entry point;

(11) whether law enforcement has been notified;

(12) whether the reporter wishes to receive notification of the initial and final reports; and

(13) if the report is from a facility with an internal reporting procedure, the name, mailing address, and telephone number of the person who initiated the report internally.

(c) The common entry point is not required to complete each item on the form prior to dispatching the report to the appropriate lead investigative agency.

(d) The common entry point shall immediately report to a law enforcement agency any incident in which there is reason to believe a crime has been committed.

(e) If a report is initially made to a law enforcement agency or a lead investigative agency, those agencies shall take the report on the appropriate common entry point intake forms and immediately forward a copy to the common entry point.

(f) The common entry point staff must receive training on how to screen and dispatch reports efficiently and in accordance with this section.

(g) ~~When a centralized database is available, the common entry point has access to the centralized database and must log the reports into the database.~~ The commissioner of human services shall maintain a centralized database for the collection of common entry

point data, lead investigative agency data including maltreatment report disposition, and appeals data.

Sec. 29. Laws 2009, chapter 79, article 8, section 81, as amended by Laws 2010, chapter 352, article 1, section 24, is amended to read:

Sec. 81. **ESTABLISHING A SINGLE SET OF STANDARDS.**

(a) The commissioner of human services shall consult with disability service providers, advocates, counties, and consumer families to develop a single set of standards, to be referred to as "quality outcome standards," governing services for people with disabilities receiving services under the home and community-based waiver services program, with the exception of customized living services because the service license is under the jurisdiction of the Department of Health, to replace all or portions of existing laws and rules including, but not limited to, data practices, licensure of facilities and providers, background studies, reporting of maltreatment of minors, reporting of maltreatment of vulnerable adults, and the psychotropic medication checklist. The standards must:

(1) enable optimum consumer choice;

(2) be consumer driven;

(3) link services to individual needs and life goals;

(4) be based on quality assurance and individual outcomes;

(5) utilize the people closest to the recipient, who may include family, friends, and health and service providers, in conjunction with the recipient's risk management plan to assist the recipient or the recipient's guardian in making decisions that meet the recipient's needs in a cost-effective manner and assure the recipient's health and safety;

(6) utilize person-centered planning; and

(7) maximize federal financial participation.

(b) The commissioner may consult with existing stakeholder groups convened under the commissioner's authority, including the home and community-based expert services panel established by the commissioner in 2008, to meet all or some of the requirements of this section.

(c) The commissioner shall provide the reports and plans required by this section to the legislative committees and budget divisions with jurisdiction over health and human services policy and finance by January 15, 2012.

Sec. 30. **DISABILITY HOME AND COMMUNITY-BASED WAIVER REQUEST.**

By December 1, 2012, the commissioner shall request all federal approvals and waiver amendments to the disability home and community-based waivers to allow properly licensed adult foster care homes to provide residential services for up to five individuals.

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

Sec. 31. **HOURLY NURSING DETERMINATION MATRIX.**

A service provider applying for medical assistance payments for private duty nursing services under Minnesota Statutes, section 256B.0654, must complete and submit to the commissioner of human services an hourly nursing determination matrix for each recipient of private duty nursing services. The commissioner of human services will collect and analyze data from the hourly nursing determination matrix.

Sec. 32. **REPEALER.**

(a) Minnesota Statutes 2010, sections 256B.431, subdivisions 2c, 2g, 2i, 2j, 2k, 2l, 2o, 3c, 11, 14, 17b, 17f, 19, 20, 25, 27, and 29; 256B.434, subdivisions 4a, 4b, 4c, 4d, 4e, 4g, 4h, 7, and 8; 256B.435; and 256B.436, are repealed.

(b) Minnesota Statutes 2011 Supplement, section 256B.431, subdivision 26, is repealed.

(c) Minnesota Rules, part 9555.7700, is repealed.

ARTICLE 2

TELEPHONE EQUIPMENT PROGRAM

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

237.50 DEFINITIONS.

Subdivision 1. **Scope.** The terms used in sections 237.50 to 237.56 have the meanings given them in this section.

Subd. 3. **Communication ~~impaired~~ disability.** "Communication ~~impaired~~ disability" means certified as ~~deaf, severely hearing impaired, hard-of-hearing~~ having a hearing loss, speech ~~impaired, deaf and blind~~ disability, or ~~mobility impaired if the mobility impairment significantly impedes the ability~~ physical disability that makes it difficult or impossible to use ~~standard customer premises~~ telecommunications services and equipment.

~~Subd. 4. **Communication device.** "Communication device" means a device that when connected to a telephone enables a communication-impaired person to communicate with another person utilizing the telephone system. A "communication device" includes a~~

~~ring signaler, an amplification device, a telephone device for the deaf, a Brailling device for use with a telephone, and any other device the Department of Human Services deems necessary.~~

Subd. 4a. **Deaf.** "Deaf" means a hearing ~~impairment~~ loss of such severity that the individual must depend primarily upon visual communication such as writing, lip reading, ~~manual communication~~ sign language, and gestures.

Subd. 4b. **Deafblind.** "Deafblind" means any combination of vision and hearing loss which interferes with acquiring information from the environment to the extent that compensatory strategies and skills are necessary to access that or other information.

~~Subd. 5. **Exchange.** "Exchange" means a unit area established and described by the tariff of a telephone company for the administration of telephone service in a specified 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 Regulations, title 47, sections 64.604 to 64.606. TRS allows an individual who has a communication disability to use telecommunications services in a manner that is functionally equivalent to the ability of an individual who does not have a communication disability.

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

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

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

237.51 TELECOMMUNICATIONS ACCESS MINNESOTA PROGRAM ADMINISTRATION.

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

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

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

For purposes of sections 237.51 to 237.56, the Department of Commerce and any organization with which it contracts pursuant to this section or section 237.54, subdivision

2, are not telephone companies or telecommunications carriers as defined in section 237.01.

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

(1) prepare the reports required by section 237.55;

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

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

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

(1) define economic hardship, special needs, and household criteria so as to 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~~ provider of services capable of originating a ~~telecommunications relay~~ TRS 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~~ the provision of TRS required by section 237.54.

(b) All costs directly associated with the establishment of the program, the purchase and distribution of ~~communication~~ telecommunications devices, and the ~~establishment and operation of the telecommunication relay service~~ provision of TRS 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~~ one or more TRS providers to indemnify the ~~local exchange carriers of the relay~~ telecommunications service providers for any fines imposed by the Federal Communications Commission related to the failure of the relay service to comply with federal service standards. Notwithstanding section 16A.41, the commissioner may advance money to the ~~contractor of the telecommunication relay service~~ TRS providers if the ~~contractor establishes~~ providers establish to the commissioner's satisfaction that the advance payment is necessary for the ~~operation~~ provision of the service. The advance payment may be used only for working capital reserve for the operation of the service. The advance payment must be offset or repaid by the end of the contract fiscal year together with interest accrued from the date of payment.

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

237.53 ~~COMMUNICATION~~ TELECOMMUNICATIONS DEVICE.

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

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

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

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

(3) be a resident of the state;

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

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

Subd. 3. **Distribution.** The commissioner of human services shall purchase and distribute a sufficient number of ~~communication~~ telecommunications devices so that each eligible household receives ~~an~~ appropriate ~~device~~ devices as determined under section 237.51, subdivision 5a. The commissioner of human services shall distribute the devices to eligible households ~~in each service area~~ free of charge ~~as determined under section 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 2011 Supplement, section 256B.0625, subdivision 56, is amended to read:

Subd. 56. **Medical service coordination.** (a) Medical assistance covers in-reach community-based service coordination that is performed ~~in~~ through a hospital emergency department as an eligible procedure under a state healthcare program ~~or private insurance~~ for a frequent user. A frequent user is defined as an individual who has frequented the hospital emergency department for services three or more times in the previous four consecutive months. In-reach community-based service coordination includes navigating services to address a client's mental health, chemical health, social, economic, and housing needs, or any other activity targeted at reducing the incidence of emergency room and other nonmedically necessary health care utilization.

(b) Reimbursement must be made in 15-minute increments ~~under current Medicaid mental health social work reimbursement methodology~~ and allowed for up to 60 days posthospital discharge based upon the specific identified emergency department visit or inpatient admitting event. ~~A frequent user who is participating in care coordination within a health care home framework is ineligible for reimbursement under this subdivision.~~ In-reach community-based service coordination shall seek to connect frequent users with existing covered services available to them, including, but not limited to, targeted case management, waiver case management, or care coordination in a health care home. Eligible in-reach service coordinators must hold a minimum of a bachelor's degree in social work, public health, corrections, or a related field. The commissioner shall submit any necessary application for waivers to the Centers for Medicare and Medicaid Services to implement this subdivision.

(c) For the purposes of this subdivision, "in-reach community-based service coordination" means the practice of a community-based worker with training, knowledge, skills, and ability to access a continuum of services, including housing, transportation, chemical and mental health treatment, employment, and peer support services, by working

with an organization's staff to transition an individual back into the individual's living environment. In-reach community-based service coordination includes working with the individual during their discharge and for up to a defined amount of time in the individual's living environment, reducing the individual's need for readmittance.

Sec. 2. 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 physical aggression towards self, others, or destruction of property that requires the immediate response of another person.

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

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

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

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

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

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

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

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

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

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

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

(m) "Personal care assistant" or "PCA" means an individual employed by a personal care assistance agency who provides personal care assistance services.

(n) "Personal care assistance care plan" means a written description of personal care assistance services developed by the personal care assistance provider according to the service plan.

(o) "Responsible party" means an individual who is capable of providing the support necessary to assist the recipient to live in the community.

(p) "Self-administered medication" means medication taken orally, by injection, nebulizer, or insertion, or applied topically without the need for assistance.

(q) "Service plan" means a written summary of the assessment and description of the services needed by the recipient.

(r) "Wages and benefits" means wages and salaries, the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, mileage reimbursement, health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and contributions to employee retirement accounts.

Sec. 3. Minnesota Statutes 2010, section 256B.0659, subdivision 2, is amended to read:

Subd. 2. **Personal care assistance services; covered services.** (a) The personal care assistance services eligible for payment include services and supports furnished to an individual, as needed, to assist in:

(1) activities of daily living;

(2) health-related procedures and tasks;

(3) observation and redirection of behaviors; and

(4) instrumental activities of daily living.

(b) Activities of daily living include the following covered services:

(1) dressing, including assistance with choosing, application, and changing of clothing and application of special appliances, wraps, or clothing;

(2) grooming, including assistance with basic hair care, oral care, shaving, applying cosmetics and deodorant, and care of eyeglasses and hearing aids. Nail care is included, except for recipients who are diabetic or have poor circulation;

(3) bathing, including assistance with basic personal hygiene and skin care;

(4) eating, including assistance with hand washing and application of orthotics required for eating, transfers, and feeding;

(5) transfers, including assistance with transferring the recipient from one seating or reclining area to another;

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

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

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

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

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

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

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

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

(d) A personal care assistant may provide health-related procedures and tasks associated with the complex health-related needs of a recipient if the procedures and tasks meet the definition of health-related procedures and tasks under this section and the personal care assistant is trained by a qualified professional and demonstrates competency to safely complete the procedures and tasks. Delegation of health-related procedures and

tasks and all training must be documented in the personal care assistance care plan and the recipient's and personal care assistant's files. A personal care assistant must not determine the medication dose or time for medication.

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

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

(2) utilization of clean rather than sterile procedure;

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

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

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

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

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

Sec. 4. Minnesota Statutes 2010, section 256B.0659, subdivision 3a, is amended to read:

Subd. 3a. **Assessment; defined.** (a) "Assessment" means a review and evaluation of a recipient's need for ~~home~~ personal care assistance services conducted in person. Assessments for personal care assistance services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county except when a long-term care consultation assessment is being conducted for the purposes of determining a person's eligibility for home and community-based waiver services including personal care assistance services according to section 256B.0911. An in-person assessment must include: documentation of health status, determination of need, evaluation of service effectiveness, identification of appropriate services, service plan development or modification, coordination of services, referrals and follow-up to appropriate payers and community resources, completion of required reports, recommendation of service authorization, and consumer education. Once the need for personal care assistance services is determined under this section ~~or sections 256B.0651, 256B.0653, 256B.0654, and 256B.0656~~, the county public health nurse or certified public health nurse under contract with the county is responsible for communicating this recommendation to the

commissioner and the recipient. An in-person assessment must occur at least annually or when there is a significant change in the recipient's condition or when there is a change in the need for personal care assistance services. A service update may substitute for the annual face-to-face assessment when there is not a significant change in recipient condition or a change in the need for personal care assistance service. A service update may be completed by telephone, used when there is no need for an increase in personal care assistance services, and used for two consecutive assessments if followed by a face-to-face assessment. A service update must be completed on a form approved by the commissioner. A service update or review for temporary increase includes a review of initial baseline data, evaluation of service effectiveness, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and on going consumer education. Assessments or reassessments must be completed on forms provided by the commissioner within 30 days of a request for home care services by a recipient or responsible party ~~or personal care provider agency~~.

(b) This subdivision expires when notification is given by the commissioner as described in section 256B.0911, subdivision 3a.

Sec. 5. Minnesota Statutes 2010, section 256B.0659, subdivision 4, is amended to read:

Subd. 4. **Assessment for personal care assistance services; limitations.** (a) An assessment as defined in subdivision 3a must be completed for personal care assistance services.

(b) The following limitations apply to the assessment:

(1) a person must be assessed as dependent in an activity of daily living based on the person's daily need or need on the days during the week the activity is completed for:

(i) cuing and constant supervision to complete the task; or

(ii) hands-on assistance to complete the task; and

(2) a child may not be found to be dependent in an activity of daily living if because of the child's age an adult would either perform the activity for the child or assist the child with the activity. Assistance needed is the assistance appropriate for a typical child of the same age.

(c) Assessment for complex health-related needs must meet the criteria in this paragraph. ~~During the assessment process,~~ A recipient qualifies as having complex health-related needs if the recipient has one or more of the interventions that are ordered by a physician, specified in a personal care assistance care plan or community support plan developed under section 256B.0911, and found in the following:

(1) tube feedings requiring:

(i) a gastrojejunostomy tube; or

(ii) continuous tube feeding lasting longer than 12 hours per day;

(2) wounds described as:

(i) stage III or stage IV;

(ii) multiple wounds;

(iii) requiring sterile or clean dressing changes or a wound vac; or

(iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require specialized care;

(3) parenteral therapy described as:

(i) IV therapy more than two times per week lasting longer than four hours for each treatment; or

(ii) total parenteral nutrition (TPN) daily;

(4) respiratory interventions, including:

(i) oxygen required more than eight hours per day;

(ii) respiratory vest more than one time per day;

(iii) bronchial drainage treatments more than two times per day;

(iv) sterile or clean suctioning more than six times per day;

(v) dependence on another to apply respiratory ventilation augmentation devices such as BiPAP and CPAP; and

(vi) ventilator dependence under section 256B.0652;

(5) insertion and maintenance of catheter, including:

(i) sterile catheter changes more than one time per month;

(ii) clean intermittent catheterization, and including self-catheterization more than six times per day; or

(iii) bladder irrigations;

(6) bowel program more than two times per week requiring more than 30 minutes to perform each time;

(7) neurological intervention, including:

(i) seizures more than two times per week and requiring significant physical assistance to maintain safety; or

(ii) swallowing disorders diagnosed by a physician and requiring specialized assistance from another on a daily basis; and

(8) other congenital or acquired diseases creating a need for significantly increased direct hands-on assistance and interventions in six to eight activities of daily living.

(d) An assessment of behaviors must meet the criteria in this paragraph. A recipient qualifies as having a need for assistance due to behaviors if the recipient's behavior requires assistance at least four times per week and shows one or more of the following behaviors:

(1) physical aggression towards self or others, or destruction of property that requires the immediate response of another person;

(2) increased vulnerability due to cognitive deficits or socially inappropriate behavior; or

(3) increased need for assistance for recipients who are verbally aggressive ~~and~~ or resistive to care so that the time needed to perform activities of daily living is increased.

Sec. 6. Minnesota Statutes 2010, section 256B.0911, subdivision 1, is amended to read:

Subdivision 1. **Purpose and goal.** (a) The purpose of long-term care consultation services is to assist persons with long-term or chronic care needs in making ~~long-term~~ care decisions and selecting support and service options that meet their needs and reflect their preferences. The availability of, and access to, information and other types of assistance, including assessment and support planning, is also intended to prevent or delay ~~certified nursing facility~~ institutional placements and to provide access to transition assistance after admission. Further, the goal of these services is to contain costs associated with unnecessary ~~certified nursing facility~~ institutional admissions. Long-term consultation services must be available to any person regardless of public program eligibility. The commissioner of human services shall seek to maximize use of available federal and state funds and establish the broadest program possible within the funding available.

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

Sec. 7. Minnesota Statutes 2011 Supplement, section 256B.0911, subdivision 1a, is amended to read:

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

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

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

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

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

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

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

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

(7) determination of home and community-based waiver and other service eligibility as required under sections 256B.0913, 256B.0915, and 256B.49, including level of care determination for individuals who need an institutional level of care as determined under section 256B.0911, subdivision 4a, paragraph (d), ~~or 256B.092, service eligibility including state plan home care services identified in sections 256B.0625, subdivisions 6, 7, and 19, paragraphs (a) and (c), and 256B.0657,~~ based on assessment and community support plan development ~~with,~~ appropriate referrals to obtain necessary diagnostic information, and including ~~the option~~ an eligibility determination for consumer-directed community supports;

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

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

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

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

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

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

(ii) section 256B.0657; or

(iii) consumer support grants under section 256.476;

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

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

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

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

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

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

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

Subd. 2b. **Certified assessors.** (a) ~~Beginning January 1, 2011,~~ Each lead agency shall use certified assessors who have completed training and the certification processes determined by the commissioner in subdivision 2c. Certified assessors shall demonstrate best practices in assessment and support planning including person-centered planning principals and have a common set of skills that must ensure consistency and equitable access to services statewide. ~~Assessors must be part of a multidisciplinary team of professionals that includes public health nurses, social workers, and other professionals as defined in paragraph (b). For persons with complex health care needs, a public health nurse or registered nurse from a multidisciplinary team must be consulted.~~ A lead agency

may choose, according to departmental policies, to contract with a qualified, certified assessor to conduct assessments and reassessments on behalf of the lead agency.

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

Sec. 9. Minnesota Statutes 2010, section 256B.0911, subdivision 2c, is amended to read:

Subd. 2c. **Assessor training and certification.** The commissioner shall develop and implement a curriculum and an assessor certification process ~~to begin no later than January 1, 2010~~. All existing lead agency staff designated to provide the services defined in subdivision 1a must be certified ~~by December 30, 2010.~~ within timelines specified by the commissioner, but no sooner than six months after statewide availability of the training and certification process. The commissioner must establish the timelines for training and certification in a manner that allows lead agencies to most efficiently adopt the automated process established in subdivision 5. Each lead agency is required to ensure that they have sufficient numbers of certified assessors to provide long-term consultation assessment and support planning within the timelines and parameters of the service ~~by January 1, 2011~~. Certified assessors are required to be recertified every three years.

Sec. 10. Minnesota Statutes 2010, section 256B.0911, subdivision 3, is amended to read:

Subd. 3. **Long-term care consultation team.** (a) ~~Until January 1, 2011,~~ A long-term care consultation team shall be established by the county board of commissioners. ~~Each local consultation team shall consist of at least one social worker and at least one public health nurse from their respective county agencies. The board may designate public health or social services as the lead agency for long-term care consultation services. If a county does not have a public health nurse available, it may request approval from the commissioner to assign a county registered nurse with at least one year experience in home care to participate on the team.~~ Two or more counties may collaborate to establish a joint local consultation team or teams.

(b) Certified assessors must be part of a multidisciplinary long-term care consultation team of professionals that includes public health nurses, social workers, and other

professionals as defined in subdivision 2b, paragraph (b). The team is responsible for providing long-term care consultation services to all persons located in the county who request the services, regardless of eligibility for Minnesota health care programs.

(c) The commissioner shall allow arrangements and make recommendations that encourage counties and tribes to collaborate to establish joint local long-term care consultation teams to ensure that long-term care consultations are done within the timelines and parameters of the service. This includes integrated service models as required in subdivision 1, paragraph (b).

(d) Tribes and health plans under contract with the commissioner must provide long-term care consultation services as specified in the contract.

(e) The lead agency must provide the commissioner with an administrative contact for communication purposes.

Sec. 11. Minnesota Statutes 2011 Supplement, section 256B.0911, subdivision 3a, is amended to read:

Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services planning, or other assistance intended to support community-based living, including persons who need assessment in order to determine waiver or alternative care program eligibility, must be visited by a long-term care consultation team within ~~15~~ 20 calendar days after the date on which an assessment was requested or recommended. ~~After January 1, 2011, these requirements also apply to~~ Upon statewide implementation of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person requesting personal care assistance services~~,~~ and private duty nursing~~, and home health agency services, on timelines established in subdivision 5~~. The commissioner shall provide at least a 90-day notice to lead agencies prior to the effective date of this requirement. Face-to-face assessments must be conducted according to paragraphs (b) to (i).

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

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

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

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

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

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

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

(3) identification of health and safety risks and how those risks will be addressed, including personal risk management strategies;

(4) referral information; and

(5) informal caregiver supports, if applicable.

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

(f) A person may request assistance in identifying community supports without participating in a complete assessment. Upon a request for assistance identifying community support, the person must be transferred or referred to ~~the~~ long-term care options counseling services available under sections 256.975, subdivision 7, and 256.01, subdivision 24, for telephone assistance and follow up.

(g) The person has the right to make the final decision between institutional placement and community placement after the recommendations have been provided, except as provided in subdivision 4a, paragraph (c).

(h) The ~~team~~ lead agency must give the person receiving assessment or support planning, or the person's legal representative, materials, and forms supplied by the commissioner containing the following information:

(1) written recommendations for community-based services and consumer-directed options;

(2) documentation that the most cost-effective alternatives available were offered to the individual. For purposes of this clause, "cost-effective" means community services and living arrangements that cost the same as or less than institutional care. For an individual found to meet eligibility criteria for home and community-based service programs under section 256B.0915 or 256B.49, "cost effectiveness" has the meaning found in the federally approved waiver plan for each program;

(3) the need for and purpose of preadmission screening if the person selects nursing facility placement;

~~(2)~~ (4) the role of ~~the~~ long-term care consultation assessment and support planning in ~~waiver and alternative care program~~ eligibility determination for waiver and alternative care programs, and state plan home care, case management, and other services as defined in subdivision 1a, paragraphs (a), clause (7), and (b);

~~(3)~~ (5) information about Minnesota health care programs;

~~(4)~~ (6) the person's freedom to accept or reject the recommendations of the team;

~~(5)~~ (7) the person's right to confidentiality under the Minnesota Government Data Practices Act, chapter 13;

~~(6)~~ (8) the ~~long-term care consultant's~~ certified assessor's decision regarding the person's need for institutional level of care as determined under criteria established in section ~~144.0724, subdivision 11, or 256B.092~~ 256B.0911, subdivision 4a, paragraph (d), and the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clause (7), and (b); and

~~(7)~~ (9) the person's right to appeal the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clause (7), and (b), and incorporating the decision regarding the need for ~~nursing facility~~ institutional level of care or the ~~county's~~ lead agency's final decisions regarding public programs eligibility according to section 256.045, subdivision 3.

(i) Face-to-face assessment completed as part of eligibility determination for the alternative care, elderly waiver, community alternatives for disabled individuals, community alternative care, and ~~traumatic~~ brain injury waiver programs under sections 256B.0913, 256B.0915, ~~256B.0917,~~ and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after the date of assessment.

(j) The effective eligibility start date for ~~these~~ programs in paragraph (i) can never be prior to the date of assessment. If an assessment was completed more than 60 days before the effective waiver or alternative care program eligibility start date, assessment and support plan information must be updated in a face-to-face visit and documented in the department's Medicaid Management Information System (MMIS). Notwithstanding retroactive medical assistance coverage of state plan services, the effective date of ~~program~~ eligibility ~~in this case~~ for programs included in paragraph (i) cannot be prior to the date the most recent updated assessment is completed.

Sec. 12. Minnesota Statutes 2010, section 256B.0911, subdivision 3b, is amended to read:

Subd. 3b. **Transition assistance.** (a) ~~A long-term care consultation team~~ Lead agency certified assessors shall provide assistance to persons residing in a nursing facility, hospital, regional treatment center, or intermediate care facility for persons with developmental disabilities who request or are referred for assistance. Transition assistance must include assessment, community support plan development, referrals to long-term care options counseling under section ~~256B.975~~ 256.975, subdivision ~~10~~ 7, for community support plan implementation and to Minnesota health care programs, including home and community-based waiver services and consumer-directed options through the waivers, and referrals to programs that provide assistance with housing. Transition assistance must also include information about the Centers for Independent Living ~~and the Senior LinkAge Line~~, Disability Linkage Line, and about other organizations that can provide assistance with relocation efforts, and information about contacting these organizations to obtain their assistance and support.

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

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

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

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

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

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

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

Sec. 13. Minnesota Statutes 2011 Supplement, section 256B.0911, subdivision 4a, is amended to read:

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

(b) A person who has a diagnosis or possible diagnosis of mental illness or developmental disability must receive a preadmission screening before admission regardless of the exemptions outlined in subdivision 4b, paragraph (b), to identify the need for further evaluation and specialized services, unless the admission prior to screening is authorized by the local mental health authority or the local developmental disabilities case manager, or unless authorized by the county agency according to Public Law 101-508.

The following criteria apply to the preadmission screening:

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

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

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

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

(c) The local county mental health authority or the state developmental disability authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a

nursing facility if the individual does not meet the nursing facility level of care criteria or needs specialized services as defined in Public Law Numbers 100-203 and 101-508. For purposes of this section, "specialized services" for a person with developmental disability means active treatment as that term is defined under Code of Federal Regulations, title 42, section 483.440 (a)(1).

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

Sec. 14. Minnesota Statutes 2010, section 256B.0911, subdivision 4c, is amended to 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. 15. 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. 16. 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 in which the cost of services funded by alternative care and client contributions exceeds the limit specified in section 256B.0915, subdivision ~~3~~ 3a, paragraph (b).

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

Sec. 17. Minnesota Statutes 2010, section 256B.0913, subdivision 8, is amended to read:

Subd. 8. **Requirements for individual ~~care~~ coordinated service and support plan.** (a) The case manager shall implement the coordinated service and support plan ~~of care~~ for each alternative care client and ensure that a client's service needs and eligibility are reassessed at least every 12 months. The coordinated service and support plan must meet the requirements in section 256B.0915, subdivision 6. The plan shall include any services prescribed by the individual's attending physician as necessary to allow the individual to remain in a community setting. In developing the individual's care plan, the case manager should include the use of volunteers from families and neighbors, religious organizations, social clubs, and civic and service organizations to support the formal home care services. The lead agency shall be held harmless for damages or injuries sustained through the use of volunteers under this subdivision including workers' compensation liability. The case manager shall provide documentation in each individual's plan ~~of care~~ and, if requested, to the commissioner that the most cost-effective alternatives available

have been offered to the individual and that the individual was free to choose among available qualified providers, both public and private, including qualified case management or service coordination providers other than those employed by any county; however, the county or tribe maintains responsibility for prior authorizing services in accordance with statutory and administrative requirements. The case manager must give the individual a ten-day written notice of any denial, termination, or reduction of alternative care services.

(b) The county of service or tribe must provide access to and arrange for case management services, including assuring implementation of the coordinated service and support plan. "County of service" has the meaning given it in Minnesota Rules, part 9505.0015, subpart 11. The county of service must notify the county of financial responsibility of the approved care plan and the amount of encumbered funds.

Sec. 18. Minnesota Statutes 2010, section 256B.0915, subdivision 1a, is amended to read:

Subd. 1a. **Elderly waiver case management services.** (a) ~~Elderly~~ Except as provided to individuals under prepaid medical assistance programs as described in paragraph (h), case management services under the home and community-based services waiver for elderly individuals are available from providers meeting qualification requirements and the standards specified in subdivision 1b. Eligible recipients may choose any qualified provider of ~~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;

(4) assisting the person in the identification of potential providers;

(5) assisting the person to access services;

(6) coordination of services; and

(7) evaluation and monitoring of the services identified in the plan, which must incorporate at least one annual face-to-face visit by the case manager with each person.

(h) Notwithstanding any requirements in this section, for individuals enrolled in prepaid medical assistance programs under section 256B.69, subdivisions 6b and 23, the health plan shall provide or arrange to provide elderly waiver case management services in paragraph (g), in accordance with contract requirements established by the commissioner.

Sec. 19. Minnesota Statutes 2010, section 256B.0915, subdivision 1b, is amended to read:

Subd. 1b. **Provider qualifications and standards.** (a) The commissioner must enroll qualified providers of ~~elderly~~ case management services under the home and community-based waiver for the elderly under section 1915(c) of the Social Security Act. The enrollment process shall ensure the provider's ability to meet the qualification requirements and standards in this subdivision and other federal and state requirements of this service. ~~An elderly~~ A case management provider is an enrolled medical

assistance provider who is determined by the commissioner to have all of the following characteristics:

(1) the demonstrated capacity and experience to provide the components of case management to coordinate and link community resources needed by the eligible population;

(2) administrative capacity and experience in serving the target population for whom it will provide services and in ensuring quality of services under state and federal requirements;

(3) a financial management system that provides accurate documentation of services and costs under state and federal requirements;

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

(5) the lead agency may allow a case manager employed by the lead agency to delegate certain aspects of the case management activity to another individual employed by the lead agency provided there is oversight of the individual by the case manager. The case manager may not delegate those aspects which require professional judgment including assessments, reassessments, and ~~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. 20. 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. 21. 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;

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

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

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

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

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

Sec. 22. Minnesota Statutes 2011 Supplement, section 256B.0915, subdivision 10, is amended to read:

Subd. 10. **Waiver payment rates; managed care organizations.** The commissioner shall adjust the elderly waiver capitation payment rates for managed care organizations paid under section 256B.69, subdivisions ~~6a~~ 6b and 23, to reflect the

maximum service rate limits for customized living services and 24-hour customized living services under subdivisions 3e and 3h. Medical assistance rates paid to customized living providers by managed care organizations under this section shall not exceed the maximum service rate limits and component rates as determined by the commissioner under subdivisions 3e and 3h.

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

Subdivision 1. **County of financial responsibility; duties.** Before any services shall be rendered to persons with developmental disabilities who are in need of social service and medical assistance, the county of financial responsibility shall conduct or arrange for a diagnostic evaluation in order to determine whether the person has or may have a developmental disability or has or may have a related condition. If the county of financial responsibility determines that the person has a developmental disability, the county shall inform the person of case management services available under this section. Except as provided in subdivision 1g or 4b, if a person is diagnosed as having a developmental disability, the county of financial responsibility shall conduct or arrange for a needs assessment by a certified assessor, and develop ~~or arrange for an individual service~~ a community support plan according to section 256B.0911, ~~provide or arrange for ongoing case management services at the level identified in the individual service plan, provide 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. 24. 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;

(2) informing the individual or the individual's legal guardian or conservator, or parent if the person is a minor, of service options;

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

(4) assisting the person in the identification of potential providers;

(5) assisting the person to access services and assisting in appeals under section 256.045;

(6) coordination of services, if coordination is not provided by another service provider;

(7) evaluation and monitoring of the services identified in the coordinated service and support plan, which must incorporate at least one annual face-to-face visit by the case manager with each person; and

(8) ~~annual reviews of service plans and services provided~~ reviewing coordinated service and support plans and providing the lead agency with recommendations for service authorization based upon the individual's needs identified in the coordinated service and support plan.

(c) Case management ~~administration and~~ service activities that are provided to the person with a developmental disability shall be provided directly by county agencies or under contract. 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 the approved federal waiver plans. 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).

(d) Case managers are responsible for ~~the administrative duties and~~ service provisions listed in paragraphs (a) and (b). Case managers shall collaborate with consumers, families, legal representatives, and relevant medical experts and service providers in the development and annual review of the ~~individualized service~~ coordinated service and support plan and habilitation ~~plans~~ plan.

(e) The Department of Human Services shall offer ongoing education in case management to case managers. Case managers shall receive no less than ten hours of case management education and disability-related training each year.

Sec. 25. Minnesota Statutes 2010, section 256B.092, subdivision 1b, is amended to 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, including the person's choices made on self-directed options and on services and supports to achieve employment goals;

(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~~.~~; and

(13) includes the authorized annual and monthly amounts for the 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. 26. 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. 27. 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. 28. 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. 29. 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~~ support plans. Services provided to persons with developmental disabilities may only be authorized and terminated by case managers or certified assessors according to (1) rules of the commissioner and (2) the ~~individual service~~ coordinated service and support plan as defined in subdivision 1b. Medical assistance services not needed shall not be authorized by county agencies or funded by the commissioner. When purchasing or arranging for unlicensed respite care services for persons with overriding health needs, the county agency shall seek the advice of a health care professional in assessing provider staff training needs and skills necessary to meet the medical needs of the person.

Sec. 30. Minnesota Statutes 2010, section 256B.092, subdivision 5, is amended to read:

Subd. 5. **Federal waivers.** (a) The commissioner shall apply for any federal waivers necessary to secure, to the extent allowed by law, federal financial participation under United States Code, title 42, sections 1396 et seq., as amended, for the provision

of services to persons who, in the absence of the services, would need the level of care provided in a regional treatment center or a community intermediate care facility for persons with developmental disabilities. The commissioner may seek amendments to the waivers or apply for additional waivers under United States Code, title 42, sections 1396 et seq., as amended, to contain costs. The commissioner shall ensure that payment for the cost of providing home and community-based alternative services under the federal waiver plan shall not exceed the cost of intermediate care services including day training and habilitation services that would have been provided without the waivered services.

The commissioner shall seek an amendment to the 1915c home and community-based waiver to allow properly licensed adult foster care homes to provide residential services to up to five individuals with developmental disabilities. If the amendment to the waiver is approved, adult foster care providers that can accommodate five individuals shall increase their capacity to five beds, provided the providers continue to meet all applicable licensing requirements.

(b) The commissioner, in administering home and community-based waivers for persons with developmental disabilities, shall ensure that day services for eligible persons are not provided by the person's residential service provider, unless the person or the person's legal representative is offered a choice of providers and agrees in writing to provision of day services by the residential service provider. The ~~individual service~~ coordinated service and support plan for individuals who choose to have their residential service provider provide their day services must describe how health, safety, protection, and habilitation needs will be met, including how frequent and regular contact with persons other than the residential service provider will occur. The ~~individualized service~~ coordinated service and support plan must address the provision of services during the day outside the residence on weekdays.

(c) When a ~~county~~ lead agency is evaluating denials, reductions, or terminations of home and community-based services under section 256B.0916 for an individual, the ~~case manager~~ lead agency shall offer to meet with the individual or the individual's guardian in order to discuss the prioritization of service needs within the ~~individualized service~~ coordinated service and support 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.

Sec. 31. Minnesota Statutes 2010, section 256B.092, subdivision 7, is amended to read:

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

(b) For persons with developmental disabilities, ~~screening teams shall be established which~~ a certified assessor shall evaluate the need for ~~the~~ an institutional level of care~~, provided by residential-based habilitation services, residential services, training and habilitation services, and nursing facility services.~~ The ~~evaluation~~ assessment shall address whether home and community-based services are appropriate for persons who are at risk of placement in an intermediate care facility for persons with developmental disabilities, or for whom there is reasonable indication that they might require this level of care. The ~~screening team~~ certified assessor shall make an evaluation of need ~~within 60 working days of a request for service by a person with a developmental disability, and~~ within five working days of an emergency admission of a person to an intermediate care facility for persons with developmental disabilities. ~~The screening team shall consist of the case manager for persons with developmental disabilities, the person, the person's legal guardian or conservator, or the parent if the person is a minor, and a qualified developmental disability professional, as defined in the Code of Federal Regulations, title 42, section 483.430, as amended through June 3, 1988. The case manager may also act as the qualified developmental disability professional if the case manager meets the federal definition. County social service agencies may contract with a public or private agency or individual who is not a service provider for the person for the public guardianship representation required by the screening or individual service planning process. The contract shall be limited to public guardianship representation for the 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. 32. 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 including self-directed service options;

~~(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 or improve existing patterns of contact and involvement with parents and other family members;

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

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

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

Sec. 33. Minnesota Statutes 2010, section 256B.092, subdivision 8a, is amended to read:

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

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

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

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

(c) The county of service shall notify the county of financial responsibility of ~~concurrence or refusal to concur~~ any concerns about the chosen provider's capacity to meet the needs of the person seeking to move to residential services in another county no later than 20 working days following receipt of the written ~~request~~ notification. Unless other mutually acceptable arrangements are made by the involved county agencies, the county of financial responsibility is responsible for costs of social services and the costs associated with the development and maintenance of the placement. The county of service may request that the county of financial responsibility purchase case management services from the county of service or from a contracted provider of case management when the county of financial responsibility is not providing case management as defined in this section and rules adopted under this section, unless other mutually acceptable arrangements are made by the involved county agencies. Standards for payment limits under this section may be established by the commissioner. Financial disputes between

counties shall be resolved as provided in section 256G.09. This subdivision also applies to home and community-based waiver services provided under section 256B.49.

Sec. 34. Minnesota Statutes 2010, section 256B.092, subdivision 9, is amended to read:

Subd. 9. **Reimbursement.** Payment for services shall not be provided to a service provider for any person placed in an intermediate care facility for persons with developmental disabilities prior to the person ~~being screened by the screening team~~ receiving an assessment by a certified assessor. The commissioner shall not deny reimbursement for: (1) a person admitted to an intermediate care facility for persons with developmental disabilities who is assessed to need long-term supportive services, if long-term supportive services other than intermediate care are not available in that community; (2) any person admitted to an intermediate care facility for persons with developmental disabilities under emergency circumstances; (3) any eligible person placed in the intermediate care facility for persons with developmental disabilities pending an appeal of the ~~screening team's~~ certified assessor's decision; or (4) any medical assistance recipient when, after full discussion of all appropriate alternatives including those that are expected to be less costly than intermediate care for persons with developmental disabilities, the person or the person's legal guardian or conservator, or the parent if the person is a minor, insists on intermediate care placement. The ~~screening team~~ certified assessor shall provide documentation that the most cost-effective alternatives available were offered to this individual or the individual's legal guardian or conservator.

Sec. 35. Minnesota Statutes 2010, section 256B.092, subdivision 11, is amended to read:

Subd. 11. **Residential support services.** (a) Upon federal approval, there is established a new service called residential support that is available on the community alternative care, community alternatives for disabled individuals, developmental disabilities, and traumatic brain injury waivers. Existing waiver service descriptions must be modified to the extent necessary to ensure there is no duplication between other services. Residential support services must be provided by vendors licensed as a community residential setting as defined in section 245A.11, subdivision 8.

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

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

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

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

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

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

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

Sec. 36. Minnesota Statutes 2010, section 256B.15, subdivision 1c, is amended to read:

Subd. 1c. **Notice of potential claim.** (a) A state agency with a claim or potential claim under this section may file a notice of potential claim under this subdivision anytime before or within one year after a medical assistance recipient dies. The claimant shall be the state agency. A notice filed prior to the recipient's death shall not take effect and shall not be effective as notice until the recipient dies. A notice filed after a recipient dies shall be effective from the time of filing.

(b) The notice of claim shall be filed or recorded in the real estate records in the office of the county recorder or registrar of titles for each county in which any part of the property is located. The recorder shall accept the notice for recording or filing. The registrar of titles shall accept the notice for filing if the recipient has a recorded interest in the property. The registrar of titles shall not carry forward to a new certificate of title any notice filed more than one year from the date of the recipient's death.

(c) The notice must be dated, state the name of the claimant, the medical assistance recipient's name and last four digits of the Social Security number if filed before their death and their date of death if filed after they die, the name and date of death of any predeceased spouse of the medical assistance recipient for whom a claim may exist, a statement that the claimant may have a claim arising under this section, generally identify the recipient's interest in the property, contain a legal description for the property and whether it is abstract or registered property, a statement of when the notice becomes effective and the effect of the notice, be signed by an authorized representative of the state agency, and may include such other contents as the state agency may deem appropriate.

Sec. 37. Minnesota Statutes 2010, section 256B.15, subdivision 1f, is amended to read:

Subd. 1f. **Agency lien.** (a) The notice shall constitute a lien in favor of the Department of Human Services against the recipient's interests in the real estate it

describes for a period of 20 years from the date of filing or the date of the recipient's death, whichever is later. Notwithstanding any law or rule to the contrary, a recipient's life estate and joint tenancy interests shall not end upon the recipient's death but shall continue according to subdivisions 1h, 1i, and 1j. The amount of the lien shall be equal to the total amount of the claims that could be presented in the recipient's estate under this section.

(b) If no estate has been opened for the deceased recipient, any holder of an interest in the property may apply to the lienholder for a statement of the amount of the lien or for a full or partial release of the lien. The application shall include the applicant's name, current mailing address, current home and work telephone numbers, and a description of their interest in the property, a legal description of the recipient's interest in the property, and the deceased recipient's name, date of birth, and last four digits of the Social Security number. The lienholder shall send the applicant by certified mail, return receipt requested, a written statement showing the amount of the lien, whether the lienholder is willing to release the lien and under what conditions, and inform them of the right to a hearing under section 256.045. The lienholder shall have the discretion to compromise and settle the lien upon any terms and conditions the lienholder deems appropriate.

(c) Any holder of an interest in property subject to the lien has a right to request a hearing under section 256.045 to determine the validity, extent, or amount of the lien. The request must be in writing, and must include the names, current addresses, and home and business telephone numbers for all other parties holding an interest in the property. A request for a hearing by any holder of an interest in the property shall be deemed to be a request for a hearing by all parties owning interests in the property. Notice of the hearing shall be given to the lienholder, the party filing the appeal, and all of the other holders of interests in the property at the addresses listed in the appeal by certified mail, return receipt requested, or by ordinary mail. Any owner of an interest in the property to whom notice of the hearing is mailed shall be deemed to have waived any and all claims or defenses in respect to the lien unless they appear and assert any claims or defenses at the hearing.

(d) If the claim the lien secures could be filed under subdivision 1h, the lienholder may collect, compromise, settle, or release the lien upon any terms and conditions it deems appropriate. If the claim the lien secures could be filed under subdivision 1i or 1j, the lien may be adjusted or enforced to the same extent had it been filed under subdivisions 1i and 1j, and the provisions of subdivisions 1i, clause (f), and 1j, clause (d), shall apply to voluntary payment, settlement, or satisfaction of the lien.

(e) If no probate proceedings have been commenced for the recipient as of the date the lien holder executes a release of the lien on a recipient's life estate or joint tenancy interest, created for purposes of this section, the release shall terminate the life estate or

joint tenancy interest created under this section as of the date it is recorded or filed to the extent of the release. If the claimant executes a release for purposes of extinguishing a life estate or a joint tenancy interest created under this section to remove a cloud on title to real property, the release shall have the effect of extinguishing any life estate or joint tenancy interests in the property it describes which may have been continued by reason of this section retroactive to the date of death of the deceased life tenant or joint tenant except as provided for in section 514.981, subdivision 6.

(f) If the deceased recipient's estate is probated, a claim shall be filed under this section. The amount of the lien shall be limited to the amount of the claim as finally allowed. If the claim the lien secures is filed under subdivision 1h, the lien may be released in full after any allowance of the claim becomes final or according to any agreement to settle and satisfy the claim. The release shall release the lien but shall not extinguish or terminate the interest being released. If the claim the lien secures is filed under subdivision 1i or 1j, the lien shall be released after the lien under subdivision 1i or 1j is filed or recorded, or settled according to any agreement to settle and satisfy the claim. The release shall not extinguish or terminate the interest being released. If the claim is finally disallowed in full, the claimant shall release the claimant's lien at the claimant's expense.

Sec. 38. Minnesota Statutes 2010, section 256B.49, subdivision 13, is amended to read:

Subd. 13. **Case management.** (a) 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. The case management service activities provided ~~will~~ must include:

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

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

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

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

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

~~(6)~~ (5) coordinating, evaluating, and monitoring of the services identified in the service plan~~;~~.

~~(7) completing the annual reviews of the service plan; and~~

~~(8) informing the recipient or legal representative of the right to have assessments completed and service plans developed within specified time periods, and to appeal county action or inaction under section 256.045, subdivision 3, including the determination of nursing facility level of care.~~

(b) The case manager may delegate certain aspects of the case management service activities to another individual provided there is oversight by the case manager. The case manager may not delegate those aspects which require professional judgment including ~~assessments, reassessments, and care plan development.~~:

(1) finalizing the coordinated service and support plan;

(2) ongoing assessment and monitoring of the person's needs and adequacy of the approved coordinated service and support plan; and

(3) adjustments to the coordinated service and support plan.

(c) 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 the approved federal waiver plans. Case management services must not be provided to a recipient by a private agency that has any 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).

Sec. 39. Minnesota Statutes 2011 Supplement, section 256B.49, subdivision 14, is amended to read:

Subd. 14. **Assessment and reassessment.** (a) Assessments ~~of each recipient's strengths, informal support systems, and need for services shall be completed within 20 working days of the recipient's request as provided in section 256B.0911. Reassessment of each recipient's strengths, support systems, and need for services shall be conducted at least every 12 months and at other times when there has been a significant change in the recipient's functioning~~ and reassessments shall be conducted by certified assessors according to section 256B.0911, subdivision 2b.

(b) There must be a determination that the client requires a hospital level of care or a nursing facility level of care as defined in section 256B.0911, subdivision 4a, paragraph (d), at initial and subsequent assessments to initiate and maintain participation in the waiver program.

(c) Regardless of other assessments identified in section 144.0724, subdivision 4, as appropriate to determine nursing facility level of care for purposes of medical assistance

payment for nursing facility services, only face-to-face assessments conducted according to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care determination or a nursing facility level of care determination must be accepted for purposes of initial and ongoing access to waiver services payment.

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

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

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

Sec. 40. Minnesota Statutes 2011 Supplement, section 256B.49, subdivision 15, is amended to read:

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

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

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

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

~~(4) promotes independence;~~

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

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

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

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

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

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

(c) Counties and other agencies responsible for funding community placement and ongoing community supportive services are responsible for the implementation of the comprehensive transitional service plans. Oversight responsibilities include both ensuring 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. 41. 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. 42. **RECOMMENDATIONS FOR FURTHER CASE MANAGEMENT REDESIGN AND STUDY OF COUNTY AND TRIBAL ADMINISTRATIVE FUNCTIONS.**

(a) By February 1, 2013, the commissioner of human services shall develop a legislative report with specific recommendations and language for proposed legislation 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.

(b) The commissioner of human services shall evaluate county and tribal administrative functions, processes, and reimbursement methodologies for the purposes of administration of home and community-based services, and compliance and oversight functions. The commissioner shall work with county, tribal, and stakeholder

representatives in the evaluation process and develop a plan for the delegation of commissioner duties to county and tribal entities after the elimination of county contracts under Minnesota Statutes, section 256B.4912, for waiver service provision and the creation of quality outcome standards under Laws 2009, chapter 79, article 8, section 81, and residential support services under Minnesota Statutes, sections 256B.092, subdivision 11, and 245A.11, subdivision 8. The commissioner shall present findings and recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance and policy by February 1, 2013, with any specific recommendations and language for proposed legislation to be effective July 1, 2013.

ARTICLE 4

CHEMICAL AND MENTAL HEALTH

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

Subd. 6. **Diagnostic codes list.** By July 1, 2013, the commissioner of human services shall develop a list of diagnostic codes to define the range of child and adult mental illnesses for the statewide mental health system. The commissioner may use the International Classification of Diseases (ICD); the American Psychiatric Association's Diagnostic and Statistical Manual (DSM); or a combination of both to develop the list. The commissioner shall establish an advisory committee, comprising mental health professional associations, counties, tribes, managed care organizations, state agencies, and consumer organizations that shall advise the commissioner regarding development of the diagnostic codes list. The commissioner shall annually notify providers of changes to the list.

Sec. 2. Minnesota Statutes 2010, section 245.462, subdivision 20, is amended to read:

Subd. 20. **Mental illness.** (a) "Mental illness" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is ~~listed in the clinical manual of the International Classification of Diseases (ICD-9-CM), current edition, code range 290.0 to 302.99 or 306.0 to 316.0 or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-MD), current edition, Axes I, II, or III~~ detailed in a diagnostic codes list published by the commissioner, and that seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation.

(b) An "adult with acute mental illness" means an adult who has a mental illness that is serious enough to require prompt intervention.

(c) For purposes of case management and community support services, a "person with serious and persistent mental illness" means an adult who has a mental illness and meets at least one of the following criteria:

(1) the adult has undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months;

(2) the adult has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months;

(3) the adult has been treated by a crisis team two or more times within the preceding 24 months;

(4) the adult:

(i) has a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder;

(ii) indicates a significant impairment in functioning; and

(iii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless ongoing case management or community support services are provided;

(5) the adult has, in the last three years, been committed by a court as a person who is mentally ill under chapter 253B, or the adult's commitment has been stayed or continued; or

(6) the adult (i) was eligible under clauses (1) to (5), but the specified time period has expired or the adult was eligible as a child under section 245.4871, subdivision 6; and (ii) has a written opinion from a mental health professional, in the last three years, stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless ongoing case management or community support services are provided.

Sec. 3. Minnesota Statutes 2010, section 245.487, is amended by adding a subdivision to read:

Subd. 7. **Diagnostic codes list.** By July 1, 2013, the commissioner of human services shall develop a list of diagnostic codes to define the range of child and adult mental illnesses for the statewide mental health system. The commissioner may use the International Classification of Diseases (ICD); the American Psychiatric Association's Diagnostic and Statistical Manual (DSM); or a combination of both to develop the list.

The commissioner shall establish an advisory committee, comprising mental health professional associations, counties, tribes, managed care organizations, state agencies, and consumer organizations that shall advise the commissioner regarding development of the diagnostic codes list. The commissioner shall annually notify providers of changes to the list.

Sec. 4. Minnesota Statutes 2010, section 245.4871, subdivision 15, is amended to read:

Subd. 15. **Emotional disturbance.** "Emotional disturbance" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that:

(1) is ~~listed in the clinical manual of the International Classification of Diseases (ICD-9-CM), current edition, code range 290.0 to 302.99 or 306.0 to 316.0 or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-MD), current edition, Axes I, II, or III~~ detailed in a diagnostic codes list 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 list 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

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

Sec. 6. Minnesota Statutes 2010, section 246.53, is amended by adding a subdivision to read:

Subd. 4. **Exception from statute of limitations.** Any statute of limitations that limits the commissioner in recovering the cost of care obligation incurred by a client or former client shall not apply to any claim against an estate made under this section to recover the cost of care.

Sec. 7. Minnesota Statutes 2011 Supplement, section 254B.04, subdivision 2a, is amended to read:

Subd. 2a. **Eligibility for treatment in residential settings.** Notwithstanding provisions of Minnesota Rules, part 9530.6622, subparts 5 and 6, related to an assessor's discretion in making placements to residential treatment settings, a person eligible for services under this section must score at level 4 on assessment dimensions related to relapse, continued use, ~~and~~ or recovery environment in order to be assigned to services with a room and board component reimbursed under this section.

Sec. 8. Minnesota Statutes 2010, section 256B.0625, subdivision 42, is amended to read:

Subd. 42. **Mental health professional.** Notwithstanding Minnesota Rules, part 9505.0175, subpart 28, the definition of a mental health professional shall include a person who is qualified as specified in section 245.462, subdivision 18, clauses ~~(5) and~~ (1) to (6); or 245.4871, subdivision 27, clauses ~~(5) and~~ (1) to (6), for the purpose of this section and Minnesota Rules, parts 9505.0170 to 9505.0475.

Sec. 9. Minnesota Statutes 2010, section 256F.13, subdivision 1, is amended to read:

Subdivision 1. **Federal revenue enhancement.** (a) The commissioner of human services may enter into an agreement with one or more family services collaboratives to enhance federal reimbursement under title IV-E of the Social Security Act and federal administrative reimbursement under title XIX of the Social Security Act. The commissioner may contract with the Department of Education for purposes of transferring 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 family services collaborative's actions in the integrated fund, or the proportional share if federal fiscal disallowances or sanctions are based on a statewide random sample; and

~~(8)~~ (7) the commissioner shall establish criteria for the family services collaborative for the accounting and financial management system that will support claims for federal reimbursement.

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

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

(2) the family services collaboratives 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, or to expand education, social, health, or health-related services to families and children;

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

(4) the family services collaborative must ensure that expenditures submitted for federal reimbursement are not made from federal funds or funds used to match other federal funds. Notwithstanding section 256B.19, subdivision 1, for the purposes of family services collaborative expenditures under agreement with the department, the nonfederal

share of costs shall be provided by the family services collaborative from sources other than federal funds or funds used to match other federal funds;

(5) the family services collaborative 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 agreement; and

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

Sec. 10. **TERMINOLOGY AUDIT.**

The commissioner of human services shall collaborate with individuals with disabilities, families, advocates, and other governmental agencies to solicit feedback and identify inappropriate and insensitive terminology relating to individuals with disabilities, conduct a comprehensive audit of the placement of this terminology in Minnesota Statutes and Minnesota Rules, and make recommendations for changes to the 2013 legislature on the repeal and replacement of this terminology with more appropriate and sensitive terminology.

ARTICLE 5

HEALTH CARE

Section 1. Minnesota Statutes 2011 Supplement, section 125A.21, subdivision 7, 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.

(b) Rate changes and recipient cost-sharing under this chapter and chapters 256D and 256L do not affect contract payments under this subdivision unless specifically identified.

(c) The commissioner may not utilize volume purchase through competitive bidding and negotiation for special transportation services under the provisions of chapter 16C.

Sec. 3. Minnesota Statutes 2011 Supplement, section 256B.056, subdivision 3, is amended to read:

Subd. 3. **Asset limitations for individuals and families.** (a) To be eligible for medical assistance, a person must not individually own more than $3,000 in assets, or if a member of a household with two family members, husband and wife, or parent and child, the household must not own more than $6,000 in assets, plus $200 for each additional legal dependent. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The accumulation of the clothing and personal needs allowance according to section 256B.35 must also be reduced to the maximum at the time of the eligibility redetermination. The value of assets that are not considered in

determining eligibility for medical assistance is the value of those assets excluded under the supplemental security income program for aged, blind, and disabled persons, with the following exceptions:

(1) household goods and personal effects are not considered;

(2) capital and operating assets of a trade or business that the local agency determines are necessary to the person's ability to earn an income are not considered;

(3) motor vehicles are excluded to the same extent excluded by the supplemental security income program;

(4) assets designated as burial expenses are excluded to the same extent excluded by the supplemental security income program. Burial expenses funded by annuity contracts or life insurance policies must irrevocably designate the individual's estate as contingent beneficiary to the extent proceeds are not used for payment of selected burial expenses; ~~and~~

(5) for a person who no longer qualifies as an employed person with a disability due to loss of earnings, assets allowed while eligible for medical assistance under section 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility as an employed person with a disability, to the extent that the person's total assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (d)~~.~~; and

(6) effective July 1, 2009, certain assets owned by American Indians are excluded as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. For purposes of this clause, an American Indian is any person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

(b) No asset limit shall apply to persons eligible under section 256B.055, subdivision 15.

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

Sec. 4. Minnesota Statutes 2010, section 256B.056, subdivision 3c, is amended to read:

Subd. 3c. **Asset limitations for families and children.** A household of two or more persons must not own more than $20,000 in total net assets, and a household of one person must not own more than $10,000 in total net assets. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance for families and children is the value of those assets excluded under the AFDC state plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193, with the following exceptions:

(1) household goods and personal effects are not considered;

(2) capital and operating assets of a trade or business up to $200,000 are not considered, except that a bank account that contains personal income or assets, or is used to pay personal expenses, is not considered a capital or operating asset of a trade or business;

(3) one motor vehicle is excluded for each person of legal driving age who is employed or seeking employment;

(4) assets designated as burial expenses are excluded to the same extent they are excluded by the Supplemental Security Income program;

(5) court-ordered settlements up to $10,000 are not considered;

(6) individual retirement accounts and funds are not considered; ~~and~~

(7) assets owned by children are not considered~~.~~; and

(8) effective July 1, 2009, certain assets owned by American Indians are excluded, as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. For purposes of this clause, an American Indian is any person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

The assets specified in clause (2) must be disclosed to the local agency at the time of application and at the time of an eligibility redetermination, and must be verified upon request of the local agency.

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

Sec. 5. Minnesota Statutes 2011 Supplement, section 256B.057, subdivision 9, is amended to read:

Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid for a person who is employed and who:

(1) but for excess earnings or assets, meets the definition of disabled under the Supplemental Security Income program;

(2) is at least 16 but less than 65 years of age;

(3) meets the asset limits in paragraph (d); and

(4) pays a premium and other obligations under paragraph (e).

(b) For purposes of eligibility, there is a $65 earned income disregard. To be eligible for medical assistance under this subdivision, a person must have more than $65 of earned income. Earned income must have Medicare, Social Security, and applicable state and federal taxes withheld. The person must document earned income tax withholding. Any spousal income or assets shall be disregarded for purposes of eligibility and premium determinations.

(c) After the month of enrollment, a person enrolled in medical assistance under this subdivision who:

(1) is temporarily unable to work and without receipt of earned income due to a medical condition, as verified by a physician; or

(2) loses employment for reasons not attributable to the enrollee, and is without receipt of earned income may retain eligibility for up to four consecutive months after the month of job loss. To receive a four-month extension, enrollees must verify the medical condition or provide notification of job loss. All other eligibility requirements must be met and the enrollee must pay all calculated premium costs for continued eligibility.

(d) For purposes of determining eligibility under this subdivision, a person's assets must not exceed $20,000, excluding:

(1) all assets excluded under section 256B.056;

(2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans, Keogh plans, and pension plans;

(3) medical expense accounts set up through the person's employer; and

(4) spousal assets, including spouse's share of jointly held assets.

(e) All enrollees must pay a premium to be eligible for medical assistance under this subdivision, except as provided under ~~section 256.01, subdivision 18b~~ clause (5).

(1) An enrollee must pay the greater of a $65 premium or the premium calculated based on the person's gross earned and unearned income and the applicable family size using a sliding fee scale established by the commissioner, which begins at one percent of income at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income for those with incomes at or above 300 percent of the federal poverty guidelines.

(2) Annual adjustments in the premium schedule based upon changes in the federal poverty guidelines shall be effective for premiums due in July of each year.

(3) All enrollees who receive unearned income must pay five percent of unearned income in addition to the premium amount, except as provided under ~~section 256.01, subdivision 18b~~ clause (5).

(4) Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year.

(5) Effective July 1, 2009, American Indians are exempt from paying premiums as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. For purposes of this clause, an American Indian is any person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

(f) A person's eligibility and premium shall be determined by the local county agency. Premiums must be paid to the commissioner. All premiums are dedicated to the commissioner.

(g) Any required premium shall be determined at application and redetermined at the enrollee's six-month income review or when a change in income or household size is reported. Enrollees must report any change in income or household size within ten days of when the change occurs. A decreased premium resulting from a reported change in income or household size shall be effective the first day of the next available billing month after the change is reported. Except for changes occurring from annual cost-of-living increases, a change resulting in an increased premium shall not affect the premium amount until the next six-month review.

(h) Premium payment is due upon notification from the commissioner of the premium amount required. Premiums may be paid in installments at the discretion of the commissioner.

(i) Nonpayment of the premium shall result in denial or termination of medical assistance unless the person demonstrates good cause for nonpayment. Good cause exists if the requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to D, are met. Except when an installment agreement is accepted by the commissioner, all persons disenrolled for nonpayment of a premium must pay any past due premiums as well as current premiums due prior to being reenrolled. Nonpayment shall include payment with a returned, refused, or dishonored instrument. The commissioner may require a guaranteed form of payment as the only means to replace a returned, refused, or dishonored instrument.

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

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

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

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

Subd. 2. **Period of ineligibility for long-term care services.** (a) For any uncompensated transfer occurring on or before August 10, 1993, the number of months

of ineligibility for long-term care services shall be the lesser of 30 months, or the uncompensated transfer amount divided by the average medical assistance rate for nursing facility services in the state in effect on the date of application. The amount used to calculate the average medical assistance payment rate shall be adjusted each July 1 to reflect payment rates for the previous calendar year. The period of ineligibility begins with the month in which the assets were transferred. If the transfer was not reported to the local agency at the time of application, and the applicant received long-term care services during what would have been the period of ineligibility if the transfer had been reported, a cause of action exists against the transferee for the cost of long-term care services provided during the period of ineligibility, or for the uncompensated amount of the transfer, whichever is less. The uncompensated transfer amount is the fair market value of the asset at the time it was given away, sold, or disposed of, less the amount of compensation received.

(b) For uncompensated transfers made after August 10, 1993, the number of months of ineligibility for long-term care services shall be the total uncompensated value of the resources transferred divided by the average medical assistance rate for nursing facility services in the state in effect on the date of application. The amount used to calculate the average medical assistance payment rate shall be adjusted each July 1 to reflect payment rates for the previous calendar year. The period of ineligibility begins with the first day of the month after the month in which the assets were transferred except that if one or more uncompensated transfers are made during a period of ineligibility, the total assets transferred during the ineligibility period shall be combined and a penalty period calculated to begin on the first day of the month after the month in which the first uncompensated transfer was made. If the transfer was reported to the local agency after the date that advance notice of a period of ineligibility that affects the next month could be provided to the recipient and the recipient received medical assistance services or the transfer was not reported to the local agency, and the applicant or recipient received medical assistance services during what would have been the period of ineligibility if the transfer had been reported, a cause of action exists against the transferee for that portion of long-term care services provided during the period of ineligibility, or for the uncompensated amount of the transfer, whichever is less. The uncompensated transfer amount is the fair market value of the asset at the time it was given away, sold, or disposed of, less the amount of compensation received. Effective for transfers made on or after March 1, 1996, involving persons who apply for medical assistance on or after April 13, 1996, no cause of action exists for a transfer unless:

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

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

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

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

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

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

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

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

(e) In the case of multiple fractional transfers of assets in more than one month for less than fair market value on or after February 8, 2006, the period of ineligibility is calculated by treating the total, cumulative, uncompensated value of all assets transferred during all months on or after February 8, 2006, as one transfer.

(f) A period of ineligibility established under paragraph (c) may be eliminated if all of the assets transferred for less than fair market value used to calculate the period of ineligibility, or cash equal to the value of the assets at the time of the transfer, are returned ~~within 12 months after the date the period of ineligibility began~~. A period of ineligibility must not be adjusted if less than the full amount of the transferred assets or the full cash value of the transferred assets are returned.

Sec. 7. Minnesota Statutes 2010, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician, physician assistant, or a nurse practitioner employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control.

(b) The dispensed quantity of a prescription drug must not exceed a 34-day supply, unless authorized by the commissioner.

(c) For the purpose of this subdivision and subdivision 13d, an "active pharmaceutical ingredient" is defined as a substance that is represented for use in a drug and when used in the manufacturing, processing, or packaging of a drug, becomes an active ingredient of the drug product. An "excipient" is defined as an inert substance used as a diluent or vehicle for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and excipients which are included in the medical assistance formulary. Medical assistance covers selected active pharmaceutical ingredients and excipients used in compounded prescriptions when the compounded combination is specifically approved by the commissioner or when a commercially available product:

(1) is not a therapeutic option for the patient;

(2) does not exist in the same combination of active ingredients in the same strengths as the compounded prescription; and

(3) cannot be used in place of the active pharmaceutical ingredient in the compounded prescription.

~~(c)~~ (d) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the formulary committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the requirements of chapter 14. A pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care

professionals. Over-the-counter medications must be dispensed in a quantity that is the lower of: (1) the number of dosage units contained in the manufacturer's original package; and (2) the number of dosage units required to complete the patient's course of therapy.

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

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

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

(b) The formulary shall not include:

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

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

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

(4) drugs or active pharmaceutical ingredients when used for the treatment of impotence or erectile dysfunction;

(5) drugs or active pharmaceutical ingredients for which medical value has not been established; and

(6) drugs from manufacturers who have not signed a rebate agreement with the Department of Health and Human Services pursuant to section 1927 of title XIX of the Social Security Act.

(c) If a single-source drug used by at least two percent of the fee-for-service medical assistance recipients is removed from the formulary due to the failure of the manufacturer to sign a rebate agreement with the Department of Health and Human Services, the commissioner shall notify prescribing practitioners within 30 days of

receiving notification from the Centers for Medicare and Medicaid Services (CMS) that a rebate agreement was not signed.

Sec. 9. Minnesota Statutes 2011 Supplement, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs or the maximum allowable cost by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be $3.65, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner at wholesale acquisition cost plus four percent for independently owned pharmacies located in a designated rural area within Minnesota, and at wholesale acquisition cost plus two percent for all other pharmacies. A pharmacy is "independently owned" if it is one of four or fewer pharmacies under the same ownership nationally. A "designated rural area" means an area defined as a small rural area or isolated rural area according to the four-category classification of the Rural Urban Commuting Area system developed for the United States Health Resources and Services Administration. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care

facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. ~~Over-the-counter medications must be dispensed in the manufacturer's unopened package.~~ The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

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

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

(e) The commissioner may negotiate lower reimbursement rates for specialty pharmacy products than the rates specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the formulary committee

to develop a list of specialty pharmacy products subject to this paragraph. In consulting with the formulary committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the reimbursement rate to prevent access to care issues.

(f) Home infusion therapy services provided by home infusion therapy pharmacies must be paid at rates according to subdivision 8d.

Sec. 10. Minnesota Statutes 2011 Supplement, section 256B.0625, subdivision 13h, is amended to read:

Subd. 13h. **Medication therapy management services.** (a) Medical assistance and general assistance medical care cover medication therapy management services for a recipient taking three or more prescriptions to treat or prevent one or more chronic medical conditions; a recipient with a drug therapy problem that is identified by the commissioner or identified by a pharmacist and approved by the commissioner; or prior authorized by the commissioner that has resulted or is likely to result in significant nondrug program costs. The commissioner may cover medical therapy management services under MinnesotaCare if the commissioner determines this is cost-effective. For purposes of this subdivision, "medication therapy management" means the provision of the following pharmaceutical care services by a licensed pharmacist to optimize the therapeutic outcomes of the patient's medications:

(1) performing or obtaining necessary assessments of the patient's health status;

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

(e) The commissioner shall establish a pilot project for an intensive medication therapy management program for patients identified by the commissioner with multiple chronic conditions and a high number of medications who are at high risk of preventable hospitalizations, emergency room use, medication complications, and suboptimal treatment outcomes due to medication-related problems. For purposes of the pilot

project, medication therapy management services may be provided in a patient's home or community setting, in addition to other authorized settings. The commissioner may waive existing payment policies and establish special payment rates for the pilot project. The pilot project must be designed to produce a net savings to the state compared to the estimated costs that would otherwise be incurred for similar patients without the program. The pilot project must begin by January 1, 2010, and end June 30, 2012.

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

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

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

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

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

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

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

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

(1) a general visual examination of the child's mouth without using probes or other dental equipment or taking radiographs;

(2) a risk assessment using the factors established by the American Academies of Pediatrics and Pediatric Dentistry; and

(3) the application of a fluoride varnish beginning at age one to those children assessed by the provider as being high risk in accordance with best practices as defined by the Department of Human Services. The provider must obtain parental or legal guardian consent before a fluoride ~~treatment~~ varnish is applied to a minor child's teeth.

At each checkup, if primary caries preventive services are provided, the provider must provide to the child's parent or legal guardian: information on caries etiology and prevention; and information on the importance of finding a dental home for their child by the age of one. The provider must also advise the parent or legal guardian to contact the child's managed care plan or the Department of Human Services in order to secure a

dental appointment with a dentist. The provider must indicate in the child's medical record that the parent or legal guardian was provided with this information and document any primary caries prevention services provided to the child.

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

Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following cost-sharing for all recipients, effective for services provided on or after September 1, 2011:

(1) $3 per nonpreventive visit, except as provided in paragraph (b). For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

~~(2) $3 for eyeglasses;~~

~~(3)~~ (2) $3.50 for nonemergency visits to a hospital-based emergency room, except that this co-payment shall be increased to $20 upon federal approval;

~~(4)~~ (3) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness;

~~(5)~~ (4) effective January 1, 2012, a family deductible equal to the maximum amount allowed under Code of Federal Regulations, title 42, part 447.54; and

~~(6)~~ (5) for individuals identified by the commissioner with income at or below 100 percent of the federal poverty guidelines, total monthly cost-sharing must not exceed five percent of family income. For purposes of this paragraph, family income is the total earned and unearned income of the individual and the individual's spouse, if the spouse is enrolled in medical assistance and also subject to the five percent limit on cost-sharing.

(b) Recipients of medical assistance are responsible for all co-payments and deductibles in this subdivision.

Sec. 13. Minnesota Statutes 2011 Supplement, section 256B.0631, subdivision 2, is amended to read:

Subd. 2. **Exceptions.** Co-payments and deductibles shall be subject to the following exceptions:

(1) children under the age of 21;

(2) pregnant women for services that relate to the pregnancy or any other medical condition that may complicate the pregnancy;

(3) recipients expected to reside for at least 30 days in a hospital, nursing home, or intermediate care facility for the developmentally disabled;

(4) recipients receiving hospice care;

(5) 100 percent federally funded services provided by an Indian health service;

(6) emergency services;

(7) family planning services;

(8) services that are paid by Medicare, resulting in the medical assistance program paying for the coinsurance and deductible; ~~and~~

(9) co-payments that exceed one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room~~.~~; and

(10) services, fee-for-service payments subject to volume purchase through competitive bidding.

Sec. 14. Minnesota Statutes 2010, section 256B.19, subdivision 1c, is amended to read:

Subd. 1c. **Additional portion of nonfederal share.** (a) Hennepin County shall be responsible for a monthly transfer payment of $1,500,000, due before noon on the 15th of each month and the University of Minnesota shall be responsible for a monthly transfer payment of $500,000 due before noon on the 15th of each month, beginning July 15, 1995. These sums shall be part of the designated governmental unit's portion of the nonfederal share of medical assistance costs.

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

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

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

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

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

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

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

Payments to providers participating in the project are exempt from the requirements of sections 256.966 and 256B.03, subdivision 2. The commissioner shall complete development of capitation rates for payments before delivery of services under this section is begun. For payments made during calendar year 1990 and later years, the commissioner shall contract with an independent actuary to establish prepayment rates.

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

Beginning July 1, 2004, the commissioner may include payments for elderly waiver services and 180 days of nursing home care in capitation payments for the prepaid medical assistance program for recipients age 65 and older. ~~Payments for elderly waiver services~~

~~shall be made no earlier than the month following the month in which services were received.~~

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

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

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

(c) Effective for services rendered on or after January 1, 2003, the commissioner shall withhold five percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care and county-based purchasing plans and providers. The managed care plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be

returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

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

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

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

(g) Effective for services rendered on or after January 1, 2011, through December 31, 2011, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency room utilization rate for state health care program enrollees by a measurable rate of five percent from the plan's utilization rate for state health care program enrollees for the previous calendar year. Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reduction shall be based on the health plan's utilization in 2009. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, excluding ~~Medicare~~ enrollees in programs described in subdivisions 23 and 28, compared to the previous ~~calendar~~ measurement

year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

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

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

(h) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than five percent of the plan's hospital admission rate for medical assistance and MinnesotaCare enrollees, excluding ~~Medicare~~ enrollees in programs described in subdivisions 23 and 28, compared to the previous calendar year until the final performance target is reached. When measuring performance, the commissioner must evaluate the difference in health risk in a plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

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

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

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

(i) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rates for subsequent hospitalizations within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding ~~Medicare~~ enrollees in programs described in subdivisions 23 and 28, of no less than five percent compared to the previous calendar year until the final performance target is reached.

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

The withhold described in this paragraph must continue for each consecutive contract period until the plan's subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding ~~Medicare~~ enrollees in programs described in subdivisions 23 and 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved.

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

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

(l) Effective for services rendered on or after January 1, 2013, through December 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

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

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

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

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

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

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

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

(2) basic health care services may also include risk for up to 100 days of nursing facility services for persons who reside in a noninstitutional setting and home health

services related to rehabilitation as defined by the commissioner after consultation with the stakeholder group.

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

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

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

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

(1) implementation efforts;

(2) consumer protections; and

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

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

(f) The commissioner is prohibited from providing the names of potential enrollees 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.12, subdivision 9, is amended to read:

Subd. 9. **Rate setting; performance withholds.** (a) Rates will be prospective, per capita, where possible. The commissioner may allow health plans to arrange for inpatient hospital services on a risk or nonrisk basis. The commissioner shall consult with an independent actuary to determine appropriate rates.

(b) For services rendered on or after January 1, 2004, the commissioner shall withhold five percent of managed care plan payments and county-based purchasing plan payments under this section pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions, when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care and county-based purchasing plans and providers. The managed care plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, such as characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if performance targets in the contract are achieved.

(c) For services rendered on or after January 1, 2011, the commissioner shall withhold an additional three percent of managed care plan or county-based purchasing plan payments under this section. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year. The return of the withhold under this paragraph is not subject to the requirements of paragraph (b).

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

medical assistance and MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reduction shall be based on the health plan's utilization in 2009. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's utilization rate for medical assistance and MinnesotaCare enrollees, excluding ~~Medicare~~ enrollees in programs described in section 256B.69, subdivisions 23 and 28, compared to the previous ~~calendar~~ measurement year, until the final performance target is reached. When measuring performance, the commissioner must evaluate the difference in health risk in a plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

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

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

(e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than five percent of the plan's hospital admission rate for medical assistance and MinnesotaCare enrollees, excluding ~~Medicare~~ enrollees in programs described in section 256B.69, subdivisions 23 and 28, compared to the previous calendar year, until the final performance target is reached. When measuring performance, the commissioner must evaluate the difference in health risk in a plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing

plan demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization rate was achieved.

The withhold described in this paragraph shall continue until there is a 25 percent reduction in the hospitals admission rate compared to the hospital admission rate for calendar year 2011 as determined by the commissioner. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved. The hospital admissions in this performance target do not include the admissions applicable to the subsequent hospital admission performance target under paragraph (f).

(f) Effective for services provided on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's hospitalization rate for a subsequent hospitalization within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of the subsequent hospital admissions rate for medical assistance and MinnesotaCare enrollees, excluding ~~Medicare~~ enrollees described in section 256B.69, subdivisions 23 and 28, of no less than five percent compared to the previous calendar year until the final performance target is reached.

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

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

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

Sec. 20. 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.

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

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

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

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

Sec. 21. Minnesota Statutes 2010, section 514.982, subdivision 1, is amended to read:

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

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

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

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

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

Sec. 22. **HEALTH SERVICES ADVISORY COUNCIL.**

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

Sec. 23. **REPEALER.**

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

ARTICLE 6

TECHNICAL

Section 1. Minnesota Statutes 2010, section 144A.071, subdivision 5a, is amended to read:

Subd. 5a. **Cost estimate of a moratorium exception project.** (a) For the purposes of this section and section 144A.073, the cost estimate of a moratorium exception project shall include the effects of the proposed project on the costs of the state subsidy for community-based services, nursing services, and housing in institutional and noninstitutional settings. The commissioner of health, in cooperation with the commissioner of human services, shall define the method for estimating these costs in the permanent rule implementing section 144A.073. The commissioner of human services shall prepare an estimate of the total state annual long-term costs of each moratorium exception proposal.

(b) The interest rate to be used for estimating the cost of each moratorium exception project proposal shall be the lesser of either the prime rate plus two percentage points, or the posted yield for standard conventional fixed rate mortgages of the Federal Home Loan Mortgage Corporation plus two percentage points as published in the Wall Street Journal and in effect 56 days prior to the application deadline. If the applicant's proposal uses this interest rate, the commissioner of human services, in determining the facility's actual property-related payment rate to be established upon completion of the project must use the actual interest rate obtained by the facility for the project's permanent financing up to the maximum permitted under ~~subdivision 6~~ Minnesota Rules, part 9549.0060, subpart 6.

The applicant may choose an alternate interest rate for estimating the project's cost. If the applicant makes this election, the commissioner of human services, in determining the facility's actual property-related payment rate to be established upon completion of the project, must use the lesser of the actual interest rate obtained for the project's permanent financing or the interest rate which was used to estimate the proposal's project cost. For succeeding rate years, the applicant is at risk for financing costs in excess of the interest rate selected.

Sec. 2. **REVISOR'S INSTRUCTION.**

(a) In Minnesota Statutes, sections 256B.038, 256B.0911, 256B.0918, 256B.092, 256B.097, 256B.49, and 256B.765, the revisor of statutes shall delete the word "traumatic" when it comes before the word "brain."

(b) In Minnesota Statutes, section 256B.093, subdivision 1, clauses (4) and (5), and subdivision 3, clause (2), the revisor of statutes shall delete the word "traumatic" when it comes before the word "brain."

(c) In Minnesota Statutes, sections 144.0724 and 144G.05, the revisor of statutes shall delete "TBI" and replace it with "BI."

APPENDIX
Article locations in H1994-2

256.01 COMMISSIONER OF HUMAN SERVICES; POWERS, DUTIES.

Subd. 18b. **Protections for American Indians.** Effective July 1, 2009, the commissioner shall comply with the federal requirements in the American Recovery and Reinvestment Act of 2009, Public Law 111-5, section 5006, regarding American Indians.

256B.431 RATE DETERMINATION.

Subd. 2c. **Operating costs after July 1, 1986.** For rate years beginning on or after July 1, 1986, the commissioner may allow a one time adjustment to historical operating costs of a nursing facility that has been found by the commissioner of health to be significantly below care related minimum standards appropriate to the mix of resident needs in that nursing facility when it is determined by the commissioners of health and human services that the nursing facility is unable to meet minimum standards through reallocation of nursing facility costs and efficiency incentives or allowances. In developing procedures to allow adjustments, the commissioner shall specify the terms and conditions governing any additional payments made to a nursing facility as a result of the adjustment. The commissioner shall establish procedures to recover amounts paid under this subdivision, in whole or in part, and to adjust current and future rates, for nursing facilities that fail to use the adjustment to satisfy care related minimum standards.

Subd. 2g. **Required consultants.** Costs considered general and administrative costs under section 256B.421 must be included in general and administrative costs in total, without direct or indirect allocation to other cost categories. In a nursing facility of 60 or fewer beds, part of an administrator's salary may be allocated to other cost categories to the extent justified in records kept by the nursing facility. Central or home office costs representing services of required consultants in areas including, but not limited to, dietary, pharmacy, social services, or activities may be allocated to the appropriate department, but only if those costs are directly identified by the nursing facility. Central, affiliated, or corporate office costs representing services of consultants not required by law in the areas of nursing, quality assurance, medical records, dietary, other care related services, and plant operations may be allocated to the appropriate operating cost category of a nursing facility according to paragraphs (a) to (e).

(a) Only the salaries, fringe benefits, and payroll taxes associated with the individual performing the service may be allocated. No other costs may be allocated.

(b) The allocation must be based on direct identification and only to the extent justified in time distribution records that show the actual time spent by the consultant performing the services in the nursing facility.

(c) The cost in paragraph (a) for each consultant must not be allocated to more than one operating cost category in the nursing facility. If more than one nursing facility is served by a consultant, all nursing facilities shall allocate the consultant's cost to the same operating category.

(d) Top management personnel must not be considered consultants.

(e) The consultant's full-time responsibilities shall be to provide the services identified in this item.

Subd. 2i. **Operating costs after July 1, 1988.** (a) Other operating cost limits.For rate years beginning on or after July 1, 1989, the adjusted other operating cost limits must be indexed as in Minnesota Rules, part 9549.0056, subparts 3 and 4. For the rate period beginning October 1, 1992, and for rate years beginning after June 30, 1993, the amount of the surcharge under section 256.9657, subdivision 1, shall be included in the plant operations and maintenance operating cost category. The surcharge shall be an allowable cost for the purpose of establishing the payment rate.

(b) Care-related operating cost limits. For rate years beginning on or after July 1, 1989, the adjusted care-related limits must be indexed as in Minnesota Rules, part 9549.0056, subparts 1 and 2.

(c) Salary adjustment per diem. Effective July 1, 1998, to June 30, 2000, the commissioner shall make available the salary adjustment per diem calculated in clause (1) or (2) to the total operating cost payment rate of each nursing facility reimbursed under this section or section 256B.434. The salary adjustment per diem for each nursing facility must be determined as follows:

(1) For each nursing facility that reports salaries for registered nurses, licensed practical nurses, and aides, orderlies and attendants separately, the commissioner shall determine the salary adjustment per diem by multiplying the total salaries, payroll taxes, and fringe benefits allowed in each operating cost category, except management fees and administrator and central office salaries and the related payroll taxes and fringe benefits, by 3.0 percent and then dividing the resulting amount by the nursing facility's actual resident days.

(2) For each nursing facility that does not report salaries for registered nurses, licensed practical nurses, aides, orderlies, and attendants separately, the salary adjustment per diem is the weighted average salary adjustment per diem increase determined under clause (1).

(3) A nursing facility may apply for the salary adjustment per diem calculated under clauses (1) and (2). The application must be made to the commissioner and contain a plan by which the nursing facility will distribute the salary adjustment to employees of the nursing facility. In order to apply for a salary adjustment, a nursing facility reimbursed under section 256B.434, must report the information required by clause (1) or (2) in the application, in the manner specified by the commissioner. For nursing facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative, after July 1, 1998, may constitute the plan for the salary distribution. The commissioner shall review the plan to ensure that the salary adjustment per diem is used solely to increase the compensation of nursing home facility employees. To be eligible, a facility must submit its plan for the salary distribution by December 31, 1998. If a facility's plan for salary distribution is effective for its employees after July 1, 1998, the salary adjustment cost per diem shall be effective the same date as its plan.

(4) Additional costs incurred by nursing facilities as a result of this salary adjustment are not allowable costs for purposes of the September 30, 1998, cost report.

(d) New base year. The commissioner shall establish a new base year for the reporting years ending September 30, 1991, and September 30, 1992. In establishing a new base year, the commissioner must take into account:

(1) statutory changes made in geographic groups;

(2) redefinitions of cost categories; and

(3) reclassification, pass-through, or exemption of certain costs.

Subd. 2j. **Hospital-attached nursing facility status.** (a) For the purpose of setting rates under Minnesota Rules, parts 9549.0010 to 9549.0080, for rate years beginning after June 30, 1989, a hospital-attached nursing facility means a nursing facility which meets the requirements of clauses (1) to (3):

(1) the nursing facility is recognized by the federal Medicare program to be a hospital-based nursing facility for purposes of being subject to higher cost limits accorded hospital-based nursing facilities under the Medicare program, or, prior to June 30, 1983, was classified as a hospital-attached nursing facility under Minnesota Rules, parts 9510.0010 to 9510.0480;

(2) the nursing facility's cost report filed under Minnesota Rules, parts 9549.0010 to 9549.0080, shall use the same cost allocation principles and methods used in the reports filed for the Medicare program except as provided in clause (3); and

(3) direct identification of costs to the nursing facility cost center will be permitted only when the comparable hospital costs have also been directly identified to a cost center which is not allocated to the nursing facility.

(b) For rate years beginning after June 30, 1989, a nursing facility and hospital, which have applied for hospital-based nursing facility status under the federal Medicare program during the reporting year or the nine-month period following the nursing facility's reporting year, shall be considered a hospital-attached nursing facility for purposes of setting payment rates under Minnesota Rules, parts 9549.0010 to 9549.0080, for the rate year following the reporting year or the nine-month period in which the facility made its Medicare application. The nursing facility must file its cost report or an amended cost report for that reporting year before the following rate year using Medicare principles and Medicare's recommended cost allocation methods had the Medicare program's hospital-based nursing facility status been granted to the nursing facility. For each subsequent rate year, the nursing facility must meet the definition requirements in paragraph (a). If the nursing facility is denied hospital-based nursing facility status under the Medicare program, the nursing facility's payment rates for the rate years the nursing facility was considered to be a hospital-attached nursing facility pursuant to this paragraph shall be recalculated treating the nursing facility as a non-hospital-attached nursing facility.

(c) For rate years beginning on or after July 1, 1995, a nursing facility shall be considered a hospital attached nursing facility for purposes of setting payment rates under Minnesota Rules, parts 9549.0010 to 9549.0080 and this section if it meets the requirements of paragraphs (a) and (b), and

(1) the hospital and nursing facility are physically attached or connected by a tunnel or skyway; or

(2) the nursing facility was recognized by the Medicare program as hospital attached as of January 1, 1995, and this status has been maintained continuously.

Subd. 2k. **Operating costs after July 1, 1989.** For rate years beginning on or after July 1, 1989, a nursing facility that is exempt under subdivision 2b, paragraph (d), clause (2); whose

total number of licensed beds are licensed under Minnesota Rules, parts 9570.2000 to 9570.3600; and that maintains an average length of stay of less than 365 days during each reporting year, is limited to 140 percent of the other-operating-cost limit for hospital-attached nursing facilities as established by Minnesota Rules, part 9549.0055, subpart 2, item E, subitem (2), as modified by subdivision 2i, paragraph (a). For purposes of this subdivision, the nursing facility's average length of stay must be computed by dividing the nursing facility's actual resident days for the reporting year by the nursing facility's total discharges for that reporting year.

Subd. 2l. **Inflation adjustments after July 1, 1990.** (a) For rate years beginning on or after July 1, 1990, the forecasted composite price index for a nursing facility's allowable operating cost per diems shall be determined using Data Resources, Inc., forecast for change in the Nursing Home Market Basket. The commissioner of human services shall use the indices as forecasted by Data Resources, Inc., in the fourth quarter of the calendar year preceding the rate year.

(b) For rate years beginning on or after July 1, 1992, the commissioner shall index the prior year's operating cost limits by the percentage change in the Data Resources, Inc., Nursing Home Market Basket between the midpoint of the current reporting year and the midpoint of the previous reporting year. The commissioner shall use the indices as forecasted by Data Resources, Inc., in the fourth quarter of the calendar year preceding the rate year.

(c) For rate years beginning on or after July 1, 1993, the commissioner shall not provide automatic annual inflation adjustments for nursing facilities. The commissioner of management and budget shall include annual adjustments in operating costs for nursing facilities as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11.

Subd. 2o. **Special payment rates for short-stay nursing facilities.** Notwithstanding contrary provisions of this section and rules adopted by the commissioner, for the rate years beginning on or after July 1, 1993, a nursing facility whose average length of stay for the preceding reporting year is (1) less than 180 days; or (2) less than 225 days in a nursing facility with more than 315 licensed beds must be reimbursed for allowable costs up to 125 percent of the total care-related limit and 105 percent of the other-operating-cost limit for hospital-attached nursing facilities. A nursing facility that received the benefit of this limit during the rate year beginning July 1, 1992, continues to receive this rate during the rate year beginning July 1, 1993, even if the facility's average length of stay is more than 180 days in the rate years subsequent to the rate year beginning July 1, 1991. For purposes of this subdivision, a nursing facility shall compute its average length of stay by dividing the nursing facility's actual resident days for the reporting year by the nursing facility's total resident discharges for that reporting year.

Subd. 3c. **Plant and maintenance costs.** For the rate years beginning on or after July 1, 1987, the commissioner shall allow as an expense in the reporting year of occurrence the lesser of the actual allowable plant and maintenance costs for supplies, minor equipment, equipment repairs, building repairs, purchased services and service contracts, except for arm's-length service contracts whose primary purpose is supervision, or $325 per licensed bed.

Subd. 11. **Special property rate setting procedures for certain nursing facilities.** (a) Notwithstanding Minnesota Rules, part 9549.0060, subpart 13, item H, to the contrary, for the rate year beginning July 1, 1990, a nursing facility leased prior to January 1, 1986, and currently subject to adverse licensure action under section 144A.04, subdivision 4, paragraph (a), or section 144A.11, subdivision 2, and whose ownership changes prior to July 1, 1990, shall be allowed a property-related payment equal to the lesser of its current lease obligation divided by its capacity days as determined in Minnesota Rules, part 9549.0060, subpart 11, as modified by subdivision 3f, paragraph (c), or the frozen property-related payment rate in effect for the rate year beginning July 1, 1989. For rate years beginning on or after July 1, 1991, the property-related payment rate shall be its rental rate computed using the previous owner's allowable principal and interest expense as allowed by the department prior to that prior owner's sale and lease-back transaction of December 1985.

(b) Notwithstanding other provisions of applicable law, a nursing facility licensed for 122 beds on January 1, 1998, and located in Columbia Heights shall have its property-related payment rate set under this subdivision. The commissioner shall make a rate adjustment by adding $2.41 to the facility's July 1, 1997, property-related payment rate. The adjusted property-related payment rate shall be effective for rate years beginning on or after July 1, 1998. The adjustment in this paragraph shall remain in effect so long as the facility's rates are set under this section. If the facility participates in the alternative payment system under section 256B.434, the adjustment in this paragraph shall be included in the facility's contract payment rate. If historical rates or property costs recognized under this section become the basis for future medical assistance payments to the facility under a managed care, capitation, or other alternative payment system, the adjustment in this paragraph shall be included in the computation of the facility's payments.

Subd. 14. **Limitations on sales of nursing facilities.** (a) For rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, a nursing facility's property-related payment rate as established under subdivision 13 shall be adjusted by either paragraph (b) or (c) for the sale of the nursing facility, including sales occurring after June 30, 1992, as provided in this subdivision.

(b) If the nursing facility's property-related payment rate under subdivision 13 prior to sale is greater than the nursing facility's rental rate under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section prior to sale, the nursing facility's property-related payment rate after sale shall be the greater of its property-related payment rate under subdivision 13 prior to sale or its rental rate under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section calculated after sale.

(c) If the nursing facility's property-related payment rate under subdivision 13 prior to sale is equal to or less than the nursing facility's rental rate under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section prior to sale, the nursing facility's property-related payment rate after sale shall be the nursing facility's property-related payment rate under subdivision 13 plus the difference between its rental rate calculated under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section prior to sale and its rental rate calculated under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section calculated after sale.

(d) For purposes of this subdivision, "sale" means the purchase of a nursing facility's capital assets with cash or debt. The term sale does not include a stock purchase of a nursing facility or any of the following transactions:

(1) a sale and leaseback to the same licensee that does not constitute a change in facility license;

(2) a transfer of an interest to a trust;

(3) gifts or other transfers for no consideration;

(4) a merger of two or more related organizations;

(5) a change in the legal form of doing business, other than a publicly held organization that becomes privately held or vice versa;

(6) the addition of a new partner, owner, or shareholder who owns less than 20 percent of the nursing facility or the issuance of stock; and

(7) a sale, merger, reorganization, or any other transfer of interest between related organizations other than those permitted in this section.

(e) For purposes of this subdivision, "sale" includes the sale or transfer of a nursing facility to a close relative as defined in Minnesota Rules, part 9549.0020, subpart 38, item C, upon the death of an owner, due to serious illness or disability, as defined under the Social Security Act, under United States Code, title 42, section 423(d)(1)(A), or upon retirement of an owner from the business of owning or operating a nursing home at 62 years of age or older. For sales to a close relative allowed under this paragraph, otherwise nonallowable debt resulting from seller financing of all or a portion of the debt resulting from the sale shall be allowed and shall not be subject to Minnesota Rules, part 9549.0060, subpart 5, item E, provided that in addition to existing requirements for allowance of debt and interest, the debt is subject to repayment through annual principal payments and the interest rate on the related organization debt does not exceed three percentage points above the posted yield for standard conventional fixed rate mortgages of the Federal Home Loan Mortgage Corporation for delivery in 60 days in effect on the day of sale. If at any time, the seller forgives the related organization debt allowed under this paragraph for other than equal amount of payment on that debt, then the buyer shall pay to the state the total revenue received by the nursing facility after the sale attributable to the amount of allowable debt which has been forgiven. Any assignment, sale, or transfer of the debt instrument entered into by the close relatives, either directly or indirectly, which grants to the close relative buyer the right to receive all or a portion of the payments under the debt instrument shall, effective on the date of the transfer, result in the prospective reduction in the corresponding portion of the allowable debt and interest expense. Upon the death of the close relative seller, any remaining balance of the close relative debt must be refinanced and such refinancing shall be subject to the provisions of Minnesota Rules, part 9549.0060, subpart 7, item G. This paragraph shall not apply to sales occurring on or after June 30, 1997.

(f) For purposes of this subdivision, "effective date of sale" means the later of either the date on which legal title to the capital assets is transferred or the date on which closing for the sale occurred.

(g) The effective day for the property-related payment rate determined under this subdivision shall be the first day of the month following the month in which the effective date of sale occurs or October 1, 1992, whichever is later, provided that the notice requirements under section 256B.47, subdivision 2, have been met.

(h) Notwithstanding Minnesota Rules, part 9549.0060, subparts 5, item A, subitems (3) and (4), and 7, items E and F, the commissioner shall limit the total allowable debt and related interest for sales occurring after June 30, 1992, to the sum of clauses (1) to (3):

(1) the historical cost of capital assets, as of the nursing facility's most recent previous effective date of sale or, if there has been no previous sale, the nursing facility's initial historical cost of constructing capital assets;

(2) the average annual capital asset additions after deduction for capital asset deletions, not including depreciations; and

(3) one-half of the allowed inflation on the nursing facility's capital assets. The commissioner shall compute the allowed inflation as described in paragraph (i).

(i) For purposes of computing the amount of allowed inflation, the commissioner must apply the following principles:

(1) the lesser of the Consumer Price Index for all urban consumers or the Dodge Construction Systems Costs for Nursing Homes for any time periods during which both are available must be used. If the Dodge Construction Systems Costs for Nursing Homes becomes unavailable, the commissioner shall substitute the index in subdivision 3f, or such other index as the secretary of the Centers for Medicare and Medicaid Services may designate;

(2) the amount of allowed inflation to be applied to the capital assets in paragraph (h), clauses (1) and (2), must be computed separately;

(3) the amount of allowed inflation must be determined on an annual basis, prorated on a monthly basis for partial years and if the initial month of use is not determinable for a capital asset, then one-half of that calendar year shall be used for purposes of prorating;

(4) the amount of allowed inflation to be applied to the capital assets in paragraph (h), clauses (1) and (2), must not exceed 300 percent of the total capital assets in any one of those clauses; and

(5) the allowed inflation must be computed starting with the month following the nursing facility's most recent previous effective date of sale or, if there has been no previous sale, the month following the date of the nursing facility's initial occupancy, and ending with the month preceding the effective date of sale.

(j) If the historical cost of a capital asset is not readily available for the date of the nursing facility's most recent previous sale or if there has been no previous sale for the date of the nursing facility's initial occupancy, then the commissioner shall limit the total allowable debt and related interest after sale to the extent recognized by the Medicare intermediary after the sale. For a nursing facility that has no historical capital asset cost data available and does not have allowable debt and interest calculated by the Medicare intermediary, the commissioner shall use the historical cost of capital asset data from the point in time for which capital asset data is recorded in the nursing facility's audited financial statements.

(k) The limitations in this subdivision apply only to debt resulting from a sale of a nursing facility occurring after June 30, 1992, including debt assumed by the purchaser of the nursing facility.

Subd. 17b. **Property-related payment rate.** The incremental increase in a nursing facility's rental rate, determined under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, resulting from the acquisition of allowable capital assets, and allowable debt and interest expense under this subdivision shall be added to its property-related payment rate and shall be effective on the first day of the month following the month in which the moratorium project was completed.

Subd. 17f. **Provisions for specific facilities.** (a) For a total replacement, as defined in subdivision 17d, authorized under section 144A.073 for a 96-bed nursing home in Carlton County, the replacement-costs-new per bed limit shall be $74,280 per licensed bed in multiple-bed rooms, $92,850 per licensed bed in semiprivate rooms with a fixed partition separating the resident's beds, and $111,420 per licensed bed in a single room. Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), does not apply. The resulting maximum allowable replacement-costs-new multiplied by 1.25 shall constitute the project's dollar threshold for purposes of application of the limit set forth in section 144A.071, subdivision 2. The commissioner of health may waive the requirements of section 144A.073, subdivision 3b, paragraph (b), clause (2), on the condition that the other requirements of that paragraph are met.

(b) For a renovation authorized under section 144A.073 for a 65-bed nursing home in St. Louis County, the incremental increase in rental rate for purposes of subdivision 17b shall be $8.16, and the total replacement cost, allowable appraised value, allowable debt, and allowable interest shall be increased according to the incremental increase.

(c) For a total replacement, as defined in subdivision 17d, authorized under section 144A.073 involving a new building addition that relocates beds from three-bed wards for an

80-bed nursing home in Redwood County, the replacement-costs-new per bed limit shall be $74,280 per licensed bed for multiple-bed rooms; $92,850 per licensed bed for semiprivate rooms with a fixed partition separating the beds; and $111,420 per licensed bed for single rooms. These amounts shall be adjusted annually, beginning January 1, 2001. Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), does not apply. The resulting maximum allowable replacement-costs-new multiplied by 1.25 shall constitute the project's dollar threshold for purposes of application of the limit set forth in section 144A.071, subdivision 2. The commissioner of health may waive the requirements of section 144A.073, subdivision 3b, paragraph (b), clause (2), on the condition that the other requirements of that paragraph are met.

Subd. 19. **Refinancing incentive.** (a) A nursing facility that refinances debt after May 30, 1992, in order to save in interest expense payments as determined in clauses (1) to (5) may be eligible for the refinancing incentive under this subdivision. To be eligible for the refinancing incentive, a nursing facility must notify the commissioner in writing of such a refinancing within 60 days following the date on which the refinancing occurs. If the nursing facility meets these conditions, the commissioner shall determine the refinancing incentive as in clauses (1) to (5).

(1) Compute the aggregate amount of interest expense, including amortized issuance and financing costs, remaining on the debt to be refinanced, and divide this amount by the number of years remaining for the term of that debt.

(2) Compute the aggregate amount of interest expense, including amortized issuance and financing costs, for the new debt, and divide this amount by the number of years for the term of that debt.

(3) Subtract the amount in clause (2) from the amount in clause (1), and multiply the amount, if positive, by .5.

(4) The amount in clause (3) shall be divided by the nursing facility's occupancy factor under subdivision 3f, paragraph (c).

(5) The per diem amount in clause (4) shall be deducted from the nursing facility's property-related payment rate for three full rate years following the rate year in which the refinancing occurs. For the fourth full rate year following the rate year in which the refinancing occurs, and each rate year thereafter, the per diem amount in clause (4) shall again be deducted from the nursing facility's property-related payment rate.

(b) An increase in a nursing facility's debt for costs in subdivision 17, paragraph (b), clause (2), including the cost of refinancing the issuance or financing costs of the debt refinanced resulting from refinancing that meets the conditions of this section shall be allowed, notwithstanding Minnesota Rules, part 9549.0060, subpart 5, item A, subitem (6).

(c) The proceeds of refinancing may not be used for the purpose of withdrawing equity from the nursing facility.

(d) Sale of a nursing facility under subdivision 14 shall terminate the payment of the incentive payments under this subdivision effective the date provided in subdivision 14, paragraph (f), for the sale, and the full amount of the refinancing incentive in paragraph (a) shall be implemented.

(e) If a nursing facility eligible under this subdivision fails to notify the commissioner as required, the commissioner shall determine the full amount of the refinancing incentive in paragraph (a), and shall deduct one-half that amount from the nursing facility's property-related payment rate effective the first day of the month following the month in which the refinancing is completed. For the next three full rate years, the commissioner shall deduct one-half the amount in paragraph (a), clause (5). The remaining per diem amount shall be deducted in each rate year thereafter.

(f) The commissioner shall reestablish the nursing facility's rental rate under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section following the refinancing using the new debt and interest expense information for the purpose of measuring future incremental rental increases.

Subd. 20. **Special property rate setting.** For rate periods beginning on October 1, 1992, and for rate years beginning after June 30, 1993, the property-related payment rate for a nursing facility approved for total replacement under the moratorium exception process in section 144A.073 through an addition to another nursing facility shall have its property-related rate under subdivision 13 recalculated using the greater of actual resident days or 80 percent of capacity days. This rate shall apply until the nursing facility is replaced or until the moratorium exception authority lapses, whichever is sooner.

Subd. 25. **Changes to nursing facility reimbursement beginning July 1, 1995.** A nursing facility licensed for 302 beds on September 30, 1993, that was approved under the moratorium exception process in section 144A.073 for a partial replacement, and completed the replacement project in December 1994, is exempt from Minnesota Statutes 1998, section 256B.431, subdivision 25, paragraphs (b) to (d) for rate years beginning on or after July 1, 1995.

For the rate year beginning July 1, 1997, after computing this nursing facility's payment rate according to section 256B.434, the commissioner shall make a one-year rate adjustment of $8.62 to the facility's contract payment rate for the rate effect of operating cost changes associated with the facility's 1994 downsizing project.

For rate years beginning on or after July 1, 1997, the commissioner shall add 35 cents to the facility's base property related payment rate for the rate effect of reducing its licensed capacity to 290 beds from 302 beds and shall add 83 cents to the facility's real estate tax and special assessment payment rate for payments in lieu of real estate taxes. The adjustments in this clause shall remain in effect for the duration of the facility's contract under section 256B.434.

Subd. 26. **Changes to nursing facility reimbursement beginning July 1, 1997.** The nursing facility reimbursement changes in paragraphs (a) to (e) shall apply in the sequence specified in Minnesota Rules, parts 9549.0010 to 9549.0080, and this section, beginning July 1, 1997.

(a) For rate years beginning on or after July 1, 1997, the commissioner shall limit a nursing facility's allowable operating per diem for each case mix category for each rate year. The commissioner shall group nursing facilities into two groups, freestanding and nonfreestanding, within each geographic group, using their operating cost per diem for the case mix A classification. A nonfreestanding nursing facility is a nursing facility whose other operating cost per diem is subject to the hospital attached, short length of stay, or the rule 80 limits. All other nursing facilities shall be considered freestanding nursing facilities. The commissioner shall then array all nursing facilities in each grouping by their allowable case mix A operating cost per diem. In calculating a nursing facility's operating cost per diem for this purpose, the commissioner shall exclude the raw food cost per diem related to providing special diets that are based on religious beliefs, as determined in subdivision 2b, paragraph (h). For those nursing facilities in each grouping whose case mix A operating cost per diem:

(1) is at or below the median of the array, the commissioner shall limit the nursing facility's allowable operating cost per diem for each case mix category to the lesser of the prior reporting year's allowable operating cost per diem as specified in Laws 1996, chapter 451, article 3, section 11, paragraph (h), plus the inflation factor as established in paragraph (d), clause (2), increased by two percentage points, or the current reporting year's corresponding allowable operating cost per diem; or

(2) is above the median of the array, the commissioner shall limit the nursing facility's allowable operating cost per diem for each case mix category to the lesser of the prior reporting year's allowable operating cost per diem as specified in Laws 1996, chapter 451, article 3, section 11, paragraph (h), plus the inflation factor as established in paragraph (d), clause (2), increased by one percentage point, or the current reporting year's corresponding allowable operating cost per diem.

For purposes of paragraph (a), if a nursing facility reports on its cost report a reduction in cost due to a refund or credit for a rate year beginning on or after July 1, 1998, the commissioner shall increase that facility's spend-up limit for the rate year following the current rate year by the amount of the cost reduction divided by its resident days for the reporting year preceding the rate year in which the adjustment is to be made.

(b) For rate years beginning on or after July 1, 1997, the commissioner shall limit the allowable operating cost per diem for high cost nursing facilities. After application of the limits in paragraph (a) to each nursing facility's operating cost per diem, the commissioner shall group nursing facilities into two groups, freestanding or nonfreestanding, within each geographic group. A nonfreestanding nursing facility is a nursing facility whose other operating cost per diem are subject to hospital attached, short length of stay, or rule 80 limits. All other nursing facilities shall be considered freestanding nursing facilities. The commissioner shall then array all nursing facilities within each grouping by their allowable case mix A operating cost per diem. In calculating a nursing facility's operating cost per diem for this purpose, the commissioner shall exclude the raw food cost per diem related to providing special diets that are based on religious beliefs, as determined in subdivision 2b, paragraph (h). For those nursing facilities in each grouping whose case mix A operating cost per diem exceeds 1.0 standard deviation above the median, the commissioner shall reduce their allowable operating cost per diem by three percent. For those nursing facilities in each grouping whose case mix A operating cost per diem exceeds 0.5 standard deviation above the median but is less than or equal to 1.0 standard deviation above the median, the commissioner shall reduce their allowable operating cost per diem by two percent. However, in no case shall a nursing facility's operating cost per diem be reduced below its grouping's limit established at 0.5 standard deviations above the median.

(c) For rate years beginning on or after July 1, 1997, the commissioner shall determine a nursing facility's efficiency incentive by first computing the allowable difference, which is

the lesser of $4.50 or the amount by which the facility's other operating cost limit exceeds its nonadjusted other operating cost per diem for that rate year. The commissioner shall compute the efficiency incentive by:

(1) subtracting the allowable difference from $4.50 and dividing the result by $4.50;

(2) multiplying 0.20 by the ratio resulting from clause (1), and then;

(3) adding 0.50 to the result from clause (2); and

(4) multiplying the result from clause (3) times the allowable difference.

The nursing facility's efficiency incentive payment shall be the lesser of $2.25 or the product obtained in clause (4).

(d) For rate years beginning on or after July 1, 1997, the forecasted price index for a nursing facility's allowable operating cost per diem shall be determined under clauses (1) and (2) using the change in the Consumer Price Index-All Items (United States city average) (CPI-U) as forecasted by Data Resources, Inc. The commissioner shall use the indices as forecasted in the fourth quarter of the calendar year preceding the rate year, subject to subdivision 2l, paragraph (c).

(1) The CPI-U forecasted index for allowable operating cost per diem shall be based on the 21-month period from the midpoint of the nursing facility's reporting year to the midpoint of the rate year following the reporting year.

(2) For rate years beginning on or after July 1, 1997, the forecasted index for operating cost limits referred to in subdivision 21, paragraph (b), shall be based on the CPI-U for the 12-month period between the midpoints of the two reporting years preceding the rate year.

(e) After applying these provisions for the respective rate years, the commissioner shall index these allowable operating cost per diem by the inflation factor provided for in paragraph (d), clause (1), and add the nursing facility's efficiency incentive as computed in paragraph (c).

(f) For the rate years beginning on July 1, 1997, July 1, 1998, and July 1, 1999, a nursing facility licensed for 40 beds effective May 1, 1992, with a subsequent increase of 20 Medicare/Medicaid certified beds, effective January 26, 1993, in accordance with an increase in licensure is exempt from paragraphs (a) and (b).

(g) For the rate year beginning July 1, 1997, the commissioner shall compute the payment rate for a nursing facility licensed for 94 beds on September 30, 1996, that applied in October 1993 for approval of a total replacement under the moratorium exception process in section 144A.073, and completed the approved replacement in June 1995, with other operating cost spend-up limit under paragraph (a), increased by $3.98, and after computing the facility's payment rate according to this section, the commissioner shall make a one-year positive rate adjustment of $3.19 for operating costs related to the newly constructed total replacement, without application of paragraphs (a) and (b). The facility's per diem, before the $3.19 adjustment, shall be used as the prior reporting year's allowable operating cost per diem for payment rate calculation for the rate year beginning July 1, 1998. A facility described in this paragraph is exempt from paragraph (b) for the rate years beginning July 1, 1997, and July 1, 1998.

(h) For the purpose of applying the limit stated in paragraph (a), a nursing facility in Kandiyohi County licensed for 86 beds that was granted hospital-attached status on December 1, 1994, shall have the prior year's allowable care-related per diem increased by $3.207 and the prior year's other operating cost per diem increased by $4.777 before adding the inflation in paragraph (d), clause (2), for the rate year beginning on July 1, 1997.

(i) For the purpose of applying the limit stated in paragraph (a), a 117 bed nursing facility located in Pine County shall have the prior year's allowable other operating cost per diem increased by $1.50 before adding the inflation in paragraph (d), clause (2), for the rate year beginning on July 1, 1997.

(j) For the purpose of applying the limit under paragraph (a), a nursing facility in Hibbing licensed for 192 beds shall have the prior year's allowable other operating cost per diem increased by $2.67 before adding the inflation in paragraph (d), clause (2), for the rate year beginning July 1, 1997.

Subd. 27. **Changes to nursing facility reimbursement beginning July 1, 1998.** (a) For the purpose of applying the limit stated in subdivision 26, paragraph (a), a nursing facility in Hennepin County licensed for 181 beds on September 30, 1996, shall have the prior year's allowable care-related per diem increased by $1.455 and the prior year's other operating cost per diem increased by $0.439 before adding the inflation in subdivision 26, paragraph (d), clause (2), for the rate year beginning on July 1, 1998.

(b) For the purpose of applying the limit stated in subdivision 26, paragraph (a), a nursing facility in Hennepin County licensed for 161 beds on September 30, 1996, shall have the prior year's allowable care-related per diem increased by $1.154 and the prior year's other operating cost per diem increased by $0.256 before adding the inflation in subdivision 26, paragraph (d), clause (2), for the rate year beginning on July 1, 1998.

(c) For the purpose of applying the limit stated in subdivision 26, paragraph (a), a nursing facility in Ramsey County licensed for 176 beds on September 30, 1996, shall have the prior year's allowable care-related per diem increased by $0.803 and the prior year's other operating cost per diem increased by $0.272 before adding the inflation in subdivision 26, paragraph (d), clause (2), for the rate year beginning on July 1, 1998.

(d) For the purpose of applying the limit stated in subdivision 26, paragraph (a), a nursing facility in Brown County licensed for 86 beds on September 30, 1996, shall have the prior year's allowable care-related per diem increased by $0.850 and the prior year's other operating cost per diem increased by $0.275 before adding the inflation in subdivision 26, paragraph (d), clause (2), for the rate year beginning on July 1, 1998.

(e) For the rate year beginning July 1, 1998, the commissioner shall compute the payment rate for a nursing facility, which was licensed for 110 beds on May 1, 1997, was granted approval in January 1994 for a replacement and remodeling project under the moratorium exception process in section 144A.073, and completed the approved replacement and remodeling project on March 14, 1997, by increasing the other operating cost spend-up limit under paragraph (a) by $1.64. After computing the facility's payment rate for the rate year beginning July 1, 1998, according to this section, the commissioner shall make a one-year positive rate adjustment of 48 cents for increased real estate taxes resulting from completion of the moratorium exception project, without application of paragraphs (a) and (b).

(f) For the rate year beginning July 1, 1998, the commissioner shall compute the payment rate for a nursing facility exempted from care-related limits under subdivision 2b, paragraph (d), clause (2), with a minimum of three-quarters of its beds licensed to provide residential services for the physically disabled under Minnesota Rules, parts 9570.2000 to 9570.3400, with the care-related spend-up limit under subdivision 26, paragraph (a), increased by $13.21 for the rate year beginning July 1, 1998, without application of subdivision 26, paragraph (b). For rate years beginning on or after July 1, 1999, the commissioner shall exclude that amount in calculating the facility's operating cost per diem for purposes of applying subdivision 26, paragraph (b).

(g) For the rate year beginning July 1, 1998, a nursing facility in Canby, Minnesota, licensed for 75 beds shall be reimbursed without the limitation imposed under subdivision 26, paragraph (a), and for rate years beginning on or after July 1, 1999, its base costs shall be calculated on the basis of its September 30, 1997, cost report.

(h) The nursing facility reimbursement changes in paragraphs (i) and (j) shall apply in the sequence specified in this section and Minnesota Rules, parts 9549.0010 to 9549.0080, beginning July 1, 1998.

(i) For rate years beginning on or after July 1, 1998, the operating cost limits established in subdivisions 2, 2b, 2i, 3c, and 22, paragraph (d), and any previously effective corresponding limits in law or rule shall not apply, except that these cost limits shall still be calculated for purposes of determining efficiency incentive per diems. For rate years beginning on or after July 1, 1998, the total operating cost payment rates for a nursing facility shall be the greater of the total operating cost payment rates determined under this section or the total operating cost payment rates in effect on June 30, 1998, subject to rate adjustments due to field audit or rate appeal resolution.

(j) For rate years beginning on or after July 1, 1998, the operating cost per diem referred to in subdivision 26, paragraph (a), clauses (1) and (2), is the sum of the care-related and other operating per diems for a given case mix class. Any reductions to the combined operating per diem shall be divided proportionately between the care-related and other operating per diems.

(k) For rate years beginning on or after July 1, 1998, the commissioner shall modify the determination of the spend-up limits referred to in subdivision 26, paragraph (a), by indexing each group's previous year's median value by the factor in subdivision 26, paragraph (d), clause (2), plus one percentage point.

(l) For rate years beginning on or after July 1, 1998, the commissioner shall modify the determination of the high cost limits referred to in subdivision 26, paragraph (b), by indexing each group's previous year's high cost per diem limits at .5 and one standard deviations above the median by the factor in subdivision 26, paragraph (d), clause (2), plus one percentage point.

Subd. 29. **Facility rate increases effective July 1, 2000.** Following the determination under subdivision 28 of the payment rate for the rate year beginning July 1, 2000, for a facility in Roseau County licensed for 49 beds, the facility's operating cost per diem shall be increased by the following amounts:

(1) case mix class A, $1.97;

(2) case mix class B, $2.11;

(3) case mix class C, $2.26;

(4) case mix class D, $2.39;

(5) case mix class E, $2.54;

(6) case mix class F, $2.55;
(7) case mix class G, $2.66;
(8) case mix class H, $2.90;
(9) case mix class I, $2.97;
(10) case mix class J, $3.10; and
(11) case mix class K, $3.36.

These increases shall be included in the facility's total payment rates for the purpose of determining future rates under this section or any other section.

256B.434 ALTERNATIVE PAYMENT DEMONSTRATION PROJECT.

Subd. 4a. **Facility rate increases.** For the rate year beginning July 1, 1999, the nursing facilities described in clauses (1) to (5) shall receive the rate increases indicated. The increases provided under this subdivision shall be included in the facility's total payment rates for the purpose of determining future rates under this section or any other section:

(1) a nursing facility in Becker County licensed for 102 nursing home beds on September 30, 1998, shall receive an increase of $1.30 in its case mix class A payment rate; an increase of $1.33 in its case mix class B payment rate; an increase of $1.36 in its case mix class C payment rate; an increase of $1.39 in its case mix class D payment rate; an increase of $1.42 in its case mix class E payment rate; an increase of $1.42 in its case mix class F payment rate; an increase of $1.45 in its case mix class G payment rate; an increase of $1.49 in its case mix class H payment rate; an increase of $1.51 in its case mix class I payment rate; an increase of $1.54 in its case mix class J payment rate; and an increase of $1.59 in its case mix class K payment rate;

(2) a nursing facility in Chisago County licensed for 101 nursing home beds on September 30, 1998, shall receive an increase of $3.67 in each case mix payment rate;

(3) a nursing facility in Canby, licensed for 75 beds shall have its property-related per diem rate increased by $1.21. This increase shall be recognized in the facility's contract payment rate under this section;

(4) a nursing facility in Golden Valley with all its beds licensed to provide residential rehabilitative services to young adults under Minnesota Rules, parts 9570.2000 to 9570.3400, shall have the payment rate computed according to this section increased by $14.83; and

(5) a county-owned 130-bed nursing facility in Park Rapids shall have its per diem contract payment rate increased by $1.02 for costs related to compliance with comparable worth requirements.

Subd. 4b. **Facility rate increases effective July 1, 2000.** For the rate year beginning July 1, 2000, the nursing facilities described in clauses (1) to (6) shall receive the rate increases indicated. The increases under this subdivision shall be added following the determination under section 256B.431, subdivision 28, of the payment rate for the rate year beginning July 1, 2000, and shall be included in the facility's total payment rates for the purposes of determining future rates under this section or any other section:

(1) a nursing facility in Hennepin County licensed for 290 beds shall receive an operating cost per diem increase of 5.9 percent, provided that the facility delicenses, decertifies, or places on layaway status, if that status is otherwise permitted by law, 70 beds;

(2) a nursing facility in Goodhue County licensed for 84 beds shall receive an increase of $1.54 in each case mix payment rate;

(3) a nursing facility located in Rochester and licensed for 103 beds on January 1, 2000, shall receive an increase in its case mix resident class A payment of $3.78, and an increase in the payment rate for all other case mix classes of that amount multiplied by the class weight for that case mix class established in Minnesota Rules, part 9549.0058, subpart 3;

(4) a nursing facility in Wright County licensed for 154 beds shall receive an increase of $2.03 in each case mix payment rate to be used for employee wage and benefit enhancements;

(5) a facility in Todd County licensed for 78 beds, shall have its operating cost per diem increased by the following amounts:

(i) case mix class A, $1.16;
(ii) case mix class B, $1.50;
(iii) case mix class C, $1.89;
(iv) case mix class D, $2.26;
(v) case mix class E, $2.63;
(vi) case mix class F, $2.65;
(vii) case mix class G, $2.96;
(viii) case mix class H, $3.55;
(ix) case mix class I, $3.76;

(x) case mix class J, $4.08; and

(xi) case mix class K, $4.76; and

(6) a nursing facility in Pine City that decertified 22 beds in calendar year 1999 shall have its property-related per diem payment rate increased by $1.59.

Subd. 4c. **Facility rate increases effective January 1, 2002.** For the rate period beginning January 1, 2002, and for the rate year beginning July 1, 2002, a nursing facility in Morrison County licensed for 83 beds as of March 1, 2001, shall receive an increase of $2.54 in each case mix payment rate to offset property tax payments due as a result of the facility's conversion from nonprofit to for-profit status. The increase under this subdivision shall be added following the determination under this chapter of the payment rate for the rate year beginning July 1, 2001, and shall be included in the facility's total payment rates for the purposes of determining future rates under this section or any other section.

Subd. 4d. **Facility rate increases effective July 1, 2001.** For the rate year beginning July 1, 2001, a nursing facility in Hennepin County licensed for 302 beds shall receive an increase of 29 cents in each case mix payment rate to correct an error in the cost-reporting system that occurred prior to the date that the facility entered the alternative payment demonstration project. The increase under this subdivision shall be added following the determination under this chapter of the payment rate for the rate year beginning July 1, 2001, and shall be included in the facility's total payment rates for the purposes of determining future rates under this section or any other section.

Subd. 4e. **Rate increase effective July 1, 2001.** A nursing facility in Anoka County licensed for 98 beds as of July 1, 2000, shall receive a total increase of $10 in each case mix rate for the rate year beginning July 1, 2001, as a result of increases provided under this subdivision and section 256B.431, subdivision 33. The increases under this subdivision shall be added prior to the determination under section 256B.431, subdivision 33, of the payment rate for the rate year beginning July 1, 2001, and shall be included in the facility's total payment rate for purposes of determining future rates under this section or any other section through June 30, 2004.

Subd. 4g. **Facility rate increase effective October 1, 2007; Otter Tail County.** For the rate year beginning October 1, 2007, a nursing facility in Otter Tail County that was licensed for 57 beds as of December 31, 2004, shall receive a rate increase to increase its operating rate to the 60th percentile of the operating rates of all other Otter Tail County nursing facilities. The commissioner shall determine the 60th percentile of the case mix portion of the operating rates with a RUG's weight of 1.0 of all other Otter Tail County nursing facilities and then apply the case mix weights. The 60th percentile of the other operating per diem for all other Otter Tail County nursing facilities will be added to the above-determined case mix rates to compute the operating payment rates. The nonoperating components of the facility's rates will not be adjusted under this subdivision.

Subd. 4h. **Nursing facility rate increase effective October 1, 2007; Martin County.** For the rate year beginning October 1, 2007, the commissioner shall provide to a nursing facility in Martin County licensed for 93 beds as of January 1, 2006, an increase in the total operating payment rate of $5 per resident day for all case mix classes.

Subd. 7. **Case mix assessments.** The commissioner may allow a contract facility to develop and implement a case mix assessment using the federal minimum data set resident assessment.

Subd. 8. **Optional higher payments for first 100 days.** The commissioner may include in the contract with a nursing facility under this section a higher rate for the first 100 days after admission than for subsequent days. The rate for the subsequent days must be reduced so that the estimated total cost to the medical assistance program will not exceed the estimated cost without the differential payment rates.

256B.435 JULY 1, 2001, NURSING FACILITY REIMBURSEMENT SYSTEM.

Subdivision 1. **In general.** Effective July 1, 2001, the commissioner shall implement a performance-based contracting system to replace the current method of setting operating cost payment rates under sections 256B.431 and 256B.434 and Minnesota Rules, parts 9549.0010 to 9549.0080. Operating cost payment rates for newly established facilities under Minnesota Rules, part 9549.0057, shall be established using section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0070. A nursing facility in operation on May 1, 1998, with payment rates not established under section 256B.431 or 256B.434 on that date, is ineligible for this performance-based contracting system. In determining prospective payment rates of nursing facility services, the commissioner shall distinguish between operating costs and property-related costs. The commissioner of management and budget shall include an annual inflationary

adjustment in operating costs for nursing facilities using the inflation factor specified in subdivision 3 and funding for incentive-based payments as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11. Property related payment rates, including real estate taxes and special assessments, shall be determined under section 256B.431 or 256B.434 or under a new property-related reimbursement system, if one is implemented by the commissioner under subdivision 3. The commissioner shall present additional recommendations for performance-based contracting for nursing facilities to the legislature by February 15, 2000, in the following specific areas:

(1) development of an interim default payment mechanism for nursing facilities that do not respond to the state's request for proposal but wish to continue participation in the medical assistance program, and nursing facilities the state does not select in the request for proposal process, and nursing facilities whose contract has been canceled;

(2) development of criteria for facilities to earn performance-based incentive payments based on relevant outcomes negotiated by nursing facilities and the commissioner and that recognize both continuous quality efforts and quality improvement;

(3) development of criteria and a process under which nursing facilities can request rate adjustments for low base rates, geographic disparities, or other reasons;

(4) development of a dispute resolution mechanism for nursing facilities that are denied a contract, denied incentive payments, or denied a rate adjustment;

(5) development of a property payment system to address the capital needs of nursing facilities that will be funded with additional appropriations;

(6) establishment of a transitional plan to move from dual assessment instruments to the federally mandated resident assessment system, whereby the financial impact for each facility would be budget neutral;

(7) identification of net cost implications for facilities and to the department of preparing for and implementing performance-based contracting or any proposed alternative system;

(8) identification of facility financial and statistical reporting requirements; and

(9) identification of exemptions from current regulations and statutes applicable under performance-based contracting.

Subd. 1a. **Requests for proposals.** (a) For nursing facilities with rates established under section 256B.434 on January 1, 2001, the commissioner shall renegotiate contracts without requiring a response to a request for proposal, notwithstanding the solicitation process described in chapter 16C.

(b) Prior to July 1, 2001, the commissioner shall publish in the State Register a request for proposals to provide nursing facility services according to this section. The commissioner will consider proposals from all nursing facilities that have payment rates established under section 256B.431. The commissioner must respond to all proposals in a timely manner.

(c) In issuing a request for proposals, the commissioner may develop reasonable requirements which, in the judgment of the commissioner, are necessary to protect residents or ensure that the performance-based contracting system furthers the interests of the state of Minnesota. The request for proposals may include, but need not be limited to:

(1) a requirement that a nursing facility make reasonable efforts to maximize Medicare payments on behalf of eligible residents;

(2) requirements designed to prevent inappropriate or illegal discrimination against residents enrolled in the medical assistance program as compared to private paying residents;

(3) requirements designed to ensure that admissions to a nursing facility are appropriate and that reasonable efforts are made to place residents in home and community-based settings when appropriate;

(4) a requirement to agree to participate in the development of data collection systems and outcome-based standards. Among other requirements specified by the commissioner, each facility entering into a contract may be required to pay an annual fee not to exceed $1,000. The commissioner must use revenue generated from the fees to contract with a qualified consultant or contractor to develop data collection systems and outcome-based contracting standards;

(5) a requirement that Medicare-certified contractors agree to maintain Medicare cost reports and to submit them to the commissioner upon request, or at times specified by the commissioner; and that contractors that are not Medicare-certified agree to maintain a uniform cost report in a format established by the commissioner and to submit the report to the commissioner upon request, or at times specified by the commissioner;

(6) a requirement that demonstrates willingness and ability to develop and maintain data collection and retrieval systems to measure outcomes; and

(7) a requirement to provide all information and assurances required by the terms and conditions of the federal waiver or federal approval.

(d) In addition to the information and assurances contained in the submitted proposals, the commissioner may consider the following criteria in developing the terms of the contract:

(1) the facility's history of compliance with federal and state laws and rules. A facility deemed to be in substantial compliance with federal and state laws and rules is eligible to respond to a request for proposals. A facility's compliance history shall not be the sole determining factor in situations where the facility has been sold and the new owners have submitted a proposal;

(2) whether the facility has a record of excessive licensure fines or sanctions or fraudulent cost reports;

(3) the facility's financial history and solvency; and

(4) other factors identified by the commissioner deemed relevant to developing the terms of the contract, including a determination that a contract with a particular facility is not in the best interests of the residents of the facility or the state of Minnesota.

(e) Notwithstanding the requirements of the solicitation process described in chapter 16C, the commissioner may contract with nursing facilities established according to section 144A.073 without issuing a request for proposals.

(f) Notwithstanding subdivision 1, after July 1, 2001, the commissioner may contract with additional nursing facilities, according to requests for proposals.

Subd. 2. **Contract provisions.** (a) The performance-based contract with each nursing facility must include provisions that:

(1) apply the resident case mix assessment provisions of Minnesota Rules, parts 9549.0051, 9549.0058, and 9549.0059, or another assessment system, with the goal of moving to a single assessment system;

(2) monitor resident outcomes through various methods, such as quality indicators based on the minimum data set and other utilization and performance measures;

(3) require the establishment and use of a continuous quality improvement process that integrates information from quality indicators and regular resident and family satisfaction interviews;

(4) require annual reporting of facility statistical information, including resident days by case mix category, productive nursing hours, wages and benefits, and raw food costs for use by the commissioner in the development of facility profiles that include trends in payment and service utilization;

(5) require from each nursing facility an annual certified audited financial statement consisting of a balance sheet, income and expense statements, and an opinion from either a licensed or certified public accountant, if a certified audit was prepared, or unaudited financial statements if no certified audit was prepared;

(6) specify the method for resolving disputes; and

(7) establish additional requirements for nursing facilities not meeting the standards set forth in the performance-based contract.

(b) The commissioner may develop additional incentive-based payments for achieving specified outcomes specified in each contract. The specified facility-specific outcomes must be measurable and approved by the commissioner.

(c) The commissioner may also contract with nursing facilities in other ways through requests for proposals, including contracts on a risk or nonrisk basis, with nursing facilities or consortia of nursing facilities, to provide comprehensive long-term care coverage on a premium or capitated basis.

(d) The commissioner may negotiate different contract terms for different nursing facilities.

Subd. 2a. **Duration and termination of contracts.** (a) All contracts entered into under this section are for a term of one year. Either party may terminate this contract at any time without cause by providing 90 calendar days' advance written notice to the other party. Notwithstanding section 16C.05, subdivisions 2, paragraph (b), and 5, if neither party provides written notice of termination, the contract shall be renegotiated for additional one-year terms or the terms of the existing contract will be extended for one year. The provisions of the contract shall be renegotiated annually by the parties prior to the expiration date of the contract. The parties may voluntarily renegotiate the terms of the contract at any time by mutual agreement.

(b) If a nursing facility fails to comply with the terms of a contract, the commissioner shall provide reasonable notice regarding the breach of contract and a reasonable opportunity for the facility to come into compliance. If the facility fails to come into compliance or to remain in compliance, the commissioner may terminate the contract. If a contract is terminated, provisions of section 256B.48, subdivision 1a, shall apply.

Subd. 3. **Payment rate provisions.** (a) For rate years beginning on or after July 1, 2001, within the limits of appropriations specifically for this purpose, the commissioner shall determine operating cost payment rates for each licensed and certified nursing facility by indexing its

operating cost payment rates in effect on June 30, 2001, for inflation. For rate years beginning on or after July 1, 2001, the inflation factor must be based on the change in the Employment Cost Index for Private Industry Workers - Total Compensation as forecasted by the commissioner of management and budget's national economic consultant, in the fourth quarter preceding the rate year. The forecasted index for operating cost payment rates shall be based on the 12-month period from the midpoint of the nursing facility's prior rate year to the midpoint of the rate year for which the operating payment rate is being determined. The operating cost payment rate to be inflated shall be the total payment rate in effect on June 30, 2001, minus the portion determined to be the property-related payment rate, minus the per diem amount of the preadmission screening cost included in the nursing facility's last payment rate established under section 256B.431.

(b) A per diem amount for preadmission screening will be added onto the contract payment rates according to the method of distribution of county allocation described in section 256B.0911, subdivision 6, paragraph (a).

(c) For rate years beginning on or after July 1, 2001, the commissioner may implement a new method of payment for property-related costs that addresses the capital needs of facilities. The new property payment system or systems, if implemented, shall replace the current methods of setting property payment rates under sections 256B.431 and 256B.434.

Subd. 4. **Contract payment rates; appeals.** If an appeal is pending concerning the cost-based payment rates that are the basis for the calculation of the payment rate under this section, the commissioner and the nursing facility may agree on an interim contract rate to be used until the appeal is resolved. When the appeal is resolved, the contract rate must be adjusted retroactively according to the appeal decision.

Subd. 5. **Consumer protection.** In addition to complying with all applicable laws regarding consumer protection, as a condition of entering into a contract under this section, a nursing facility must agree to:

(1) establish resident grievance procedures;

(2) establish expedited grievance procedures to resolve complaints made by short-stay residents; and

(3) make available to residents and families a copy of the performance-based contract and outcomes to be achieved.

Subd. 6. **Contracts are voluntary.** Participation of nursing facilities in the medical assistance program is voluntary. The terms and procedures governing the performance-based contract are determined under this section and through negotiations between the commissioner and nursing facilities.

Subd. 7. **Federal requirements.** The commissioner shall implement the performance-based contracting system subject to any required federal waivers or approval and in a manner that is consistent with federal requirements. If a provision of this section is inconsistent with a federal requirement, the federal requirement supersedes the inconsistent provision. The commissioner shall seek federal approval and request waivers as necessary to implement this section.

Subd. 8. **Case-mix adjustments based upon the minimum data set.** The performance-based contracting system must include case-mix adjustments that are based upon the federally mandated minimum data set assessment instrument. These case-mix adjustments must be incorporated into the performance-based contracting system beginning on or after July 1, 2001, but no later than January 1, 2002, and must have a budget neutral financial impact on each facility at the time of implementation, relative to case-mix adjustments based upon the current state case-mix.

256B.436 VOLUNTARY CLOSURES; PLANNING.

Subdivision 1. **Definitions.** (a) "Closure" means the voluntary cessation of operations of a nursing facility and voluntary delicensure and decertification of all nursing facility beds of the nursing facility.

(b) "Commencement of closure" means the date on which the commissioner of health is notified of a planned closure in accordance with an approved closure plan.

(c) "Completion of closure" means the date on which the final resident of the nursing facility or nursing facilities designated for closure in an approved closure plan is discharged from the facility or facilities.

(d) "Closure plan" means a plan to close one or more nursing facilities and reallocate the resulting savings to provide special rate adjustments at other facilities.

(e) "Interim closure payments" means the medical assistance payments that may be made to a nursing facility designated for closure in an approved plan under this section.

(f) "Phased plan" means a closure plan affecting more than one nursing facility undergoing closure that is commenced and completed in phases.

(g) "Special rate adjustment" means an increase in a nursing facility's operating rates under this section.

(h) "Standardized resident days" means the standardized resident days as calculated under Minnesota Rules, part 9549.0054, subpart 2, based on the resident days in each resident class for the most recent reporting period required to be reported to the commissioner.

Subd. 2. **Proposal for a closure plan.** (a) One or more nursing facilities that are owned or operated by a nonprofit corporation owning or operating more than 22 nursing facilities licensed in the state of Minnesota may submit to the commissioner a proposal for a closure plan under this section. Between February 25, 2000, and June 30, 2001, the commissioner may negotiate phased plans for closure of up to seven nursing facilities.

(b) A facility or facilities reimbursed under section 256B.431 or 256B.434 with a closure plan approved by the commissioner under subdivision 4 are eligible for the following payments:

(1) facilities designated for closure are eligible for interim closure payments under subdivision 5; and

(2) facilities that remain open are eligible for a special rate adjustment.

(c) To be considered for approval, a proposal must include the following:

(1) a description of the proposed closure plan, which shall include identification of the facility or facilities to receive a special rate adjustment, the amount and timing of a special rate adjustment proposed for each facility for the case mix level "A" operating rate, the standardized resident days for each facility for which a special rate adjustment is proposed, and the effective date for each special rate adjustment. The actual special rate adjustment for a facility shall be allocated proportionately to the various rate per diems included in that facility's operating rate;

(2) an analysis of the projected state medical assistance costs of the closure plan as proposed, including the estimated costs of the special rate adjustments and estimated resident relocation costs, including county government costs;

(3) an analysis of the projected state medical assistance savings of the closure plan as proposed, including any savings projected to result from closure of one or more nursing facilities;

(4) the proposed timetable for any proposed closure, including the proposed dates for commencement and completion of closure;

(5) the proposed relocation plan for current residents of any facility designated for closure. The proposed relocation plan must be designed to comply with all applicable state and federal statutes and regulations, including, but not limited to, Minnesota Rules, parts 4655.6810 to 4655.6830; parts 4658.1600 to 4658.1690; and parts 9546.0010 to 9546.0060; and

(6) documentation, in a format approved by the commissioner, that all the nursing facilities receiving a special rate adjustment under the plan have accepted joint and several liability for recovery of overpayments under section 256B.0641, subdivision 2, for the facilities designated for closure under the plan.

Subd. 3. **Phased closure plans.** A proposal for a phased plan may include more than one closure, each of which must meet the requirements of this section and each of which may be implemented in phases at different times. As part of a phased plan, a nursing facility may receive a special rate adjustment under more than one phase of the plan, and the cost savings from the closure of a nursing facility designated for closure under the plan may be applied as an offset to the subsequent costs of more than one phase of the plan. If a facility is proposed to receive a special rate adjustment or provide cost savings under more than one phase of a plan, the proposal must describe the special rate adjustments or cost savings in each of the affected phases of the plan. Review and approval of a phased plan under subdivision 4 shall apply to all phases of the plan as proposed.

Subd. 4. **Review and approval of proposals.** (a) The commissioner may grant interim closure payments or special rate adjustments for a nursing facility or facilities according to an approved plan that satisfies the requirements of this section. The commissioner shall not approve a proposal unless the commissioner determines that projected state savings of the plan equal or exceed projected state and county government costs, including facility costs during the closure period, the estimated costs of special rate adjustments, estimated resident relocation costs, the cost of services to relocated residents, and state agency administrative costs directly related to the accomplishment of duties specified in this subdivision relative to that proposal. To achieve cost neutrality costs may only be offset against savings that occur within the same fiscal year. For purposes of a phased plan, the requirement that costs must not exceed savings applies to both the aggregate costs and savings of the plan and to each phase of the plan. A special rate adjustment under this section shall be effective no earlier than the first day of the month following completion of closure of all facilities designated for closure under the plan. For purposes of a phased plan, the

special rate adjustment for each phase shall be effective no earlier than the first day of the month following completion of closure of all facilities designated for closure in that phase of the plan. No special rate adjustment under this section shall take effect prior to July 1, 2000.

(b) Upon receipt of a proposal for a closure plan, the commissioner shall provide a copy of the proposal to the commissioner of health. The commissioner of health shall certify to the commissioner within 30 days whether the proposal, if implemented, will satisfy the requirements of Minnesota Rules, parts 4655.6810 to 4655.6830, and parts 4658.1600 to 4658.1690. The commissioner shall not approve a plan under this section unless the commissioner of health has made the certification required under this paragraph.

(c) The commissioner shall review a proposal for a closure plan to determine whether it satisfies the requirements of this section. A determination shall be made within 60 days of the date the proposal is submitted. If the commissioner determines that the proposal does not satisfy the requirements of this section, or if the commissioner of health does not certify the proposal under paragraph (b), the applicant shall be provided written notice as soon as practicable specifying the deficiencies of the proposal. The proposal may be modified and resubmitted for further review by each commissioner. The commissioner of health shall review a modified proposal within 30 days from the date it is submitted, and the commissioner shall make a final determination on whether the proposal satisfies the requirements of this section within 60 days of the date the modified proposal is submitted.

(d) Approval of a closure plan expires 18 months after approval by the commissioner, unless commencement of closure has occurred at all facilities designated for closure under the plan.

Subd. 5. **Interim closure payments.** Instead of payments under section 256B.431 or 256B.434, the commissioner may approve a closure plan under which the commissioner shall:

(1) apply the interim and settle-up rate provisions under Minnesota Rules, part 9549.0057, to include facilities covered by this section, effective from commencement of closure to completion of closure;

(2) extend the length of the interim period but not to exceed 12 months;

(3) limit the amount of reimbursable expenses related to the acquisition of new capital assets;

(4) prohibit the acquisition of additional capital debt or refinancing of existing capital debt unless prior approval is obtained from the commissioner;

(5) establish as the aggregate administrative operating cost limitation for the interim period the actual aggregate administrative operating costs for the period immediately prior to commencement of closure that is of the same duration as the interim period;

(6) require the retention of financial and statistical records until the commissioner has audited the interim period and the settle-up rate;

(7) make aggregate payments under this subdivision for the interim period up to the level of the aggregate payments for the period immediately prior to commencement of closure that is of the same duration as the interim period; or

(8) change any other provision to which all parties to the plan agree.

Subd. 6. **Cost savings of closure.** For purposes of this section, the calculation of medical assistance cost savings from the closure of a nursing facility designated for closure under a closure plan shall be according to the following criteria:

(a) The projected medical assistance savings of the closure of a facility shall be the aggregate medical assistance payments to the facility for the most recently completed state fiscal year prior to submission of the proposal, as reflected in the number of resident days of care for each resident class provided by the facility in that fiscal year, multiplied by the payment rate for each resident class.

(b) If one or more facilities designated for closure in an approved closure plan are not able to be closed for any reason, or projection of savings for that closure are otherwise prohibited under this section, the projected medical assistance savings from that closure may not be offset against the medical assistance costs of special rate adjustments under the plan. In that event, the applicant must notify the commissioner in writing and the applicant must either amend its proposal by reducing the special rate adjustment to reduce the medical assistance cost of the plan by at least the amount of the medical assistance savings that were projected from the closure of that facility or withdraw the plan.

(c) No medical assistance savings shall be projected from closure of a nursing facility that is designated for closure under a closure plan, if the facility is:

(1) subject to adverse licensure action under section 144A.11; or

(2) located in a county with a ratio of nursing facility beds to county residents age 85 and over that is in the lowest quartile of all counties in the state, at the time the proposal is submitted or at the commencement of closure.

(d) Medical assistance savings under paragraph (a) shall be recognized for purposes of this section beginning the first day of the month following the month of completion of closure for all facilities designated for closure under the plan, or all facilities designated for closure under that phase for a phased plan.

Subd. 7. **Other rate adjustments.** Except as otherwise provided in subdivision 5, facilities subject to this section remain eligible for any applicable rate adjustments provided under section 256B.431, 256B.434, or any other section.

Subd. 8. **County costs.** A portion of the savings estimated under subdivision 4, not to exceed $75,000 per closing facility, may be transferred from the medical assistance account to the commissioner to be used for relocation costs incurred by counties.