A bill for an act

relating to human services; modifying continuing care programs; amending Minnesota Statutes 2010, sections 245A.03, subdivision 2; 252.27, subdivision 2a; 252.291, subdivision 2; 256.045, subdivision 4a; 256B.056, by adding a subdivision; 256B.0657; 256B.0659, subdivisions 2, 11; 256B.0911, subdivisions 1a, 3a, 6; 256B.0916, subdivision 6a; 256B.092, subdivisions 1a, 1b, 1e, 1g, 3, 8, 8a; 256B.19, by adding a subdivision; 256B.431, by adding a subdivision; 256B.434, subdivision 4; 256B.441, by adding a subdivision; 256B.49, subdivisions 13, 14, 15, by adding a subdivision; 256G.02, subdivision 6; proposing coding for new law in Minnesota Statutes, chapter 256B; repealing Minnesota Statutes 2010, section 16B.054.

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

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

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

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

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

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

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

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

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

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

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

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

(10) programs licensed by the commissioner of corrections;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(29) residential facilities that are federally certified as intermediate care facilities that serve people with developmental disabilities.

A program that asserts its exemption from licensure under clause (28), item (ii) shall, upon request from the commissioner, provide the commissioner with documentation from the accrediting agency that verifies: that the accreditation is current; that the accrediting

agency investigates complaints about services; and that the accrediting agency's standards require background studies on all people providing direct contact services.

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

(c) Nothing in this chapter shall be construed to require licensure for any services provided and funded according to an approved federal waiver plan where licensure is specifically identified as not being a condition for the services and funding.

Sec. 2. Minnesota Statutes 2010, section 252.27, subdivision 2a, is amended to read:

Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor child, including a child determined eligible for medical assistance without consideration of parental income, must contribute to the cost of services used by making monthly payments on a sliding scale based on income, unless the child is married or has been married, parental rights have been terminated, or the child's adoption is subsidized according to section 259.67 or through title IV-E of the Social Security Act. The parental contribution is a partial or full payment for medical services provided for diagnostic, therapeutic, curing, treating, mitigating, rehabilitation, maintenance, and personal care services as defined in United States Code, title 26, section 213, needed by the child with a chronic illness or disability.

(b) For households with adjusted gross income equal to or greater than 100 percent of federal poverty guidelines, the parental contribution shall be computed by applying the following schedule of rates to the adjusted gross income of the natural or adoptive parents:

(1) if the adjusted gross income is equal to or greater than 100 percent of federal poverty guidelines and less than 175 percent of federal poverty guidelines, the parental contribution is $4 per month;

(2) if the adjusted gross income is equal to or greater than 175 percent of federal poverty guidelines and less than or equal to ~~545~~ 525 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at one percent of adjusted gross income at 175 percent of federal poverty guidelines and increases to ~~7.5~~ eight percent of adjusted gross income for those with adjusted gross income up to ~~545~~ 525 percent of federal poverty guidelines;

(3) if the adjusted gross income is greater than ~~545~~ 525 percent of federal poverty guidelines and less than 675 percent of federal poverty guidelines, the parental contribution shall be ~~7.5~~ 9.5 percent of adjusted gross income;

(4) if the adjusted gross income is equal to or greater than 675 percent of federal poverty guidelines and less than ~~975~~ 900 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at ~~7.5~~ 9.5 percent of adjusted gross income at 675 percent of federal poverty guidelines and increases to ~~ten~~ 12 percent of adjusted gross income for those with adjusted gross income up to ~~975~~ 900 percent of federal poverty guidelines; and

(5) if the adjusted gross income is equal to or greater than ~~975~~ 900 percent of federal poverty guidelines, the parental contribution shall be ~~12.5~~ 13.5 percent of adjusted gross income.

If the child lives with the parent, the annual adjusted gross income is reduced by $2,400 prior to calculating the parental contribution. If the child resides in an institution specified in section 256B.35, the parent is responsible for the personal needs allowance specified under that section in addition to the parental contribution determined under this section. The parental contribution is reduced by any amount required to be paid directly to the child pursuant to a court order, but only if actually paid.

(c) The household size to be used in determining the amount of contribution under paragraph (b) includes natural and adoptive parents and their dependents, including the child receiving services. Adjustments in the contribution amount due to annual changes in the federal poverty guidelines shall be implemented on the first day of July following publication of the changes.

(d) For purposes of paragraph (b), "income" means the adjusted gross income of the natural or adoptive parents determined according to the previous year's federal tax form, except, effective retroactive to July 1, 2003, taxable capital gains to the extent the funds have been used to purchase a home shall not be counted as income.

(e) The contribution shall be explained in writing to the parents at the time eligibility for services is being determined. The contribution shall be made on a monthly basis effective with the first month in which the child receives services. Annually upon redetermination or at termination of eligibility, if the contribution exceeded the cost of services provided, the local agency or the state shall reimburse that excess amount to the parents, either by direct reimbursement if the parent is no longer required to pay a contribution, or by a reduction in or waiver of parental fees until the excess amount is exhausted. All reimbursements must include a notice that the amount reimbursed may be taxable income if the parent paid for the parent's fees through an employer's health care

flexible spending account under the Internal Revenue Code, section 125, and that the parent is responsible for paying the taxes owed on the amount reimbursed.

(f) The monthly contribution amount must be reviewed at least every 12 months; when there is a change in household size; and when there is a loss of or gain in income from one month to another in excess of ten percent. The local agency shall mail a written notice 30 days in advance of the effective date of a change in the contribution amount. A decrease in the contribution amount is effective in the month that the parent verifies a reduction in income or change in household size.

(g) Parents of a minor child who do not live with each other shall each pay the contribution required under paragraph (a). An amount equal to the annual court-ordered child support payment actually paid on behalf of the child receiving services shall be deducted from the adjusted gross income of the parent making the payment prior to calculating the parental contribution under paragraph (b).

(h) The contribution under paragraph (b) shall be increased by an additional five percent if the local agency determines that insurance coverage is available but not obtained for the child. For purposes of this section, "available" means the insurance is a benefit of employment for a family member at an annual cost of no more than five percent of the family's annual income. For purposes of this section, "insurance" means health and accident insurance coverage, enrollment in a nonprofit health service plan, health maintenance organization, self-insured plan, or preferred provider organization.

Parents who have more than one child receiving services shall not be required to pay more than the amount for the child with the highest expenditures. There shall be no resource contribution from the parents. The parent shall not be required to pay a contribution in excess of the cost of the services provided to the child, not counting payments made to school districts for education-related services. Notice of an increase in fee payment must be given at least 30 days before the increased fee is due.

(i) The contribution under paragraph (b) shall be reduced by $300 per fiscal year if, in the 12 months prior to July 1:

(1) the parent applied for insurance for the child;

(2) the insurer denied insurance;

(3) the parents submitted a complaint or appeal, in writing to the insurer, submitted a complaint or appeal, in writing, to the commissioner of health or the commissioner of commerce, or litigated the complaint or appeal; and

(4) as a result of the dispute, the insurer reversed its decision and granted insurance.

For purposes of this section, "insurance" has the meaning given in paragraph (h).

A parent who has requested a reduction in the contribution amount under this paragraph shall submit proof in the form and manner prescribed by the commissioner or county agency, including, but not limited to, the insurer's denial of insurance, the written letter or complaint of the parents, court documents, and the written response of the insurer approving insurance. The determinations of the commissioner or county agency under this paragraph are not rules subject to chapter 14.

~~(j) Notwithstanding paragraph (b), for the period from July 1, 2010, to June 30, 2013, the parental contribution shall be computed by applying the following contribution schedule to the adjusted gross income of the natural or adoptive parents:~~

~~(1) if the adjusted gross income is equal to or greater than 100 percent of federal poverty guidelines and less than 175 percent of federal poverty guidelines, the parental contribution is $4 per month;~~

~~(2) if the adjusted gross income is equal to or greater than 175 percent of federal poverty guidelines and less than or equal to 525 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at one percent of adjusted gross income at 175 percent of federal poverty guidelines and increases to eight percent of adjusted gross income for those with adjusted gross income up to 525 percent of federal poverty guidelines;~~

~~(3) if the adjusted gross income is greater than 525 percent of federal poverty guidelines and less than 675 percent of federal poverty guidelines, the parental contribution shall be 9.5 percent of adjusted gross income;~~

~~(4) if the adjusted gross income is equal to or greater than 675 percent of federal poverty guidelines and less than 900 percent of federal poverty guidelines, the parental contribution shall be determined using a sliding fee scale established by the commissioner of human services which begins at 9.5 percent of adjusted gross income at 675 percent of federal poverty guidelines and increases to 12 percent of adjusted gross income for those with adjusted gross income up to 900 percent of federal poverty guidelines; and~~

~~(5) if the adjusted gross income is equal to or greater than 900 percent of federal poverty guidelines, the parental contribution shall be 13.5 percent of adjusted gross income. If the child lives with the parent, the annual adjusted gross income is reduced by $2,400 prior to calculating the parental contribution. If the child resides in an institution specified in section 256B.35, the parent is responsible for the personal needs allowance specified under that section in addition to the parental contribution determined under this section. The parental contribution is reduced by any amount required to be paid directly to the child pursuant to a court order, but only if actually paid.~~

Sec. 3. Minnesota Statutes 2010, section 252.291, subdivision 2, is amended to read:

Subd. 2. **Exceptions.** (a) The commissioner of human services in coordination with the commissioner of health may approve a newly constructed or newly established publicly or privately operated community intermediate care facility for ~~six~~ 16 or fewer persons with developmental disabilities only when:

(1) the facility is developed in accordance with a request for proposal approved by the commissioner of human services;

(2) the facility is necessary to serve the needs of identified persons with developmental disabilities who are seriously behaviorally disordered or who are seriously physically or sensorily impaired. No more than 40 percent of the capacity specified in the proposal submitted to the commissioner must be used for persons being discharged from regional treatment centers; and

(3) the commissioner determines that the need for increased service capacity cannot be met by the use of alternative resources or the modification of existing facilities.

(b) The percentage limitation in paragraph (a), clause (2), does not apply to state-operated, community-based facilities.

Sec. 4. Minnesota Statutes 2010, section 256.045, subdivision 4a, is amended to read:

Subd. 4a. **Case management ~~appeals~~ temporary stay of demission.** ~~Any recipient of case management services pursuant to section 256B.092, who contests the county agency's action or failure to act in the provision of those services, other than a failure to act with reasonable promptness or a suspension, reduction, denial, or termination of services, must submit a written request for a conciliation conference to the county agency. The county agency shall inform the commissioner of the receipt of a request when it is submitted and shall schedule a conciliation conference. The county agency shall notify the recipient, the commissioner, and all interested persons of the time, date, and location of the conciliation conference. The commissioner may assist the county by providing mediation services or by identifying other resources that may assist in the mediation between the parties. Within 30 days, the county agency shall conduct the conciliation conference and inform the recipient in writing of the action the county agency is going to take and when that action will be taken and notify the recipient of the right to a hearing under this subdivision. The conciliation conference shall be conducted in a manner consistent with the commissioner's instructions. If the county fails to conduct the conciliation conference and issue its report within 30 days, or, at any time up to 90 days after the conciliation conference is held, a recipient may submit to the commissioner a written request for a hearing before a state human services referee to determine whether case management~~

~~services have been provided in accordance with applicable laws and rules or whether the county agency has assured that the services identified in the recipient's individual service plan have been delivered in accordance with the laws and rules governing the provision of those services. The state human services referee shall recommend an order to the commissioner, who shall, in accordance with the procedure in subdivision 5, issue a final order within 60 days of the receipt of the request for a hearing, unless the commissioner refuses to accept the recommended order, in which event a final order shall issue within 90 days of the receipt of that request. The order may direct the county agency to take those actions necessary to comply with applicable laws or rules.~~ The commissioner may issue a temporary order prohibiting the demission of a recipient of case management services under section 256B.092 from a residential or day habilitation program licensed under chapter 245A, while a county agency review process or an appeal brought by a recipient under this subdivision is pending, or for the period of time necessary for the county agency to implement the commissioner's order. The commissioner shall not issue a final order staying the demission of a recipient of case management services from a residential or day habilitation program licensed under chapter 245A.

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

Sec. 5. Minnesota Statutes 2010, section 256B.056, is amended by adding a subdivision to read:

Subd. 5d. **Spenddown adjustments.** When income is projected for a six-month budget period, retroactive adjustments to income determined to be available to a person under 256B.0575 must be made at the end of each six-month budget period based on changes occurring during the budget period. For changes occurring outside the six-month budget period, such retroactive adjustments are limited to the six full calendar months before the month the change is reported or discovered.

Sec. 6. Minnesota Statutes 2010, section 256B.0657, is amended to read:

256B.0657 SELF-DIRECTED SUPPORTS OPTION.

Subdivision 1. **Definition.** (a) "Lead agency" has the meaning given in section 256B.0911, subdivision 1a, paragraph (d).

(b) "Legal representative" means a legal guardian of a child or an adult, or parent of a minor child.

(c) "Managing partner" means an individual who has been authorized, in a written statement by the person or the person's legal representative, to speak on the person's

behalf and help the person understand and make informed choices in matters related to identification of needs and choice of services and supports and assist the person to implement an approved support plan.

(d) "Self-directed supports option" means personal assistance, supports, items, and related services purchased under an approved budget plan and budget by a recipient.

Subd. 2. **Eligibility.** (a) The self-directed supports option is available to a person who:

(1) is a recipient of medical assistance as determined under sections 256B.055, 256B.056, and 256B.057, subdivision 9;

(2) is eligible for personal care assistance services under section 256B.0659, or for a home and community-based services waiver program under section 256B.0915, 256B.092, or 256B.49, or alternative care under section 256B.0913;

(3) lives in the person's own apartment or home, which is not owned, operated, or controlled by a provider of services not related by blood or marriage;

(4) has the ability to hire, fire, supervise, establish staff compensation for, and manage the individuals providing services, and to choose and obtain items, related services, and supports as described in the participant's plan. If the recipient is not able to carry out these functions but has a legal guardian, managing partner, or parent to carry them out, the guardian, managing partner, or parent may fulfill these functions on behalf of the recipient; and

(5) has not been excluded or disenrolled by the commissioner.

(b) The commissioner may disenroll or exclude recipients, including guardians ~~and~~, parents, and managing partners under the following circumstances:

(1) recipients who have been restricted by the Primary Care Utilization Review Committee may be excluded for a specified time period;

(2) recipients who exit the self-directed supports option during the recipient's service plan year shall not access the self-directed supports option for the remainder of that service plan year; and

(3) when the department determines that the recipient cannot manage recipient responsibilities under the program.

Subd. 3. **Eligibility for other services.** Selection of the self-directed supports option by a recipient shall not restrict access to other medically necessary care and services furnished under the state plan medical assistance benefit~~, including home care targeted case management~~, except that a person ~~receiving~~ choosing agency-provided home and community-based waiver services, agency-provided personal care assistance

services, a family support grant, or a consumer support grant is not eligible for funding under the self-directed supports option.

Subd. 4. **Assessment requirements.** (a) The self-directed supports option assessment must meet the following requirements:

(1) it shall be conducted ~~by the county public health nurse or a certified public health nurse under contract with the county~~ consistent with the requirements of personal care assistant services under section 256B.0659, subdivision 3a; home and community-based waiver services programs under section 256B.0915, 256B.092, or 256B.49; and the alternative care program under section 256B.0913, until section 256B.0911, subdivision 3a, has been implemented;

(2) it shall be conducted face-to-face in the recipient's home initially, and at least annually thereafter; when there is a significant change in the recipient's condition; and when there is a change in the person's need for ~~personal care assistance~~ services under the programs listed in subdivision 2, paragraph (a), clause (2). A recipient who is residing in a facility may be assessed for the self-directed support option for the purpose of returning to the community using this option; and

(3) it shall be completed using the format established by the commissioner.

(b) The results of the personal care assistance assessment and recommendations shall be communicated to the commissioner and the recipient ~~by the county public health nurse or certified public health nurse under contract with the county~~ as required under section 256B.0659, subdivision 3a. The person's annual and self-directed budget amount shall be provided within 40 days after the personal care assessment or reassessment, or within ten days after a request not related to an assessment.

(c) The lead agency responsible for administration of home and community-based waiver services under section 256B.0915, 256B.092, or 256B.49, and alternative care under section 256B.0913 shall provide annual and monthly self-directed services budget amounts for all eligible persons within 40 days after an initial assessment or annual review and within ten days if requested at a time unrelated to the assessment or annual review.

Subd. 5. **Self-directed supports option plan requirements.** (a) The plan for the self-directed supports option must meet the following requirements:

(1) the plan must be completed using a person-centered process that:

(i) builds upon the recipient's capacity to engage in activities that promote community life;

(ii) respects the recipient's preferences, choices, and abilities;

(iii) involves families, friends, and professionals in the planning or delivery of services or supports as desired or required by the recipient; and

(iv) addresses the need for personal care assistance services identified in the recipient's self-directed supports option assessment;

(2) the plan shall be developed by the recipient, legal representative, or ~~by the guardian of an adult recipient or by a parent or guardian of a minor child,~~ managing partner, and may be assisted by a provider who meets the requirements established for using a person-centered planning process and shall be reviewed at least annually upon reassessment or when there is a significant change in the recipient's condition; and

(3) the plan must include the total budget amount available divided into monthly amounts that cover the number of months of personal care assistance services or home and community-based waiver or alternative care authorization included in the budget. A recipient may reserve funds monthly for the purchase of items that meet the standards in subdivision 6, paragraph (a), clause (2), and are reflected in the support plan. The amount used each month may vary, but additional funds shall not be provided above the annual personal care assistance services authorized amount unless a change in condition is documented.

(b) The commissioner or the commissioner's designee shall:

(1) establish the format and criteria for the plan as well as the provider enrollment requirements for providers who will engage in outreach and training on self-directed options, assist with plan development, and offer person-centered plan support services;

(2) review the assessment and plan and, within 30 days after receiving the assessment and plan, make a decision on approval of the plan;

(3) notify the recipient, ~~parent, or guardian~~ legal representative, or managing partner of approval or denial of the plan and provide notice of the right to appeal under section 256.045; and

(4) provide a copy of the plan to the fiscal support entity selected by the recipient from among at least three certified entities.

Subd. 6. **Services covered.** (a) Services covered under the self-directed supports option include:

(1) personal care assistance services under section 256B.0659, and services under the home and community-based waivers, except those provided in licensed or registered settings; and

(2) items, related services, and supports, including assistive technology, that increase independence or substitute for human assistance to the extent expenditures would otherwise be used for human assistance.

(b) Items, supports, and related services purchased under this option shall not be considered home care services for the purposes of section 144A.43.

Subd. 7. **Noncovered services.** Services or supports that are not eligible for payment under the self-directed supports option include:

(1) services, goods, or supports that do not benefit the recipient;

(2) any fees incurred by the recipient, such as Minnesota health care program fees and co-pays, legal fees, or costs related to advocate agencies;

(3) insurance, except for insurance costs related to employee coverage or fiscal support entity payments;

(4) room and board and personal items that are not related to the disability, except that medically prescribed specialized diet items may be covered if they reduce the need for human assistance;

(5) home modifications that add square footage, except those modifications that configure a bathroom to accommodate a wheelchair;

(6) home modifications for a residence other than the primary residence of the recipient, or in the event of a minor with parents not living together, the primary residences of the parents;

(7) expenses for travel, lodging, or meals related to training the recipient, the ~~parent or guardian of an adult recipient, or the parent or guardian of a minor child~~ legal representative, or paid or unpaid caregivers that exceed $500 in a 12-month period;

(8) experimental treatment;

(9) any service or item to the extent the service or item is covered by other medical assistance state plan services, including prescription and over-the-counter medications, compounds, and solutions and related fees, including premiums and co-payments;

(10) membership dues or costs, except when the service is necessary and appropriate to treat a physical condition or to improve or maintain the recipient's physical condition. The condition must be identified in the recipient's plan of care and monitored by a Minnesota health care program enrolled physician;

(11) vacation expenses other than the cost of direct services;

(12) vehicle maintenance or modifications not related to the disability;

(13) tickets and related costs to attend sporting or other recreational events that are not related to a need or goal identified in the person-centered service plan; and

(14) costs related to Internet access, except when necessary for operation of assistive technology, to increase independence, or to substitute for human assistance.

Subd. 8. **Self-directed budget requirements.** (a) The budget for the provision of the self-directed service option shall be established for persons eligible for personal care assistant services under section 256B.0659 based on:

(1) assessed personal care assistance units, not to exceed the maximum number of personal care assistance units available, as determined by section 256B.0659; and

(2) the personal care assistance unit rate:

(i) with a reduction to the unit rate to pay for a program administrator as defined in subdivision 10; and

(ii) an additional adjustment to the unit rate as needed to ensure cost neutrality for the state.

(b) The budget for persons eligible for programs listed in subdivision 2, paragraph (a), clause (2), is based on the approved budget methodologies for each program.

Subd. 9. **Quality assurance and risk management.** (a) The commissioner shall establish quality assurance and risk management measures for use in developing and implementing self-directed plans and budgets that (1) recognize the roles and responsibilities involved in obtaining services in a self-directed manner, and (2) assure the appropriateness of such plans and budgets based upon a recipient's resources and capabilities. These measures must include (i) background studies, and (ii) backup and emergency plans, including disaster planning.

(b) The commissioner shall provide ongoing technical assistance and resource and educational materials for families and recipients selecting the self-directed option, including information on the quality assurance efforts and activities of region 10 under sections 256B.095 to 256B.096.

(c) Performance assessments measures, such as of a recipient's functioning, satisfaction with the services and supports, and ongoing monitoring of health and well-being shall be identified in consultation with the stakeholder group.

Subd. 10. **Fiscal support entity.** (a) Each recipient or legal representative shall choose a fiscal support entity provider certified by the commissioner to make payments for services, items, supports, and administrative costs related to managing a self-directed service plan authorized for payment in the approved plan and budget. ~~Recipients~~ The recipient or legal representative shall also choose the payroll, agency with choice, or the fiscal conduit model of financial and service management.

(b) The fiscal support entity:

(1) may not limit or restrict the recipient's choice of service or support providers, including use of the payroll, agency with choice, or fiscal conduit model of financial and service management;

(2) must have a written agreement with the recipient, managing partner, or the recipient's legal representative that identifies the duties and responsibilities to be performed and the specific related charges;

(3) must provide the recipient ~~and the home care targeted case manager~~, legal representative, and managing partner with a monthly written summary of the self-directed supports option services that were billed, including charges from the fiscal support entity;

(4) must be knowledgeable of and comply with Internal Revenue Service requirements necessary to process employer and employee deductions, provide appropriate and timely submission of employer tax liabilities, and maintain documentation to support medical assistance claims;

(5) must have current and adequate liability insurance and bonding and sufficient cash flow and have on staff or under contract a certified public accountant or an individual with a baccalaureate degree in accounting; and

(6) must maintain records to track all self-directed supports option services expenditures, including time records of persons paid to provide supports and receipts for any goods purchased. The records must be maintained for a minimum of five years from the claim date and be available for audit or review upon request. Claims submitted by the fiscal support entity must correspond with services, amounts, and time periods as authorized in the recipient's self-directed supports option plan.

(c) The commissioner shall have authority to:

(1) set or negotiate rates with fiscal support entities;

(2) limit the number of fiscal support entities;

(3) identify a process to certify and recertify fiscal support entities and assure fiscal support entities are available to recipients throughout the state; and

(4) establish a uniform format and protocol to be used by eligible fiscal support entities.

Subd. 11. **Stakeholder consultation.** The commissioner shall consult with a statewide ~~consumer-directed~~ self-directed services stakeholder group, including representatives of all types of ~~consumer-directed~~ self-directed service users, advocacy organizations, counties, and ~~consumer-directed~~ self-directed service providers. The commissioner shall seek recommendations from this stakeholder group in developing, monitoring, evaluating, and modifying:

(1) the self-directed plan format;

(2) requirements and guidelines for the person-centered plan assessment and planning process;

(3) implementation of the option and the quality assurance and risk management techniques; ~~and~~

(4) standards and requirements, including rates for the personal support plan development provider and the fiscal support entity; policies; training; and implementation; and

(5) the self-directed supports options available through the home and community-based waivers under section 256B.0916 and the personal care assistance program under section 256B.0659, including ways to increase participation, improve flexibility, and include incentives for recipients to participate in a life transition and crisis funding pool with others to save and contribute part of their authorized budgets, which can be carried over year to year and used according to priority standards under section 256B.092, subdivision 12, clauses (1), (3), (4), (5), and (6).

The stakeholder group shall provide recommendations on the repeal of the personal care assistance choice option, transition issues, and whether the consumer support grant program under section 256.476 should be modified. The stakeholder group shall meet at least three times each year to provide advice on policy, implementation, and other aspects of ~~consumer and~~ self-directed services.

Subd. 12. **Enrollment and evaluation.** Enrollment in the self-directed supports option is available to current personal care assistance recipients upon annual personal care assistance reassessment, with a maximum enrollment of ~~1,000~~ 2,000 people in the first fiscal year of implementation and an additional ~~1,000~~ 3,000 people in the second fiscal year. The commissioner shall evaluate the self-directed supports option during the first two years of implementation and make any necessary changes ~~prior to the option becoming available statewide~~.

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

Sec. 7. 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;

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

(4) rehabilitation services; and

~~(4)~~ (5) 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.

(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. 8. Minnesota Statutes 2010, 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) Effective January 1, 2010, persons who do not qualify as a personal care assistant include parents and stepparents of minors, spouses, paid legal guardians, family foster care providers, except as otherwise allowed in section 256B.0625, subdivision 19a, or staff of a residential setting. Personal care assistants who are providing care for a relative are limited to being paid a rate that is 80 percent of the rate they would be paid for providing services to non-relatives.

Sec. 9. **[256B.0661] HOME AND COMMUNITY-BASED ATTENDANT SERVICES AND SUPPORTS.**

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meaning given:

(a) "Activities of daily living" means basic personal everyday activities, including eating, toileting, grooming, dressing, bathing, transferring, positioning, and mobility.

(b) "Health-related tasks" means those tasks and procedures listed in section 256B.0659, subdivision 2, paragraph (c).

(c) "Home and community-based attendant services and supports" means personal assistance, supports, items, and related services which provide assistance with accomplishing activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related tasks including necessary supervision by a qualified professional.

(d) "Individual's representative" means a parent, family member, advocate, or other representative of the individual, authorized in a written statement by the person or the person's legal representative, to speak on the person's behalf and help the person understand and make informed choices in matters related to identification of needs and choice of services and supports and assist the person in the implementation of an approved support plan. For minor children and adults who cannot direct their own care, the individual representative must meet the requirements of section 256B.0659, subdivisions 9 and 10, and shall not act as the home and community-based attendant for the individual.

(e) "Instrumental activities of daily living" means activities related to living independently in the community, including meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community.

(f) "Legal representative" means the legal guardian or parent of a minor.

(g) "Qualified professional" means a professional providing supervision of home and community-based attendant services and staff as defined in section 256B.0625, subdivision 19c.

Subd. 2. **Eligibility.** (a) The home and community-based attendant services and supports option is available to a person who:

(1) is a recipient of medical assistance as determined under sections 256B.055; 256B.056; and 256B.057, subdivision 9;

(2) has an income that meets one of the following thresholds as determined annually:

(i) is equal to or less than 150 percent of the federal poverty guidelines; or

(ii) is eligible for nursing facility services under the state plan and for whom it has been determined that in the absence of home and community-based attendant services and supports, the individual would otherwise require a level of care covered by medical

assistance and furnished in a hospital, a nursing facility, an intermediate care facility for persons with developmental disabilities, or an institution for mental diseases;

(3) meets the qualification criteria for personal care assistance services under section 256B.0625, subdivision 19a, in effect on July 1, 2010, which requires at least one dependency in an activity of daily living or Level I behavior; and

(4) lives in the persons's own apartment or home, which is not owned, operated, or controlled by a provider of services under this section, not related by blood, adoption, family foster care, or marriage. The person does not live in a nursing facility, institution for mental diseases, intermediate care facility for persons with developmental disabilities, or any setting located in a building that is also an inpatient institution or custodial care facility or a building on the grounds or immediately adjacent to a public institution or disability-specific housing complex, as defined by the commissioner.

Subd. 3. **Eligibility for other services.** Selection of the home and community-based attendant services and supports option by a recipient shall not restrict access to other medically necessary care and services furnished under the state plan medical assistance benefit or through other funding, except that a person receiving personal care assistant (PCA) services, a family support grant, semi-independent living services, or a consumer support grant is not eligible for funding under the home and community-based attendant services and supports option.

Subd. 4. **Assessment requirements.** (a) The home and community-based attendant services and supports option assessment must meet the following requirements:

(1) for persons whose income is below 150 percent of the federal poverty guidelines, be consistent with the requirements of the personal care assistant services assessment under section 256B.0659, subdivision 3a;

(2) for persons whose income is above 150 percent of the federal poverty guidelines the person must meet the level of care for a nursing facility, intermediate care facility for persons with developmental disabilities, neurobehavioral hospital, or an institution for mental disease;

(3) be conducted face-to-face in the recipient's home initially and at least annually thereafter; when there is a significant change in the recipient's condition; and when there is a change in the person's need for services under this option. A recipient who is residing in a facility may be assessed for home and community-based attendant services and supports for purposes of returning to the community using this option; and

(4) be completed using the format established by the commissioner.

(b) The results of the home and community-based attendant services and supports option assessment and recommendations shall be communicated to the commissioner and the recipient as required under section 256B.0659, subdivision 3a.

(c) The lead agency responsible for administration and implementation of the home and community-based attendant services and supports shall provide the annual and monthly self-directed service budget amounts for all eligible persons within 40 days after an initial assessment or annual review and within ten days if requested at a time unrelated to the assessment or annual review.

Subd. 5. **State plan option requirements.** (a) The plan for home and community-based attendant services and supports option must meet the following requirements:

(1) the plan must be completed using a person-centered process consistent with the requirements in section 256B.0657, subdivision 5a;

(2) reflects the clinical and support needs identified through the assessment;

(3) includes the person's chosen individual goals and providers;

(4) includes the services and supports, both paid and unpaid, that will assist the individual to achieve identified goals;

(5) includes an assessment of risk factors and measures to minimize risks and a backup plan; and

(6) must be signed by the individual or legal representative and other persons responsible for aspects of the plan.

Subd. 6. **Covered services.** (a) Services covered under the home and community-based attendant services and supports option include:

(1) assistance with activities of daily living, as described under section 256B.0659, subdivision 2;

(2) assistance with instrumental activities of daily living as defined in section 256B.0659, subdivision 1, paragraph (i), for both children and adults;

(3) assistance with health-related procedures and tasks, as defined in section 256B.0659, subdivision 2;

(4) backup systems or mechanisms to ensure continuity of services and supports;

(5) voluntary training for recipients on how to select, manage, and dismiss staff;

(6) expenditures for transition costs such as rent, utility deposits, first and last month's rent, basic kitchen supplies, and other necessities required for an individual to transition from a nursing facility, institution for mental diseases, or intermediate care facility for persons with developmental disabilities to a community-based home setting where the individual resides; and

(7) expenditures related to a need identified in the individual's person-centered plan of services that increase a participant's independence or substitute for human assistance, to the extent that expenditures would otherwise be made for human assistance.

(b) The services and supports that are purchased must be linked to an assessed need or goal established in the individual's person-centered service plan.

(c) All services must be provided to assist the recipient to acquire or enhance skills or to maintain functioning so that the individual can accomplish the activities of daily living, instrumental activities of daily living, and health-related tasks in order to remain or become as independent as possible at home and in the community.

(d) Shared services under this section must meet the requirements of section 256B.0659, subdivisions 16 and 17.

Subd. 7. **Noncovered services.** Services and supports that are not eligible for payment under the home and community-based attendant services and supports option include:

(1) services, goods, or supports that do not benefit the recipient;

(2) special education and related services provided under the Individuals with Disabilities Education Act that are related to education only and vocational rehabilitation services provided under the Rehabilitation Act of 1973;

(3) room and board costs for the individual, except for allowable transition services listed in subdivision 6, paragraph (f);

(4) assistive devices and assistive technology services other than those identified in subdivision 6, paragraph (g), or those that are based on a specific need identified in the service plan when used in conjunction with other home and community-based attendant services;

(5) medical supplies and equipment;

(6) home modifications; and

(7) items or services listed in section 256B.0659, subdivision 3, except that essential household chores and instrumental activities of daily living for children are allowed to the extent the need and service is documented in the support plan.

Subd. 8. **Service budget requirements.** The budget allocation for a person's home and community-based attendant services and supports option must be based on the budget amount allowed under the assessment for personal care assistant services in section 256B.0659.

Subd. 9. **Staff and qualified professional requirements.** (a) A home and community-based attendant must meet the requirements in section 256B.0659, subdivisions 11, 11a, and 12.

(b) Qualified professionals must meet the requirements in section 256B.0659, subdivisions 13 and 14.

Subd. 10. **Requirements for initial enrollment; annual reenrollment; enrollment after termination.** (a) All home and community-based attendant services and supports option provider agencies must meet the enrollment requirements under section 256B.0659, subdivision 21.

(b) All home and community-based attendant services and supports option provider agencies shall resubmit, on an annual basis, the information required in a format determined by the commissioner as required under section 256B.0659, subdivision 22.

(c) A home and community-based attendant services and supports provider agency which has been disenrolled, must meet the requirements of section 256B.0659, subdivision 23, to reenroll.

Subd. 11. **General duties of provider agencies.** Home and community-based attendant services and supports option provider agencies are required to follow section 256B.0659, subdivisions 24, 25, 26, 27, and 28.

Subd. 12. **Stakeholder development and implementation council.** (a) The commissioner shall establish and consult with a stakeholder development and implementation council comprised primarily of individuals with disabilities, elderly individuals and their representatives, and other interested stakeholders including representatives of assessment agencies, and provider agencies.

(b) The commissioner must consult and collaborate with the council in the development and implementation of a state plan amendment to provide home and community-based attendant services and supports, on matters of data collection, analysis, and outcomes, including the cost of services provided and the cost of alternatives if home and community-based attendant services and supports were not provided, and other health care and community support and social service costs, as well as other costs involving local, state, and federal funds, and quality assurance issues and measures.

Subd. 13. **Quality assurance and risk management.** (a) The commissioner shall establish quality assurance and risk management measures for the home and community-based attendant services and supports option which:

(1) recognizes the person-centered services role of the recipient and chosen advocate or other legal representative, and assure the appropriateness of support plans and budgets based upon the person's resources, capabilities, and needs; and

(2) measures must include background studies and backup emergency plans, including disaster planning.

(b) The commissioner shall provide ongoing technical assistance and resource education and materials for recipients and their legal representatives and other involved parties, including appropriate information, counseling, training, and assistance.

(c) Performance assessment measures and other outcome data such as the recipient's functioning in their home and community, satisfaction with services and supports, and ongoing monitoring of health and safety shall be identified in consultation with the stakeholder council.

Subd. 14. **Self-directed home and community-based services and supports.** The home and community-based services and supports option includes the option to self-direct services under section 256B.0657.

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

Sec. 10. Minnesota Statutes 2010, section 256B.0911, subdivision 1a, is amended to read:

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

(a) "Long-term care consultation services" means:

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

(2) providing recommendations on 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 screening to determine the need for an institutional level of care under subdivision 4a;

(7) determination of home and community-based waiver service eligibility including level of care determination for individuals who need an institutional level of care as defined under section 144.0724, subdivision 11, 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 support plan development with appropriate referrals, including the option for ~~consumer-directed community~~ self-directed supports;

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

(9) assistance to transition people back to community settings after facility admission; and

(10) providing notice to the individual and legal representative of the annual and monthly amount authorized for traditional agency services and self-directed services under section 256B.0657 for which the recipient is found eligible.

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

(d) "Lead agencies" means counties or a collaboration of counties, tribes, and health plans administering long-term care consultation assessment and support planning services.

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

Sec. 11. Minnesota Statutes 2010, 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 calendar~~ 20 working days after the date on which an assessment was requested or recommended. After January 1, 2011, these requirements also apply to personal care assistance services, private duty nursing, and home health agency services, on timelines established in subdivision 5. Face-to-face assessments must be conducted according to paragraphs (b) to (i).

(b) The county may utilize a team of either the social worker or public health nurse, or both. After January 1, 2011, lead agencies shall use certified assessors to conduct the assessment in a face-to-face interview. The consultation team members must confer regarding the most appropriate care for each individual screened or assessed.

(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 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 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~~ self-directed options, or institutional care that include documentation that the most cost-effective alternatives available were offered to the individual. For purposes of this requirement, "cost-effective alternatives" means community services and living arrangements that cost the same as or less than institutional care. For persons determined eligible for services defined under subdivision 1a, paragraph (a), clauses (7) to (9), the community support plan must also include the estimated annual and monthly budget amount for those services.

(f) 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, regardless of whether the individual is eligible for Minnesota health care programs. 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 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 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) the need for and purpose of preadmission screening if the person selects nursing facility placement;

(2) the role of the long-term care consultation assessment and support planning in waiver and alternative care program eligibility determination;

(3) information about Minnesota health care programs;

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

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

(6) the long-term care consultant'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; and

(7) the person's right to appeal the decision regarding the need for nursing facility level of care or the county'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.0915, 256B.0917, and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after the date of assessment. The effective eligibility start date for these programs 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). The updated assessment may be completed by face-to-face visit, written communication, or phone. The effective date of program eligibility in this case cannot be prior to the date the updated assessment is completed.

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

Sec. 12. 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).

(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) 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.~~ Counties may set a fee schedule for initial assessments and support plan development for individuals who are not financially eligible for medical assistance or MinnesotaCare. The maximum fee must not be greater than the actual cost of the initial assessment and support plan development.

(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 federal funding for this activity.

Sec. 13. Minnesota Statutes 2010, section 256B.0911, subdivision 6, is amended to read:

Subd. 6. **Payment for long-term care consultation services.** (a) ~~The~~ Seventy-five percent of 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).

(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) 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 federal funding for this activity.

Sec. 14. Minnesota Statutes 2010, section 256B.0916, subdivision 6a, is amended to read:

Subd. 6a. **Statewide availability of ~~consumer-directed community~~ self-directed support services.** (a) The commissioner shall submit to the federal Health Care Financing Administration by August 1, 2001, an amendment to the home and community-based waiver ~~for persons with developmental disabilities~~ under section 256B.092 and by April 1, 2005, for waivers under sections 256B.0915 and 256B.49, to make ~~consumer-directed community~~ self-directed support services available in every county of the state ~~by January 1, 2002~~.

(b) Until the waiver amendment under section 18 of this act is effective, if a county declines to meet the requirements for provision of ~~consumer-directed community~~ self-directed supports, the commissioner shall contract with another county, a group of counties, or a private agency to plan for and administer ~~consumer-directed community~~ self-directed supports in that county.

(c) The state of Minnesota, county agencies, tribal governments, or administrative entities under contract to participate in the implementation and administration of the home and community-based waiver for persons with developmental disabilities, shall not be liable for damages, injuries, or liabilities sustained through the purchase of support by the individual, the individual's family, legal representative, or the authorized representative with funds received through the ~~consumer-directed community~~ self-directed support service under this section. Liabilities include but are not limited to: workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA).

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

Sec. 15. 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:~~

~~(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~~ Case management services shall be provided by public or private agencies that are 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 cannot be provided to a recipient by a private agency that has any financial interest in the provisions of any other services included in the recipient's coordinated service and support plan.

(b) Case management ~~service activities provided to or arranged for a person include~~ services shall be provided to each recipient of home and community-based waiver services and available to those eligible for case management under sections 256B.0621 and 256B.0924, subdivision 4, who choose this service. Case management services for an eligible person include:

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

(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;

(6) coordination of services, including coordinating with the person's health care home or health coordinator, if coordination of long-term care or community supports and health care is not provided by another service provider;

(7) evaluation and monitoring of the services identified in the plan including at least one face-to-face visit with each person annually by the case manager; and

(8) ~~annual reviews of service plans and services provided~~ review and provide the lead agency with recommendations for service authorization based upon the individual's needs identified in the support plan within ten working days after receiving the community support plan from the certified assessor under section 256B.0911.

(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~~ a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in section 256B.0621, subdivision 5, paragraphs (a) and (b), clauses (1) to (5), and have no financial interest in the provision of any other services to the person choosing case management service.

(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 and habilitation plans.

(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.

(f) For persons eligible for home and community-based waiver services under this section, case management service must be provided and paid for under the terms of the approved federal waiver plans and cannot be billed as targeted case management.

(g) Persons may choose a case management service provider from among the public or private vendors enrolled according to paragraph (d).

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

Sec. 16. Minnesota Statutes 2010, section 256B.092, subdivision 1b, is amended to read:

Subd. 1b. **~~Individual~~ Coordinated service and support plan.** ~~The individual~~ Each recipient of case management service and any legal representative shall be provided a written copy of the coordinated service and support plan ~~must~~, which:

(1) ~~include~~ is developed within ten working days after the case management service receives the community support plan from the certified assessor under section 256B.0911;

(2) includes the results of the assessment information on 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 assures the health, safety, and welfare of the recipient;

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

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

~~(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~~ 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~~ individual's provider 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~~ coordinated service and support plan;

~~(7) include~~ (10) includes notice of the right to have assessments completed and service plans developed within specified time periods, the right to appeal action or inaction, and the right to request ~~a conciliation conference or a hearing~~ an appeal under section 256.045;

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

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

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

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

Sec. 17. Minnesota Statutes 2010, section 256B.092, subdivision 1e, is amended to read:

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

(3) are consistent with other aspects of the ~~individual~~ 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~~ management service provider shall monitor the provision of services:

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

(2) to identify any changes or modifications that might be needed in the individual service 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~~ coordinated service and support plan.

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

Sec. 18. Minnesota Statutes 2010, section 256B.092, subdivision 1g, is amended to read:

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

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

Sec. 19. Minnesota Statutes 2010, section 256B.092, subdivision 3, is amended to read:

Subd. 3. **Authorization and termination of services.** ~~County agency case managers~~ Lead agencies, under rules of the commissioner, shall authorize and terminate

services of community and regional treatment center providers according to ~~individual~~ coordinated service and support plans. Services provided to persons with developmental disabilities may only be authorized and terminated ~~by case managers~~ according to (1) rules of the commissioner and (2) the ~~individual~~ 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.

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

Sec. 20. Minnesota Statutes 2010, section 256B.092, subdivision 8, is amended to read:

Subd. 8. ~~**Screening team**~~ **Additional certified assessor duties.** The ~~screening team~~ certified assessor shall:

(1) review diagnostic data;

(2) review health, social, and developmental assessment data using a ~~uniform screening~~ comprehensive assessment 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) identify other noninstitutional public assistance or social service that may prevent or delay long-term residential placement;

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

(6) make recommendations regarding ~~placement~~ services 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 ~~placement~~ services; ~~(iv) regional treatment center placement;~~ or ~~(v)~~ (iv) a home and community-based service alternative to community residential placement or regional treatment center placement;

(7) evaluate the availability, location, and quality of the services listed in clause (6), including the impact of ~~placement alternatives~~ services and supports options on the person's ability to maintain or improve existing patterns of contact and involvement with parents and other family members;

(8) identify the cost implications of recommendations in clause (6) and provide written notice of the annual and monthly amount authorized to be spent for services for the recipient;

(9) 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.

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

Sec. 21. 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 plan. The county where services are provided may not make changes in the person's service 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.

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

Sec. 22. Minnesota Statutes 2010, section 256B.19, is amended by adding a subdivision to read:

Subd. 2d. **Obligation of local agency to process medical assistance applications within established timelines.** (a) Except as provided in paragraph (b), when an individual submits an application for medical assistance and the applicant's eligibility is based on disability or on being age 65 or older, the county must determine the applicant's eligibility and mail a notice of its decision to the applicant within:

(1) 60 days from the date of the application for an individual whose eligibility is based on disability; and

(2) 45 days from the date of the application for an individual whose eligibility is based on being age 65 or older.

(b) The county must determine eligibility and mail a notice of its decision within the time frames stated in paragraph (a), except in the following circumstances:

(1) the county cannot make a determination because, despite reasonable efforts by the county to communicate what is required, the applicant or an examining physician delays or fails to take a required action; or

(2) there is an administrative or other emergency beyond the county's control. For purposes of clause (2), a staffing shortage does not constitute an emergency beyond the county's control.

For the events in either clause (1) or (2), the county must document in the applicant's case record the reason for delaying beyond the established time frames.

(c) The county must not use the time frames established in paragraph (a) as a waiting period before determining eligibility or as a reason for denying eligibility because it has not determined eligibility within the established time frames.

(d) Effective July 1, 2011, unless one of the exceptions listed under paragraph (b) applies, if a county fails to comply with paragraph (a) and the applicant ultimately is determined to be eligible for medical assistance, the county is responsible for the entire cost of medical assistance services provided to the applicant by a nursing facility and not paid for by federal funds, from and including the first date of eligibility through the date on which the county mails written notice of its decision on the application. The applicable facility will bill and receive payment directly from the commissioner in customary fashion, and the commissioner shall deduct any obligation incurred under this paragraph from the amount due to the local agency under subdivision 1.

(e) This subdivision supersedes subdivision 1, clause (2), if both apply to an applicant.

Sec. 23. Minnesota Statutes 2010, section 256B.431, is amended by adding a subdivision to read:

Subd. 44. **Property rate increase for a facility in Bloomington effective November 1, 2010.** Notwithstanding any other law to the contrary, monies available for moratorium projects under section 144A.073, subdivision 11, shall be used, effective November 1, 2010, to fund an approved moratorium exception project for a nursing facility in Bloomington licensed for 137 beds as of November 1, 2010, up to a total property rate adjustment of $19.33.

Sec. 24. Minnesota Statutes 2010, section 256B.434, subdivision 4, is amended to read:

Subd. 4. **Alternate rates for nursing facilities.** (a) For nursing facilities which have their payment rates determined under this section rather than section 256B.431, the commissioner shall establish a rate under this subdivision. The nursing facility must enter into a written contract with the commissioner.

(b) A nursing facility's case mix payment rate for the first rate year of a facility's contract under this section is the payment rate the facility would have received under section 256B.431.

(c) A nursing facility's case mix payment rates for the second and subsequent years of a facility's contract under this section are the previous rate year's contract payment rates plus an inflation adjustment and, for facilities reimbursed under this section or section 256B.431, an adjustment to include the cost of any increase in Health Department licensing fees for the facility taking effect on or after July 1, 2001. The index for the inflation adjustment must be based on the change in the Consumer Price Index-All Items (United States City average) (CPI-U) forecasted by the commissioner of management and

budget's national economic consultant, as forecasted in the fourth quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined. For the rate years beginning on July 1, 1999, July 1, 2000, July 1, 2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006, July 1, 2007, July 1, 2008, October 1, 2009, and October 1, 2010, ~~October 1, 2011, and October 1, 2012.~~ this paragraph shall apply only to the property-related payment rate~~, except that adjustments to include the cost of any increase in Health Department licensing fees taking effect on or after July 1, 2001, shall be provided~~. For the rate years beginning on October 1, 2011, and October 1, 2012, the rate adjustment under this paragraph shall be suspended. Beginning in 2005, adjustment to the property payment rate under this section and section 256B.431 shall be effective on October 1. In determining the amount of the property-related payment rate adjustment under this paragraph, the commissioner shall determine the proportion of the facility's rates that are property-related based on the facility's most recent cost report.

(d) The commissioner shall develop additional incentive-based payments of up to five percent above a facility's operating payment rate for achieving outcomes specified in a contract. The commissioner may solicit contract amendments and implement those which, on a competitive basis, best meet the state's policy objectives. The commissioner shall limit the amount of any incentive payment and the number of contract amendments under this paragraph to operate the incentive payments within funds appropriated for this purpose. The contract amendments may specify various levels of payment for various levels of performance. Incentive payments to facilities under this paragraph may be in the form of time-limited rate adjustments or onetime supplemental payments. In establishing the specified outcomes and related criteria, the commissioner shall consider the following state policy objectives:

(1) successful diversion or discharge of residents to the residents' prior home or other community-based alternatives;

(2) adoption of new technology to improve quality or efficiency;

(3) improved quality as measured in the Nursing Home Report Card;

(4) reduced acute care costs; and

(5) any additional outcomes proposed by a nursing facility that the commissioner finds desirable.

(e) Notwithstanding the threshold in section 256B.431, subdivision 16, facilities that take action to come into compliance with existing or pending requirements of the life safety code provisions or federal regulations governing sprinkler systems must receive

reimbursement for the costs associated with compliance if all of the following conditions are met:

(1) the expenses associated with compliance occurred on or after January 1, 2005, and before December 31, 2008;

(2) the costs were not otherwise reimbursed under subdivision 4f or section 144A.071 or 144A.073; and

(3) the total allowable costs reported under this paragraph are less than the minimum threshold established under section 256B.431, subdivision 15, paragraph (e), and subdivision 16.

The commissioner shall use money appropriated for this purpose to provide to qualifying nursing facilities a rate adjustment beginning October 1, 2007, and ending September 30, 2008. Nursing facilities that have spent money or anticipate the need to spend money to satisfy the most recent life safety code requirements by (1) installing a sprinkler system or (2) replacing all or portions of an existing sprinkler system may submit to the commissioner by June 30, 2007, on a form provided by the commissioner the actual costs of a completed project or the estimated costs, based on a project bid, of a planned project. The commissioner shall calculate a rate adjustment equal to the allowable costs of the project divided by the resident days reported for the report year ending September 30, 2006. If the costs from all projects exceed the appropriation for this purpose, the commissioner shall allocate the money appropriated on a pro rata basis to the qualifying facilities by reducing the rate adjustment determined for each facility by an equal percentage. Facilities that used estimated costs when requesting the rate adjustment shall report to the commissioner by January 31, 2009, on the use of this money on a form provided by the commissioner. If the nursing facility fails to provide the report, the commissioner shall recoup the money paid to the facility for this purpose. If the facility reports expenditures allowable under this subdivision that are less than the amount received in the facility's annualized rate adjustment, the commissioner shall recoup the difference.

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

Subd. 60. **Rate increase for low-rate facilities.** (a) Effective October 1, 2011, the commissioner shall adjust the operating payment rates of a nursing facility whose operating payment rate on September 30, 2011, is greater than the 95th percentile of all nursing facilities operating payment rates. The commissioner shall:

(1) array all operating payment rates in effect on September 30, 2011, at a case-mix weight equal to 1.00 (DDF) from lowest to highest;

(2) determine the 95th percentile of the array in clause (1);

(3) compute a reduction amount if a facility's amount in clause (1) is greater than the amount computed in clause (2) by subtracting a facility's DDF rate in clause (1) from the amount computed in clause (2);

(4) compute the portion of each facility's DDF operating payment rate that is the direct care per diem based on the rates in effect on September 30, 2011; and

(5) determine the change for all other case-mix levels, by multiplying the amount in clause (3) by the percentage in clause (4) and by the corresponding case-mix weight for each care level. Add to this product the non-direct care per diem portion of the amount in clause (3).

(b) The total amount to be saved by the rate reductions will be computed. The commissioner shall:

(1) for each facility receiving a rate change in paragraph (a), multiply each case-mix level's rate change in paragraph (a), clause (5), by the corresponding case-mix resident days from the most recent cost report that has been desk audited; and

(2) sum all the products computed in clause (1).

(c) The amount of total payment reductions computed in paragraph (b), clause (2), shall be distributed to the facilities with the lowest DDF operating payment rates determined in paragraph (a), clause (1). The commissioner shall:

(1) start with the facility or facilities with the lowest DDF operating payment rate and compute the amount of a rate adjustment needed to make the DDF rate equal to the DDF of the facility directly below it in the array;

(2) compute the rate increases for the other case-mix levels using the amount computed in clause (1), and the process stated in paragraph (a), clauses (4) and (5);

(3) compute the total amount the lowest facilities will receive using the process described in paragraph (b);

(4) compute the running total to be spent at all facilities receiving an increase under this paragraph by summing each facility's amount computed in clause (3); and

(5) repeat the process in clauses (1) to (4) as long as the amount in clause (4) does not exceed the amount in paragraph (b), clause (2).

Sec. 26. Minnesota Statutes 2010, section 256B.49, is amended by adding a subdivision to read:

Subd. 10a. **Definitions.** For purposes of this section, the following terms have the meaning given.

(a) "Comprehensive transitional service plan" means a plan detailing specific measurable functional skills and timelines and additional systems of support for achieving the fundamental service outcome.

(b) "Functional milestone" means a functional skill attained through service outcomes which takes the place of a provider funded service.

(c) "Fundamental service outcome" means the specific end objective for the service being provided.

(d) "Natural community supports" means relationships developed with friends, family, work places, neighborhoods, and organizations which are not reimbursed to provide supportive relationships that enhance the quality and security of individuals in their communities.

(e) "Short-term service outcome" means the measurable functional skill outcomes necessary to achieve the fundamental service outcome.

(f) "Transitional service planning team" means the individual receiving services; the case manager; service providers; the guardian, if applicable; and other identified individuals such as advocates, family members, and other natural supports who are able to commit to a plan of support, housing, and treatment which will maximize the individual's opportunity for success in transitioning to community living or the next level of care.

Sec. 27. 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 under this section shall be provided case management services according to section 256B.092, subdivisions 1a, 1b, and 1e, by qualified vendors as described in the federally approved waiver application. ~~The case management service activities provided will include:~~

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

~~(2) developing the written individual service plan within ten working days after the assessment is completed;~~

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

~~(4) assisting the recipient in the identification of potential service providers;~~

~~(5) assisting the recipient to access services;~~

~~(6) 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.~~

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

Sec. 28. Minnesota Statutes 2010, 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.

(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 144.0724, subdivision 11, 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.

(e) 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) The commissioner shall develop criteria to identify individuals whose level of functioning is reasonably expected to improve and reassess these individuals every six months. Individuals who meet these criteria must have a comprehensive transitional service plan developed under subdivision 15, paragraphs (b) and (c).

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

Sec. 29. Minnesota Statutes 2010, section 256B.49, subdivision 15, is amended to read:

Subd. 15. ~~**Individualized**~~ **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:~~ that complies with the requirements of 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 will be identified. A team leader will 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 individual to the next level of service.

Within ten days following an assessment, a comprehensive transitional service plan will be developed incorporating elements of a comprehensive functional assessment and will include 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 will identify additional supports which 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, their units, 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 individual 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 his or her current level of functioning. Individuals who move from a transitional to a maintenance service plan must be reassessed to determine if he or she would benefit from a transitional service plan on at least an annual basis. This assessment should consider any changes to technological or natural community supports.

~~(b)~~ (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 service 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.

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

Sec. 30. Minnesota Statutes 2010, section 256G.02, subdivision 6, is amended to read:

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

(a) 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) 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; day training and habilitation programs and assisted living services; and

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

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

Sec. 31. **ABOLISHING THE MINNESOTA GOVERNOR'S COUNCIL ON DEVELOPMENTAL DISABILITIES.**

The Minnesota Governor's Council on Developmental Disabilities is abolished and all responsibilities under the Developmental Disabilities Assistance Bill of Rights Act of 2000, also known as United States Code, title 42, sections 15001 to 15115, and Public Law 106-402, are transferred to the Minnesota State Council on Disability.

Sec. 32. **HOME- AND COMMUNITY-BASED WAIVER APPROPRIATIONS LIMITS.**

Notwithstanding any law or rule to the contrary, the 2012 and 2013 general fund appropriations for the medicaid home- and community-based waivers for the elderly and persons with disabilities including elderly waiver under Minnesota Statutes, section 256B.0915; DD waiver under Minnesota Statutes, section 256B.092; and the CAC, CADI, and TBI waivers under Minnesota Statutes, section 256B.49, are capped as follows: the DD waiver is capped at $982,172,000 in each year; elderly waiver fee-for-service is capped at $34,557,000 in each year; elderly waiver managed care is capped at $265,283,000 in each year; the CADI waiver is capped at $410,088,000 in each year; the CAC waiver is capped at $20,722,000 in each year; and the TBI waiver is capped at $97,046,000 in each year. The commissioner must ensure that at least the same number of people are served on

the home- and community-based waiver programs as were served on March 22, 2010. The commissioner may adjust county home- and community-based waiver allocations as needed. Priorities for the use of waiver slots will be for individuals anticipated to be discharged from an institutional setting or who are at imminent risk of an institutional placement. The limits include conversions and diversions, unless the commissioner has approved a plan to convert funding due to the restructuring, closure, or downsizing of a residential facility or nursing facility to serve directly affected individuals on the home- and community-based waivers. The commissioner and counties are prohibited from reducing provider rates under this provision. The commissioner shall maintain the waiting list and access to the waiver.

Sec. 33. **DIRECTIONS TO COMMISSIONER.**

Subdivision 1. **Community first choice option.** (a) The commissioner shall provide information on all state-funded grants and medical assistance-funded services and programs which could be included in the Community First Choice option, including those in the Continuing Care and Mental Health and Children's Mental Health divisions which provide assistance in a home or in the community for individuals in the eligibility categories described in paragraph (b). Recommendations on the grants and programs and the number of persons who use those grants and programs and would be eligible for home and community-based attendant services and supports and any changes to Minnesota Statutes or Minnesota Rules needed shall be provided to the legislative committees with jurisdiction over health and human services finance and policy by January 15, 2012.

(b) For individuals whose income is less than 150 percent of the federal poverty guidelines and who qualify for semi-independent living services under section 252.275, and epilepsy demonstration project funding, the commissioner shall assure an assessment under section 256B.0659, subdivision 3a, is completed by November 30, 2011, for home and community-based attendant services and supports.

Subd. 2. **Co-payments for home and community-based services.** Upon federal approval, the commissioner of human services shall develop and implement a co-payment schedule for individuals receiving home- and community-based services under Minnesota Statutes, chapter 256B.

Subd. 3. **Federal waiver amendment.** The commissioner shall seek an amendment to the 1915c home and community-based waivers under Minnesota Statutes, sections 256B.092 and 256B.49, to allow properly licensed residential programs under section 245A.02, subdivision 14, to provide residential services to up to eight individuals with physical or developmental disabilities, chronic illnesses, or traumatic brain injuries.

Subd. 4. **Recommendations for personal care assistance service changes.** The commissioner shall consult with stakeholder groups, including counties, advocates, persons receiving personal care assistance services, and personal care assistance providers, and make recommendations to the legislature by February 1, 2012, on changes that could be made to the program to improve oversight, program efficiency, and cost-effectiveness.

Subd. 5. **Nursing facility pay-for-performance reimbursement system.** The commissioner of human services shall report to the legislative committees with jurisdiction over nursing facility policy and finance with recommendations for developing and implementing a pay-for-performance reimbursement system with a quality add-on by January 15, 2012.

Subd. 6. **ICF/DD transition plan.** The commissioner of human services shall work with stakeholders to develop a plan to transition individuals currently residing in intermediate care facilities for persons with developmental disabilities into the least restrictive community settings possible. Individuals residing in intermediate care facilities for persons with developmental disabilities who choose to remain there or whose health or safety would be put at risk in a less restrictive setting may continue to reside in intermediate care facilities for persons with developmental disabilities.

Sec. 34. **STATE PLAN AMENDMENT TO IMPLEMENT SELF-DIRECTED PERSONAL SUPPORTS.**

By July 15, 2011, the commissioner shall submit a state plan amendment to implement Minnesota Statutes, section 256B.0657, as soon as possible upon federal approval.

Sec. 35. **AMENDMENT FOR SELF-DIRECTED COMMUNITY SUPPORTS.**

By September 1, 2011, the commissioner shall submit an amendment to the home and community-based waiver programs consistent with implementing the self-directed option under Minnesota Statutes, section 256B.0657, through statewide enrolled providers contracted to provide outreach information, training, and fiscal support entity services to all eligible recipients choosing this option and with shared care in some types of services. The waiver amendment shall be consistent with changes in case management service under Minnesota Statutes, section 256B.092.

Sec. 36. **ESTABLISHMENT OF RATES FOR SHARED HOME AND COMMUNITY-BASED WAIVER ADMINISTRATIVE SERVICES.**

By January 1, 2012, the commissioner shall establish rates to be paid for in-home services and personal supports under all of the home and community-based waiver services programs consistent with the standards in Minnesota Statutes, section 256B.4912, subdivision 2.

Sec. 37. **ESTABLISHMENT OF RATES FOR CASE MANAGEMENT SERVICES.**

By January 1, 2012, the commissioner shall establish the rate to be paid for case management services under Minnesota Statutes, sections 256B.092 and 256B.49, consistent with the standards in Minnesota Statutes, section 256B.4912, subdivision 2.

Sec. 38. **RECOMMENDATIONS FOR FURTHER CASE MANAGEMENT REDESIGN.**

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

(1) definitions of service and consolidation of standards and rates to the extent appropriate for all types of medical assistance case management services, including targeted case management under Minnesota Statutes, sections 256B.0621; 256B.0625, subdivision 20; and 256B.0924; mental health case management services for children and adults, all types of home and community-based waiver case management, and case management under Minnesota Rules, parts 9525.0004 to 9525.0036. This work shall 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.

Sec. 39. **MY LIFE, MY CHOICES TASK FORCE.**

Subd. 1. **Establishment.** The My Life, My Choices Task Force is established to create a system of supports and services for people with disabilities governed by the following principles:

(1) freedom to act as a consumer of services in the marketplace;

(2) freedom to choose to take as much risk as any other citizen;

(3) more choices in levels of service that may vary throughout life;

(4) opportunity to work with a trusted partner and fiscal support entity to manage and personal budget and to be accountable for reporting spending and personal outcomes;

(5) opportunity to live with minimal constraints instead of minimal freedoms; and

(6) ability to consolidate funding streams into an individualized budget.

Subd. 2. **Membership.** The My Life, My Choices Task Force shall consist of the lieutenant governor; the commissioner of human services, or designee; a representative of the Minnesota Chamber of Commerce; and the following to be appointed by the governor, one administrative law judge, one labor representative, two family members of people with disabilities, and one individual with disabilities. In addition, the following shall be appointed jointly by the speaker of the house and the senate Subcommittee on Committees of the Committee on Rules and Administration, a representative of a disability advocacy organization; a representative of a disability legal services advocacy organization; representatives of two nonprofit organizations, on of which serves all 87 counties; and a representative of a philanthropic organization. The chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance shall serve as ex officio members.

Subd. 3. **Duties.** The task force shall make recommendations, including proposed legislation, and report to the legislative committees with jurisdiction over health and human services policy and finance by November 15, 2011, on creating a system of supports and services for people with disabilities by July 1, 2012, as governed by the principles under subdivision 1. In making recommendations and proposed legislation, the council shall work in conjunction with the Consumer-Directed Community Supports Task Force and shall include self-directed planning, individual budgeting, choice of trusted partner, self-directed purchasing of services and supports, reporting of outcomes, ability to share in any savings, and any additional rules or laws that may need to be waived. Recommendations from the task force shall be fully implemented by July 1, 2013.

Subd. 4. **Expense reimbursement.** The members of the task force shall not be reimbursed for expenses related to the duties of the task force.

Subd. 5. **Expiration.** The task force expires on July 1, 2013.

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

Sec. 40. **REPEALER.**

Minnesota Statutes 2010, section 16B.054, is repealed.