House Language H1406-2

Senate Language UEH1406-1

ARTICLE 1
TELEPHONE EQUIPMENT PROGRAM

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

237.50 DEFINITIONS.

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

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

~~Subd. 4. **Communication device.** "Communication device" means a device that when connected to a telephone enables a communication impaired person to communicate with another person utilizing the telephone system. A "communication device" includes a ring signaler, an amplification device, a telephone device for the deaf, a Brailling device for use with a telephone, and any other device the Department of Human Services deems necessary.~~

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

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

~~Subd. 5. **Exchange.** "Exchange" means a unit area established and described by the tariff of a telephone company for the administration of telephone service in a specified geographical area, usually embracing a city, town, or village and its environs, and served by one or more central offices, together with associated facilities used in providing service within that area.~~

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

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

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

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

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

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

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

Subd. 11. **~~Telecommunication~~ Telecommunications Relay ~~service~~ Services.** "~~Telecommunication~~ Telecommunications Relay ~~service~~ Services" or "TRS" means ~~a central statewide service through which a communication-impaired person, using a communication device, may send and receive messages to and from a non-communication-impaired person whose telephone is not equipped with a communication device and through which a non-communication-impaired person may, by using voice communication, send and receive messages to and from a communication-impaired person~~ the telecommunications transmission services required under Federal Communications Commission (FCC) regulations at Code of Federal Regulations, title 47, sections 64.604 to 64.606. TRS allows an individual who has a communication disability to use telecommunications services in a manner that is functionally equivalent to the ability of an individual who does not have a communication disability.

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

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

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

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

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

237.51 TELECOMMUNICATIONS ACCESS MINNESOTA PROGRAM ADMINISTRATION.

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

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

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

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

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

(1) prepare the reports required by section 237.55;

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

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

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

(1) define economic hardship, special needs, and household criteria so as to determine the priority of eligible applicants for initial distribution of devices and to determine circumstances necessitating provision of more than one ~~communication~~ telecommunications device per household;

(2) establish a method to verify eligibility requirements;

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

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

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

Senate Language UEH1406-1

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

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(2) establish a method to verify eligibility requirements;

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

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

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

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

(1) at least one member who is deaf;

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

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

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

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

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

237.52 TELECOMMUNICATIONS ACCESS MINNESOTA FUND.

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

Subd. 2. **Assessment.** (a) The commissioner of commerce, the commissioner of employment and economic development, and the commissioner of human services shall annually recommend to the Public Utilities Commission (PUC) an adequate and appropriate surcharge and budget to implement sections 237.50 to 237.56, 248.062, and 256C.30, respectively. The maximum annual budget for section 248.062 must not exceed $100,000 and for section 256C.30 must not exceed $300,000. The Public Utilities Commission shall review the budgets for reasonableness and may modify the budget to the extent it is unreasonable. The commission shall annually determine the funding mechanism to be used within 60 days of receipt of the recommendation of the departments and shall order the imposition of surcharges effective on the earliest practicable date. The commission shall establish a monthly charge no greater than 20 cents for each customer access line, including trunk equivalents as designated by the commission pursuant to section 403.11, subdivision 1.

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

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

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

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

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

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

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

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

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

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

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

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

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

237.53 ~~COMMUNICATION~~ TELECOMMUNICATIONS DEVICE.

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

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

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

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

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

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

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

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

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

237.53 ~~COMMUNICATION~~ TELECOMMUNICATIONS DEVICE.

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

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

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

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

(3) be a resident of the state;

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

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

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

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

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

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

Senate Language UEH1406-1

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

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

(3) be a resident of the state;

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

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

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

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

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

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

(b) The ~~telecommunication relay service provider~~ TRS providers shall operate the relay service within the state of Minnesota. The ~~operator of the system~~ TRS providers shall ~~keep all messages confidential, shall train personnel in the unique needs of communication-impaired people, and shall inform communication-impaired persons and the public of the availability and use of the system. Except in the case of a speech- or mobility-impaired person, the operator shall not relay a message unless it originates or terminates through a communication device for the deaf or a Brailling device for use with a telephone~~ comply with all current and subsequent FCC regulations at Code of Federal Regulations, title 47, sections 64.601 to 64.606, and shall inform persons who have communication disabilities and the public of the availability and use of TRS.

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

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

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

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

237.56 ADEQUATE SERVICE ENFORCEMENT.

Senate Language UEH1406-1

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

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

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

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

(b) The ~~telecommunication relay service provider~~ TRS providers shall operate the relay service within the state of Minnesota. The ~~operator of the system~~ TRS providers shall ~~keep all messages confidential, shall train personnel in the unique needs of communication-impaired people, and shall inform communication-impaired persons and the public of the availability and use of the system. Except in the case of a speech- or mobility-impaired person, the operator shall not relay a message unless it originates or terminates through a communication device for the deaf or a Brailling device for use with a telephone~~ comply with all current and subsequent FCC regulations at Code of Federal Regulations, title 47, sections 64.601 to 64.606, and shall inform persons who have communication disabilities and the public of the availability and use of TRS.

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

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

237.56 ADEQUATE SERVICE ENFORCEMENT.

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

ARTICLE 2
DISABILITY SERVICES

Section 1. Minnesota Statutes 2010, section 245A.03, subdivision 7, is amended to read:

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

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

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

(3) new foster care licenses determined to be needed by the commissioner under paragraph (b) for the closure or downsizing of a nursing facility, ICF/MR, or regional treatment center;

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

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

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

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

ARTICLE 2
DISABILITY SERVICES

Section 1. Minnesota Statutes 2010, section 245A.03, subdivision 7, is amended to read:

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

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

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

(3) new foster care licenses determined to be needed by the commissioner under paragraph (b) for the closure or downsizing of a nursing facility, ICF/MR, or regional treatment center;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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(e) License holders of foster care homes identified under paragraph (e) that are not the primary residence of the license holder and that also provide services in the foster care home that are covered by a federally approved home and community-based services waiver, as authorized under section 256B.0915, 256B.092, or 256B.49 must inform the human services licensing division that the license holder provides or intends to provide these waiver-funded services. These license holders must be considered registered under section 256B.092, subdivision 11, paragraph (c), and this registration status must be identified on their license certificates.

Sec. 2. Minnesota Statutes 2010, section 245A.11, subdivision 8, is amended to read:

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

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

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(e) License holders of foster care homes identified under paragraph (e) that are not the primary residence of the license holder and that also provide services in the foster care home that are covered by a federally approved home and community-based services waiver, as authorized under section 256B.0915, 256B.092, or 256B.49 must inform the human services licensing division that the license holder provides or intends to provide these waiver-funded services. These license holders must be considered registered under section 256B.092, subdivision 11, paragraph (c), and this registration status must be identified on their license certificates.

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

Subd. 2b. **Adult foster care; family adult day services.** An adult foster care license holder licensed under the conditions in subdivision 2a may also provide family adult day care for adults ~~age 55~~ age 18 or over ~~if no persons in the adult foster or family adult day services program have a serious and persistent mental illness or a developmental disability~~. Family adult day services provided in a licensed adult foster care setting must be provided as specified under section 245A.143. Authorization to provide family adult day services in the adult foster care setting shall be printed on the license certificate by the commissioner. Adult foster care homes licensed under this section and family adult day services licensed under section 245A.143 shall not be subject to licensure by the commissioner of health under the provisions of chapter 144, 144A, 157, or any other law requiring facility licensure by the commissioner of health. A separate license is not required to provide family adult day services in a licensed adult foster care home.

Sec. 3. Minnesota Statutes 2010, section 245A.11, subdivision 8, is amended to read:

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

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

Sec. 4. Minnesota Statutes 2010, section 245A.143, subdivision 1, is amended to read:

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Subdivision 1. **Scope.** (a) The licensing standards in this section must be met to obtain and maintain a license to provide family adult day services. For the purposes of this section, family adult day services means a program operating fewer than 24 hours per day that provides functionally impaired adults~~, none of which are under age 55, have serious or persistent mental illness, or have developmental disabilities,~~ age 18 or older with an individualized and coordinated set of services including health services, social services, and nutritional services that are directed at maintaining or improving the participants' capabilities for self-care.

(b) A family adult day services license shall only be issued when the services are provided in the license holder's primary residence, and the license holder is the primary provider of care. The license holder may not serve more than eight adults at one time, including residents, if any, served under a license issued under Minnesota Rules, parts 9555.5105 to 9555.6265.

(c) An adult foster care license holder may provide family adult day services under the license holder's adult foster care license if the license holder meets the requirements of this section.

~~(d) When an applicant or license holder submits an application for initial licensure or relicensure for both adult foster care and family adult day services, the county agency shall process the request as a single application and shall conduct concurrent routine licensing inspections.~~

~~(e) Adult foster care license holders providing family adult day services under their foster care license on March 30, 2004, shall be permitted to continue providing these services with no additional requirements until their adult foster care license is due for renewal. At the time of relicensure, an adult foster care license holder may continue to provide family adult day services upon demonstration of compliance with this section. Adult foster care license holders who provide only family adult day services on August 1, 2004, may apply for a license under this section instead of an adult foster care license.~~

Sec. 3. Minnesota Statutes 2010, section 252.32, subdivision 1a, is amended to read:

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

Sec. 5. Minnesota Statutes 2010, section 252.32, subdivision 1a, is amended to read:

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

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

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

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

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

Sec. 4. **[252.34] REPORT BY COMMISSIONER.**

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

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

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

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

Sec. 5. Minnesota Statutes 2010, section 252A.21, subdivision 2, is amended to read:

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

Sec. 6. Minnesota Statutes 2010, section 256.476, subdivision 11, is amended to read:

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

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

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

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

Sec. 6. **[252.34] REPORT BY COMMISSIONER.**

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

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

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

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

Sec. 7. Minnesota Statutes 2010, section 252A.21, subdivision 2, is amended to read:

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

Sec. 8. Minnesota Statutes 2010, section 256.476, subdivision 11, is amended to read:

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

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

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

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

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

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

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

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

Sec. 7. Minnesota Statutes 2010, section 256B.0625, subdivision 19c, is amended to read:

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

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

Sec. 8. Minnesota Statutes 2010, section 256B.0659, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

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

Sec. 9. Minnesota Statutes 2010, section 256B.0625, subdivision 19c, is amended to read:

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

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

Sec. 10. Minnesota Statutes 2010, section 256B.0659, subdivision 1, is amended to read:

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

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

(c) "Behavior," effective January 1, 2010, means a category to determine the home care rating and is based on the criteria found in this section. "Level I behavior" means physical aggression towards self, others, or destruction of property that requires the immediate response of another person.

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

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

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

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

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

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

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

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

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

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

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

(c) "Behavior," effective January 1, 2010, means a category to determine the home care rating and is based on the criteria found in this section. "Level I behavior" means physical aggression towards self, others, or destruction of property that requires the immediate response of another person.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 9. Minnesota Statutes 2010, section 256B.0659, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 11. Minnesota Statutes 2010, section 256B.0659, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

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

(1) sterile procedures;

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

(3) home maintenance or chore services;

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

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

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

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

Sec. 10. Minnesota Statutes 2010, section 256B.0659, subdivision 9, is amended to read:

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

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

(c) A responsible party must not be the:

(1) personal care assistant;

(2) qualified professional;

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

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

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

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

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

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

(1) sterile procedures;

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

(3) home maintenance or chore services;

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

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

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

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

Sec. 12. Minnesota Statutes 2010, section 256B.0659, subdivision 9, is amended to read:

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

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

(c) A responsible party must not be the:

(1) personal care assistant;

(2) qualified professional;

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

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

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

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

(e) A responsible party is required when:

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

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

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

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

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

Sec. 11. 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;

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

(e) A responsible party is required when:

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

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

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

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

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

Sec. 13. 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;

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(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, and legal guardians of minors~~,~~; spouses~~,~~; paid legal guardians~~,~~ of adults; family foster care providers, except as otherwise allowed in section 256B.0625, subdivision 19a~~, or~~; and staff of a residential setting.

Sec. 12. Minnesota Statutes 2010, section 256B.0659, subdivision 13, is amended to read:

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(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, and legal guardians of minors~~,~~; spouses~~,~~; paid legal guardians~~,~~ of adults; family foster care providers, except as otherwise allowed in section 256B.0625, subdivision 19a~~, or~~; and staff of a residential setting.

Sec. 14. Minnesota Statutes 2010, section 256B.0659, subdivision 13, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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from the training required in this subdivision. When available, the qualified professional working for a Medicare-certified home health agency must successfully complete the competency test. The commissioner shall ensure there is a mechanism in place to verify the identity of persons completing the competency testing electronically.

Sec. 13. Minnesota Statutes 2010, section 256B.0659, subdivision 14, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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from the training required in this subdivision. When available, the qualified professional working for a Medicare-certified home health agency must successfully complete the competency test. The commissioner shall ensure there is a mechanism in place to verify the identity of persons completing the competency testing electronically.

Sec. 15. Minnesota Statutes 2010, section 256B.0659, subdivision 14, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Sec. 14. Minnesota Statutes 2010, section 256B.0659, subdivision 19, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Sec. 16. Minnesota Statutes 2010, section 256B.0659, subdivision 19, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 15. Minnesota Statutes 2010, section 256B.0659, subdivision 21, is amended to read:

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

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

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

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

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

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

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

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

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

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

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

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

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

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

Sec. 17. Minnesota Statutes 2010, section 256B.0659, subdivision 21, is amended to read:

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

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

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

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

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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(b) Personal care assistance provider agencies shall provide the information specified in paragraph (a) to the commissioner at the time the personal care assistance provider agency enrolls as a vendor or upon request from the commissioner. The commissioner shall collect the information specified in paragraph (a) from all personal care assistance providers beginning July 1, 2009.

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

Sec. 16. Minnesota Statutes 2010, section 256B.0659, subdivision 30, is amended to read:

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

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

(2) effective through January 1, 2012, notice of changes in medical assistance personal care assistance services to each affected recipient at least 30 days before the effective date of the change.

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(b) Personal care assistance provider agencies shall provide the information specified in paragraph (a) to the commissioner at the time the personal care assistance provider agency enrolls as a vendor or upon request from the commissioner. The commissioner shall collect the information specified in paragraph (a) from all personal care assistance providers beginning July 1, 2009.

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

Sec. 18. Minnesota Statutes 2010, section 256B.0659, subdivision 30, is amended to read:

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

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

(2) effective through January 1, 2012, notice of changes in medical assistance personal care assistance services to each affected recipient at least 30 days before the effective date of the change.

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

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

Sec. 17. Minnesota Statutes 2010, section 256B.0916, subdivision 7, is amended to read:

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

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

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

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

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

(5) the services needed;

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

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

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

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

(b) This subdivision expires January 1, 2012.

Sec. 18. Minnesota Statutes 2010, section 256B.092, subdivision 11, is amended to read:

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

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

Sec. 19. Minnesota Statutes 2010, section 256B.0916, subdivision 7, is amended to read:

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

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

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

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

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

(5) the services needed;

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

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

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

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

(b) This subdivision expires January 1, 2012.

Sec. 20. Minnesota Statutes 2010, section 256B.092, subdivision 11, is amended to read:

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

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

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

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

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

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

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

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

Sec. 19. Minnesota Statutes 2010, section 256B.096, subdivision 5, is amended to read:

Subd. 5. **Biennial report.** (a) The commissioner shall provide a biennial report to the chairs of the legislative committees with jurisdiction over health and human services policy and funding beginning January 15, 2009, on the development and activities of the quality management, assurance, and improvement system designed to meet the federal requirements under the home and community-based services waiver programs for persons with disabilities. By January 15, 2008, the commissioner shall provide a preliminary report on priorities for meeting the federal requirements, progress on development and field testing of the annual survey, appropriations necessary to implement an annual survey of service recipients once field testing is completed, recommendations for improvements in the incident reporting system, and a plan for incorporating quality assurance efforts under section 256B.095 and other regional efforts into the statewide system.

(b) This subdivision expires January 1, 2012.

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

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

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

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

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

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

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

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

Sec. 21. Minnesota Statutes 2010, section 256B.096, subdivision 5, is amended to read:

Subd. 5. **Biennial report.** (a) The commissioner shall provide a biennial report to the chairs of the legislative committees with jurisdiction over health and human services policy and funding beginning January 15, 2009, on the development and activities of the quality management, assurance, and improvement system designed to meet the federal requirements under the home and community-based services waiver programs for persons with disabilities. By January 15, 2008, the commissioner shall provide a preliminary report on priorities for meeting the federal requirements, progress on development and field testing of the annual survey, appropriations necessary to implement an annual survey of service recipients once field testing is completed, recommendations for improvements in the incident reporting system, and a plan for incorporating quality assurance efforts under section 256B.095 and other regional efforts into the statewide system.

(b) This subdivision expires January 1, 2012.

Sec. 22. Minnesota Statutes 2010, section 256B.49, subdivision 16a, is amended to read:

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

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

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

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

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

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

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

(2) risk assessment and planning;

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

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

(5) complaint and grievance procedures;

(6) service termination or suspension;

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

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

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

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

(iv) when applicable:

(A) safe medication administration;

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(B) proper handling of consumer funds; and

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

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

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

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

(3) safe medication management and administration.

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

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

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

Sec. 20. Minnesota Statutes 2010, section 256B.49, subdivision 21, is amended to read:

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

(1) receiving those services;

(2) screened and waiting for waiver services; and

Sec. 23. Minnesota Statutes 2010, section 256B.49, subdivision 21, is amended to read:

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

(1) receiving those services;

(2) screened and waiting for waiver services; and

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

(b) This subdivision expires January 1, 2012.

Sec. 21. Minnesota Statutes 2010, section 256B.4912, is amended to read:

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

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

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

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

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

~~By July 2010,~~ Beginning July 2011, staff that provide direct contact~~, as defined in section 245C.02, subdivision 11, that are employees of waiver service providers~~ for services specified in the federally approved waiver plans must meet the requirements of chapter 245C prior to providing waiver services and as part of ongoing enrollment. Beginning July 2012, service owners and managerial officials overseeing the management or policies of services that provide direct contact as specified in the federally approved waiver plans must meet the requirements of chapter 245C prior to reenrollment or, for new providers, prior to initial enrollment. Upon federal approval, this requirement must also apply to consumer-directed community supports.

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

(a) "Home and community-based service providers" means approved vendors who provide community services and long-term supports under medical assistance programs that include waiver programs as defined in sections 256B.092, 256B.0915, and 256B.49, and state plan home care services as defined in section 256B.0651.

(b) "Home and community-based service administrators" means counties and tribes that, individually or collaboratively, administer home and community-based waiver services delivery in a consistent manner under a state agency directive.

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

(b) This subdivision expires January 1, 2012.

Sec. 24. Minnesota Statutes 2010, section 256B.4912, is amended to read:

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

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

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

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

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

~~By July 2010,~~ Beginning July 2011, staff that provide direct contact~~, as defined in section 245C.02, subdivision 11, that are employees of waiver service providers~~ for services specified in the federally approved waiver plans must meet the requirements of chapter 245C prior to providing waiver services and as part of ongoing enrollment. Beginning July 2012, service owners and managerial officials overseeing the management or policies of services that provide direct contact as specified in the federally approved waiver plans must meet the requirements of chapter 245C prior to reenrollment or, for new providers, prior to initial enrollment. Upon federal approval, this requirement must also apply to consumer-directed community supports.

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

(a) "Home and community-based service providers" means approved vendors who provide community services and long-term supports under medical assistance programs that include waiver programs as defined in sections 245B.092, 256B.0915, and 256B.49, and state plan home care services as defined in section 256B.0651.

(b) "Home and community-based service administrators" means counties and tribes that, individually or collaboratively, administer home and community-based waiver services delivery in a consistent manner under a state agency directive.

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

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

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

(c) The commissioner must not reimburse:

(1) unauthorized service delivery;

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

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

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

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

Subd. 4. **Rate exception process.** The payment structures and methodologies under this section must include procedures to seek authorization from the commissioner for exceptions for very dependent persons with special needs to the rates in excess of the amounts as determined utilizing individualized payment structures and methodologies established by the commissioner under subdivision 2.

Subd. 5. **Shared service limits.** The commissioner retains authority to limit the number of people that share waiver and day services. Individualized payment structures and methodologies established by the commissioner under subdivision 2 must reflect the option to share services within the limits established by the commissioner.

Subd. 6. **Home and community-based service administrator roles and responsibilities.** The commissioner shall define roles and responsibilities of home and community-based service administrators to include:

(1) certification functions to include monitoring and review of waiver home and community-based service providers in compliance with federal requirements; and

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

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

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

(c) The commissioner must not reimburse:

(1) unauthorized service delivery;

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

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

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

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

Subd. 4. **Rate exception process.** The payment structures and methodologies under this section must include procedures to seek authorization from the commissioner for exceptions for very dependent persons with special needs to the rates in excess of the amounts as determined utilizing individualized payment structures and methodologies established by the commissioner under subdivision 2.

Subd. 5. **Shared service limits.** The commissioner retains authority to limit the number of people that share waiver and day services. Individualized payment structures and methodologies established by the commissioner under subdivision 2 must reflect the option to share services within the limits established by the commissioner.

Subd. 6. **Home and community-based service administrator roles and responsibilities.** The commissioner shall define roles and responsibilities of home and community-based service administrators to include:

(1) certification functions to include monitoring and review of waiver home and community-based service providers in compliance with federal requirements; and

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(2) assessment of home and community-based waiver service capacity and development to address identified service gaps.

Subd. 7. **Recommendations to the legislature.** The commissioner shall consult with existing advisory groups on rate-setting methodologies, provider qualifications, and home and community-based service administrator roles and responsibilities to develop and test processes, roles, and rate-setting methodologies described in this section. The commissioner shall recommend by January 15, 2012, to the chairs of the legislative committees with jurisdiction over health and human services policy and finance, statutory changes that define the processes, roles, and rate-setting methodologies for full implementation by January 1, 2013.

Sec. 22. **STREAMLINE CONSUMER-DIRECTED SERVICES.**

The commissioner of human services shall prepare and provide recommendations for streamlining administrative oversight, financial management, and payment protocols for consumer-directed services administered through the commissioner, including consumer-directed community supports, under Minnesota Statutes, sections 256B.49, subdivision 16, and 256B.0916, subdivision 6a; consumer support grants, under Minnesota Statutes, section 256.476; family support grants, under Minnesota Statutes, section 252.32; and any other consumer directed service options identified by the commissioner. The commissioner shall report to the legislature by January 15, 2012, with recommendations prepared under this section.

ARTICLE 3
COMPREHENSIVE ASSESSMENT AND CASE MANAGEMENT REFORM

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

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

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

(c) "Level I behavior~~,~~" ~~effective January 1, 2010,~~ means a category to determine the home care rating ~~and is based on the criteria found in this section. "Level I behavior"~~ ~~means~~ and is defined as physical aggression towards self, others, or destruction of property that requires the immediate response of another person and either:

(1) has occurred within 30 days prior to the assessment; or

(2) there is objective evidence that, without intervention, it would have occurred 30 days prior to the assessment. Objective evidence includes logs of intervention kept by the family or provider.

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(2) assessment of home and community-based waiver service capacity and development to address identified service gaps.

Subd. 7. **Recommendations to the legislature.** The commissioner shall consult with existing advisory groups on rate-setting methodologies, provider qualifications, and home and community-based service administrator roles and responsibilities to develop and test processes, roles, and rate-setting methodologies described in this section. The commissioner shall recommend by January 15, 2012, to the chairs of the legislative committees with jurisdiction over health and human services policy and funding, statutory changes that define the processes, roles, and rate-setting methodologies for full implementation by January 1, 2013.

Sec. 25. **STREAMLINE CONSUMER-DIRECTED SERVICES.**

The commissioner of human services shall prepare and provide recommendations for streamlining administrative oversight, financial management, and payment protocols for consumer-directed services administered through the commissioner, including consumer-directed community supports, under Minnesota Statutes, sections 256B.49, subdivision 16, and 256B.0916, subdivision 6a; consumer support grants, under Minnesota Statutes, section 256.476; family support grants, under Minnesota Statutes, section 252.32; and any other consumer directed service options identified by the commissioner. The commissioner shall report to the legislature by January 15, 2012, with recommendations prepared under this section.

ARTICLE 3
COMPREHENSIVE ASSESSMENT AND CASE MANAGEMENT REFORM

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

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

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

(c) "Level I behavior~~,~~" ~~effective January 1, 2010,~~ means a category to determine the home care rating ~~and is based on the criteria found in this section. "Level I behavior"~~ ~~means~~ and is defined as physical aggression towards self, others, or destruction of property that requires the immediate response of another person and either:

(1) has occurred within 30 days prior to the assessment; or

(2) there is objective evidence that, without intervention, it would have occurred 30 days prior to the assessment. Objective evidence includes logs of intervention kept by the family or provider.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 2. 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;

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

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

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

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

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

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(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;

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(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~~. The personal care assistant must not determine the medication dose or time for the medication. Assistance with medications includes reminders to take medication, bringing medication to the recipient, and assistance with opening medication under the direction of the recipient or responsible party, including medications given through a nebulizer;

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

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

(d) A personal care assistant may provide health-related procedures and tasks associated with the complex health-related needs of a recipient if the procedures and tasks meet the definition of health-related procedures and tasks under this section and the personal care assistant is trained by a qualified professional and demonstrates competency to safely complete the procedures and tasks. Delegation of health-related procedures and tasks and all training must be documented in the personal care assistance care plan and the recipient's and personal care assistant's files.

(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

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(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~~. The personal care assistant must not determine the medication dose or time for the medication. Assistance with medications includes reminders to take medication, bringing medication to the recipient, and assistance with opening medication under the direction of the recipient or responsible party, including medications given through a nebulizer;

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

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

(d) A personal care assistant may provide health-related procedures and tasks associated with the complex health-related needs of a recipient if the procedures and tasks meet the definition of health-related procedures and tasks under this section and the personal care assistant is trained by a qualified professional and demonstrates competency to safely complete the procedures and tasks. Delegation of health-related procedures and tasks and all training must be documented in the personal care assistance care plan and the recipient's and personal care assistant's files.

(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

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

Subd. 3a. **Assessment; defined.** This subdivision is effective until notification is given by the commissioner as described under section 256B.0911, subdivision 3a. "Assessment" means a review and evaluation of a recipient's need for ~~home~~ personal care assistance services conducted in person. Assessments for personal care assistance services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county except when a long-term care consultation is being conducted for the purposes of determining a person's eligibility for home and community-based waiver services according to section 256B.0911 and the support plan may include personal care assistance services. An in-person assessment must include: documentation of health status, determination of need, evaluation of service effectiveness, identification of appropriate services, service plan development or modification, coordination of services, referrals and follow-up to appropriate payers and community resources, completion of required reports, recommendation of service authorization, and consumer education. Once the need for personal care assistance services is determined under this section or sections 256B.0651, 256B.0653, 256B.0654, and 256B.0656, the county public health nurse or certified public health nurse under contract with the county is responsible for communicating this recommendation to the commissioner and the recipient. An in-person assessment must occur at least annually or when there is a significant change in the recipient's condition or when there is a change in the need for personal care assistance services. A service update may substitute for the annual face-to-face assessment when there is not a significant change in recipient condition or a change in the need for personal care assistance service. A service update may be completed by telephone, used when there is no need for an increase in personal care assistance services, and used for two consecutive assessments if followed by a face-to-face assessment. A service update must be completed on a form approved by the commissioner. A service update or review for temporary increase includes a review of initial baseline data, evaluation of service effectiveness, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and on going consumer education. Assessments or reassessments must be completed on forms provided by the commissioner within ~~30~~ 20 days of a request for home care services by a recipient or responsible party ~~or personal care provider agency~~.

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

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

Subd. 3a. **Assessment; defined.** This subdivision is effective until notification is given by the commissioner as described under section 256B.0911, subdivision 3a. "Assessment" means a review and evaluation of a recipient's need for ~~home~~ personal care assistance services conducted in person. Assessments for personal care assistance services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county except when a long-term care consultation is being conducted for the purposes of determining a person's eligibility for home and community-based waiver services according to section 256B.0911 and the support plan may include personal care assistance services. An in-person assessment must include: documentation of health status, determination of need, evaluation of service effectiveness, identification of appropriate services, service plan development or modification, coordination of services, referrals and follow-up to appropriate payers and community resources, completion of required reports, recommendation of service authorization, and consumer education. Once the need for personal care assistance services is determined under this section or sections 256B.0651, 256B.0653, 256B.0654, and 256B.0656, the county public health nurse or certified public health nurse under contract with the county is responsible for communicating this recommendation to the commissioner and the recipient. An in-person assessment must occur at least annually or when there is a significant change in the recipient's condition or when there is a change in the need for personal care assistance services. A service update may substitute for the annual face-to-face assessment when there is not a significant change in recipient condition or a change in the need for personal care assistance service. A service update may be completed by telephone, used when there is no need for an increase in personal care assistance services, and used for two consecutive assessments if followed by a face-to-face assessment. A service update must be completed on a form approved by the commissioner. A service update or review for temporary increase includes a review of initial baseline data, evaluation of service effectiveness, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and on going consumer education. Assessments or reassessments must be completed on forms provided by the commissioner within ~~30~~ 20 days of a request for home care services by a recipient or responsible party ~~or personal care provider agency~~.

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

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

(b) The following limitations apply to the assessment:

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

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

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

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

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

(1) tube feedings requiring:

(i) a gastrojejunostomy tube; or

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

(2) wounds described as:

(i) stage III or stage IV;

(ii) multiple wounds;

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

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

(3) parenteral therapy described as:

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

(ii) total parenteral nutrition (TPN) daily;

(4) respiratory interventions, including:

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

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

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

(b) The following limitations apply to the assessment:

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

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

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

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

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

(1) tube feedings requiring:

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(3) parenteral therapy described as:

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

(ii) total parenteral nutrition (TPN) daily;

(4) respiratory interventions, including:

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

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

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

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

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

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

(5) insertion and maintenance of catheter, including:

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

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

(iii) bladder irrigations;

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

(7) neurological intervention, including:

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

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

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

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

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

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

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

Sec. 5. Minnesota Statutes 2010, section 256B.0911, subdivision 1, is amended to read:

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

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

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

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

(5) insertion and maintenance of catheter, including:

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

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

(iii) bladder irrigations;

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

(7) neurological intervention, including:

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

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

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

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

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

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

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

Sec. 5. Minnesota Statutes 2010, section 256B.0911, subdivision 1, is amended to read:

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

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

Sec. 6. 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) intake for and access to assistance in identifying services needed to maintain an individual in the most inclusive environment;

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

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

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

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

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

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

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

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

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

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

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

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

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

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(7) determination of home and community-based waiver and other service eligibility as required under sections 256B.0913, 256B.0915, and 256B.49, including level of care determination for individuals who need an institutional level of care as 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 community support plan development ~~with~~, appropriate referrals to obtain necessary diagnostic information, and including ~~the option~~ an eligibility determination for consumer-directed community supports;

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

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

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

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

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

(ii) section 256B.0657; or

(iii) consumer support grants under section 256.476;

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

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

~~(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.~~

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

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

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(7) determination of home and community-based waiver and other service eligibility as required under sections 256B.0913, 256B.0915, and 256B.49, including level of care determination for individuals who need an institutional level of care as 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 community support plan development ~~with~~, appropriate referrals to obtain necessary diagnostic information, and including ~~the option~~ an eligibility determination for consumer-directed community supports;

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

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

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

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

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

(ii) section 256B.0657; or

(iii) consumer support grants under section 256.476;

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

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

~~(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.~~

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

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

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

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

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

(b) Certified assessors are persons with a minimum of a bachelor's degree in social work, nursing with a public health nursing certificate, or other closely related field with at least one year of home and community-based experience or a two-year registered nursing degree with at least three years of home and community-based experience that have received training and certification specific to assessment and consultation for long-term care services in the state.

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

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

Sec. 9. Minnesota Statutes 2010, section 256B.0911, subdivision 3, is amended to read:

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

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

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

(b) Certified assessors are persons with a minimum of a bachelor's degree in social work, nursing with a public health nursing certificate, or other closely related field with at least one year of home and community-based experience or a two-year registered nursing degree with at least three years of home and community-based experience that have received training and certification specific to assessment and consultation for long-term care services in the state.

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

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

Sec. 9. Minnesota Statutes 2010, section 256B.0911, subdivision 3, is amended to read:

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

(b) Certified assessors must be part of a multidisciplinary team of professionals that includes public health nurses, social workers, and other professionals as defined in subdivision 2b, paragraph (b). The team is responsible for providing long-term care consultation services to all persons located in the county who request the services, regardless of eligibility for Minnesota health care programs.

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

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

Sec. 10. 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~~ 20 calendar days after the date on which an assessment was requested or recommended. ~~After January 1, 2011~~ Upon statewide implementation of subdivisions 2b, 2c, and 5, ~~these requirements~~ this requirement also ~~apply~~ applies to assessment of persons requesting personal care assistance services, and private duty nursing~~, and home health agency services, on timelines established in subdivision 5~~. The commissioner shall provide at least a 90-day notice to lead agencies prior to the effective date of this requirement. Face-to-face assessments must be conducted according to paragraphs (b) to (i).

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

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

(b) Certified assessors must be part of a multidisciplinary team of professionals that includes public health nurses, social workers, and other professionals as defined in subdivision 2b, paragraph (b). The team is responsible for providing long-term care consultation services to all persons located in the county who request the services, regardless of eligibility for Minnesota health care programs.

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

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

Sec. 10. 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~~ 20 calendar days after the date on which an assessment was requested or recommended. ~~After January 1, 2011~~ Upon statewide implementation of subdivisions 2b, 2c, and 5, ~~these requirements~~ this requirement also ~~apply~~ applies to assessment of persons requesting personal care assistance services, and private duty nursing~~, and home health agency services, on timelines established in subdivision 5~~. The commissioner shall provide at least a 90-day notice to lead agencies prior to the effective date of this requirement. Face-to-face assessments must be conducted according to paragraphs (b) to (i).

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

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

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

~~(e) The person, or the person's legal representative, must be provided with written recommendations for community-based services, including consumer-directed options, or institutional care that include documentation that the most cost-effective alternatives available were offered to the individual. For purposes of this requirement, "cost-effective alternatives" means community services and living arrangements that cost the same as or less than institutional care.~~

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

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

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

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

(4) referral information; and

(5) informal caregiver supports, if applicable.

For persons determined eligible for services defined under subdivision 1a, paragraphs (a), clause (7), and (b), the community support plan must also include the estimated annual and monthly budget amount for those services. In addition, for persons determined eligible for state plan home care under subdivision 1a, paragraph (b), clause (1), the person or person's representative must also receive a copy of the home care service plan developed by the certified assessor.

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

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

~~(e) The person, or the person's legal representative, must be provided with written recommendations for community-based services, including consumer-directed options, or institutional care that include documentation that the most cost-effective alternatives available were offered to the individual. For purposes of this requirement, "cost-effective alternatives" means community services and living arrangements that cost the same as or less than institutional care.~~

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

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

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

(4) referral information; and

(5) informal caregiver supports, if applicable.

For persons determined eligible for services defined under subdivision 1a, paragraph (a), clause (7), and paragraph (b), the community support plan must also include the estimated annual and monthly budget amount for those services. In addition, for persons determined eligible for state plan home care under subdivision 1a, paragraph (b), clause (1), the person or person's representative must also receive a copy of the home care service plan developed by the certified assessor.

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

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

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

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

(2) documentation that the most cost-effective alternatives available were offered to the individual. For purposes of this clause, "cost-effective" means community services and living arrangements that cost the same as or less than institutional care. For individuals found to meet eligibility criteria for home and community-based service programs under sections 256B.0915, 256B.092, or 256B.49, "cost effectiveness" has the meaning found in the federally approved waiver plan for each program;

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

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

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

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

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

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

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

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

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

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

(2) documentation that the most cost-effective alternatives available were offered to the individual. For purposes of this clause, "cost-effective" means community services and living arrangements that cost the same as or less than institutional care;

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

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

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

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

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

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

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

(i) Face-to-face assessment completed as part of eligibility determination for the alternative care, elderly waiver, community alternatives for disabled individuals, community alternative care, and traumatic brain injury waiver programs under sections 256B.0913, 256B.0915, ~~256B.0917,~~ and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after the date of assessment. 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). Notwithstanding retroactive medical assistance coverage of state plan services, the effective date of ~~program~~ eligibility ~~in this case~~ for programs included in this item cannot be prior to the date the most recent updated assessment is completed.

Sec. 11. Minnesota Statutes 2010, section 256B.0911, subdivision 3b, is amended to read:

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

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

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

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

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

(i) Face-to-face assessment completed as part of eligibility determination for the alternative care, elderly waiver, community alternatives for disabled individuals, community alternative care, and traumatic brain injury waiver programs under sections 256B.0913, 256B.0915, ~~256B.0917,~~ and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after the date of assessment. 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). Notwithstanding retroactive medical assistance coverage of state plan services, the effective date of ~~program~~ eligibility ~~in this case~~ for programs included in this item cannot be prior to the date the most recent updated assessment is completed.

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

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

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

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

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

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

Subd. 3c. **Transition to housing with services.** (a) Housing with services establishments offering or providing assisted living under chapter 144G shall inform all prospective residents of the availability of and contact information for transitional consultation services under this subdivision prior to executing a lease or contract with the prospective resident. The purpose of transitional long-term care consultation is to support persons with current or anticipated long-term care needs in making informed choices among options that include the most cost-effective and least restrictive settings, and to delay spenddown to eligibility for publicly funded programs by connecting people to alternative services in their homes before transition to housing with services. Regardless of the consultation, prospective residents maintain the right to choose housing with services or assisted living if that option is their preference.

(b) Transitional consultation services are provided as determined by the commissioner of human services in partnership with ~~county~~ long-term care consultation units, and the Area Agencies on Aging, and are a combination of telephone-based and in-person assistance provided under models developed by the commissioner. The consultation shall be performed in a manner that provides objective and complete information. Transitional consultation must be provided within five working days of the request of the prospective resident as follows:

(1) the consultation must be provided by a qualified professional as determined by the commissioner;

(2) the consultation must include a review of the prospective resident's reasons for considering assisted living, the prospective resident's personal goals, a discussion of the prospective resident's immediate and projected long-term care needs, and alternative community services or assisted living settings that may meet the prospective resident's needs; and

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

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

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

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(b) Transitional consultation services are provided as determined by the commissioner of human services in partnership with ~~county~~ long-term care consultation units, and the Area Agencies on Aging, and are a combination of telephone-based and in-person assistance provided under models developed by the commissioner. The consultation shall be performed in a manner that provides objective and complete information. Transitional consultation must be provided within five working days of the request of the prospective resident as follows:

(1) the consultation must be provided by a qualified professional as determined by the commissioner;

(2) the consultation must include a review of the prospective resident's reasons for considering assisted living, the prospective resident's personal goals, a discussion of the prospective resident's immediate and projected long-term care needs, and alternative community services or assisted living settings that may meet the prospective resident's needs; and

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(3) the prospective resident shall be informed of the availability of long-term care consultation services described in subdivision 3a that are available at no charge to the prospective resident to assist the prospective resident in assessment and planning to meet the prospective resident's long-term care needs. The Senior LinkAge Line and long-term care consultation team shall give the highest priority to referrals of individuals who are at highest risk of nursing facility placement or as needed for determining eligibility.

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

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

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

The following criteria apply to the preadmission screening:

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

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

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

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

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(3) the prospective resident shall be informed of the availability of long-term care consultation services described in subdivision 3a that are available at no charge to the prospective resident to assist the prospective resident in assessment and planning to meet the prospective resident's long-term care needs. The Senior LinkAge Line and long-term care consultation team shall give the highest priority to referrals of individuals who are at highest risk of nursing facility placement or as needed for determining eligibility.

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

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

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

The following criteria apply to the preadmission screening:

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

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

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

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

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

(d) The determination of the need for nursing facility level of care must be made according to criteria established in section 144.0724, subdivision 11, and 256B.092, using forms developed by the commissioner. In assessing a person's needs, consultation team members shall have a physician available for consultation and shall consider the assessment of the individual's attending physician, if any. The individual's physician must be included if the physician chooses to participate. Other personnel may be included on the team as deemed appropriate by the ~~county~~ lead agency.

Sec. 14. Minnesota Statutes 2010, section 256B.0911, subdivision 4c, is amended to read:

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

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

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

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

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

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

Sec. 15. Minnesota Statutes 2010, section 256B.0911, subdivision 6, is amended to read:

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

(d) The determination of the need for nursing facility level of care must be made according to criteria established in section 144.0724, subdivision 11, and 256B.092, using forms developed by the commissioner. In assessing a person's needs, consultation team members shall have a physician available for consultation and shall consider the assessment of the individual's attending physician, if any. The individual's physician must be included if the physician chooses to participate. Other personnel may be included on the team as deemed appropriate by the ~~county~~ lead agency.

Sec. 14. Minnesota Statutes 2010, section 256B.0911, subdivision 4c, is amended to read:

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

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

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

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

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

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

Sec. 15. Minnesota Statutes 2010, section 256B.0911, subdivision 6, is amended to read:

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

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

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

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

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

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

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

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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, or 256B.441 ~~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) Until the alternative payment methodology in paragraph (h) is implemented, the county may bill, as case management services, assessments, support planning, and follow-along provided to persons determined to be eligible for case management under Minnesota health care programs. No individual or family member shall be charged for an initial assessment or initial support plan development provided under subdivision 3a or 3b.

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

Sec. 16. Minnesota Statutes 2010, section 256B.0913, subdivision 7, is amended to read:

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

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

(c) The case manager is responsible for the cost-effectiveness of the alternative care individual ~~care~~ coordinated services and support plan and must not approve any ~~care~~ plan in which the cost of services funded by alternative care and client contributions exceeds the limit specified in section 256B.0915, subdivision 3, paragraph (b).

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

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

Subd. 8. **Requirements for individual ~~care~~ coordinated services and support plan.** (a) The case manager shall implement the coordinated services and support plan ~~of care~~ for each alternative care client and ensure that a client's service needs and eligibility are reassessed at least every 12 months. The coordinated services and support plan must meet the requirements in section 256B.0915, subdivision 6. The plan shall include any services prescribed by the individual's attending physician as necessary to allow the individual to remain in a community setting. In developing the individual's care plan, the case manager should include the use of volunteers from families and neighbors, religious organizations, social clubs, and civic and service organizations to support the formal home care services. The lead agency shall be held harmless for damages or injuries sustained through the use of volunteers under this subdivision including workers' compensation liability. The case manager shall provide documentation in each individual's plan ~~of care~~ and, if requested, to the commissioner that the most cost-effective alternatives available have been offered to the individual and that the individual was free to choose among available qualified providers, both public and private, including qualified case management or service coordination providers other than those employed by any county; however, the county or tribe maintains responsibility for prior authorizing services in accordance with statutory and administrative requirements. The case manager must give the individual a

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

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ten-day written notice of any denial, termination, or reduction of alternative care services.

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

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

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

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

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

(d) Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care. Case managers shall initiate ~~and oversee~~ the process of ~~assessment and~~ reassessment of the individual's ~~care~~ coordinated services and support plan as defined in subdivision 6 and review the plan ~~of care~~ at intervals specified in the federally approved waiver plan.

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

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ten-day written notice of any denial, termination, or reduction of alternative care services.

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

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

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(d) Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care. Case managers shall initiate ~~and oversee~~ the process of ~~assessment and~~ reassessment of the individual's ~~care~~ coordinated services and support plan as defined in subdivision 6 and review the plan ~~of care~~ at intervals specified in the federally approved waiver plan.

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

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

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

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

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

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

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

(5) assisting the person to access services;

(6) coordination of services; and

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

(h) For individuals enrolled in prepaid medical assistance programs under section 256B.69, subdivisions 6b and 23, the health plan shall provide or arrange to provide elderly waiver case management services in paragraph (g), as part of an integrated delivery system in accordance with contract requirements established by the commissioner.

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

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

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

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

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

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

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

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

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

(5) assisting the person to access services;

(6) coordination of services; and

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

(h) For individuals enrolled in prepaid medical assistance programs under section 256B.69, subdivisions 6b and 23, the health plan will provide or arrange to provide elderly waiver case management services in paragraph (g), as part of an integrated delivery system in accordance with contract requirements established by the commissioner.

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

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

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

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

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

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

(5) the lead agency may allow a case manager employed by the lead agency to delegate certain aspects of the case management activity to another individual employed by the lead agency provided there is oversight of the individual by the case manager. The case manager may not delegate those aspects which require professional judgment including assessments, reassessments, and ~~care~~ coordinated services and support plan development. Lead agencies include counties, health plans, and federally recognized tribes who authorize services under this section.

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

Sec. 20. Minnesota Statutes 2010, section 256B.0915, subdivision 3c, is amended to read:

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

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

Sec. 21. Minnesota Statutes 2010, section 256B.0915, subdivision 6, is amended to read:

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

(1) is developed and signed by the recipient within ten working days after the case manager receives the community support plan from the certified assessor;

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

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

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

(5) the lead agency may allow a case manager employed by the lead agency to delegate certain aspects of the case management activity to another individual employed by the lead agency provided there is oversight of the individual by the case manager. The case manager may not delegate those aspects which require professional judgment including assessments, reassessments, and ~~care~~ coordinated services and support plan development. Lead agencies include counties, health plans, and federally recognized tribes who authorize services under this section.

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

Sec. 20. Minnesota Statutes 2010, section 256B.0915, subdivision 3c, is amended to read:

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

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

Sec. 21. Minnesota Statutes 2010, section 256B.0915, subdivision 6, is amended to read:

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

(1) is developed and signed by the recipient within ten working days after the case manager receives the community support plan from the certified assessor;

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

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

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

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

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

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

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

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

Sec. 22. Minnesota Statutes 2010, section 256B.0915, subdivision 10, is amended to read:

Subd. 10. **Waiver payment rates; managed care organizations.** The commissioner shall adjust the elderly waiver capitation payment rates for managed care organizations paid under section 256B.69, subdivisions ~~6a~~ 6b and 23, to reflect the maximum service rate limits for customized living services and 24-hour customized living services under subdivisions 3e and 3h for the contract period beginning October 1, 2009. Medical assistance rates paid to customized living providers by managed care organizations under this section shall not exceed the maximum service rate limits determined by the commissioner under subdivisions 3e and 3h.

Sec. 23. Minnesota Statutes 2010, section 256B.092, subdivision 1, is amended to read:

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(2) includes the results of the assessment information on the person's need for service and identification of service needs that will be or that are met by the person's relatives, friends, and others, as well as community services used by the general public;

(3) reasonably ensures the health and safety of the recipient;

(4) identifies the person's preferences for services as stated by the person or the person's legal guardian or conservator;

(5) reflects the person's informed choice between institutional and community-based services, as well as choice of services, supports, and providers, including available case manager providers;

(6) identifies long and short-range goals for the person;

(7) identifies specific services and the amount, frequency, duration, and cost of the services to be provided to the person based on assessed needs, preferences, and available resources; and

(8) includes information about the right to appeal decisions under section 256.045;

(b) In developing the coordinated services and support plan, the case manager should also include the use of volunteers, religious organizations, social clubs, and civic and service organizations to support the individual in the community. The lead agency must be held harmless for damages or injuries sustained through the use of volunteers and agencies under this paragraph, including workers' compensation liability.

Sec. 22. Minnesota Statutes 2010, section 256B.0915, subdivision 10, is amended to read:

Subd. 10. **Waiver payment rates; managed care organizations.** The commissioner shall adjust the elderly waiver capitation payment rates for managed care organizations paid under section 256B.69, subdivisions ~~6a~~ 6b and 23, to reflect the maximum service rate limits for customized living services and 24-hour customized living services under subdivisions 3e and 3h for the contract period beginning October 1, 2009. Medical assistance rates paid to customized living providers by managed care organizations under this section shall not exceed the maximum service rate limits determined by the commissioner under subdivisions 3e and 3h.

Sec. 23. Minnesota Statutes 2010, section 256B.092, subdivision 1, is amended to read:

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Subdivision 1. **County of financial responsibility; duties.** Before any services shall be rendered to persons with developmental disabilities who are in need of social service and medical assistance, the county of financial responsibility shall conduct or arrange for a diagnostic evaluation in order to determine whether the person has or may have a developmental disability or has or may have a related condition. If the county of financial responsibility determines that the person has a developmental disability, the county shall inform the person of case management services available under this section. Except as provided in subdivision 1g or 4b, if a person is diagnosed as having a developmental disability, the county of financial responsibility shall conduct or arrange for a needs assessment by a certified assessor, and develop ~~or arrange for an individual service~~ a community support plan according to section 256B.0911, ~~provide or arrange for ongoing case management services at the level identified in the individual service plan, provide or arrange for case management administration,~~ and authorize services identified in the person's ~~individual service~~ coordinated services and support plan developed according to subdivision 1b. Diagnostic information, obtained by other providers or agencies, may be used by the county agency in determining eligibility for case management. Nothing in this section shall be construed as requiring: (1) assessment in areas agreed to as unnecessary by ~~the case manager~~ a certified assessor and the person, or the person's legal guardian or conservator, or the parent if the person is a minor, or (2) assessments in areas where there has been a functional assessment completed in the previous 12 months for which the ~~case manager~~ certified assessor and the person or person's guardian or conservator, or the parent if the person is a minor, agree that further assessment is not necessary. For persons under state guardianship, the ~~case manager~~ certified assessor shall seek authorization from the public guardianship office for waiving any assessment requirements. Assessments related to health, safety, and protection of the person for the purpose of identifying service type, amount, and frequency or assessments required to authorize services may not be waived. To the extent possible, for wards of the commissioner the county shall consider the opinions of the parent of the person with a developmental disability when developing the person's ~~individual service~~ community support plan and coordinated services and support plan.

Sec. 24. Minnesota Statutes 2010, section 256B.092, subdivision 1a, is amended to read:

Subd. 1a. **Case management ~~administration and~~ services.** (a) ~~The administrative functions of case management provided to or arranged for a person include:~~ Each recipient of a home and community-based waiver shall be provided case management services by qualified vendors as described in the federally approved waiver application.

~~(1) review of eligibility for services;~~

~~(2) screening;~~

~~(3) intake;~~

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Subdivision 1. **County of financial responsibility; duties.** Before any services shall be rendered to persons with developmental disabilities who are in need of social service and medical assistance, the county of financial responsibility shall conduct or arrange for a diagnostic evaluation in order to determine whether the person has or may have a developmental disability or has or may have a related condition. If the county of financial responsibility determines that the person has a developmental disability, the county shall inform the person of case management services available under this section. Except as provided in subdivision 1g or 4b, if a person is diagnosed as having a developmental disability, the county of financial responsibility shall conduct or arrange for a needs assessment by a certified assessor, and develop ~~or arrange for an individual service~~ a community support plan according to section 256B.0911, ~~provide or arrange for ongoing case management services at the level identified in the individual service plan, provide or arrange for case management administration,~~ and authorize services identified in the person's ~~individual service~~ coordinated services and support plan developed according to subdivision 1b. Diagnostic information, obtained by other providers or agencies, may be used by the county agency in determining eligibility for case management. Nothing in this section shall be construed as requiring: (1) assessment in areas agreed to as unnecessary by ~~the case manager~~ a certified assessor and the person, or the person's legal guardian or conservator, or the parent if the person is a minor, or (2) assessments in areas where there has been a functional assessment completed in the previous 12 months for which the ~~case manager~~ certified assessor and the person or person's guardian or conservator, or the parent if the person is a minor, agree that further assessment is not necessary. For persons under state guardianship, the ~~case manager~~ certified assessor shall seek authorization from the public guardianship office for waiving any assessment requirements. Assessments related to health, safety, and protection of the person for the purpose of identifying service type, amount, and frequency or assessments required to authorize services may not be waived. To the extent possible, for wards of the commissioner the county shall consider the opinions of the parent of the person with a developmental disability when developing the person's ~~individual service~~ community support plan and coordinated services and support plan.

Sec. 24. Minnesota Statutes 2010, section 256B.092, subdivision 1a, is amended to read:

Subd. 1a. **Case management ~~administration and~~ services.** (a) ~~The administrative functions of case management provided to or arranged for a person include:~~ Each recipient of a home and community-based waiver shall be provided case management services by qualified vendors as described in the federally approved waiver application.

~~(1) review of eligibility for services;~~

~~(2) screening;~~

~~(3) intake;~~

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~~(4) diagnosis;~~

~~(5) the review and authorization of services based upon an individualized service plan; and~~

~~(6) responding to requests for conciliation conferences and appeals according to section 256.045 made by the person, the person's legal guardian or conservator, or the parent if the person is a minor.~~

(b) Case management service activities provided to or arranged for a person include:

(1) development of the ~~individual service~~ coordinated services and support plan under subdivision 1b;

(2) informing the individual or the individual's legal guardian or conservator, or parent if the person is a minor, of service options;

(3) consulting with relevant medical experts or service providers;

(4) assisting the person in the identification of potential providers;

(5) assisting the person to access services and assisting in appeals under section 256.045;

(6) coordination of services, if coordination is not provided by another service provider;

(7) evaluation and monitoring of the services identified in the coordinated services and support plan, which must incorporate at least one annual face-to-face visit by the case manager with each person; and

(8) ~~annual reviews of service plans and services provided~~ review and provide the lead agency with recommendations for service authorization based upon the individual's needs identified in the coordinated services and support plan.

(c) Case management ~~administration and~~ service activities that are provided to the person with a developmental disability shall be provided directly by county agencies or under contract. Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in the approved federal waiver plans. Case management services must not be provided to a recipient by a private agency that has a financial interest in the provision of any other services included in the recipient's coordinated services and support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision 1a, paragraph (d).

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~~(4) diagnosis;~~

~~(5) the review and authorization of services based upon an individualized service plan; and~~

~~(6) responding to requests for conciliation conferences and appeals according to section 256.045 made by the person, the person's legal guardian or conservator, or the parent if the person is a minor.~~

(b) Case management service activities provided to or arranged for a person include:

(1) development of the ~~individual service~~ coordinated services and support plan under subdivision 1b;

(2) informing the individual or the individual's legal guardian or conservator, or parent if the person is a minor, of service options;

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(6) coordination of services, if coordination is not provided by another service provider;

(7) evaluation and monitoring of the services identified in the coordinated services and support plan, which must incorporate at least one annual face-to-face visit by the case manager with each person; and

(8) ~~annual reviews of service plans and services provided~~ review and provide the lead agency with recommendations for service authorization based upon the individual's needs identified in the coordinated services and support plan.

(c) Case management ~~administration and~~ service activities that are provided to the person with a developmental disability shall be provided directly by county agencies or under contract. Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in the approved federal waiver plans. Case management services must not be provided to a recipient by a private agency that has a financial interest in the provision of any other services included in the recipient's coordinated services and support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision 1a, paragraph (d).

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(d) Case managers are responsible for ~~the administrative duties and~~ service provisions listed in paragraphs (a) and (b). Case managers shall collaborate with consumers, families, legal representatives, and relevant medical experts and service providers in the development and annual review of the ~~individualized service~~ coordinated services and support plan and habilitation ~~plans~~ plan.

(e) The Department of Human Services shall offer ongoing education in case management to case managers. Case managers shall receive no less than ten hours of case management education and disability-related training each year.

Sec. 25. Minnesota Statutes 2010, section 256B.092, subdivision 1b, is amended to read:

Subd. 1b. **~~Individual~~ Coordinated service and support plan.** ~~The individual service plan must~~ (a) Each recipient of home and community-based waivered services shall be provided a copy of the written coordinated service and support plan which:

(1) is developed and signed by the recipient within ten working days after the case manager receives the community support plan from the certified assessor;

~~(1) include~~ (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 ensures the health and safety of the recipient;

~~(2) identify~~ (4) identifies the person's preferences for services as stated by the person, the person's legal guardian or conservator, or the parent if the person is a minor;

(5) provides for an informed choice, as defined in section 256B.77, subdivision 2, paragraph (o), of service and support providers, and identifies all available options for case management services and providers;

~~(3) identify~~ (6) identifies long- and short-range goals for the person;

~~(4) identify~~ (7) identifies specific services and the amount and frequency of the services to be provided to the person based on assessed needs, preferences, and available resources. The ~~individual service~~ coordinated service and support plan shall also specify other services the person needs that are not available;

~~(5) identify~~ (8) identifies the need for an individual program plan to be developed by the provider according to the respective state and federal licensing and certification standards, and additional assessments to be completed or arranged by the provider after service initiation;

~~(6) identify~~ (9) identifies provider responsibilities to implement and make recommendations for modification to the ~~individual service~~ coordinated service and support plan;

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(d) Case managers are responsible for ~~the administrative duties and~~ service provisions listed in paragraphs (a) and (b). Case managers shall collaborate with consumers, families, legal representatives, and relevant medical experts and service providers in the development and annual review of the ~~individualized service~~ coordinated services and support plan and habilitation ~~plans~~ plan.

(e) The Department of Human Services shall offer ongoing education in case management to case managers. Case managers shall receive no less than ten hours of case management education and disability-related training each year.

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(3) reasonably ensures the health and safety of the recipient;

~~(2) identify~~ (4) identifies the person's preferences for services as stated by the person, the person's legal guardian or conservator, or the parent if the person is a minor;

(5) provides for an informed choice, as defined in section 256B.77, subdivision 2, paragraph (o), of service and support providers, and identifies all available options for case management services and providers;

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~~(5) identify~~ (8) identifies the need for an individual program plan to be developed by the provider according to the respective state and federal licensing and certification standards, and additional assessments to be completed or arranged by the provider after service initiation;

~~(6) identify~~ (9) identifies provider responsibilities to implement and make recommendations for modification to the ~~individual service~~ coordinated service and support plan;

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~~(7) include~~ (10) includes notice of the right to request a conciliation conference or a hearing under section 256.045;

~~(8) be~~ (11) is agreed upon and signed by the person, the person's legal guardian or conservator, or the parent if the person is a minor, and the authorized county representative; and

~~(9) be~~ (12) is reviewed by a health professional if the person has overriding medical needs that impact the delivery of services.

~~Service planning formats developed for interagency planning such as transition, vocational, and individual family service plans may be substituted for service planning formats developed by county agencies.~~

(b) In developing the coordinated services and support plan, the case manager is encouraged to include the use of volunteers, religious organizations, social clubs, and civic and service organizations to support the individual in the community. The lead agency must be held harmless for damages or injuries sustained through the use of volunteers and agencies under this paragraph, including workers' compensation liability.

Sec. 26. Minnesota Statutes 2010, section 256B.092, subdivision 1e, is amended to read:

Subd. 1e. **Coordination, evaluation, and monitoring of services.** (a) If the ~~individual service~~ coordinated service and support plan identifies the need for individual program plans for authorized services, the case manager shall assure that individual program plans are developed by the providers according to clauses (2) to (5). The providers shall assure that the individual program plans:

(1) are developed according to the respective state and federal licensing and certification requirements;

(2) are designed to achieve the goals of the ~~individual service~~ coordinated service and support plan;

(3) are consistent with other aspects of the ~~individual service~~ coordinated service and support plan;

(4) assure the health and safety of the person; and

(5) are developed with consistent and coordinated approaches to services among the various service providers.

(b) The case manager shall monitor the provision of services:

(1) to assure that the ~~individual service~~ coordinated service and support plan is being followed according to paragraph (a);

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~~(7) include~~ (10) includes notice of the right to request a conciliation conference or a hearing under section 256.045;

~~(8) be~~ (11) is agreed upon and signed by the person, the person's legal guardian or conservator, or the parent if the person is a minor, and the authorized county representative; and

~~(9) be~~ (12) is reviewed by a health professional if the person has overriding medical needs that impact the delivery of services.

~~Service planning formats developed for interagency planning such as transition, vocational, and individual family service plans may be substituted for service planning formats developed by county agencies.~~

(b) In developing the coordinated services and support plan, the case manager is encouraged to include the use of volunteers, religious organizations, social clubs, and civic and service organizations to support the individual in the community. The lead agency must be held harmless for damages or injuries sustained through the use of volunteers and agencies under this paragraph, including workers' compensation liability.

Sec. 26. Minnesota Statutes 2010, section 256B.092, subdivision 1e, is amended to read:

Subd. 1e. **Coordination, evaluation, and monitoring of services.** (a) If the ~~individual service~~ coordinated service and support plan identifies the need for individual program plans for authorized services, the case manager shall assure that individual program plans are developed by the providers according to clauses (2) to (5). The providers shall assure that the individual program plans:

(1) are developed according to the respective state and federal licensing and certification requirements;

(2) are designed to achieve the goals of the ~~individual service~~ coordinated service and support plan;

(3) are consistent with other aspects of the ~~individual service~~ coordinated service and support plan;

(4) assure the health and safety of the person; and

(5) are developed with consistent and coordinated approaches to services among the various service providers.

(b) The case manager shall monitor the provision of services:

(1) to assure that the ~~individual service~~ coordinated service and support plan is being followed according to paragraph (a);

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(2) to identify any changes or modifications that might be needed in the ~~individual service~~ coordinated service and support plan, including changes resulting from recommendations of current service providers;

(3) to determine if the person's legal rights are protected, and if not, notify the person's legal guardian or conservator, or the parent if the person is a minor, protection services, or licensing agencies as appropriate; and

(4) to determine if the person, the person's legal guardian or conservator, or the parent if the person is a minor, is satisfied with the services provided.

(c) If the provider fails to develop or carry out the individual program plan according to paragraph (a), the case manager shall notify the person's legal guardian or conservator, or the parent if the person is a minor, the provider, the respective licensing and certification agencies, and the county board where the services are being provided. In addition, the case manager shall identify other steps needed to assure the person receives the services identified in the ~~individual service~~ coordinated service and support plan.

Sec. 27. Minnesota Statutes 2010, section 256B.092, subdivision 1g, is amended to read:

Subd. 1g. **Conditions not requiring development of ~~individual service~~ coordinated service and support plan.** Unless otherwise required by federal law, the county agency is not required to complete ~~an individual service~~ a coordinated service and support plan as defined in subdivision 1b for:

(1) persons whose families are requesting respite care for their family member who resides with them, or whose families are requesting a family support grant and are not requesting purchase or arrangement of habilitative services; and

(2) persons with developmental disabilities, living independently without authorized services or receiving funding for services at a rehabilitation facility as defined in section 268A.01, subdivision 6, and not in need of or requesting additional services.

Sec. 28. Minnesota Statutes 2010, section 256B.092, subdivision 2, is amended to read:

Subd. 2. **Medical assistance.** To assure quality case management to those persons who are eligible for medical assistance, the commissioner shall, upon request:

(1) provide consultation on the case management process;

(2) assist county agencies in the ~~screening and~~ annual reviews of clients review process to assure that appropriate levels of service are provided to persons;

(3) provide consultation on service planning and development of services with appropriate options;

(4) provide training and technical assistance to county case managers; and

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(2) to identify any changes or modifications that might be needed in the ~~individual service~~ coordinated service and support plan, including changes resulting from recommendations of current service providers;

(3) to determine if the person's legal rights are protected, and if not, notify the person's legal guardian or conservator, or the parent if the person is a minor, protection services, or licensing agencies as appropriate; and

(4) to determine if the person, the person's legal guardian or conservator, or the parent if the person is a minor, is satisfied with the services provided.

(c) If the provider fails to develop or carry out the individual program plan according to paragraph (a), the case manager shall notify the person's legal guardian or conservator, or the parent if the person is a minor, the provider, the respective licensing and certification agencies, and the county board where the services are being provided. In addition, the case manager shall identify other steps needed to assure the person receives the services identified in the ~~individual service~~ coordinated service and support plan.

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(3) provide consultation on service planning and development of services with appropriate options;

(4) provide training and technical assistance to county case managers; and

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(5) authorize payment for medical assistance services according to this chapter and rules implementing it.

Sec. 29. Minnesota Statutes 2010, section 256B.092, subdivision 3, is amended to read:

Subd. 3. **Authorization and termination of services.** County agency case managers, under rules of the commissioner, shall authorize and terminate services of community and regional treatment center providers according to ~~individual service~~ support plans. Services provided to persons with developmental disabilities may only be authorized and terminated by case managers or certified assessors according to (1) rules of the commissioner and (2) the ~~individual service~~ support plan as defined in subdivision 1b and section 256B.0911. Medical assistance services not needed shall not be authorized by county agencies or funded by the commissioner. When purchasing or arranging for unlicensed respite care services for persons with overriding health needs, the county agency shall seek the advice of a health care professional in assessing provider staff training needs and skills necessary to meet the medical needs of the person.

Sec. 30. Minnesota Statutes 2010, section 256B.092, subdivision 5, is amended to read:

Subd. 5. **Federal waivers.** (a) The commissioner shall apply for any federal waivers necessary to secure, to the extent allowed by law, federal financial participation under United States Code, title 42, sections 1396 et seq., as amended, for the provision of services to persons who, in the absence of the services, would need the level of care provided in a regional treatment center or a community intermediate care facility for persons with developmental disabilities. The commissioner may seek amendments to the waivers or apply for additional waivers under United States Code, title 42, sections 1396 et seq., as amended, to contain costs. The commissioner shall ensure that payment for the cost of providing home and community-based alternative services under the federal waiver plan shall not exceed the cost of intermediate care services including day training and habilitation services that would have been provided without the waivered services.

The commissioner shall seek an amendment to the 1915c home and community-based waiver to allow properly licensed adult foster care homes to provide residential services to up to five individuals with developmental disabilities. If the amendment to the waiver is approved, adult foster care providers that can accommodate five individuals shall increase their capacity to five beds, provided the providers continue to meet all applicable licensing requirements.

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(5) authorize payment for medical assistance services according to this chapter and rules implementing it.

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The commissioner shall seek an amendment to the 1915c home and community-based waiver to allow properly licensed adult foster care homes to provide residential services to up to five individuals with developmental disabilities. If the amendment to the waiver is approved, adult foster care providers that can accommodate five individuals shall increase their capacity to five beds, provided the providers continue to meet all applicable licensing requirements.

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(b) The commissioner, in administering home and community-based waivers for persons with developmental disabilities, shall ensure that day services for eligible persons are not provided by the person's residential service provider, unless the person or the person's legal representative is offered a choice of providers and agrees in writing to provision of day services by the residential service provider. The ~~individual service~~ coordinated service and support plan for individuals who choose to have their residential service provider provide their day services must describe how health, safety, protection, and habilitation needs will be met, including how frequent and regular contact with persons other than the residential service provider will occur. The ~~individualized service~~ coordinated service and support plan must address the provision of services during the day outside the residence on weekdays.

(c) When a ~~county~~ lead agency is evaluating denials, reductions, or terminations of home and community-based services under section 256B.0916 for an individual, the ~~case manager~~ lead agency shall offer to meet with the individual or the individual's guardian in order to discuss the prioritization of service needs within the ~~individualized service~~ coordinated service and support plan. The reduction in the authorized services for an individual due to changes in funding for waivered services may not exceed the amount needed to ensure medically necessary services to meet the individual's health, safety, and welfare.

Sec. 31. Minnesota Statutes 2010, section 256B.092, subdivision 7, is amended to read:

Subd. 7. **~~Screening teams~~ Assessments.** (a) Assessments and reassessments shall be conducted by certified assessors according to section 256B.0911, and must incorporate appropriate referrals to determine eligibility for case management under subdivision 1a.

(b) For persons with developmental disabilities, ~~screening teams shall be established which~~ a certified assessor shall evaluate the need for the level of care provided by residential-based habilitation services, residential services, training and habilitation services, and nursing facility services. The ~~evaluation~~ assessment shall address whether home and community-based services are appropriate for persons who are at risk of placement in an intermediate care facility for persons with developmental disabilities, or for whom there is reasonable indication that they might require this level of care. The ~~screening team~~ certified assessor shall make an evaluation of need ~~within 60 working days of a request for service by a person with a developmental disability, and~~ within five working days of an emergency admission of a person to an intermediate care facility for persons with developmental disabilities. ~~The screening team shall consist of the case manager for persons with developmental disabilities, the person, the person's legal guardian or conservator, or the parent if the person is a minor, and a qualified developmental disability professional, as defined in the Code of Federal Regulations, title 42, section 483.430, as amended through June 3, 1988. The case manager may also act as the qualified developmental disability professional if the case manager meets the federal definition. County social service agencies may contract with a public or private agency or individual who is not a service provider for the person for the public~~

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(b) The commissioner, in administering home and community-based waivers for persons with developmental disabilities, shall ensure that day services for eligible persons are not provided by the person's residential service provider, unless the person or the person's legal representative is offered a choice of providers and agrees in writing to provision of day services by the residential service provider. The ~~individual service~~ coordinated service and support plan for individuals who choose to have their residential service provider provide their day services must describe how health, safety, protection, and habilitation needs will be met, including how frequent and regular contact with persons other than the residential service provider will occur. The ~~individualized service~~ coordinated service and support plan must address the provision of services during the day outside the residence on weekdays.

(c) When a ~~county~~ lead agency is evaluating denials, reductions, or terminations of home and community-based services under section 256B.0916 for an individual, the ~~case manager~~ lead agency shall offer to meet with the individual or the individual's guardian in order to discuss the prioritization of service needs within the ~~individualized service~~ coordinated service and support plan. The reduction in the authorized services for an individual due to changes in funding for waivered services may not exceed the amount needed to ensure medically necessary services to meet the individual's health, safety, and welfare.

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Subd. 7. **~~Screening teams~~ Assessments.** (a) Assessments and reassessments shall be conducted by certified assessors according to section 256B.0911, and must incorporate appropriate referrals to determine eligibility for case management under subdivision 1a.

(b) For persons with developmental disabilities, ~~screening teams shall be established which~~ a certified assessor shall evaluate the need for the level of care provided by residential-based habilitation services, residential services, training and habilitation services, and nursing facility services. The ~~evaluation~~ assessment shall address whether home and community-based services are appropriate for persons who are at risk of placement in an intermediate care facility for persons with developmental disabilities, or for whom there is reasonable indication that they might require this level of care. The ~~screening team~~ certified assessor shall make an evaluation of need ~~within 60 working days of a request for service by a person with a developmental disability, and~~ within five working days of an emergency admission of a person to an intermediate care facility for persons with developmental disabilities. ~~The screening team shall consist of the case manager for persons with developmental disabilities, the person, the person's legal guardian or conservator, or the parent if the person is a minor, and a qualified developmental disability professional, as defined in the Code of Federal Regulations, title 42, section 483.430, as amended through June 3, 1988. The case manager may also act as the qualified developmental disability professional if the case manager meets the federal definition. County social service agencies may contract with a public or private agency or individual who is not a service provider for the person for the public~~

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~~guardianship representation required by the screening or individual service planning process. The contract shall be limited to public guardianship representation for the screening and individual service planning activities. The contract shall require compliance with the commissioner's instructions and may be for paid or voluntary services. For persons determined to have overriding health care needs and are seeking admission to a nursing facility or an ICF/MR, or seeking access to home and community-based waivered services, a registered nurse must be designated as either the case manager or the qualified developmental disability professional. For persons under the jurisdiction of a correctional agency, the case manager must consult with the corrections administrator regarding additional health, safety, and supervision needs. The case manager, with the concurrence of the person, the person's legal guardian or conservator, or the parent if the person is a minor, may invite other individuals to attend meetings of the screening team. No member of the screening team shall have any direct or indirect service provider interest in the case. Nothing in this section shall be construed as requiring the screening team meeting to be separate from the service planning meeting.~~

Sec. 32. Minnesota Statutes 2010, section 256B.092, subdivision 8, is amended to read:

Subd. 8. **~~Screening team~~ Additional certified assessor duties.** In addition to the responsibilities of certified assessors described in section 256B.0911, for persons with developmental disabilities, the ~~screening team~~ certified assessor shall:

~~(1) review diagnostic data;~~

~~(2) review health, social, and developmental assessment data using a uniform screening tool specified by the commissioner;~~

~~(3) identify the level of services appropriate to maintain the person in the most normal and least restrictive setting that is consistent with the person's treatment needs;~~

~~(4)~~ (1) identify other noninstitutional public assistance or social service that may prevent or delay long-term residential placement;

~~(5)~~ (2) assess whether a person is in need of long-term residential care;

~~(6)~~ (3) make recommendations regarding placement and payment for: (i) social service or public assistance support, or both, to maintain a person in the person's own home or other place of residence; (ii) training and habilitation service, vocational rehabilitation, and employment training activities; (iii) community residential placement; (iv) regional treatment center placement; or (v) a home and community-based service alternative to community residential placement or regional treatment center placement;

~~(7)~~ (4) evaluate the availability, location, and quality of the services listed in clause ~~(6)~~ (3), including the impact of placement alternatives on the person's ability to maintain or improve existing patterns of contact and involvement with parents and other family members;

~~(8)~~ (5) identify the cost implications of recommendations in clause ~~(6)~~ (3); and

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~~guardianship representation required by the screening or individual service planning process. The contract shall be limited to public guardianship representation for the screening and individual service planning activities. The contract shall require compliance with the commissioner's instructions and may be for paid or voluntary services. For persons determined to have overriding health care needs and are seeking admission to a nursing facility or an ICF/MR, or seeking access to home and community-based waivered services, a registered nurse must be designated as either the case manager or the qualified developmental disability professional. For persons under the jurisdiction of a correctional agency, the case manager must consult with the corrections administrator regarding additional health, safety, and supervision needs. The case manager, with the concurrence of the person, the person's legal guardian or conservator, or the parent if the person is a minor, may invite other individuals to attend meetings of the screening team. No member of the screening team shall have any direct or indirect service provider interest in the case. Nothing in this section shall be construed as requiring the screening team meeting to be separate from the service planning meeting.~~

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~~(1) review diagnostic data;~~

~~(2) review health, social, and developmental assessment data using a uniform screening tool specified by the commissioner;~~

~~(3) identify the level of services appropriate to maintain the person in the most normal and least restrictive setting that is consistent with the person's treatment needs;~~

~~(4)~~ (1) identify other noninstitutional public assistance or social service that may prevent or delay long-term residential placement;

~~(5)~~ (2) assess whether a person is in need of long-term residential care;

~~(6)~~ (3) make recommendations regarding placement and payment for: (i) social service or public assistance support, or both, to maintain a person in the person's own home or other place of residence; (ii) training and habilitation service, vocational rehabilitation, and employment training activities; (iii) community residential placement; (iv) regional treatment center placement; or (v) a home and community-based service alternative to community residential placement or regional treatment center placement;

~~(7)~~ (4) evaluate the availability, location, and quality of the services listed in clause ~~(6)~~ (3), including the impact of placement alternatives on the person's ability to maintain or improve existing patterns of contact and involvement with parents and other family members;

~~(8)~~ (5) identify the cost implications of recommendations in clause ~~(6)~~ (3); and

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~~(9)~~ (6) make recommendations to a court as may be needed to assist the court in making decisions regarding commitment of persons with developmental disabilities~~; and~~

~~(10) inform the person and the person's legal guardian or conservator, or the parent if the person is a minor, that appeal may be made to the commissioner pursuant to section 256.045~~.

Sec. 33. Minnesota Statutes 2010, section 256B.092, subdivision 8a, is amended to read:

Subd. 8a. **County ~~concurrence~~ notification.** (a) If the county of financial responsibility wishes to place a person in another county for services, the county of financial responsibility shall ~~seek concurrence from~~ notify the proposed county of service and the placement shall be made cooperatively between the two counties. Arrangements shall be made between the two counties for ongoing social service, including annual reviews of the person's ~~individual service~~ coordinated service and support plan. The county where services are provided may not make changes in the person's ~~service~~ coordinated service and support plan without approval by the county of financial responsibility.

(b) ~~When a person has been screened and authorized for services in an intermediate care facility for persons with developmental disabilities or for home and community-based services for persons with developmental disabilities, the case manager shall assist that person in identifying a service provider who is able to meet the needs of the person according to the person's individual service plan. If the identified service is to be provided in a county other than the county of financial responsibility, the county of financial responsibility shall request concurrence of the county where the person is requesting to receive the identified services.~~ The county of service ~~may refuse to concur~~ shall notify the county of financial responsibility if~~:~~

~~(1) it can demonstrate that the provider is unable to provide the services identified in the person's individual service plan as services that are needed and are to be provided; or~~

~~(2),~~ in the case of an intermediate care facility for persons with developmental disabilities, there has been no authorization for admission by the admission review team as required in section 256B.0926.

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~~(9)~~ (6) make recommendations to a court as may be needed to assist the court in making decisions regarding commitment of persons with developmental disabilities~~; and~~

~~(10) inform the person and the person's legal guardian or conservator, or the parent if the person is a minor, that appeal may be made to the commissioner pursuant to section 256.045~~.

Sec. 33. Minnesota Statutes 2010, section 256B.092, subdivision 8a, is amended to read:

Subd. 8a. **County ~~concurrence~~ notification.** (a) If the county of financial responsibility wishes to place a person in another county for services, the county of financial responsibility shall ~~seek concurrence from~~ notify the proposed county of service and the placement shall be made cooperatively between the two counties. Arrangements shall be made between the two counties for ongoing social service, including annual reviews of the person's ~~individual service~~ coordinated service and support plan. The county where services are provided may not make changes in the person's ~~service~~ coordinated service and support plan without approval by the county of financial responsibility.

(b) ~~When a person has been screened and authorized for services in an intermediate care facility for persons with developmental disabilities or for home and community-based services for persons with developmental disabilities, the case manager shall assist that person in identifying a service provider who is able to meet the needs of the person according to the person's individual service plan. If the identified service is to be provided in a county other than the county of financial responsibility, the county of financial responsibility shall request concurrence of the county where the person is requesting to receive the identified services.~~ The county of service ~~may refuse to concur~~ shall notify the county of financial responsibility if~~:~~

~~(1) it can demonstrate that the provider is unable to provide the services identified in the person's individual service plan as services that are needed and are to be provided; or~~

~~(2),~~ in the case of an intermediate care facility for persons with developmental disabilities, there has been no authorization for admission by the admission review team as required in section 256B.0926.

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(c) The county of service shall notify the county of financial responsibility of ~~concurrence or refusal to concur~~ any concerns about the chosen provider's capacity to meet the needs of the person seeking to move to residential services in another county no later than 20 working days following receipt of the written ~~request~~ notification. Unless other mutually acceptable arrangements are made by the involved county agencies, the county of financial responsibility is responsible for costs of social services and the costs associated with the development and maintenance of the placement. The county of service may request that the county of financial responsibility purchase case management services from the county of service or from a contracted provider of case management when the county of financial responsibility is not providing case management as defined in this section and rules adopted under this section, unless other mutually acceptable arrangements are made by the involved county agencies. Standards for payment limits under this section may be established by the commissioner. Financial disputes between counties shall be resolved as provided in section 256G.09. This subdivision also applies to home and community-based waiver services provided under section 256B.49.

Sec. 34. Minnesota Statutes 2010, section 256B.092, subdivision 9, is amended to read:

Subd. 9. **Reimbursement.** Payment for services shall not be provided to a service provider for any person placed in an intermediate care facility for persons with developmental disabilities prior to the person ~~being screened by the screening team~~ receiving an assessment by a certified assessor. The commissioner shall not deny reimbursement for: (1) a person admitted to an intermediate care facility for persons with developmental disabilities who is assessed to need long-term supportive services, if long-term supportive services other than intermediate care are not available in that community; (2) any person admitted to an intermediate care facility for persons with developmental disabilities under emergency circumstances; (3) any eligible person placed in the intermediate care facility for persons with developmental disabilities pending an appeal of the ~~screening team's~~ certified assessor's decision; or (4) any medical assistance recipient when, after full discussion of all appropriate alternatives including those that are expected to be less costly than intermediate care for persons with developmental disabilities, the person or the person's legal guardian or conservator, or the parent if the person is a minor, insists on intermediate care placement. The ~~screening team~~ certified assessor shall provide documentation that the most cost-effective alternatives available were offered to this individual or the individual's legal guardian or conservator.

Sec. 35. Minnesota Statutes 2010, section 256B.092, subdivision 11, is amended to read:

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(c) The county of service shall notify the county of financial responsibility of ~~concurrence or refusal to concur~~ any concerns about the chosen provider's capacity to meet the needs of the person seeking to move to residential services in another county no later than 20 working days following receipt of the written ~~request~~ notification. Unless other mutually acceptable arrangements are made by the involved county agencies, the county of financial responsibility is responsible for costs of social services and the costs associated with the development and maintenance of the placement. The county of service may request that the county of financial responsibility purchase case management services from the county of service or from a contracted provider of case management when the county of financial responsibility is not providing case management as defined in this section and rules adopted under this section, unless other mutually acceptable arrangements are made by the involved county agencies. Standards for payment limits under this section may be established by the commissioner. Financial disputes between counties shall be resolved as provided in section 256G.09. This subdivision also applies to home and community-based waiver services provided under section 256B.49.

Sec. 34. Minnesota Statutes 2010, section 256B.092, subdivision 9, is amended to read:

Subd. 9. **Reimbursement.** Payment for services shall not be provided to a service provider for any person placed in an intermediate care facility for persons with developmental disabilities prior to the person ~~being screened by the screening team~~ receiving an assessment by a certified assessor. The commissioner shall not deny reimbursement for: (1) a person admitted to an intermediate care facility for persons with developmental disabilities who is assessed to need long-term supportive services, if long-term supportive services other than intermediate care are not available in that community; (2) any person admitted to an intermediate care facility for persons with developmental disabilities under emergency circumstances; (3) any eligible person placed in the intermediate care facility for persons with developmental disabilities pending an appeal of the ~~screening team's~~ certified assessor's decision; or (4) any medical assistance recipient when, after full discussion of all appropriate alternatives including those that are expected to be less costly than intermediate care for persons with developmental disabilities, the person or the person's legal guardian or conservator, or the parent if the person is a minor, insists on intermediate care placement. The ~~screening team~~ certified assessor shall provide documentation that the most cost-effective alternatives available were offered to this individual or the individual's legal guardian or conservator.

Sec. 35. Minnesota Statutes 2010, section 256B.092, subdivision 11, is amended to read:

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Subd. 11. **Residential support services.** (a) Upon federal approval, there is established a new service called residential support that is available on the community alternative care, community alternatives for disabled individuals, developmental disabilities, and traumatic brain injury waivers. Existing waiver service descriptions must be modified to the extent necessary to ensure there is no duplication between other services. Residential support services must be provided by vendors licensed as a community residential setting as defined in section 245A.11, subdivision 8.

(b) Residential support services must meet the following criteria:

(1) providers of residential support services must own or control the residential site;

(2) the residential site must not be the primary residence of the license holder;

(3) the residential site must have a designated program supervisor responsible for program oversight, development, and implementation of policies and procedures;

(4) the provider of residential support services must provide supervision, training, and assistance as described in the person's ~~community~~ coordinated services and support plan; and

(5) the provider of residential support services must meet the requirements of licensure and additional requirements of the person's ~~community~~ coordinated services and support plan.

(c) Providers of residential support services that meet the definition in paragraph (a) must be registered using a process determined by the commissioner beginning July 1, 2009.

Sec. 36. Minnesota Statutes 2010, section 256B.49, subdivision 13, is amended to read:

Subd. 13. **Case management.** (a) Each recipient of a home and community-based waiver shall be provided case management services by qualified vendors as described in the federally approved waiver application. The case management service activities provided ~~will~~ must include:

(1) assessing the needs of the individual within 20 working days of a recipient's request;

(2) ~~developing~~ finalizing the written ~~individual service~~ coordinated service and support plan within ten working days after the ~~assessment is completed~~ case manager receives the plan from the certified assessor;

(3) 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 and available options for case management service and providers;

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Subd. 11. **Residential support services.** (a) Upon federal approval, there is established a new service called residential support that is available on the community alternative care, community alternatives for disabled individuals, developmental disabilities, and traumatic brain injury waivers. Existing waiver service descriptions must be modified to the extent necessary to ensure there is no duplication between other services. Residential support services must be provided by vendors licensed as a community residential setting as defined in section 245A.11, subdivision 8.

(b) Residential support services must meet the following criteria:

(1) providers of residential support services must own or control the residential site;

(2) the residential site must not be the primary residence of the license holder;

(3) the residential site must have a designated program supervisor responsible for program oversight, development, and implementation of policies and procedures;

(4) the provider of residential support services must provide supervision, training, and assistance as described in the person's ~~community~~ coordinated services and support plan; and

(5) the provider of residential support services must meet the requirements of licensure and additional requirements of the person's ~~community~~ coordinated services and support plan.

(c) Providers of residential support services that meet the definition in paragraph (a) must be registered using a process determined by the commissioner beginning July 1, 2009.

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~~(1) assessing the needs of the individual within 20 working days of a recipient's request;~~

~~(2) developing~~ (1) finalizing the written ~~individual service~~ coordinated service and support plan within ten working days after the ~~assessment is completed~~ case manager receives the plan from the certified assessor;

~~(3)~~ (2) informing the recipient or the recipient's legal guardian or conservator of service options;

~~(4)~~ (3) assisting the recipient in the identification of potential service providers and available options for case management service and providers;

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(5) assisting the recipient to access services and assisting with appeals under section 256.045; and

(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.~~:

(1) finalizing the coordinated service and support plan;

(2) ongoing assessment and monitoring of the person's needs and adequacy of the approved coordinated service and support plan; and

(3) adjustments to the coordinated service and support plan.

(c) Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in the approved federal waiver plans. Case management services must not be provided to a recipient by a private agency that has any financial interest in the provision of any other services included in the recipient's coordinated services and support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision 1a, paragraph (d).

Sec. 37. 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. Reassessment of each recipient's strengths, support systems, and need for services shall be conducted at least every 12 months and at other times when there has been a significant change in the recipient's functioning~~ and reassessments shall be conducted by certified assessors according to section 256B.0911, subdivision 2b.

(b) There must be a determination that the client requires a hospital level of care or a nursing facility level of care as defined in section 144.0724, subdivision 11, at initial and subsequent assessments to initiate and maintain participation in the waiver program.

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~~(5)~~ (4) assisting the recipient to access services and assisting with appeals under section 256.045; and

~~(6)~~ (5) coordinating, evaluating, and monitoring of the services identified in the service plan;.

~~(7) completing the annual reviews of the service plan; and~~

~~(8) informing the recipient or legal representative of the right to have assessments completed and service plans developed within specified time periods, and to appeal county action or inaction under section 256.045, subdivision 3, including the determination of nursing facility level of care.~~

(b) The case manager may delegate certain aspects of the case management service activities to another individual provided there is oversight by the case manager. The case manager may not delegate those aspects which require professional judgment including ~~assessments, reassessments, and care plan development.~~:

(1) finalizing the coordinated service and support plan;

(2) ongoing assessment and monitoring of the person's needs and adequacy of the approved coordinated service and support plan; and

(3) adjustments to the coordinated service and support plan.

(c) Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in the approved federal waiver plans. Case management services must not be provided to a recipient by a private agency that has any financial interest in the provision of any other services included in the recipient's coordinated services and support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision 1a, paragraph (d).

Sec. 37. Minnesota Statutes 2010, section 256B.49, subdivision 14, is amended to read:

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(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.

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(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)~~ (d) Recipients who are found eligible for home and community-based services under this section before their 65th birthday may remain eligible for these services after their 65th birthday if they continue to meet all other eligibility factors.

Sec. 38. Minnesota Statutes 2010, section 256B.49, subdivision 15, is amended to read:

Subd. 15. **~~Individualized~~ Coordinated service and support plan.** (a) Each recipient of home and community-based waivered services shall be provided a copy of the written ~~service~~ coordinated service and support plan which~~:~~

~~(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~~ meets the requirements in section 256B.092, subdivision 1b.

(b) 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~~ coordinated services and support plan. The reduction in the authorized services for an individual due to changes in funding for waivered services may not exceed the amount needed to ensure medically necessary services to meet the individual's health, safety, and welfare.

Sec. 39. Minnesota Statutes 2010, section 256G.02, subdivision 6, is amended to read:

Subd. 6. **Excluded time.** "Excluded time" means:

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(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)~~ (d) Recipients who are found eligible for home and community-based services under this section before their 65th birthday may remain eligible for these services after their 65th birthday if they continue to meet all other eligibility factors.

Sec. 38. Minnesota Statutes 2010, section 256B.49, subdivision 15, is amended to read:

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~~(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~~ meets the requirements in section 256B.092, subdivision 1b.

(b) 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~~ coordinated services and support plan. The reduction in the authorized services for an individual due to changes in funding for waivered services may not exceed the amount needed to ensure medically necessary services to meet the individual's health, safety, and welfare.

Sec. 39. Minnesota Statutes 2010, section 256G.02, subdivision 6, is amended to read:

Subd. 6. **Excluded time.** "Excluded time" means:

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~~(a)~~ (1) any period an applicant spends in a hospital, sanitarium, nursing home, shelter other than an emergency shelter, halfway house, foster home, semi-independent living domicile or services program, residential facility offering care, board and lodging facility or other institution for the hospitalization or care of human beings, as defined in section 144.50, 144A.01, or 245A.02, subdivision 14; maternity home, battered women's shelter, or correctional facility; or any facility based on an emergency hold under sections 253B.05, subdivisions 1 and 2, and 253B.07, subdivision 6;

~~(b)~~ (2) any period an applicant spends on a placement basis in a training and habilitation program, including: a rehabilitation facility or work or employment program as defined in section 268A.01; ~~or receiving personal care assistance services pursuant to section 256B.0659;~~ semi-independent living services provided under section 252.275, and Minnesota Rules, parts 9525.0500 to 9525.0660; or day training and habilitation programs and assisted living services; and

~~(c)~~ (3) any placement for a person with an indeterminate commitment, including independent living.

Sec. 40. **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:

(a) definitions of service and consolidation of standards and rates to the extent appropriate for all types of medical assistance case management service services, including targeted case management under Minnesota Statutes, sections 256B.0621, 256B.0924, and 256B.094, and all types of home and community-based waiver case management and case management under Minnesota Rules, parts 9525.0004 to 9525.0036. This work must be completed in collaboration with efforts under Minnesota Statutes, section 256B.4912;

(b) recommendations on county of financial responsibility requirements and quality assurance measures for case management; and

(c) identification of county administrative functions that may remain entwined in case management service delivery models.

ARTICLE 4
NURSING FACILITIES

Section 1. Minnesota Statutes 2010, section 144A.071, subdivision 3, is amended to read:

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~~(a)~~ (1) any period an applicant spends in a hospital, sanitarium, nursing home, shelter other than an emergency shelter, halfway house, foster home, semi-independent living domicile or services program, residential facility offering care, board and lodging facility or other institution for the hospitalization or care of human beings, as defined in section 144.50, 144A.01, or 245A.02, subdivision 14; maternity home, battered women's shelter, or correctional facility; or any facility based on an emergency hold under sections 253B.05, subdivisions 1 and 2, and 253B.07, subdivision 6;

~~(b)~~ (2) any period an applicant spends on a placement basis in a training and habilitation program, including: a rehabilitation facility or work or employment program as defined in section 268A.01; ~~or receiving personal care assistance services pursuant to section 256B.0659;~~ semi-independent living services provided under section 252.275, and Minnesota Rules, parts 9525.0500 to 9525.0660; or day training and habilitation programs and assisted living services; and

~~(c)~~ (3) any placement for a person with an indeterminate commitment, including independent living.

Sec. 40. **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:

(a) definitions of service and consolidation of standards and rates to the extent appropriate for all types of medical assistance case management service services, including targeted case management under Minnesota Statutes, sections 256B.0621, 256B.0924, and 256B.094, and all types of home and community-based waiver case management and case management under Minnesota Rules, parts 9525.0004 to 9525.0036. This work must be completed in collaboration with efforts under Minnesota Statutes, section 256B.4912;

(b) recommendations on county of financial responsibility requirements and quality assurance measures for case management; and

(c) identification of county administrative functions that may remain entwined in case management service delivery models.

ARTICLE 4
NURSING FACILITIES

Section 1. Minnesota Statutes 2010, section 144A.071, subdivision 3, is amended to read:

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Subd. 3. **Exceptions authorizing increase in beds; hardship areas.** (a) The commissioner of health, in coordination with the commissioner of human services, may approve the addition of ~~a~~ new ~~certified bed or the addition of a new~~ licensed and Medicare and Medicaid-certified nursing home ~~bed~~ beds, ~~under~~ using the ~~following conditions:~~ criteria and process in this subdivision.

~~(a) to license or certify a new bed in place of one decertified after July 1, 1993, as long as the number of certified plus newly certified or recertified beds does not exceed the number of beds licensed or certified on July 1, 1993, or to address an extreme hardship situation, in a particular county that, together with all contiguous Minnesota counties, has fewer nursing home beds per 1,000 elderly than the number that is ten percent higher than the national average of nursing home beds per 1,000 elderly individuals. For the purposes of this section, the national average of nursing home beds shall be the most recent figure that can be supplied by the federal Centers for Medicare and Medicaid Services and the number of elderly in the county or the nation shall be determined by the most recent federal census or the most recent estimate of the state demographer as of July 1, of each year of persons age 65 and older, whichever is the most recent at the time of the request for replacement. An extreme hardship situation can only be found after the county documents the existence of unmet medical needs that cannot be addressed by any other alternatives;~~

(b) The commissioner, in cooperation with the commissioner of human services, shall consider the following criteria when determining that an area of the state is a hardship area with regard to access to nursing facility services:

(1) a low number of beds per 1,000 in a specified area using as a standard beds per 1,000 persons age 65 and older, in five-year age groups, using data from the most recent census and population projections, weighted by each group's most recent nursing home utilization, of the county at the 20th percentile, as determined by the commissioner of human services;

(2) a high level of out-migration for nursing facility services associated with a described area from the county or counties of residence to other Minnesota counties, as determined by the commissioner of human services, using as a standard an amount greater than the out-migration of the county ranked at the 50th percentile;

(3) an adequate level of availability of noninstitutional long-term care services measured as public spending for home and community-based long-term care services per individual age 65 and older, in five-year age groups, using data from the most recent census and population projections, weighted by each group's most recent nursing home utilization, as determined by the commissioner of human services, using as a standard an amount greater than the 50th percentile of counties;

(4) there must be a declaration of hardship resulting from insufficient access to nursing home beds by local county agencies and area agencies on aging; and

(5) other factors that may demonstrate the need to add new nursing facility beds.

Senate Language UEH1406-1

Subd. 3. **Exceptions authorizing increase in beds; hardship areas.** (a) The commissioner of health, in coordination with the commissioner of human services, may approve the addition of ~~a~~ new ~~certified bed or the addition of a new~~ licensed and Medicare and Medicaid-certified nursing home ~~bed~~ beds, ~~under~~ using the ~~following conditions:~~ criteria and process in this subdivision.

~~(a) to license or certify a new bed in place of one decertified after July 1, 1993, as long as the number of certified plus newly certified or recertified beds does not exceed the number of beds licensed or certified on July 1, 1993, or to address an extreme hardship situation, in a particular county that, together with all contiguous Minnesota counties, has fewer nursing home beds per 1,000 elderly than the number that is ten percent higher than the national average of nursing home beds per 1,000 elderly individuals. For the purposes of this section, the national average of nursing home beds shall be the most recent figure that can be supplied by the federal Centers for Medicare and Medicaid Services and the number of elderly in the county or the nation shall be determined by the most recent federal census or the most recent estimate of the state demographer as of July 1, of each year of persons age 65 and older, whichever is the most recent at the time of the request for replacement. An extreme hardship situation can only be found after the county documents the existence of unmet medical needs that cannot be addressed by any other alternatives;~~

(b) The commissioner, in cooperation with the commissioner of human services, shall consider the following criteria when determining that an area of the state is a hardship area with regard to access to nursing facility services:

(1) a low number of beds per 1,000 in a specified area using as a standard beds per 1,000 persons age 65 and older, in five-year age groups, using data from the most recent census and population projections, weighted by each group's most recent nursing home utilization, of the county at the 20th percentile, as determined by the commissioner of human services;

(2) a high level of out-migration for nursing facility services associated with a described area from the county or counties of residence to other Minnesota counties, as determined by the commissioner of human services, using as a standard an amount greater than the out-migration of the county ranked at the 50th percentile;

(3) an adequate level of availability of noninstitutional long-term care services measured as public spending for home and community-based long-term care services per individual age 65 and older, in five-year age groups, using data from the most recent census and population projections, weighted by each group's most recent nursing home utilization, as determined by the commissioner of human services, using as a standard an amount greater than the 50th percentile of counties;

(4) there must be a declaration of hardship resulting from insufficient access to nursing home beds by local county agencies and area agencies on aging; and

(5) other factors that may demonstrate the need to add new nursing facility beds.

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(c) On August 15 of odd-numbered years, the commissioner, in cooperation with the commissioner of human services, may publish in the State Register a request for information in which interested parties, using the data provided under section 144A.351, along with any other relevant data, demonstrate that a specified area is a hardship area with regard to access to nursing facility services. For a response to be considered, the commissioner must receive it by November 15. The commissioner shall make responses to the request for information available to the public and shall allow 30 days for comment. The commissioner shall review responses and comments and determine if any areas of the state are to be declared hardship areas.

(d) For each designated hardship area determined in paragraph (c), the commissioner shall publish a request for proposals in accordance with section 144A.073 and Minnesota Rules, parts 4655.1070 to 4655.1098. The request for proposals must be published in the State Register by March 15 following receipt of responses to the request for information. The request for proposals must specify the number of new beds which may be added in the designated hardship area, which must not exceed the number which, if added to the existing number of beds in the area, including beds in layaway status, would have prevented it from being determined to be a hardship area under paragraph (b), clause (1). Beginning July 1, 2011, the number of new beds approved must not exceed 200 beds statewide per biennium. After June 30, 2019, the number of new beds that may be approved in a biennium must not exceed 300 statewide. For a proposal to be considered, the commissioner must receive it within six months of the publication of the request for proposals. The commissioner shall review responses to the request for proposals and shall approve or disapprove each proposal by the following July 15, in accordance with section 144A.073 and Minnesota Rules, parts 4655.1070 to 4655.1098. The commissioner shall base approvals or disapprovals on a comparison and ranking of proposals using only the criteria in subdivision 4a. Approval of a proposal expires after 18 months unless the facility has added the new beds using existing space, subject to approval by the commissioner, or has commenced construction as defined in section 144A.071, subdivision 1a, paragraph (d). If fewer than 50 percent of the beds in a facility are newly licensed, after the beds have been added, the operating payment rates previously in effect shall remain. If 50 percent or more of the beds in a facility are newly licensed after the approved beds have been added, then determination of operating payment rates shall be done according to Minnesota Rules, part 9549.0057, using limits determined under section 256B.441. Determination of external fixed payment rates must be done according to section 256B.441, subdivision 53. Determinations of property payment rates for facilities with beds added under this subdivision must be done in the same manner as rate determinations resulting from projects approved and completed under section 144A.073.

~~(b) to~~ (e) The commissioner may:

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(c) On August 15 of odd-numbered years, the commissioner, in cooperation with the commissioner of human services, may publish in the State Register a request for information in which interested parties, using the data provided under section 144A.351, along with any other relevant data, demonstrate that a specified area is a hardship area with regard to access to nursing facility services. For a response to be considered, the commissioner must receive it by November 15. The commissioner shall make responses to the request for information available to the public and shall allow 30 days for comment. The commissioner shall review responses and comments and determine if any areas of the state are to be declared hardship areas.

(d) For each designated hardship area determined in paragraph (c), the commissioner shall publish a request for proposals in accordance with section 144A.073 and Minnesota Rules, parts 4655.1070 to 4655.1098. The request for proposals must be published in the State Register by March 15 following receipt of responses to the request for information. The request for proposals must specify the number of new beds which may be added in the designated hardship area, which must not exceed the number which, if added to the existing number of beds in the area, including beds in layaway status, would have prevented it from being determined to be a hardship area under paragraph (b), clause (1). Beginning July 1, 2011, the number of new beds approved must not exceed 200 beds statewide per biennium. After June 30, 2019, the number of new beds that may be approved in a biennium must not exceed 300 statewide. For a proposal to be considered, the commissioner must receive it within six months of the publication of the request for proposals. The commissioner shall review responses to the request for proposals and shall approve or disapprove each proposal by the following July 15, in accordance with section 144A.073 and Minnesota Rules, parts 4655.1070 to 4655.1098. The commissioner shall base approvals or disapprovals on a comparison and ranking of proposals using only the criteria in subdivision 4a. Approval of a proposal expires after 18 months unless the facility has added the new beds using existing space, subject to approval by the commissioner, or has commenced construction as defined in section 144A.071, subdivision 1a, paragraph (d). If fewer than 50 percent of the beds in a facility are newly licensed, after the beds have been added, the operating payment rates previously in effect shall remain. If 50 percent or more of the beds in a facility are newly licensed after the approved beds have been added, then determination of operating payment rates shall be done according to Minnesota Rules, part 9549.0057, using limits determined under section 256B.441. Determination of external fixed payment rates must be done according to section 256B.441, subdivision 53. Determinations of property payment rates for facilities with beds added under this subdivision must be done in the same manner as rate determinations resulting from projects approved and completed under section 144A.073.

~~(b) to~~ (e) The commissioner may:

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(1) certify or license new beds in a new facility that is to be operated by the commissioner of veterans affairs or when the costs of constructing and operating the new beds are to be reimbursed by the commissioner of veterans affairs or the United States Veterans Administration; and

~~(c) to~~ (2) license or certify beds in a facility that has been involuntarily delicensed or decertified for participation in the medical assistance program, provided that an application for relicensure or recertification is submitted to the commissioner by an organization that is not a related organization as defined in section 256B.441, subdivision 34, to the prior licensee within 120 days after delicensure or decertification~~;~~.

~~(d) to certify two existing beds in a facility with 66 licensed beds on January 1, 1994, that had an average occupancy rate of 98 percent or higher in both calendar years 1992 and 1993, and which began construction of four attached assisted living units in April 1993; or~~

~~(e) to certify four existing beds in a facility in Winona with 139 beds, of which 129 beds are certified.~~

Sec. 2. Minnesota Statutes 2010, section 144D.08, is amended to read:

144D.08 UNIFORM CONSUMER INFORMATION GUIDE.

All housing with services establishments shall make available to all prospective and current residents information consistent with the uniform format and the required components adopted by the commissioner under section 144G.06. This section does not apply to an establishment registered under section 144D.025, serving the homeless.

Sec. 3. Minnesota Statutes 2010, section 256B.19, subdivision 1e, is amended to read:

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(1) certify or license new beds in a new facility that is to be operated by the commissioner of veterans affairs or when the costs of constructing and operating the new beds are to be reimbursed by the commissioner of veterans affairs or the United States Veterans Administration; and

~~(c) to~~ (2) license or certify beds in a facility that has been involuntarily delicensed or decertified for participation in the medical assistance program, provided that an application for relicensure or recertification is submitted to the commissioner by an organization that is not a related organization as defined in section 256B.441, subdivision 34, to the prior licensee within 120 days after delicensure or decertification~~;~~.

~~(d) to certify two existing beds in a facility with 66 licensed beds on January 1, 1994, that had an average occupancy rate of 98 percent or higher in both calendar years 1992 and 1993, and which began construction of four attached assisted living units in April 1993; or~~

~~(e) to certify four existing beds in a facility in Winona with 139 beds, of which 129 beds are certified.~~

Sec. 2. Minnesota Statutes 2010, section 144A.073, subdivision 3c, is amended to read:

Subd. 3c. **Cost neutral relocation projects.** (a) Notwithstanding subdivision 3, the commissioner may at any time accept proposals, or amendments to proposals previously approved under this section, for relocations that are cost neutral with respect to state costs as defined in section 144A.071, subdivision 5a. The commissioner, in consultation with the commissioner of human services, shall evaluate proposals according to subdivision 4 4a, clauses (1), ~~(2), (3), and (9)~~ (4), (5), (6), and (8), and other criteria established in rule~~.~~ or law. The commissioner of human services shall determine the allowable payment rates of the facility receiving the beds in accordance with section 256B.441, subdivision 60. The commissioner shall approve or disapprove a project within 90 days. ~~Proposals and amendments approved under this subdivision are not subject to the six-mile limit in subdivision 5, paragraph (e).~~

(b) For the purposes of paragraph (a), cost neutrality shall be measured over the first three 12-month periods of operation after completion of the project.

Sec. 3. Minnesota Statutes 2010, section 144D.08, is amended to read:

144D.08 UNIFORM CONSUMER INFORMATION GUIDE.

All housing with services establishments shall make available to all prospective and current residents information consistent with the uniform format and the required components adopted by the commissioner under section 144G.06. This section does not apply to an establishment registered under section 144D.025, serving the homeless.

Sec. 4. Minnesota Statutes 2010, section 256B.19, subdivision 1e, is amended to read:

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Subd. 1e. **Additional local share of certain nursing facility costs.** Beginning on the latter of January 1, 2011, or the first day of the month beginning no less than 45 days following federal approval, local government entities that own the physical plant or are the license holders of nursing facilities receiving rate adjustments under section 256B.441, subdivision 55a, shall be responsible for paying the portion of nonfederal costs calculated under section 256B.441, subdivision 55a, paragraph (d). This responsibility remains in effect through the day before the phase-in under section 256B.441, subdivision 55, is complete. Beginning the day when the phase-in under section 256B.441, subdivision 55, is complete, local government entities that own the physical plant or are the license holders of nursing facilities receiving rate adjustments under section 256B.441, subdivision 55a, shall be responsible for paying the portion of nonfederal costs calculated under section 256B.441, subdivision 55a, paragraph (e). Payments of the nonfederal share shall be made monthly to the commissioner in amounts determined in accordance with section 256B.441, subdivision 55a, paragraph ~~(d)~~ (e). Payments for each month beginning ~~in January 2011 through September 2015~~ on the effective date of the rate adjustment shall be due by the 15th day of the following month. If any provider obligated to pay an amount under this subdivision is more than ~~two months~~ 30 days delinquent in the timely payment of the monthly installment, the commissioner may ~~withhold payments, penalties, and interest in accordance with the methods outlined in section 256.9657, subdivision 7a~~ revoke participation under this subdivision and end payments determined under section 256B.441, subdivision 55a, to the participating nursing facility effective on the first day of the month following the month in which such notice was mailed. In the event of revocation, any amounts paid by private residents under this subdivision for days of service on or after the first day of the month following the month in which such notice was mailed must be refunded.

Sec. 4. Minnesota Statutes 2010, section 256B.431, subdivision 2t, is amended to read:

Subd. 2t. **Payment limitation.** For services rendered on or after July 1, 2003, for facilities reimbursed under this ~~section or section 256B.434~~ chapter, the Medicaid program shall only pay a co-payment during a Medicare-covered skilled nursing facility stay if the Medicare rate less the resident's co-payment responsibility is less than the Medicaid RUG-III case-mix payment rate, or, beginning January 1, 2012, the Medicaid RUG-IV case-mix payment rate. The amount that shall be paid by the Medicaid program is equal to the amount by which the Medicaid RUG-III or RUG-IV case-mix payment rate exceeds the Medicare rate less the co-payment responsibility. Health plans paying for nursing home services under section 256B.69, subdivision 6a, may limit payments as allowed under this subdivision.

Sec. 5. Minnesota Statutes 2010, section 256B.438, subdivision 1, is amended to read:

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Subd. 1e. **Additional local share of certain nursing facility costs.** Beginning on the latter of January 1, 2011, or the first day of the month beginning no less than 45 days following federal approval, local government entities that own the physical plant or are the license holders of nursing facilities receiving rate adjustments under section 256B.441, subdivision 55a, shall be responsible for paying the portion of nonfederal costs calculated under section 256B.441, subdivision 55a, paragraph (d). This responsibility remains in effect through the day before the phase-in under section 256B.441, subdivision 55, is complete. Beginning the day when the phase-in under section 256B.441, subdivision 55, is complete, local government entities that own the physical plant or are the license holders of nursing facilities receiving rate adjustments under section 256B.441, subdivision 55a, shall be responsible for paying the portion of nonfederal costs calculated under section 256B.441, subdivision 55a, paragraph (e). Payments of the nonfederal share shall be made monthly to the commissioner in amounts determined in accordance with section 256B.441, subdivision 55a, paragraph ~~(d)~~ (e). Payments for each month beginning ~~in January 2011 through September 2015~~ on the effective date of the rate adjustment shall be due by the 15th day of the following month. If any provider obligated to pay an amount under this subdivision is more than ~~two months~~ 30 days delinquent in the timely payment of the monthly installment, the commissioner may ~~withhold payments, penalties, and interest in accordance with the methods outlined in section 256.9657, subdivision 7a~~ revoke participation under this subdivision and end payments determined under section 256B.441, subdivision 55a, to the participating nursing facility effective on the first day of the month following the month in which such notice was mailed. In the event of revocation, any amounts paid by private residents under this subdivision for days of service on or after the first day of the month following the month in which such notice was mailed must be refunded.

Sec. 5. Minnesota Statutes 2010, section 256B.431, subdivision 2t, is amended to read:

Subd. 2t. **Payment limitation.** For services rendered on or after July 1, 2003, for facilities reimbursed under this ~~section or section 256B.434~~ chapter, the Medicaid program shall only pay a co-payment during a Medicare-covered skilled nursing facility stay if the Medicare rate less the resident's co-payment responsibility is less than the Medicaid RUG-III case-mix payment rate, or, beginning January 1, 2012, the Medicaid RUG-IV case-mix payment rate. The amount that shall be paid by the Medicaid program is equal to the amount by which the Medicaid RUG-III or RUG-IV case-mix payment rate exceeds the Medicare rate less the co-payment responsibility. Health plans paying for nursing home services under section 256B.69, subdivision 6a, may limit payments as allowed under this subdivision.

Sec. 6. Minnesota Statutes 2010, section 256B.438, subdivision 1, is amended to read:

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Subdivision 1. **Scope.** This section establishes the method and criteria used to determine resident reimbursement classifications based upon the assessments of residents of nursing homes and boarding care homes whose payment rates are established under section 256B.431, 256B.434, or ~~256B.435~~ 256B.441 or any other section. Resident reimbursement classifications shall be established according to the 34 group, resource utilization groups, version III or RUG-III model as described in section 144.0724. Reimbursement classifications established under this section shall be implemented after June 30, 2002, but no later than January 1, 2003. Reimbursement classifications established under this section shall be implemented no earlier than six weeks after the commissioner mails notices of payment rates to the facilities. Effective January 1, 2012, resident reimbursement classifications shall be established according to the 48 group, resource utilization groups, RUG-IV model under section 144.0724.

Sec. 6. Minnesota Statutes 2010, section 256B.438, subdivision 3, is amended to read:

Subd. 3. **Case mix indices.** (a) The commissioner of human services shall assign a case mix index to each resident class based on the Centers for Medicare and Medicaid Services staff time measurement study and adjusted for Minnesota-specific wage indices. The case mix indices assigned to each resident class shall be published in the Minnesota State Register at least 120 days prior to the implementation of the 34 group, RUG-III resident classification system.

(b) An index maximization approach shall be used to classify residents.

(c) After implementation of the revised case mix system, the commissioner of human services may annually rebase case mix indices and base rates using more current data on average wage rates and staff time measurement studies. This rebasing shall be calculated under subdivision 7, paragraph (b). The commissioner shall publish in the Minnesota State Register adjusted case mix indices at least 45 days prior to the effective date of the adjusted case mix indices.

(d) Upon implementation of the 48-group RUG-IV resident classification system, the commissioner of human services shall assign a case mix index to each resident class based on the Centers for Medicare and Medicaid Services staff time measurement study. The case mix indices assigned to each resident class shall be published in the State Register at least 120 days prior to the implementation of the RUG-IV resident classification system.

Sec. 7. Minnesota Statutes 2010, section 256B.438, subdivision 4, is amended to read:

Subd. 4. **Resident assessment schedule.** (a) Nursing facilities shall conduct and submit case mix assessments according to the schedule established by the commissioner of health under section 144.0724, subdivisions 4 and 5.

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Subdivision 1. **Scope.** This section establishes the method and criteria used to determine resident reimbursement classifications based upon the assessments of residents of nursing homes and boarding care homes whose payment rates are established under section 256B.431, 256B.434, or ~~256B.435~~ 256B.441 or any other section. Resident reimbursement classifications shall be established according to the 34 group, resource utilization groups, version III or RUG-III model as described in section 144.0724. Reimbursement classifications established under this section shall be implemented after June 30, 2002, but no later than January 1, 2003. Reimbursement classifications established under this section shall be implemented no earlier than six weeks after the commissioner mails notices of payment rates to the facilities. Effective January 1, 2012, resident reimbursement classifications shall be established according to the 48 group, resource utilization groups, RUG-IV model under section 144.0724.

Sec. 7. Minnesota Statutes 2010, section 256B.438, subdivision 3, is amended to read:

Subd. 3. **Case mix indices.** (a) The commissioner of human services shall assign a case mix index to each resident class based on the Centers for Medicare and Medicaid Services staff time measurement study and adjusted for Minnesota-specific wage indices. The case mix indices assigned to each resident class shall be published in the Minnesota State Register at least 120 days prior to the implementation of the 34 group, RUG-III resident classification system.

(b) An index maximization approach shall be used to classify residents.

(c) After implementation of the revised case mix system, the commissioner of human services may annually rebase case mix indices and base rates using more current data on average wage rates and staff time measurement studies. This rebasing shall be calculated under subdivision 7, paragraph (b). The commissioner shall publish in the Minnesota State Register adjusted case mix indices at least 45 days prior to the effective date of the adjusted case mix indices.

(d) Upon implementation of the 48-group RUG-IV resident classification system, the commissioner of human services shall assign a case mix index to each resident class based on the Centers for Medicare and Medicaid Services staff time measurement study. The case mix indices assigned to each resident class shall be published in the State Register at least 120 days prior to the implementation of the RUG-IV resident classification system.

Sec. 8. Minnesota Statutes 2010, section 256B.438, subdivision 4, is amended to read:

Subd. 4. **Resident assessment schedule.** (a) Nursing facilities shall conduct and submit case mix assessments according to the schedule established by the commissioner of health under section 144.0724, subdivisions 4 and 5.

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(b) The resident reimbursement classifications established under section 144.0724, subdivision 3, shall be effective the day of admission for new admission assessments. The effective date for significant change assessments shall be the assessment reference date. The effective date for annual and quarterly assessments shall be the first day of the month following assessment reference date.

(c) Effective October 1, 2006, the commissioner shall rebase payment rates to account for the change in the resident assessment schedule in section 144.0724, subdivision 4, paragraph (b), clause (4), in a facility specific budget neutral manner, according to subdivision 7, paragraph (b).

(d) Effective January 1, 2012, the commissioner shall determine payment rates to account for the transition to RUG-IV, in a facility-specific, revenue-neutral manner, according to subdivision 8, paragraph (b).

Sec. 8. Minnesota Statutes 2010, section 256B.438, is amended by adding a subdivision to read:

Subd. 8. **Rate determination upon transition to RUG-IV payment rates.** (a) The commissioner of human services shall determine payment rates at the time of transition to the RUG-IV-based payment model in a facility-specific, revenue-neutral manner. To transition from the current calculation methodology to the RUG-IV-based methodology, nursing facilities shall report to the commissioner of human services the private pay and Medicaid resident days classified according to the categories defined in subdivision 3, paragraphs (a) and (d), for the six-month reporting period ending June 30, 2011. This report must be submitted to the commissioner, in a form prescribed by the commissioner, by August 15, 2011. The commissioner of human services shall use this data to compute the standardized days for the RUG-III and RUG-IV classification systems.

(b) The commissioner of human services shall determine the case mix adjusted component for the January 1, 2012, rate as follows:

(1) using the September 30, 2010, cost report, determine the case mix portion of the operating cost for each facility;

(2) multiply the 36 operating payment rates in effect on December 31, 2011, by the number of private pay and Medicaid resident days assigned to each group for the reporting period ending June 30, 2011, and compute the total;

(3) compute the product of the amounts in clauses (1) and (2);

(4) determine the private pay and Medicaid RUG standardized days for the reporting period ending June 30, 2011, using the new indices calculated under subdivision 3, paragraph (d);

(5) divide the amount determined in clause (3) by the amount in clause (4), which shall be the default rate (DDF) unadjusted case mix component of the rate under the RUG-IV method; and

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(b) The resident reimbursement classifications established under section 144.0724, subdivision 3, shall be effective the day of admission for new admission assessments. The effective date for significant change assessments shall be the assessment reference date. The effective date for annual and quarterly assessments shall be the first day of the month following assessment reference date.

(c) Effective October 1, 2006, the commissioner shall rebase payment rates to account for the change in the resident assessment schedule in section 144.0724, subdivision 4, paragraph (b), clause (4), in a facility specific budget neutral manner, according to subdivision 7, paragraph (b).

(d) Effective January 1, 2012, the commissioner shall determine payment rates to account for the transition to RUG-IV, in a facility-specific, revenue-neutral manner, according to subdivision 8, paragraph (b).

Sec. 9. Minnesota Statutes 2010, section 256B.438, is amended by adding a subdivision to read:

Subd. 8. **Rate determination upon transition to RUG-IV payment rates.** (a) The commissioner of human services shall determine payment rates at the time of transition to the RUG-IV-based payment model in a facility-specific, revenue-neutral manner. To transition from the current calculation methodology to the RUG-IV-based methodology, nursing facilities shall report to the commissioner of human services the private pay and Medicaid resident days classified according to the categories defined in subdivision 3, paragraphs (a) and (d), for the six-month reporting period ending June 30, 2011. This report must be submitted to the commissioner, in a form prescribed by the commissioner, by August 15, 2011. The commissioner of human services shall use this data to compute the standardized days for the RUG-III and RUG-IV classification systems.

(b) The commissioner of human services shall determine the case mix adjusted component for the January 1, 2012, rate as follows:

(1) using the September 30, 2010, cost report, determine the case mix portion of the operating cost for each facility;

(2) multiply the 36 operating payment rates in effect on December 31, 2011, by the number of private pay and Medicaid resident days assigned to each group for the reporting period ending June 30, 2011, and compute the total;

(3) compute the product of the amounts in clauses (1) and (2);

(4) determine the private pay and Medicaid RUG standardized days for the reporting period ending June 30, 2011, using the new indices calculated under subdivision 3, paragraph (d);

(5) divide the amount determined in clause (3) by the amount in clause (4), which shall be the default rate (DDF) unadjusted case mix component of the rate under the RUG-IV method; and

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(6) determine the case mix adjusted component of each operating rate by multiplying the default rate (DDF) unadjusted case mix component by the case mix weight in subdivision 3, paragraph (d), for each RUG-IV group.

(c) The noncase mix components will be allocated to each RUG group as a constant amount to determine the operating payment rate.

Sec. 9. Minnesota Statutes 2010, section 256B.441, subdivision 55a, is amended to read:

Subd. 55a. **Alternative to phase-in for publicly owned nursing facilities.** (a) For operating payment rates implemented between ~~January 1, 2011, and September 30, 2015,~~ the first day of the month beginning no less than 45 days following federal approval, and the day before the phase-in under subdivision 55 is complete, the commissioner shall allow nursing facilities whose physical plant is owned or whose license is held by a city, county, or hospital district to apply for a higher payment rate under this section if the local government entity agrees to pay a specified portion of the nonfederal share of medical assistance costs. Nursing facilities that apply shall be eligible to select an operating payment rate, with a weight of 1.00, up to the rate calculated in subdivision 54, without application of the phase-in under subdivision 55. The rates for the other ~~RUG's levels~~ RUGS shall be computed as provided under subdivision 54.

(b) For operating payment rates implemented beginning the day when the phase-in under subdivision 55 is complete, the commissioner shall allow nursing facilities whose physical plant is owned or whose license is held by a city, county, or hospital district to apply for a higher payment rate under this section if the local government entity agrees to pay a specified portion of the nonfederal share of medical assistance costs. Nursing facilities that apply are eligible to select an operating payment rate, with a weight of 1.00, up to an amount determined by the commissioner to be allowable under the Medicare upper payment limit test. The rates for the other RUGS shall be computed under subdivision 54.

~~(b)~~ (c) Rates determined under this subdivision shall take effect beginning on the latter of January 1, 2011, or the first day of the month beginning no less than 45 days following federal approval, based on cost reports for the rate year ending September 30, 2009, and in future rate years, rates determined for nursing facilities participating under this subdivision shall take effect on October 1 of each year, based on the most recent available cost report.

~~(c)~~ (d) Eligible nursing facilities that wish to participate under this subdivision shall make an application to the commissioner by September 30, 2010, or by June 30 of any subsequent year. ~~Participation under this subdivision is irrevocable. If paragraph (a) does not result in a rate greater than what would have been provided without application of this subdivision, a facility's rates shall be calculated as otherwise provided and no payment by the local government entity shall be required under paragraph (d).~~

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(6) determine the case mix adjusted component of each operating rate by multiplying the default rate (DDF) unadjusted case mix component by the case mix weight in subdivision 3, paragraph (d), for each RUG-IV group.

(c) The noncase mix components will be allocated to each RUG group as a constant amount to determine the operating payment rate.

Sec. 10. Minnesota Statutes 2010, section 256B.441, subdivision 55a, is amended to read:

Subd. 55a. **Alternative to phase-in for publicly owned nursing facilities.** (a) For operating payment rates implemented between ~~January 1, 2011, and September 30, 2015,~~ the first day of the month beginning no less than 45 days following federal approval, and the day before the phase-in under subdivision 55 is complete, the commissioner shall allow nursing facilities whose physical plant is owned or whose license is held by a city, county, or hospital district to apply for a higher payment rate under this section if the local government entity agrees to pay a specified portion of the nonfederal share of medical assistance costs. Nursing facilities that apply shall be eligible to select an operating payment rate, with a weight of 1.00, up to the rate calculated in subdivision 54, without application of the phase-in under subdivision 55. The rates for the other ~~RUG's levels~~ RUGS shall be computed as provided under subdivision 54.

(b) For operating payment rates implemented beginning the day when the phase-in under subdivision 55 is complete, the commissioner shall allow nursing facilities whose physical plant is owned or whose license is held by a city, county, or hospital district to apply for a higher payment rate under this section if the local government entity agrees to pay a specified portion of the nonfederal share of medical assistance costs. Nursing facilities that apply are eligible to select an operating payment rate, with a weight of 1.00, up to an amount determined by the commissioner to be allowable under the Medicare upper payment limit test. The rates for the other RUGS shall be computed under subdivision 54.

~~(b)~~ (c) Rates determined under this subdivision shall take effect beginning on the latter of January 1, 2011, or the first day of the month beginning no less than 45 days following federal approval, based on cost reports for the rate year ending September 30, 2009, and in future rate years, rates determined for nursing facilities participating under this subdivision shall take effect on October 1 of each year, based on the most recent available cost report.

~~(c)~~ (d) Eligible nursing facilities that wish to participate under this subdivision shall make an application to the commissioner by September 30, 2010, or by June 30 of any subsequent year. ~~Participation under this subdivision is irrevocable. If paragraph (a) does not result in a rate greater than what would have been provided without application of this subdivision, a facility's rates shall be calculated as otherwise provided and no payment by the local government entity shall be required under paragraph (d).~~

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~~(d)~~ (e) For each participating nursing facility, the public entity that owns the physical plant or is the license holder of the nursing facility shall pay to the state the entire nonfederal share of medical assistance payments received as a result of the difference between the nursing facility's payment rate under ~~subdivision 54,~~ paragraph (a) or (b), and the rates that the nursing facility would otherwise be paid without application of this subdivision under subdivision 54 or 55 as determined by the commissioner.

~~(e)~~ (f) The commissioner may, at any time, reduce the payments under this subdivision based on the commissioner's determination that the payments shall cause nursing facility rates to exceed the state's Medicare upper payment limit or any other federal limitation. If the commissioner determines a reduction is necessary, the commissioner shall reduce all payment rates for participating nursing facilities by a percentage applied to the amount of increase they would otherwise receive under this subdivision and shall notify participating facilities of the reductions. If payments to a nursing facility are reduced, payments under section 256B.19, subdivision 1e, shall be reduced accordingly.

Sec. 10. **REPEALER.**

Minnesota Statutes 2010, section 144A.073, subdivisions 4 and 5, are repealed.

ARTICLE 5
TECHNICAL

Section 1. Minnesota Statutes 2010, section 144A.071, subdivision 5a, is amended to read:

Subd. 5a. **Cost estimate of a moratorium exception project.** (a) For the purposes of this section and section 144A.073, the cost estimate of a moratorium exception project shall include the effects of the proposed project on the costs of the state subsidy for community-based services, nursing services, and housing in institutional and noninstitutional settings. The commissioner of health, in cooperation with the commissioner of human services, shall define the method for estimating these costs in the permanent rule implementing section 144A.073. The commissioner of human services shall prepare an estimate of the total state annual long-term costs of each moratorium exception proposal.

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~~(d)~~ (e) For each participating nursing facility, the public entity that owns the physical plant or is the license holder of the nursing facility shall pay to the state the entire nonfederal share of medical assistance payments received as a result of the difference between the nursing facility's payment rate under ~~subdivision 54,~~ paragraph (a) or (b), and the rates that the nursing facility would otherwise be paid without application of this subdivision under subdivision 54 or 55 as determined by the commissioner.

~~(e)~~ (f) The commissioner may, at any time, reduce the payments under this subdivision based on the commissioner's determination that the payments shall cause nursing facility rates to exceed the state's Medicare upper payment limit or any other federal limitation. If the commissioner determines a reduction is necessary, the commissioner shall reduce all payment rates for participating nursing facilities by a percentage applied to the amount of increase they would otherwise receive under this subdivision and shall notify participating facilities of the reductions. If payments to a nursing facility are reduced, payments under section 256B.19, subdivision 1e, shall be reduced accordingly.

Sec. 11. **REPEALER.**

Minnesota Statutes 2010, section 144A.073, subdivisions 4 and 5, are repealed.

ARTICLE 5
TECHNICAL

Section 1. Minnesota Statutes 2010, section 144A.071, subdivision 5a, is amended to read:

Subd. 5a. **Cost estimate of a moratorium exception project.** (a) For the purposes of this section and section 144A.073, the cost estimate of a moratorium exception project shall include the effects of the proposed project on the costs of the state subsidy for community-based services, nursing services, and housing in institutional and noninstitutional settings. The commissioner of health, in cooperation with the commissioner of human services, shall define the method for estimating these costs in the permanent rule implementing section 144A.073. The commissioner of human services shall prepare an estimate of the total state annual long-term costs of each moratorium exception proposal.

House Language H1406-2

(b) The interest rate to be used for estimating the cost of each moratorium exception project proposal shall be the lesser of either the prime rate plus two percentage points, or the posted yield for standard conventional fixed rate mortgages of the Federal Home Loan Mortgage Corporation plus two percentage points as published in the Wall Street Journal and in effect 56 days prior to the application deadline. If the applicant's proposal uses this interest rate, the commissioner of human services, in determining the facility's actual property-related payment rate to be established upon completion of the project must use the actual interest rate obtained by the facility for the project's permanent financing up to the maximum permitted under ~~subdivision 6~~ Minnesota Rules, part 9549.0060, subpart 6.

The applicant may choose an alternate interest rate for estimating the project's cost. If the applicant makes this election, the commissioner of human services, in determining the facility's actual property-related payment rate to be established upon completion of the project, must use the lesser of the actual interest rate obtained for the project's permanent financing or the interest rate which was used to estimate the proposal's project cost. For succeeding rate years, the applicant is at risk for financing costs in excess of the interest rate selected.

Senate Language UEH1406-1

(b) The interest rate to be used for estimating the cost of each moratorium exception project proposal shall be the lesser of either the prime rate plus two percentage points, or the posted yield for standard conventional fixed rate mortgages of the Federal Home Loan Mortgage Corporation plus two percentage points as published in the Wall Street Journal and in effect 56 days prior to the application deadline. If the applicant's proposal uses this interest rate, the commissioner of human services, in determining the facility's actual property-related payment rate to be established upon completion of the project must use the actual interest rate obtained by the facility for the project's permanent financing up to the maximum permitted under ~~subdivision 6~~ Minnesota Rules, part 9549.0060, subpart 6.

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