

1.1 moves to amend H.F. No. 2456 as follows:

1.2 Page 1, after line 17, insert:

1.3 "ARTICLE 1

1.4 STATEWIDE PROVIDER ENROLLMENT, PERFORMANCE STANDARDS,
1.5 AND RATE-SETTING METHODOLOGY"

1.6 Page 55, delete section 44

1.7 Page 55, after line 26, insert:

1.8 "ARTICLE 2

1.9 PAYMENT RATE-SETTING METHODOLOGIES

1.10 Section 1. Minnesota Statutes 2010, section 256B.0911, is amended by adding a
1.11 subdivision to read:

1.12 Subd. 10. Disability waived services assessment requirements. The
1.13 commissioner of human services shall establish an assessment methodology to determine
1.14 reimbursement classifications based upon each individual's assessed needs for services
1.15 reimbursed under section 256B.4913.

1.16 (a) For purposes of this subdivision, the following terms have the meanings given
1.17 them:

1.18 (1) "high medical needs" means complex health-related needs that require on-site
1.19 medical attention and are specified in the coordinated service and support plan;

1.20 (2) "high behavioral needs" means a history of observable behavior that deviates
1.21 from social norms as defined and counted in the assessment that require comprehensive
1.22 training in behavior management, behavior programming, de-escalation techniques, or
1.23 medication management training for behavior medications. Examples of participant needs
1.24 include, but are not limited to, a participant at risk of or with a history of:

1.25 (i) elopement, defined as when a patient or resident who is cognitively, physically,
1.26 mentally, emotionally, or chemically impaired wanders away, walks away, runs away,

2.1 escapes, or otherwise leaves a caregiving facility or environment unsupervised, unnoticed,
 2.2 or prior to their scheduled discharge; or

2.3 (ii) serious harm to self or others;

2.4 (3) "high mental health needs" means a history of a mental disorder, diagnosed by a
 2.5 physician and confirmed in the assessment, that requires constant staff oversight without
 2.6 which the consequences of the participant's behaviors are severe. The management of
 2.7 these needs requires comprehensive training in mental health issues, dual diagnosis, and
 2.8 medication management training. This means a current diagnosis of severe and persistent
 2.9 mental illness or severe emotional disturbance that manifests itself through one of the
 2.10 following:

2.11 (i) serious harm to self or others; or

2.12 (ii) other extreme behaviors that interfere with major life activities; and

2.13 (4) "deaf or hard-of-hearing" means a loss of hearing diagnosed by a physician and
 2.14 confirmed in the assessment that requires staff proficient in one or more of the following
 2.15 to communicate:

2.16 (i) American sign language;

2.17 (ii) tactile interpretation; or

2.18 (iii) other sign language.

2.19 (b) The commissioner shall ensure that:

2.20 (1) the assessment includes a full and accurate accounting of each individual's
 2.21 need for supports;

2.22 (2) the results of the methodology for each individual are statistically valid and
 2.23 reliable, and for each individual's result, there is a statistically significant level of
 2.24 interrated reliability; and

2.25 (3) the assessment determines if an individual fits the definitions of high medical
 2.26 needs, high behavioral needs, high mental health needs, or deaf or hard-of-hearing.

2.27 (c) The assessment methodology must be completed prior to the implementation of
 2.28 any changes to rates determined under section 246B.4913.

2.29 (d) Any individual may appeal the results of the individual's assessment as outlined
 2.30 in section 256.045.

2.31 (e) The commissioner shall adopt rules under section 14.05 to implement this
 2.32 methodology.

2.33 Sec. 2. Minnesota Statutes 2010, section 256B.0916, subdivision 2, is amended to read:

2.34 Subd. 2. **Distribution of funds; partnerships.** (a) Beginning with fiscal year 2000,
 2.35 the commissioner shall distribute all funding available for home and community-based

3.1 waiver services for persons with developmental disabilities to individual counties or to
3.2 groups of counties that form partnerships to jointly plan, administer, and authorize funding
3.3 for eligible individuals. The commissioner shall encourage counties to form partnerships
3.4 that have a sufficient number of recipients and funding to adequately manage the risk
3.5 and maximize use of available resources.

3.6 (b) Counties must submit a request for funds and a plan for administering the
3.7 program as required by the commissioner. The plan must identify the number of clients to
3.8 be served, their ages, and their priority listing based on:

3.9 (1) requirements in Minnesota Rules, part 9525.1880; and

3.10 (2) statewide priorities identified in section 256B.092, subdivision 12.

3.11 The plan must also identify changes made to improve services to eligible persons and to
3.12 improve program management.

3.13 (c) In allocating resources to counties, priority must be given to groups of counties
3.14 that form partnerships to jointly plan, administer, and authorize funding for eligible
3.15 individuals and to counties determined by the commissioner to have sufficient waiver
3.16 capacity to maximize resource use.

3.17 (d) Within 30 days after receiving the county request for funds and plans, the
3.18 commissioner shall provide a written response to the plan that includes the level of
3.19 resources available to serve additional persons.

3.20 (e) Counties are eligible to receive medical assistance administrative reimbursement
3.21 for administrative costs under criteria established by the commissioner.

3.22 (f) Upon implementation of rate methodologies developed under section 256B.4913,
3.23 the commissioner shall adjust allocations to local agencies for home and community-based
3.24 waivered service allocations to reflect the total amount of spending for all recipients
3.25 with disabilities in their respective counties in need of the level of care provided in an
3.26 intermediate care facility for individuals with developmental disabilities, a nursing facility,
3.27 or a hospital as determined by the methodology in section 256B.4913.

3.28 Sec. 3. Minnesota Statutes 2010, section 256B.092, subdivision 4, is amended to read:

3.29 Subd. 4. **Home and community-based services for developmental disabilities.**

3.30 (a) The commissioner shall make payments to approved vendors participating in the
3.31 medical assistance program to pay costs of providing home and community-based
3.32 services, including case management service activities provided as an approved home and
3.33 community-based service, to medical assistance eligible persons with developmental
3.34 disabilities who have been screened under subdivision 7 and according to federal
3.35 requirements. Federal requirements include those services and limitations included in the

4.1 federally approved application for home and community-based services for persons with
4.2 developmental disabilities and subsequent amendments.

4.3 (b) Effective July 1, 1995, contingent upon federal approval and state appropriations
4.4 made available for this purpose, and in conjunction with Laws 1995, chapter 207, article 8,
4.5 section 40, the commissioner of human services shall allocate resources to county agencies
4.6 for home and community-based waived services for persons with developmental
4.7 disabilities authorized but not receiving those services as of June 30, 1995, based upon the
4.8 average resource need of persons with similar functional characteristics. To ensure service
4.9 continuity for service recipients receiving home and community-based waived services
4.10 for persons with developmental disabilities prior to July 1, 1995, the commissioner shall
4.11 make available to the county of financial responsibility home and community-based
4.12 waived services resources based upon fiscal year 1995 authorized levels.

4.13 (c) Home and community-based resources for all recipients shall be managed by ~~the~~
4.14 ~~county of financial responsibility within an allowable reimbursement average established~~
4.15 ~~for~~ each county. Payments for home and community-based services provided to individual
4.16 recipients shall not exceed amounts authorized by the county of financial responsibility.
4.17 For specifically identified former residents of nursing facilities, the commissioner shall be
4.18 responsible for authorizing payments and payment limits under the appropriate home and
4.19 community-based service program. Payment is available under this subdivision only for
4.20 persons who, if not provided these services, would require the level of care provided in an
4.21 intermediate care facility for persons with developmental disabilities.

4.22 (d) Resources and payment rates for all recipients of home and community-based
4.23 services shall remain as negotiated by each county of fiscal responsibility as of January
4.24 1, 2012.

4.25 (e) Resources and payment rates for recipients of home and community-based
4.26 services enrolled prior to January 1, 2012, may be adjusted for changes in needs using
4.27 processes by county agencies established as of January 1, 2012.

4.28 (f) Any new recipients of home and community-based services after January 1,
4.29 2012, shall have resources managed by the county using the process in place in each
4.30 county as of January 1, 2012.

4.31 (g) Counties may not implement changes to resources for individuals under section
4.32 256B.4913, until the implementation of a statistically valid and reliable process for
4.33 assessing each individual's needs under section 256B.0911, subdivision 10.

4.34 Sec. 4. Minnesota Statutes 2010, section 256B.49, subdivision 17, is amended to read:

5.1 Subd. 17. **Cost of services and supports.** (a) The commissioner shall ensure
5.2 that the average per capita expenditures estimated in any fiscal year for home and
5.3 community-based waiver recipients does not exceed the average per capita expenditures
5.4 that would have been made to provide institutional services for recipients in the absence
5.5 of the waiver.

5.6 ~~(b) The commissioner shall implement on January 1, 2002, one or more aggregate,~~
5.7 ~~need-based methods for allocating to local agencies the home and community-based~~
5.8 ~~waivered service resources available to support recipients with disabilities in need of~~
5.9 ~~the level of care provided in a nursing facility or a hospital. Upon implementation~~
5.10 ~~of rate methodologies developed under section 256B.4913, the commissioner shall~~
5.11 ~~adjust allocations to local agencies for home and community-based waivered service~~
5.12 ~~allocations to reflect the total amount of spending for all recipients with disabilities in their~~
5.13 ~~respective counties in need of the level of care provided in an intermediate care facility for~~
5.14 ~~individuals with developmental disabilities, a nursing facility, or a hospital as determined~~
5.15 ~~by the methodology in section 256B.4913:~~

5.16 (1) the commissioner shall set each county's allocation to include resources for
5.17 the total amount of spending for each respective county based on the total number of
5.18 individuals estimated to be served multiplied by each individual's service rate determined
5.19 under section 256B.4913; and

5.20 (2) if an individual relocates from one county to another within a calendar year, the
5.21 commissioner shall adjust county allocations to reflect where the individual is receiving
5.22 services.

5.23 (c) Until the allocation method described in paragraph (b) is implemented, the
5.24 commissioner shall allocate resources to single counties and county partnerships in a
5.25 manner that reflects consideration of:

- 5.26 (1) an incentive-based payment process for achieving outcomes;
5.27 (2) the need for a state-level risk pool;
5.28 (3) the need for retention of management responsibility at the state agency level; and
5.29 (4) a phase-in strategy as appropriate.

5.30 ~~(e) Until the allocation methods described in paragraph (b) are implemented, the~~
5.31 ~~annual allowable reimbursement level of home and community-based waiver services~~
5.32 ~~shall be the greater of:~~

5.33 ~~(1) the statewide average payment amount which the recipient is assigned under the~~
5.34 ~~waiver reimbursement system in place on June 30, 2001, modified by the percentage of~~
5.35 ~~any provider rate increase appropriated for home and community-based services; or~~

6.1 ~~(2) an amount approved by the commissioner based on the recipient's extraordinary~~
 6.2 ~~needs that cannot be met within the current allowable reimbursement level. The~~
 6.3 ~~increased reimbursement level must be necessary to allow the recipient to be discharged~~
 6.4 ~~from an institution or to prevent imminent placement in an institution. The additional~~
 6.5 ~~reimbursement may be used to secure environmental modifications; assistive technology~~
 6.6 ~~and equipment; and increased costs for supervision, training, and support services~~
 6.7 ~~necessary to address the recipient's extraordinary needs. The commissioner may approve~~
 6.8 ~~an increased reimbursement level for up to one year of the recipient's relocation from an~~
 6.9 ~~institution or up to six months of a determination that a current waiver recipient is at~~
 6.10 ~~imminent risk of being placed in an institution.~~

6.11 (d) Beginning July 1, 2001, medically necessary private duty nursing services will be
 6.12 authorized under this section as complex and regular care according to sections 256B.0651
 6.13 to 256B.0656 and 256B.0659. The rate established by the commissioner for registered
 6.14 nurse or licensed practical nurse services under any home and community-based waiver as
 6.15 of January 1, 2001, shall not be reduced.

6.16 (e) Notwithstanding section 252.28, subdivision 3, paragraph (d), if the 2009
 6.17 legislature adopts a rate reduction that impacts payment to providers of adult foster care
 6.18 services, the commissioner may issue adult foster care licenses that permit a capacity of
 6.19 five adults. The application for a five-bed license must meet the requirements of section
 6.20 245A.11, subdivision 2a. Prior to admission of the fifth recipient of adult foster care
 6.21 services, the county must negotiate a revised per diem rate for room and board and waiver
 6.22 services that reflects the legislated rate reduction and results in an overall average per
 6.23 diem reduction for all foster care recipients in that home. The revised per diem must allow
 6.24 the provider to maintain, as much as possible, the level of services or enhanced services
 6.25 provided in the residence, while mitigating the losses of the legislated rate reduction.

6.26 Sec. 5. Minnesota Statutes 2010, section 256B.4912, is amended to read:

6.27 **256B.4912 HOME AND COMMUNITY-BASED WAIVERS; PROVIDERS**
 6.28 **AND PAYMENT.**

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

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

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

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

7.3 ~~By July 2010~~ (b) Beginning July 2011, staff that provide direct contact, as defined
7.4 in section 245C.02, subdivision 11, that are employees of waiver service providers for
7.5 services specified in the federally approved waiver plans must meet the requirements
7.6 of chapter 245C prior to providing waiver services and as part of ongoing enrollment.
7.7 Upon federal approval, this requirement must also apply to consumer-directed community
7.8 supports.

7.9 (c) Upon enactment of section 256B.4913, providers of waiver services must
7.10 reenroll with the state. County and tribal agency contracts existing prior to January 1,
7.11 2013, are not effective beginning January 1, 2013.

7.12 **Subd. 2. Rate-setting methodologies.** (a) The commissioner shall establish
7.13 statewide prospective rate-setting methodologies that meet federal waiver requirements
7.14 for home and community-based waiver services for individuals with disabilities. The
7.15 rate-setting methodologies must abide by the principles of transparency and equitability
7.16 across the state. The methodologies must involve a uniform process of structuring rates
7.17 for each service and must promote quality and participant choice.

7.18 (b) No changes in existing provider rates are effective until the development and
7.19 implementation of an assessment methodology for individuals assessed under section
7.20 256B.0911, subdivision 10, that provides a statistically reliable and valid means for
7.21 assessing each individual's support needs.

7.22 **Subd. 3. Payment rate criteria.** (a) The payment structures and methodologies
7.23 under this section shall reflect the payment rate criteria in paragraphs (b) and (c).

7.24 (b) Payment rates shall be determined according to reasonable, ordinary, and
7.25 necessary costs that accurately reflect the actual cost of service delivery.

7.26 (c) Payment rates shall be sufficient to enlist enough providers so that care and
7.27 services are available under the plan at least to the extent that care and services are
7.28 available to the general population in the geographic area as required by section
7.29 1902(a)(30)(A) of the Social Security Act.

7.30 (d) The commissioner must not reimburse:

7.31 (1) unauthorized service delivery;

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

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

7.34 (4) extended employment services under Minnesota Rules, parts 3300.2005 to
7.35 3300.3100; or vocational rehabilitation services provided under the federal Rehabilitation

8.1 Act, United States Code, title I, section 110, as amended; or United States Code, title VI,
8.2 part C, and not through use of medical assistance or county social service funds; or

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

8.6 (e) Payment rates are set prospectively and may not be enforced retroactively.

8.7 **Sec. 6. [256B.4913] HOME AND COMMUNITY-BASED WAIVERS;**
8.8 **RATE-SETTING METHODOLOGIES.**

8.9 Subdivision 1. **Applicable services.** "Applicable services" are those authorized
8.10 under the state's home and community-based waivers under sections 256B.092 and
8.11 256B.49, including those defined in the federally approved home and community-based
8.12 services plan, as follows:

8.13 (1) adult day care;

8.14 (2) family adult day services;

8.15 (3) day training and habilitation;

8.16 (4) prevocational services;

8.17 (5) structured day services;

8.18 (6) supported employment services;

8.19 (7) behavioral programming;

8.20 (8) housing access coordination;

8.21 (9) independent living services;

8.22 (10) in-home family supports;

8.23 (11) night supervision;

8.24 (12) personal support;

8.25 (13) supported living services;

8.26 (14) transportation services;

8.27 (15) respite services;

8.28 (16) residential services; or

8.29 (17) any other services approved as part of the state's home and community-based
8.30 services plan.

8.31 Subd. 2. **Base wage index.** (a) The base wage index is established to determine
8.32 staffing costs associated with providing services to individuals receiving home and
8.33 community-based services.

8.34 (b) The base wage shall be calculated using a composite of wages taken from job
8.35 descriptions and standard occupational classification (SOC) codes from the Bureau

9.1 of Labor Statistics, as defined in the most recent edition of the Occupational Outlook
9.2 Handbook. The base wage index shall be calculated as follows:

9.3 (1) for day services, 20 percent of the median wage for nursing aide (SOC code
9.4 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
9.5 and 60 percent of the median wage for social and human services workers (SOC code
9.6 21-1093);

9.7 (2) for residential direct care staff, 20 percent of the median wage for home health
9.8 aide (SOC code 31-1011); 20 percent of the median wage for personal and home health
9.9 aide (SOC code 39-9021); 20 percent of the median wage for nursing aide (SOC code
9.10 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
9.11 and 20 percent of the median wage for social and human services aide (SOC code
9.12 21-1093);

9.13 (3) for residential awake overnight staff, 20 percent of the median wage for home
9.14 health aide (SOC code 31-1011); 20 percent of the median wage for personal and home
9.15 health aide (SOC code 39-9021); 20 percent of the median wage for nursing aide (SOC
9.16 code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code
9.17 29-2053); and 20 percent of the median wage for social and human services aide (SOC
9.18 code 21-1093);

9.19 (4) for residential asleep overnight staff, the wage will be \$7.66 per hour, adjusted
9.20 annually by the Consumer Price Index for urban wage earners;

9.21 (5) for supported living services hourly staff, 20 percent of the median wage
9.22 for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric
9.23 technician (SOC code 29-2053); and 60 percent of the median wage for social and human
9.24 services aide (SOC code 21-1093);

9.25 (6) for behavior programming aide staff, 20 percent of the median wage for nursing
9.26 aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC
9.27 code 29-2053); and 60 percent of the median wage for social and human services aide
9.28 (SOC code 21-1093);

9.29 (7) for behavioral programming professional staff, 100 percent of the median wage
9.30 for clinical counseling and school psychologist (SOC code 19-3031);

9.31 (8) for supported employment job coach staff, 20 percent of the median wage
9.32 for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric
9.33 technician (SOC code 29-2053); and 60 percent of the median wage for social and human
9.34 services aide (SOC code 21-1093);

10.1 (9) for supported employment job developer staff, 50 percent of the median wage
10.2 for rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for
10.3 social and human services aide (SOC code 21-1093);

10.4 (10) for in-home family support, 20 percent of the median wage for nursing aide
10.5 (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC
10.6 code 29-2053); and 60 percent of the median wage for social and human services aide
10.7 (SOC code 21-1093);

10.8 (11) for housing access coordination staff, 50 percent of the median wage for
10.9 community and social services specialist (SOC code 21-1099); and 50 percent of the
10.10 median wage for social and human services aide (SOC code 21-1093);

10.11 (12) for night supervision staff, 20 percent of the median wage for home health aide
10.12 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide
10.13 (SOC code 39-9021); 20 percent of the median wage for nursing aide (SOC code 31-1012);
10.14 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20
10.15 percent of the median wage for social and human services aide (SOC code 21-1093);

10.16 (13) for respite staff, 50 percent of the median wage for personal and home care aide
10.17 (SOC code 39-9021); and 50 percent of the median wage for nursing aides, orderlies, and
10.18 attendants (SOC code 31-1012);

10.19 (14) for personal support staff, 50 percent of the median wage for personal and home
10.20 care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides,
10.21 orderlies, and attendants (SOC code 31-1012);

10.22 (15) for transportation staff, 20 percent of the median wage for nursing aide (SOC
10.23 code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code
10.24 29-2053); and 60 percent of the median wage for social and human services aide (SOC
10.25 code 21-1093);

10.26 (16) for independent living skills staff, ten percent of the median wage for nursing
10.27 aides, orderlies, and attendants (SOC code 31-1012); 30 percent of the median wage for
10.28 psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social
10.29 and human services aide (SOC code 21-1093); and

10.30 (17) for supervisory staff, 55 percent of the median wage for medical and health
10.31 services managers (SOC code 11-9111).

10.32 (c) The commissioner shall update the base wage index on an annual basis upon
10.33 the release of the December 31 data of the most recent year from the Bureau of Labor
10.34 Statistics and publish the base wage index on July 1 of the beginning of the next fiscal year.

10.35 (d) The commissioner shall adjust payment rates for changes in the base wage index
10.36 on an annual basis for each individual receiving waived services.

11.1 (e) The commissioner shall determine the staffing component of each individual's
11.2 payment rate receiving services under sections 256B.092 and 256B.49 using the base
11.3 wage index.

11.4 Subd. 3. **Payments for residential services.** (a) Payments for services in residential
11.5 settings include supported living services, foster care, residential care, customized living,
11.6 and 24-hour customized living.

11.7 (b) The separate components of each individual's payment rate for residential
11.8 services shall be calculated as follows:

11.9 (1) for direct supervision, the commissioner shall determine the number of units of
11.10 service to be delivered utilizing the assessment process in section 256B.0911, subdivision
11.11 10. The provider may deliver services using direct staffing or supervision technology:

11.12 (i) for direct staff cost:

11.13 (A) the commissioner shall determine staff wages for shared staff, individual
11.14 staffing, and supervision staffing using the base wage index in subdivision 2. The direct
11.15 care cost is the staff wage multiplied by the number of direct staff hours specified by
11.16 each individual's support team;

11.17 (B) for individuals that qualify for a customization under subdivision 6, add the
11.18 customization rate provided in subdivision 6 to the base wage amount determined in
11.19 the direct care cost;

11.20 (C) multiply the number of direct staff hours by the staff wage; and

11.21 (D) multiply the result of the previous calculation by one plus 9.4 percent;

11.22 (ii) for supervision technology cost:

11.23 (A) the commissioner shall determine supervision technology wages using the base
11.24 wage index in subdivision 2. The supervision technology cost is the staff wage multiplied
11.25 by the number of supervision technology hours specified by each individual's support team;

11.26 (B) for individuals that qualify for a customization under subdivision 6, add the
11.27 customization rate provided in subdivision 6 to the base wage amount determined in
11.28 the supervision technology cost;

11.29 (C) multiply the number of supervision technology hours by the staff wage; and

11.30 (D) add the amounts under subitems (B) and (C) to obtain the direct staffing cost;

11.31 (iii) add the amounts from items (i) and (ii) to obtain the direct supervision cost;

11.32 (2) for employee-related expenses:

11.33 (i) the commissioner shall include an adjustment of 10.3 percent for the cost of
11.34 taxes and workers' compensation;

11.35 (ii) the commissioner shall include an adjustment of 16.2 percent for the cost of
11.36 other benefits, including health insurance, dental insurance, life insurance, short-term

12.1 disability insurance, long-term disability insurance, vision insurance, retirement, and
12.2 tuition reimbursement; and

12.3 (iii) the total of the two percentages under items (i) and (ii) is the total percentage
12.4 for employee-related expenses;

12.5 (3) for transportation:

12.6 (i) the commissioner shall include an amount for the costs of acquiring and
12.7 maintaining vehicles for the transportation of individuals, as follows: \$1,875 for a
12.8 standard vehicle; \$3,803 for a full-size adapted van; and \$2,208 for a minivan;

12.9 (ii) for individuals requiring individualized customization, the commissioner shall
12.10 include the number of miles multiplied by \$0.51 per mile for a standard vehicle, \$1.43 for
12.11 a full-size adapted van, and \$0.61 for a minivan. The amount of miles for customization
12.12 shall be determined by each individual's support team under section 245A.11, subdivision
12.13 8; and

12.14 (iii) the total under items (i) and (ii) is the total for transportation;

12.15 (4) for client programming and supports:

12.16 (i) the commissioner shall add \$2,179 for the cost of client programming and
12.17 supports; and

12.18 (ii) for individuals that had previously received an adjustment to rates under section
12.19 256B.501, subdivision 4, the commissioner shall add an amount to reflect the costs of
12.20 providing services allowable under title XIX of the Social Security Act to obtain the
12.21 total for client programming and supports;

12.22 (5) for support costs:

12.23 (i) the commissioner shall include an adjustment of 16.5 percent for standard and
12.24 general administrative support;

12.25 (ii) the commissioner shall include an adjustment of 2.65 percent for program
12.26 support; and

12.27 (iii) the total of the adjustments under items (i) and (ii) is the total percentage for
12.28 support costs; and

12.29 (6) for administrative overhead:

12.30 (i) the commissioner shall include an adjustment of 6.58 percent for costs associated
12.31 with absence overhead;

12.32 (ii) the commissioner shall include an adjustment of 3.8 percent for utilization
12.33 overhead; and

12.34 (iii) the total of the adjustments under items (i) and (ii) is the total percentage for
12.35 administrative overhead.

12.36 (c) The total rate shall be calculated using the following steps:

- 13.1 (1) the direct supervision cost multiplied by one plus the total percentage for
13.2 employee-related expenses;
- 13.3 (2) plus the total for transportation;
- 13.4 (3) plus the total for client programming and supports;
- 13.5 (4) the subtotal of clauses (1) to (3), multiplied by one plus the total percentage for
13.6 support costs;
- 13.7 (5) the subtotal of clauses (1) to (4), multiplied by one plus the total percentage
13.8 for administrative overhead; and
- 13.9 (6) divide the total of clause (5) by 365 to obtain the daily rate.
- 13.10 **Subd. 4. Payment for day program services.** (a) Payments for services with day
13.11 programs include adult day care, family adult day care, day training and habilitation,
13.12 prevocational services, and structured day services.
- 13.13 (b) The separate components of each individual's payment rate for day program
13.14 services shall be calculated as follows:
- 13.15 (1) for direct staffing:
- 13.16 (i) the commissioner shall determine the number of units of service to be used and
13.17 each individual's support ratio utilizing the assessment process in section 256B.0911,
13.18 subdivision 10;
- 13.19 (ii) the commissioner shall determine staff wages using the base wage index in
13.20 subdivision 2. The direct care cost is the staff wage multiplied by the number of units
13.21 of service. The commissioner shall include 4.5 supervisory hours per week for each
13.22 individual at a staffing ratio of 1:1. Supervisory hours will reduce as ratios increase, but
13.23 shall not be less than 2.5 hours per week. The number of hours shall be prorated for
13.24 less than full-day participation;
- 13.25 (iii) for individuals that qualify for a customization under subdivision 6, add the
13.26 customization rate provided in subdivision 6 to the base wage amount determined in
13.27 the direct care cost;
- 13.28 (iv) multiply the units of service by the staff wage;
- 13.29 (v) multiply the result of the calculation in item (iv) by 9.4 percent; and
- 13.30 (vi) add the amounts under items (iv) and (v) to obtain the direct staffing cost;
- 13.31 (2) for employee-related expenses:
- 13.32 (i) the commissioner shall include an adjustment of 10.3 percent for the cost of
13.33 taxes and workers' compensation;
- 13.34 (ii) the commissioner shall include an adjustment of 16.2 percent for the cost of
13.35 other benefits, including health insurance, dental insurance, life insurance, short-term

14.1 disability insurance, long-term disability insurance, vision insurance, retirement, and
14.2 tuition reimbursement; and

14.3 (iii) the total of the two percentages under items (i) and (ii) is the total percentage
14.4 for employee-related expenses;

14.5 (3) for transportation:

14.6 (i) the commissioner shall determine the number of trips required, as determined
14.7 under the assessment process in section 256B.0911, subdivision 10;

14.8 (ii) the commissioner shall determine the total distance transported from the person's
14.9 residence to the initial day service destination and whether an individual requires the use
14.10 of a lift;

14.11 (iii) for each trip to and from each individual's residence, the commissioner shall
14.12 add a value of:

14.13 (A) for distances of zero to ten miles, the commissioner shall pay \$7.77 per trip for
14.14 individuals transported in a vehicle equipped with a wheelchair lift, and \$7.00 for those
14.15 who are transported in other vehicles;

14.16 (B) for individuals who are transported 11 to 20 miles, the commissioner shall pay
14.17 \$10.27 per trip for individuals transported in a vehicle equipped with a wheelchair lift,
14.18 and \$7.87 for those who are transported in other vehicles;

14.19 (C) for individuals who are transported 21 to 50 miles, the commissioner shall pay
14.20 \$15.04 per trip for individuals transported in a vehicle equipped with a wheelchair lift, and
14.21 \$9.53 for those who are transported in other vehicles; and

14.22 (D) for individuals transported 51 or more miles, the commissioner shall pay \$18.74
14.23 per trip for individuals transported in a vehicle equipped with a wheelchair lift, and \$10.80
14.24 for those who are transported in other vehicles;

14.25 (iv) these rates shall apply regardless of whether the person is being transported
14.26 alone or with others;

14.27 (v) the rates identified in paragraph (c) shall be adjusted within 30 days by the
14.28 commissioner using the same percentage as used by the Internal Revenue Service when
14.29 adjusting standard mileage rates for business purposes; and

14.30 (vi) the rates determined in this clause are the total for transportation;

14.31 (4) for program plan and supports, the commissioner shall add 16.6 percent for the
14.32 cost of program plan and supports;

14.33 (5) the commissioner shall include an adjustment of ten percent for the cost of
14.34 client programming and supports;

14.35 (6) for support costs;

15.1 (i) the commissioner shall include an adjustment of 16.5 percent for standard and
15.2 general administrative support;

15.3 (ii) the commissioner shall include an adjustment of 2.65 percent for program
15.4 support;

15.5 (iii) the commissioner shall add \$31.69 per week for the facility reasonable-use
15.6 rate; and

15.7 (iv) the total of the adjustments under items (i) to (iii) is the total percentage for
15.8 support costs; and

15.9 (7) for administrative overhead:

15.10 (i) the commissioner shall include an adjustment of 6.58 percent for costs associated
15.11 with absence overhead;

15.12 (ii) the commissioner shall include an adjustment of 3.8 percent for utilization
15.13 overhead; and

15.14 (iii) the total of the adjustments under items (i) and (ii) is the total percentage for
15.15 administrative overhead.

15.16 (c) The total rate shall be calculated using the following steps:

15.17 (1) the direct staffing cost multiplied by one plus the total percentage for
15.18 employee-related expenses;

15.19 (2) plus the total for transportation;

15.20 (3) plus the cost for program plan and supports;

15.21 (4) plus the cost for client programming and supports;

15.22 (5) the subtotal of clauses (1) to (4), multiplied by one plus the total percentage for
15.23 support costs;

15.24 (6) the subtotal of clauses (1) to (5), multiplied by one plus the total percentage
15.25 for administrative overhead; and

15.26 (7) divide the total in clause (6) by 365 to obtain the daily rate.

15.27 **Subd. 5. Payment for individualized services.** (a) Payments for individualized
15.28 services include supported employment, behavioral programming, housing access
15.29 coordination, independent living services, in-home family supports, night supervision,
15.30 personal support, and respite services.

15.31 (b) The separate components of each individual's payment rate for individualized
15.32 services shall be calculated as follows:

15.33 (1) for direct staffing:

15.34 (i) the commissioner shall determine the number of units of service to be used
15.35 utilizing the assessment process in section 256B.0911, subdivision 10;

16.1 (ii) the commissioner shall determine staff wages for shared staff, individual staffing,
16.2 and supervision staffing using the base wage index in subdivision 2. The direct care cost is
16.3 the staff wage multiplied by the number of units of service;

16.4 (iii) for individuals that qualify for a customization under subdivision 6, add the
16.5 customization rate provided in subdivision 6 to the base wage amount determined in
16.6 the direct care cost;

16.7 (iv) multiply the units of service by the staff wage;

16.8 (v) multiply the result of the calculation in item (iv) by 9.4 percent; and

16.9 (vi) add the amounts under items (iv) and (v) to obtain the direct staffing cost;

16.10 (2) for employee-related expenses:

16.11 (i) the commissioner shall include an adjustment of 10.3 percent for the cost of
16.12 taxes and workers' compensation;

16.13 (ii) the commissioner shall include an adjustment of 16.2 percent for the cost of
16.14 other benefits, including health insurance, dental insurance, life insurance, short-term
16.15 disability insurance, long-term disability insurance, vision insurance, retirement, and
16.16 tuition reimbursement; and

16.17 (iii) the total of the percentages under items (i) and (ii) is the total percentage for
16.18 employee-related expenses;

16.19 (3) for program plan and supports, the commissioner shall add 16.6 percent for the
16.20 cost of program plan supports;

16.21 (4) for client programming and supports, the commissioner shall include an
16.22 adjustment of ten percent for the cost of client programming and supports; and

16.23 (5) for support costs:

16.24 (i) the commissioner shall include an adjustment of 16.5 percent for standard and
16.25 general administrative support;

16.26 (ii) the commissioner shall include an adjustment of 2.65 percent for program
16.27 support; and

16.28 (iii) the total of the adjustments under the two previous items is the total percentage
16.29 for support costs; and

16.30 (6) for administrative overhead:

16.31 (i) the commissioner shall include an adjustment of 6.58 percent for costs associated
16.32 with absence overhead;

16.33 (ii) the commissioner shall include an adjustment of 3.8 percent for utilization
16.34 overhead; and

16.35 (iii) the total of the adjustments under items (i) and (ii) is the total percentage for
16.36 administrative overhead.

- 17.1 (c) The total rate shall be calculated using the following steps:
17.2 (1) the direct staffing cost multiplied by one plus the total percentage for
17.3 employee-related expenses;
17.4 (2) plus the cost for program plan supports;
17.5 (3) plus the cost for client programming and supports;
17.6 (4) the subtotal of clauses (1) to (3), multiplied by one plus the total percentage for
17.7 support costs;
17.8 (5) the subtotal of clauses (1) to (4), multiplied by one plus the total percentage
17.9 for administrative overhead; and
17.10 (6) adjust the total in clause (5) to reflect the hourly units of service that will be
17.11 provided to the individual per year, and divide by four to obtain the 15-minute rate.

17.12 Subd. 6. **Customization of rates for individuals.** For persons determined to have
17.13 higher needs based on their assessed needs, as determined by the process in section
17.14 256B.0911, subdivision 10, those individuals will receive an increase in staffing wages.
17.15 The customization add-on shall be:

- 17.16 (1) for individuals assessed as having high medical needs, \$1.79 per authorized hour;
17.17 (2) for individuals assessed as having high behavioral needs, \$2.01 per authorized
17.18 hour;
17.19 (3) for individuals assessed as having high mental health needs, \$2.01 per authorized
17.20 hour; and
17.21 (4) for individuals assessed as being deaf or hard-of-hearing, \$1.79 per authorized
17.22 hour.

17.23 Subd. 7. **Rate exception process.** (a) A variance from rates determined in
17.24 subdivisions 3, 4, and 5 may be granted by the lead agency when:

- 17.25 (1) an individual is set to be discharged; and
17.26 (2) the rate determined is inadequate to meet the health and safety needs of that
17.27 individual.

17.28 (b) The lead agency shall have 30 calendar days from the date of the receipt of the
17.29 complete request from the vendor for a rate variance to accept or reject it, or the request
17.30 shall be deemed to have been granted. The lead agency shall state in writing the specific
17.31 objections to the request and the reasons for its rejection.

17.32 (c) If the lead agency rejects the request from the vendor for a rate variance, the
17.33 vendor may appeal the decision to the commissioner of human services. The commissioner
17.34 shall have 30 calendar days to consider the appeal. The commissioner shall state in writing
17.35 the specific objections to the request and the reasons for its rejection of the appeal.

18.1 (d) The commissioner shall collect information annually and report on the number of
18.2 exceptions granted under this subdivision.

18.3 Subd. 8. **Cost neutrality adjustment.** (a) The commissioner shall calculate the
18.4 spending for all long-term care waived services under the payments as defined in
18.5 subdivisions 3, 4, and 5 for each group of service. These groups are defined as:

18.6 (1) residential services, including corporate foster care, family foster care, residential
18.7 care, supported living services, customized living, and 24-hour customized living;

18.8 (2) day program services, including adult day care, day training and habilitation,
18.9 prevocational services, and structured day services;

18.10 (3) hourly services with programming, including in-home family support,
18.11 independent living services, supported living services, supported employment, behavior
18.12 programming, and housing access coordination;

18.13 (4) hourly services without programming, including respite, personal support, and
18.14 night supervision; and

18.15 (5) individualized services, including 24-hour emergency assistance, assistive
18.16 technology, caregiver training and education, consumer education and training, crisis
18.17 respite, family counseling and training, independent living service therapies, live-in
18.18 caregiver expenses, modification and adaptations, specialist services, specialized supplies
18.19 and equipment, transitional, and transportation services.

18.20 (b) If spending for each group of service does not equal the total spending under
18.21 current law, the commissioner shall apply an across-the-board adjustment to payment rates
18.22 to align the levels of overall spending under current law.

18.23 Subd. 9. **Budget neutrality adjustment.** (a) The commissioner shall calculate the
18.24 total spending for all long-term care waived services under the payments as defined in
18.25 subdivisions 3, 4, and 5, and total spending under current law for the fiscal year beginning
18.26 July 1, 2013. If total spending under subdivisions 3, 4, and 5 is projected to be higher than
18.27 under current law, the commissioner shall adjust the rate by whatever percentage is needed
18.28 to reduce aggregate spending to the same level as projected under current law.

18.29 (b) The commissioner shall make any future across-the-board adjustment to provider
18.30 rates in this portion of the rate calculation.

18.31 Subd. 10. **Individual rate notification.** Upon request, the commissioner shall
18.32 make available the rate calculation for each individual to any member of the individual's
18.33 support team under sections 245A.11, subdivision 8, and 256B.4913, subdivisions 3, 4,
18.34 and 5, prior to any cost or budget neutrality adjustments.

18.35 Subd. 11. **Rulemaking authority.** The commissioner shall adopt rules under
18.36 section 14.05 to address the implementation of the payment methodology system. These

19.1 rules will address processes for detailing the implementation of this payment methodology
19.2 system, including the roles and responsibilities of the department, lead agencies, and
19.3 service providers.

19.4 Subd. 12. **Rate review and adjustments.** (a) If an individual's needs change,
19.5 the commissioner shall reassess that individual's needs under the process as outlined in
19.6 section 256B.0911, subdivision 10.

19.7 (b) If there is a material change to an individual's existing services, the commissioner
19.8 shall reassess that individual's needs under the assessment process outlined in section
19.9 256B.0911, subdivision 10.

19.10 Subd. 13. **Reports and data.** Twelve months prior to final implementation, the
19.11 commissioner shall:

19.12 (1) generate and publish provider rates calculated under this section;

19.13 (2) provide an analysis of the impact of the rate methodology system to the
19.14 legislature that includes:

19.15 (i) the average individual rate for residential services and day training and
19.16 habilitation services under the new and previous methodologies; and

19.17 (ii) the projected supply of service providers prior to and after implementation.

19.18 Sec. 7. **EFFECTIVE DATE; APPLICATION.**

19.19 Sections 1 to 7 are effective the day following final enactment. The rate-setting
19.20 methodologies in section 7 apply on January 1, 2013, following the implementation of the
19.21 assessment methodology under Minnesota Statutes, section 256B.0911, subdivision 10."

19.22 Renumber the sections in sequence and correct the internal references

19.23 Amend the title accordingly