

1.21 ARTICLE 1

1.22 TELEPHONE EQUIPMENT PROGRAM

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

1.24 **237.50 DEFINITIONS.**

1.25 Subdivision 1. **Scope.** The terms used in sections 237.50 to 237.56 have the

1.26 meanings given them in this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 3.28 the offering of telecommunications for fee directly to the public, or to such classes of users
 3.29 as to be effectively available to the public, regardless of the facilities used.

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

3.31 **237.51 TELECOMMUNICATIONS ACCESS MINNESOTA PROGRAM**

3.32 **ADMINISTRATION.**

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

4.1 (1) administer through interagency agreement with the commissioner of human

4.2 services a program to distribute ~~communication~~ telecommunications devices to eligible

4.3 ~~communication-impaired~~ persons who have communication disabilities; and

4.4 (2) contract with a one or more qualified vendor vendors that serves

4.5 ~~communication-impaired~~ serve persons who have communication disabilities to create

4.6 ~~and maintain a telecommunication~~ provide telecommunications relay service services.

4.7 For purposes of sections 237.51 to 237.56, the Department of Commerce and any

4.8 organization with which it contracts pursuant to this section or section 237.54, subdivision

4.9 2, are not telephone companies or telecommunications carriers as defined in section

4.10 237.01.

4.11 Subd. 5. **Commissioner of commerce duties.** In addition to any duties specified

4.12 elsewhere in sections 237.51 to 237.56, the commissioner of commerce shall:

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

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

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

4.16 to 237.56.

4.17 Subd. 5a. **Department Commissioner of human services duties.** (a) In addition to

4.18 any duties specified elsewhere in sections 237.51 to 237.56, the commissioner of human

4.19 services shall:

4.20 (1) define economic hardship, special needs, and household criteria so as to

4.21 determine the priority of eligible applicants for initial distribution of devices and to

4.22 determine circumstances necessitating provision of more than one ~~communication~~

4.23 telecommunications device per household;

4.24 (2) establish a method to verify eligibility requirements;

4.25 (3) establish specifications for ~~communication~~ telecommunications devices to be

4.26 purchased provided under section 237.53, subdivision 3; ~~and~~

4.27 (4) inform the public and specifically ~~the community of communication-impaired~~

4.28 persons who have communication disabilities of the program; ~~and~~

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

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

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4.26 purchased provided under section 237.53, subdivision 3; ~~and~~

4.27 (4) inform the public and specifically ~~the community of communication-impaired~~

4.28 persons who have communication disabilities of the program; ~~and~~

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

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

4.34 (1) at least one member who is deaf;

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

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

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

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

5.7 Sec. 3. Minnesota Statutes 2010, section 237.52, is amended to read:
 5.8 **237.52 TELECOMMUNICATIONS ACCESS MINNESOTA FUND.**

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

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

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

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 5.2 makes it difficult or impossible for the person to access telecommunications services; and

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

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

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

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

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

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

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

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

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

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

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

6.33 **237.53 COMMUNICATION TELECOMMUNICATIONS DEVICE.**

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

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 6.4 commerce to implement sections 237.51 to 237.56, to the commissioner of employment
 6.5 and economic development to implement section 248.062, and to the commissioner of
 6.6 human services to implement section 256C.30.

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 6.10 expenses not to exceed ten percent of total program expenditures;

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 6.12 provided pursuant to section 237.53;

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

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

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 6.29 payment may be used only for working capital reserve for the operation of the service.
 6.30 The advance payment must be offset or repaid by the end of the contract fiscal year
 6.31 together with interest accrued from the date of payment.

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

6.33 **237.53 COMMUNICATION TELECOMMUNICATIONS DEVICE.**

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

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

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

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

7.8 (3) be a resident of the state;

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

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

7.18 Subd. 3. **Distribution.** The commissioner of human services shall purchase and
7.19 distribute a sufficient number of ~~communication~~ telecommunications devices so that each
7.20 eligible household receives ~~an appropriate device~~ devices as determined under section
7.21 237.51, subdivision 5a. The commissioner of human services shall distribute the devices
7.22 to eligible households ~~in each service area free of charge as determined under section~~
7.23 ~~237.51, subdivision 5a.~~

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

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

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

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7.8 (3) be a resident of the state;

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

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

7.18 Subd. 3. **Distribution.** The commissioner of human services shall purchase and
7.19 distribute a sufficient number of ~~communication~~ telecommunications devices so that each
7.20 eligible household receives ~~an appropriate device~~ devices as determined under section
7.21 237.51, subdivision 5a. The commissioner of human services shall distribute the devices
7.22 to eligible households ~~in each service area free of charge as determined under section~~
7.23 ~~237.51, subdivision 5a.~~

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

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

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

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

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

8.11 **237.54 TELECOMMUNICATION TELECOMMUNICATIONS RELAY**

8.12 **SERVICE SERVICES (TRS).**

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

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

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

8.27 **237.55 ANNUAL REPORT ON COMMUNICATION**

8.28 **TELECOMMUNICATIONS ACCESS.**

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

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

9.4 **237.56 ADEQUATE SERVICE ENFORCEMENT.**

8.1 Subd. 7. **Standards.** The ~~communication~~ telecommunications devices distributed
 8.2 under this section must comply with the electronic industries ~~association~~ alliance standards
 8.3 and be approved by the Federal Communications Commission. The commissioner of
 8.4 human services must provide each eligible person a choice of several models of devices,
 8.5 the retail value of which may not exceed \$600 for a ~~communication device for the deaf~~
 8.6 text telephone, and a retail value of \$7,000 for a ~~telebraille~~ Braille device, or an amount
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 8.20 ~~and the public of the availability and use of the system. Except in the case of a speech-~~
 8.21 ~~or mobility-impaired person, the operator shall not relay a message unless it originates~~
 8.22 ~~or terminates through a communication device for the deaf or a Braille device for use~~
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 8.34 communication disabilities, describe services provided, account for ~~money received and~~
 9.1 ~~disbursed annually~~ annual revenues and expenditures for each aspect of the ~~program fund~~
 9.2 to date, and include predicted program future operation.

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

9.4 **237.56 ADEQUATE SERVICE ENFORCEMENT.**

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

9.11 **ARTICLE 2**

9.12 **DISABILITY SERVICES**

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

9.15 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an
 9.16 initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to
 9.17 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to
 9.18 9555.6265, under this chapter for a physical location that will not be the primary residence
 9.19 of the license holder for the entire period of licensure. If a license is issued during this
 9.20 moratorium, and the license holder changes the license holder's primary residence away
 9.21 from the physical location of the foster care license, the commissioner shall revoke the
 9.22 license according to section 245A.07. Exceptions to the moratorium include:

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

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

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

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

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

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

9.5 The services required to be provided under sections 237.50 to 237.55 may be
 9.6 enforced under section 237.081 upon a complaint of at least two ~~communication-impaired~~
 9.7 persons within the service area of any one ~~telephone company~~ telecommunications
 9.8 service provider, provided that if only one person within the service area of a company
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 10.4 operate, and the recommendation of the local county board. The determination by the
 10.5 commissioner must be final. A determination of need is not required for a change in
 10.6 ownership at the same address.

~~10.7 (e) Residential settings that would otherwise be subject to the moratorium established
10.8 in paragraph (a), that are in the process of receiving an adult or child foster care license as
10.9 of July 1, 2009, shall be allowed to continue to complete the process of receiving an adult
10.10 or child foster care license. For this paragraph, all of the following conditions must be met
10.11 to be considered in the process of receiving an adult or child foster care license:~~

~~10.12 (1) participants have made decisions to move into the residential setting, including
10.13 documentation in each participant's care plan;~~

~~10.14 (2) the provider has purchased housing or has made a financial investment in the
10.15 property;~~

~~10.16 (3) the lead agency has approved the plans, including costs for the residential setting
10.17 for each individual;~~

~~10.18 (4) the completion of the licensing process, including all necessary inspections, is
10.19 the only remaining component prior to being able to provide services; and~~

~~10.20 (5) the needs of the individuals cannot be met within the existing capacity in that
10.21 county.~~

~~10.22 To qualify for the process under this paragraph, the lead agency must submit
10.23 documentation to the commissioner by August 1, 2009, that all of the above criteria are
10.24 met.~~

~~10.25 (d)(c) The commissioner shall study the effects of the license moratorium under this
10.26 subdivision and shall report back to the legislature by January 15, 2011. This study shall
10.27 include, but is not limited to the following:~~

~~10.28 (1) the overall capacity and utilization of foster care beds where the physical location
10.29 is not the primary residence of the license holder prior to and after implementation
10.30 of the moratorium;~~

~~10.31 (2) the overall capacity and utilization of foster care beds where the physical
10.32 location is the primary residence of the license holder prior to and after implementation
10.33 of the moratorium; and~~

~~10.34 (3) the number of licensed and occupied ICF/MR beds prior to and after
10.35 implementation of the moratorium.~~

~~11.1 (d) At the time of application and reapplication for licensure, the applicant and the
11.2 license holder that are subject to the moratorium or an exclusion established in paragraph
11.3 (a) are required to inform the commissioner whether the physical location where the foster
11.4 care will be provided is or will be the primary residence of the license holder for the entire
11.5 period of licensure. If the primary residence of the applicant or license holder changes, the
11.6 applicant or license holder must notify the commissioner immediately. The commissioner
11.7 shall print on the foster care license certificate whether or not the physical location is the
11.8 primary residence of the license holder.~~

~~10.7 (e) Residential settings that would otherwise be subject to the moratorium established
10.8 in paragraph (a), that are in the process of receiving an adult or child foster care license as
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10.11 to be considered in the process of receiving an adult or child foster care license:~~

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10.13 documentation in each participant's care plan;~~

~~10.14 (2) the provider has purchased housing or has made a financial investment in the
10.15 property;~~

~~10.16 (3) the lead agency has approved the plans, including costs for the residential setting
10.17 for each individual;~~

~~10.18 (4) the completion of the licensing process, including all necessary inspections, is
10.19 the only remaining component prior to being able to provide services; and~~

~~10.20 (5) the needs of the individuals cannot be met within the existing capacity in that
10.21 county.~~

~~10.22 To qualify for the process under this paragraph, the lead agency must submit
10.23 documentation to the commissioner by August 1, 2009, that all of the above criteria are
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10.29 is not the primary residence of the license holder prior to and after implementation
10.30 of the moratorium;~~

~~10.31 (2) the overall capacity and utilization of foster care beds where the physical
10.32 location is the primary residence of the license holder prior to and after implementation
10.33 of the moratorium; and~~

~~10.34 (3) the number of licensed and occupied ICF/MR beds prior to and after
10.35 implementation of the moratorium.~~

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11.2 license holder that are subject to the moratorium or an exclusion established in paragraph
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11.4 care will be provided is or will be the primary residence of the license holder for the entire
11.5 period of licensure. If the primary residence of the applicant or license holder changes, the
11.6 applicant or license holder must notify the commissioner immediately. The commissioner
11.7 shall print on the foster care license certificate whether or not the physical location is the
11.8 primary residence of the license holder.~~

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

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

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

11.24 (b) Providers licensed under chapter 245B, and providing, contracting, or arranging
 11.25 for services in settings licensed as adult foster care under Minnesota Rules, parts
 11.26 9555.5105 to 9555.6265, or child foster care under Minnesota Rules, parts 2960.3000 to
 11.27 2960.3340; and meeting the provisions of section 256B.092, subdivision 11, paragraph
 11.28 (b), must be required to obtain a community residential setting license.

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

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

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

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

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

12.3 (b) Providers licensed under chapter 245B, and providing, contracting, or arranging
 12.4 for services in settings licensed as adult foster care under Minnesota Rules, parts
 12.5 9555.5105 to 9555.6265, or child foster care under Minnesota Rules, parts 2960.3000 to
 12.6 2960.3340; and meeting the provisions of section 256B.092, subdivision 11, paragraph
 12.7 (b), must be required to obtain a community residential setting license.

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

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

12.17 (b) A family adult day services license shall only be issued when the services are
 12.18 provided in the license holder's primary residence, and the license holder is the primary
 12.19 provider of care. The license holder may not serve more than eight adults at one time,
 12.20 including residents, if any, served under a license issued under Minnesota Rules, parts
 12.21 9555.5105 to 9555.6265.

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

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

12.29 ~~(e) Adult foster care license holders providing family adult day services under their~~
 12.30 ~~foster care license on March 30, 2004, shall be permitted to continue providing these~~
 12.31 ~~services with no additional requirements until their adult foster care license is due for~~
 12.32 ~~renewal. At the time of relicensure, an adult foster care license holder may continue to~~
 12.33 ~~provide family adult day services upon demonstration of compliance with this section.~~
 12.34 ~~Adult foster care license holders who provide only family adult day services on August 1,~~
 12.35 ~~2004, may apply for a license under this section instead of an adult foster care license.~~

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

11.30 Subd. 1a. **Support grants.** (a) Provision of support grants must be limited to
 11.31 families who require support and whose dependents are under the age of 21 and who
 11.32 have been certified disabled under section 256B.055, subdivision 12, paragraphs (a),
 11.33 (b), (c), (d), and (e). Families who are receiving: home and community-based waived
 11.34 services for persons with ~~developmental~~ disabilities authorized under section 256B.092 or
 12.1 256B.49; personal care assistance under section 256B.0652; or a consumer support grant
 12.2 under section 256.476 are not eligible for support grants.

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

13.2 Subd. 1a. **Support grants.** (a) Provision of support grants must be limited to
 13.3 families who require support and whose dependents are under the age of 21 and who
 13.4 have been certified disabled under section 256B.055, subdivision 12, paragraphs (a),
 13.5 (b), (c), (d), and (e). Families who are receiving: home and community-based waived
 13.6 services for persons with ~~developmental~~ disabilities authorized under section 256B.092 or
 13.7 256B.49; personal care assistance under section 256B.0652; or a consumer support grant
 13.8 under section 256.476 are not eligible for support grants.

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

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

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

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

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

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

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

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

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

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

12.26 Subd. 2. **Rules.** The commissioner shall adopt rules to implement this chapter.

12.27 The rules must include standards for performance of guardianship or conservatorship
 12.28 duties including, but not limited to: twice a year visits with the ward; ~~quarterly reviews~~
 12.29 ~~of records from day, residential, and support services~~; a requirement that the duties of
 12.30 guardianship or conservatorship and case management not be performed by the same
 12.31 person; specific standards for action on "do not resuscitate" orders, sterilization requests,
 12.32 and the use of psychotropic medication and aversive procedures.

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

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

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 13.26 administered by the commissioner is supporting the overarching goals and priorities:

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

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

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

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

13.32 Subd. 2. **Rules.** The commissioner shall adopt rules to implement this chapter.

13.33 The rules must include standards for performance of guardianship or conservatorship
 13.34 duties including, but not limited to: twice a year visits with the ward; ~~quarterly reviews~~
 14.1 ~~of records from day, residential, and support services~~; a requirement that the duties of
 14.2 guardianship or conservatorship and case management not be performed by the same
 14.3 person; specific standards for action on "do not resuscitate" orders, sterilization requests,
 14.4 and the use of psychotropic medication and aversive procedures.

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

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

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

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

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

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

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

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

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

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

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

13.27 "Qualified professional" means a mental health professional as defined in section
 13.28 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6);
 13.29 or a registered nurse as defined in sections 148.171 to 148.285, a licensed social worker
 13.30 as defined in sections 148D.010 and 148D.055, or a qualified developmental disabilities
 13.31 specialist under section 245B.07, subdivision 4. The qualified professional shall perform
 13.32 the duties required in section 256B.0659.

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

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

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

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

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

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

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

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

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

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

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

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

14.32 "Qualified professional" means a mental health professional as defined in section
 14.33 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6);
 14.34 or a registered nurse as defined in sections 148.171 to 148.285, a licensed social worker
 15.1 as defined in sections 148D.010 and 148D.055, or a qualified developmental disabilities
 15.2 specialist under section 245B.07, subdivision 4. The qualified professional shall perform
 15.3 the duties required in section 256B.0659.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15.27 (1) by the recipient's spouse, parent of a recipient under the age of 18, paid legal
15.28 guardian, licensed foster provider, except as allowed under section 256B.0652, subdivision
15.29 10, or responsible party;

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

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

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

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

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

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

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

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

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

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

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

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

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

17.1 (1) by the recipient's spouse, parent of a recipient under the age of 18, paid legal
17.2 guardian, licensed foster provider, except as allowed under section 256B.0652, subdivision
17.3 10, or responsible party;

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

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

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

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

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

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

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

16.9 (1) sterile procedures;

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

16.11 (3) home maintenance or chore services;

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

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

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

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

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

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

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

16.27 (c) A responsible party must not be the:

16.28 (1) personal care assistant;

16.29 (2) qualified professional;

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

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

16.33 ~~(3)~~ (5) county staff acting as part of employment.

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

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

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

17.18 (1) sterile procedures;

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

17.20 (3) home maintenance or chore services;

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

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

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

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

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

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

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

18.1 (c) A responsible party must not be the:

18.2 (1) personal care assistant;

18.3 (2) qualified professional;

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

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

18.7 ~~(3)~~ (5) county staff acting as part of employment.

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

17.4 (e) A responsible party is required when:

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

17.6 (2) the person is an incapacitated adult according to section 524.5-102, subdivision
 17.7 6, resulting in a court-appointed guardian; or

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

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

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

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

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

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

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

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

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

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

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

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

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

18.11 (e) A responsible party is required when:

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

18.13 (2) the person is an incapacitated adult according to section 524.5-102, subdivision
 18.14 6, resulting in a court-appointed guardian; or

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

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

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

18.24 Sec. 13. Minnesota Statutes 2010, section 256B.0659, subdivision 11, is amended to
 18.25 read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18.22 (10) be limited to providing and being paid for up to 275 hours per month, ~~except~~
 18.23 ~~that this limit shall be 275 hours per month for the period July 1, 2009, through June 30,~~
 18.24 ~~2011,~~ of personal care assistance services regardless of the number of recipients being
 18.25 served or the number of personal care assistance provider agencies enrolled with. The
 18.26 number of hours worked per day shall not be disallowed by the department unless in
 18.27 violation of the law.

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

18.30 (c) ~~Effective January 1, 2010, Persons who do not qualify as a personal care assistant~~
 18.31 ~~include parents and stepparents, and legal guardians of minors; spouses; paid legal~~
 18.32 ~~guardians of adults; family foster care providers, except as otherwise allowed in section~~
 18.33 ~~256B.0625, subdivision 19a, or; and staff of a residential setting.~~

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

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

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

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

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

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

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

19.29 (10) be limited to providing and being paid for up to 275 hours per month, ~~except~~
 19.30 ~~that this limit shall be 275 hours per month for the period July 1, 2009, through June 30,~~
 19.31 ~~2011,~~ of personal care assistance services regardless of the number of recipients being
 19.32 served or the number of personal care assistance provider agencies enrolled with. The
 19.33 number of hours worked per day shall not be disallowed by the department unless in
 19.34 violation of the law.

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

20.1 (c) ~~Effective January 1, 2010, Persons who do not qualify as a personal care assistant~~
 20.2 ~~include parents, and stepparents, and legal guardians of minors; spouses; paid legal~~
 20.3 ~~guardians of adults; family foster care providers, except as otherwise allowed in section~~
 20.4 ~~256B.0625, subdivision 19a, or; and staff of a residential setting.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21.8 (4) whether the personal care assistance services are meeting the goals of the service

21.9 as stated in the personal care assistance care plan and service plan;

21.10 (5) a written record of the results of the evaluation and actions taken to correct any

21.11 deficiencies in the work of a personal care assistant; and

21.12 (6) revision of the personal care assistance care plan as necessary in consultation

21.13 with the recipient or responsible party, to meet the needs of the recipient.

21.14 (f) The qualified professional shall complete the required documentation in the

21.15 agency recipient and employee files and the recipient's home, including the following

21.16 documentation:

21.17 (1) the personal care assistance care plan based on the service plan and individualized

21.18 needs of the recipient;

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

21.20 (3) changes in need of the recipient requiring a change to the level of service and the

21.21 personal care assistance care plan;

21.22 (4) evaluation results of supervision visits and identified issues with personal care

21.23 assistance staff with actions taken;

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

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

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

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

21.28 include:

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

21.30 nursing tasks;

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

21.32 ~~(3)~~ (2) agency administrative activities;

21.33 ~~(4)~~ (3) training other than the individualized training required to provide care for a

21.34 recipient; and

21.35 ~~(5)~~ (4) any other activity that is not described in this section.

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

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

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

22.15 (4) whether the personal care assistance services are meeting the goals of the service

22.16 as stated in the personal care assistance care plan and service plan;

22.17 (5) a written record of the results of the evaluation and actions taken to correct any

22.18 deficiencies in the work of a personal care assistant; and

22.19 (6) revision of the personal care assistance care plan as necessary in consultation

22.20 with the recipient or responsible party, to meet the needs of the recipient.

22.21 (f) The qualified professional shall complete the required documentation in the

22.22 agency recipient and employee files and the recipient's home, including the following

22.23 documentation:

22.24 (1) the personal care assistance care plan based on the service plan and individualized

22.25 needs of the recipient;

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

22.27 (3) changes in need of the recipient requiring a change to the level of service and the

22.28 personal care assistance care plan;

22.29 (4) evaluation results of supervision visits and identified issues with personal care

22.30 assistance staff with actions taken;

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

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

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

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

22.35 include:

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

23.2 nursing tasks;

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

23.4 ~~(3)~~ (2) agency administrative activities;

23.5 ~~(4)~~ (3) training other than the individualized training required to provide care for a

23.6 recipient; and

23.7 ~~(5)~~ (4) any other activity that is not described in this section.

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

22.3 Subd. 19. **Personal care assistance choice option; qualifications; duties.** (a)

22.4 Under personal care assistance choice, the recipient or responsible party shall:

22.5 (1) recruit, hire, schedule, and terminate personal care assistants according to the

22.6 terms of the written agreement required under subdivision 20, paragraph (a);

22.7 (2) develop a personal care assistance care plan based on the assessed needs

22.8 and addressing the health and safety of the recipient with the assistance of a qualified

22.9 professional as needed;

22.10 (3) orient and train the personal care assistant with assistance as needed from the

22.11 qualified professional;

22.12 (4) effective January 1, 2010, supervise and evaluate the personal care assistant with

22.13 the qualified professional, who is required to visit the recipient at least every 180 days;

22.14 (5) monitor and verify in writing and report to the personal care assistance choice

22.15 agency the number of hours worked by the personal care assistant and the qualified

22.16 professional;

22.17 (6) engage in an annual face-to-face reassessment to determine continuing eligibility

22.18 and service authorization; and

22.19 (7) use the same personal care assistance choice provider agency if shared personal

22.20 assistance care is being used.

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

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

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

22.24 care assistants;

22.25 (3) not be related as a parent, child, sibling, or spouse to the recipient, ~~qualified~~

22.26 ~~professional~~, or the personal care assistant; and

22.27 (4) ensure arm's-length transactions without undue influence or coercion with the

22.28 recipient and personal care assistant.

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

22.30 (1) be the employer of the personal care assistant and the qualified professional for

22.31 employment law and related regulations including, but not limited to, purchasing and

22.32 maintaining workers' compensation, unemployment insurance, surety and fidelity bonds,

22.33 and liability insurance, and submit any or all necessary documentation including, but not

22.34 limited to, workers' compensation and unemployment insurance;

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

23.10 Subd. 19. **Personal care assistance choice option; qualifications; duties.** (a)

23.11 Under personal care assistance choice, the recipient or responsible party shall:

23.12 (1) recruit, hire, schedule, and terminate personal care assistants according to the

23.13 terms of the written agreement required under subdivision 20, paragraph (a);

23.14 (2) develop a personal care assistance care plan based on the assessed needs

23.15 and addressing the health and safety of the recipient with the assistance of a qualified

23.16 professional as needed;

23.17 (3) orient and train the personal care assistant with assistance as needed from the

23.18 qualified professional;

23.19 (4) effective January 1, 2010, supervise and evaluate the personal care assistant with

23.20 the qualified professional, who is required to visit the recipient at least every 180 days;

23.21 (5) monitor and verify in writing and report to the personal care assistance choice

23.22 agency the number of hours worked by the personal care assistant and the qualified

23.23 professional;

23.24 (6) engage in an annual face-to-face reassessment to determine continuing eligibility

23.25 and service authorization; and

23.26 (7) use the same personal care assistance choice provider agency if shared personal

23.27 assistance care is being used.

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

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

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

23.31 care assistants;

23.32 (3) not be related as a parent, child, sibling, or spouse to the recipient, ~~qualified~~

23.33 ~~professional~~, or the personal care assistant; and

23.34 (4) ensure arm's-length transactions without undue influence or coercion with the

23.35 recipient and personal care assistant.

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

24.2 (1) be the employer of the personal care assistant and the qualified professional for

24.3 employment law and related regulations including, but not limited to, purchasing and

24.4 maintaining workers' compensation, unemployment insurance, surety and fidelity bonds,

24.5 and liability insurance, and submit any or all necessary documentation including, but not

24.6 limited to, workers' compensation and unemployment insurance;

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

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

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

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

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

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

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

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

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

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

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

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

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

23.26 (4) proof of workers' compensation insurance coverage;

23.27 (5) proof of liability insurance;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24.34 (4) proof of workers' compensation insurance coverage;

24.35 (5) proof of liability insurance;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24.35 (c) All personal care assistance provider agencies shall require all employees in
 24.36 management and supervisory positions and owners of the agency who are active in the
 25.1 day-to-day management and operations of the agency to complete mandatory training
 25.2 as determined by the commissioner before enrollment of the agency as a provider.
 25.3 Employees in management and supervisory positions and owners who are active in
 25.4 the day-to-day operations of an agency who have completed the required training as
 25.5 an employee with a personal care assistance provider agency do not need to repeat
 25.6 the required training if they are hired by another agency, if they have completed the
 25.7 training within the past three years. By September 1, 2010, the required training must be
 25.8 available ~~in languages other than English and to those who need accommodations due~~
 25.9 ~~to disabilities, with meaningful access according to title VI of the Civil Rights Act and~~
 25.10 ~~federal regulations adopted under that law or any guidance from the United States Health~~
 25.11 ~~and Human Services Department. The required training must be available online, or by~~
 25.12 ~~electronic remote connection, and. The required training must provide for competency~~
 25.13 testing. Personal care assistance provider agency billing staff shall complete training about
 25.14 personal care assistance program financial management. This training is effective July 1,
 25.15 2009. Any personal care assistance provider agency enrolled before that date shall, if it
 25.16 has not already, complete the provider training within 18 months of July 1, 2009. Any new
 25.17 owners or employees in management and supervisory positions involved in the day-to-day
 25.18 operations are required to complete mandatory training as a requisite of working for the
 25.19 agency. Personal care assistance provider agencies certified for participation in Medicare
 25.20 as home health agencies are exempt from the training required in this subdivision. When
 25.21 available, Medicare-certified home health agency owners, supervisors, or managers must
 25.22 successfully complete the competency test.

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

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

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

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

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

26.8 (c) All personal care assistance provider agencies shall require all employees in
 26.9 management and supervisory positions and owners of the agency who are active in the
 26.10 day-to-day management and operations of the agency to complete mandatory training
 26.11 as determined by the commissioner before enrollment of the agency as a provider.
 26.12 Employees in management and supervisory positions and owners who are active in
 26.13 the day-to-day operations of an agency who have completed the required training as
 26.14 an employee with a personal care assistance provider agency do not need to repeat
 26.15 the required training if they are hired by another agency, if they have completed the
 26.16 training within the past three years. By September 1, 2010, the required training must be
 26.17 available ~~in languages other than English and to those who need accommodations due~~
 26.18 ~~to disabilities, with meaningful access according to title VI of the Civil Rights Act and~~
 26.19 ~~federal regulations adopted under that law or any guidance from the United States Health~~
 26.20 ~~and Human Services Department. The required training must be available online, or by~~
 26.21 ~~electronic remote connection, and. The required training must provide for competency~~
 26.22 testing. Personal care assistance provider agency billing staff shall complete training about
 26.23 personal care assistance program financial management. This training is effective July 1,
 26.24 2009. Any personal care assistance provider agency enrolled before that date shall, if it
 26.25 has not already, complete the provider training within 18 months of July 1, 2009. Any new
 26.26 owners or employees in management and supervisory positions involved in the day-to-day
 26.27 operations are required to complete mandatory training as a requisite of working for the
 26.28 agency. Personal care assistance provider agencies certified for participation in Medicare
 26.29 as home health agencies are exempt from the training required in this subdivision. When
 26.30 available, Medicare-certified home health agency owners, supervisors, or managers must
 26.31 successfully complete the competency test.

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

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

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

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

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

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

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

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

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

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

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

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

26.18 (5) the services needed;

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

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

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

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

26.27 (b) This subdivision expires January 1, 2012.

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

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

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

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

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

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

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

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

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

27.27 (5) the services needed;

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

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

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

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

28.1 (b) This subdivision expires January 1, 2012.

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

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

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

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

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

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

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

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

27.12 (c) Providers of residential support services that meet the definition in paragraph
 27.13 (a) must be registered using a process determined by the commissioner beginning July
 27.14 1, 2009. Providers licensed to provide child foster care under Minnesota Rules, parts
 27.15 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts
 27.16 9555.5105 to 9555.6265, and that meet the requirements in section 245A.03, subdivision
 27.17 7, paragraph (e), are considered registered under this section.

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

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

27.30 (b) This subdivision expires January 1, 2012.

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

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

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

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

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

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

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

28.20 (c) Providers of residential support services that meet the definition in paragraph
 28.21 (a) must be registered using a process determined by the commissioner beginning July
 28.22 1, 2009. Providers licensed to provide child foster care under Minnesota Rules, parts
 28.23 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts
 28.24 9555.5105 to 9555.6265, and that meet the requirements in section 245A.03, subdivision
 28.25 7, paragraph (e), are considered registered under this section.

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

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

29.4 (b) This subdivision expires January 1, 2012.

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

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

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

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

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

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

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

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

29.27 (2) risk assessment and planning;

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

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

29.31 (5) complaint and grievance procedures;

29.32 (6) service termination or suspension;

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

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

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

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

30.4 (iv) when applicable:

30.5 (A) safe medication administration;

30.6 (B) proper handling of consumer funds; and

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

30.12 (e) The commissioner shall seek federal approval for Medicaid reimbursement
 30.13 of foster care services under the home and community-based waiver for persons with
 30.14 a traumatic brain injury, the community alternatives for disabled individuals waiver,
 30.15 and community alternative care waiver when the provider demonstrates evidence of
 30.16 its capacity to meet basic health, safety, and protection standards. The commissioner
 30.17 shall verify that the adult foster care provider is licensed under Minnesota Rules, parts
 30.18 9555.5105 to 9555.6265; that the child foster care provider is licensed as a family foster
 30.19 care or a foster care residence under Minnesota Rules, parts 2960.3000 to 2960.3340, and
 30.20 certify that the provider has policies and procedures that govern:

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

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

30.25 (3) safe medication management and administration.

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

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

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

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

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

28.3 (1) receiving those services;

28.4 (2) screened and waiting for waiver services; and

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

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

31.5 (1) receiving those services;

31.6 (2) screened and waiting for waiver services; and

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

28.6 (b) This subdivision expires January 1, 2012.

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

28.8 **256B.4912 HOME AND COMMUNITY-BASED WAIVERS; PROVIDERS**
28.9 **AND PAYMENT.**

28.10 Subdivision 1. **Provider qualifications.** For the home and community-based

28.11 waivers providing services to seniors and individuals with disabilities, the commissioner

28.12 shall establish:

28.13 (1) agreements with enrolled waiver service providers to ensure providers meet

28.14 ~~qualifications defined in the waiver plans~~ Minnesota health care program requirements;

28.15 (2) regular reviews of provider qualifications, ~~and including requests of proof of~~

28.16 ~~documentation;~~ and

28.17 (3) processes to gather the necessary information to determine provider

28.18 qualifications.

28.19 ~~By July 2010, Beginning July 2011, staff that provide direct contact, as defined~~

28.20 ~~in section 245C.02, subdivision 11, that are employees of waiver service providers for~~

28.21 ~~services specified in the federally approved waiver plans~~ must meet the requirements

28.22 of chapter 245C prior to providing waiver services and as part of ongoing enrollment.

28.23 Beginning July 2012, service owners and managerial officials overseeing the management

28.24 or policies of services that provide direct contact as specified in the federally approved

28.25 waiver plans must meet the requirements of chapter 245C prior to reenrollment or, for new

28.26 providers, prior to initial enrollment. Upon federal approval, this requirement must also

28.27 apply to consumer-directed community supports.

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

28.29 apply.

28.30 (a) "Home and community-based service providers" means approved vendors who

28.31 provide community services and long-term supports under medical assistance programs

28.32 that include waiver programs as defined in sections 256B.092, 256B.0915, and 256B.49,

28.33 and state plan home care services as defined in section 256B.0651.

29.1 (b) "Home and community-based service administrators" means counties and tribes

29.2 that, individually or collaboratively, administer home and community-based waiver

29.3 services delivery in a consistent manner under a state agency directive.

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

31.8 (b) This subdivision expires January 1, 2012.

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

31.10 **256B.4912 HOME AND COMMUNITY-BASED WAIVERS; PROVIDERS**
31.11 **AND PAYMENT.**

31.12 Subdivision 1. **Provider qualifications.** For the home and community-based

31.13 waivers providing services to seniors and individuals with disabilities, the commissioner

31.14 shall establish:

31.15 (1) agreements with enrolled waiver service providers to ensure providers meet

31.16 ~~qualifications defined in the waiver plans~~ Minnesota health care program requirements;

31.17 (2) regular reviews of provider qualifications, ~~and including requests of proof of~~

31.18 ~~documentation;~~ and

31.19 (3) processes to gather the necessary information to determine provider

31.20 qualifications.

31.21 ~~By July 2010, Beginning July 2011, staff that provide direct contact, as defined~~

31.22 ~~in section 245C.02, subdivision 11, that are employees of waiver service providers for~~

31.23 ~~services specified in the federally approved waiver plans~~ must meet the requirements

31.24 of chapter 245C prior to providing waiver services and as part of ongoing enrollment.

31.25 Beginning July 2012, service owners and managerial officials overseeing the management

31.26 or policies of services that provide direct contact as specified in the federally approved

31.27 waiver plans must meet the requirements of chapter 245C prior to reenrollment or, for new

31.28 providers, prior to initial enrollment. Upon federal approval, this requirement must also

31.29 apply to consumer-directed community supports.

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

31.31 apply.

31.32 (a) "Home and community-based service providers" means approved vendors who

31.33 provide community services and long-term supports under medical assistance programs

31.34 that include waiver programs as defined in sections 245B.092, 256B.0915, and 256B.49,

31.35 and state plan home care services as defined in section 256B.0651.

32.1 (b) "Home and community-based service administrators" means counties and tribes

32.2 that, individually or collaboratively, administer home and community-based waiver

32.3 services delivery in a consistent manner under a state agency directive.

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

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

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

29.14 (c) The commissioner must not reimburse:

29.15 (1) unauthorized service delivery;

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

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

29.18 (4) extended employment services under Minnesota Rules, parts 3300.2005 to
 29.19 3300.3100, or vocational rehabilitation services provided under the federal Rehabilitation
 29.20 Act, as amended, Title I, section 110, or Title VI-C, and not through use of medical
 29.21 assistance or county social service funds; or

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

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

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

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

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

~~32.4 Subd. 2. **Rate-setting methodologies.** The commissioner shall establish~~
~~32.5 statewide rate-setting methodologies that meet federal waiver requirements for home~~
~~32.6 and community-based waiver services for individuals with disabilities. The rate-setting~~
~~32.7 methodologies must abide by the principles of transparency and equitability across the~~
~~32.8 state. The methodologies must involve a uniform process of structuring rates for each~~
~~32.9 service and must promote quality and participant choice.~~

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

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

32.14 (c) The commissioner must not reimburse:

32.15 (1) unauthorized service delivery;

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

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

32.18 (4) extended employment services under Minnesota Rules, parts 3300.2005 to
 32.19 3300.3100, or vocational rehabilitation services provided under the federal Rehabilitation
 32.20 Act, as amended, Title I, section 110, or Title VI-C, and not through use of medical
 32.21 assistance or county social service funds; or

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

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

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

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

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

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

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

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

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

30.23 **ARTICLE 3**

30.24 **COMPREHENSIVE ASSESSMENT AND CASE MANAGEMENT REFORM**

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

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

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

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

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

31.2 (2) there is objective evidence that, without intervention, it would have occurred

31.3 30 days prior to the assessment. Objective evidence includes logs of intervention kept

31.4 by the family or provider.

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

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

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

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

33.23 **ARTICLE 3**

33.24 **COMPREHENSIVE ASSESSMENT AND CASE MANAGEMENT REFORM**

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

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

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

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

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

34.2 (2) there is objective evidence that, without intervention, it would have occurred

34.3 30 days prior to the assessment. Objective evidence includes logs of intervention kept

34.4 by the family or provider.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

32.23 (1) activities of daily living;

32.24 (2) health-related procedures and tasks;

32.25 (3) observation and redirection of behaviors; and

32.26 (4) instrumental activities of daily living.

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

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

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

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

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

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

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

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

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

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

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

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

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 35.21 care assistance services eligible for payment include services and supports furnished
 35.22 to an individual, as needed, to assist in:

35.23 (1) activities of daily living;

35.24 (2) health-related procedures and tasks;

35.25 (3) observation and redirection of behaviors; and

35.26 (4) instrumental activities of daily living.

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

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

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

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

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

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

33.3 (6) mobility, including assistance with ambulation, including use of a wheelchair.
 33.4 Mobility does not include providing transportation for a recipient;
 33.5 (7) positioning, including assistance with positioning or turning a recipient for
 33.6 necessary care and comfort; and
 33.7 (8) toileting, including assistance with helping recipient with bowel or bladder
 33.8 elimination and care including transfers, mobility, positioning, feminine hygiene, use of
 33.9 toileting equipment or supplies, cleansing the perineal area, inspection of the skin, and
 33.10 adjusting clothing.
 33.11 (c) Health-related procedures and tasks include the following covered services:
 33.12 (1) range of motion and passive exercise to maintain a recipient's strength and
 33.13 muscle functioning;
 33.14 (2) assistance with self-administered medication as defined by this section, ~~including~~
 33.15 The personal care assistant must not determine the medication dose or time for the
 33.16 medication. Assistance with medications includes reminders to take medication, bringing
 33.17 medication to the recipient, and assistance with opening medication under the direction of
 33.18 the recipient or responsible party, including medications given through a nebulizer;
 33.19 (3) interventions for seizure disorders, including monitoring and observation; and
 33.20 (4) other activities considered within the scope of the personal care service and
 33.21 meeting the definition of health-related procedures and tasks under this section.
 33.22 (d) A personal care assistant may provide health-related procedures and tasks
 33.23 associated with the complex health-related needs of a recipient if the procedures and
 33.24 tasks meet the definition of health-related procedures and tasks under this section and the
 33.25 personal care assistant is trained by a qualified professional and demonstrates competency
 33.26 to safely complete the procedures and tasks. Delegation of health-related procedures and
 33.27 tasks and all training must be documented in the personal care assistance care plan and the
 33.28 recipient's and personal care assistant's files.
 33.29 (e) Effective January 1, 2010, for a personal care assistant to provide the
 33.30 health-related procedures and tasks of tracheostomy suctioning and services to recipients
 33.31 on ventilator support there must be:
 33.32 (1) delegation and training by a registered nurse, certified or licensed respiratory
 33.33 therapist, or a physician;
 33.34 (2) utilization of clean rather than sterile procedure;
 33.35 (3) specialized training about the health-related procedures and tasks and equipment,
 33.36 including ventilator operation and maintenance;
 34.1 (4) individualized training regarding the needs of the recipient; and

36.3 (6) mobility, including assistance with ambulation, including use of a wheelchair.
 36.4 Mobility does not include providing transportation for a recipient;
 36.5 (7) positioning, including assistance with positioning or turning a recipient for
 36.6 necessary care and comfort; and
 36.7 (8) toileting, including assistance with helping recipient with bowel or bladder
 36.8 elimination and care including transfers, mobility, positioning, feminine hygiene, use of
 36.9 toileting equipment or supplies, cleansing the perineal area, inspection of the skin, and
 36.10 adjusting clothing.
 36.11 (c) Health-related procedures and tasks include the following covered services:
 36.12 (1) range of motion and passive exercise to maintain a recipient's strength and
 36.13 muscle functioning;
 36.14 (2) assistance with self-administered medication as defined by this section, ~~including~~
 36.15 The personal care assistant must not determine the medication dose or time for the
 36.16 medication. Assistance with medications includes reminders to take medication, bringing
 36.17 medication to the recipient, and assistance with opening medication under the direction of
 36.18 the recipient or responsible party, including medications given through a nebulizer;
 36.19 (3) interventions for seizure disorders, including monitoring and observation; and
 36.20 (4) other activities considered within the scope of the personal care service and
 36.21 meeting the definition of health-related procedures and tasks under this section.
 36.22 (d) A personal care assistant may provide health-related procedures and tasks
 36.23 associated with the complex health-related needs of a recipient if the procedures and
 36.24 tasks meet the definition of health-related procedures and tasks under this section and the
 36.25 personal care assistant is trained by a qualified professional and demonstrates competency
 36.26 to safely complete the procedures and tasks. Delegation of health-related procedures and
 36.27 tasks and all training must be documented in the personal care assistance care plan and the
 36.28 recipient's and personal care assistant's files.
 36.29 (e) Effective January 1, 2010, for a personal care assistant to provide the
 36.30 health-related procedures and tasks of tracheostomy suctioning and services to recipients
 36.31 on ventilator support there must be:
 36.32 (1) delegation and training by a registered nurse, certified or licensed respiratory
 36.33 therapist, or a physician;
 36.34 (2) utilization of clean rather than sterile procedure;
 36.35 (3) specialized training about the health-related procedures and tasks and equipment,
 36.36 including ventilator operation and maintenance;
 37.1 (4) individualized training regarding the needs of the recipient; and

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

34.3 (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

34.4 the personal care assistant must occur based on the needs of the recipient, the personal

34.5 care assistance care plan, and any other support services provided.

34.6 care assistance care plan, and any other support services provided.

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

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

34.9 read:

34.10 Subd. 3a. **Assessment; defined.** This subdivision is effective until notification

34.11 is given by the commissioner as described under section 256B.0911, subdivision 3a.

34.12 "Assessment" means a review and evaluation of a recipient's need for ~~home~~ personal care

34.13 assistance services conducted in person. Assessments for personal care assistance services

34.14 shall be conducted by the county public health nurse or a certified public health nurse under

34.15 contract with the county except when a long-term care consultation is being conducted

34.16 for the purposes of determining a person's eligibility for home and community-based

34.17 waiver services according to section 256B.0911 and the support plan may include personal

34.18 care assistance services. An in-person assessment must include: documentation of

34.19 health status, determination of need, evaluation of service effectiveness, identification of

34.20 appropriate services, service plan development or modification, coordination of services,

34.21 referrals and follow-up to appropriate payers and community resources, completion of

34.22 required reports, recommendation of service authorization, and consumer education.

34.23 Once the need for personal care assistance services is determined under this section or

34.24 sections 256B.0651, 256B.0653, 256B.0654, and 256B.0656, the county public health

34.25 nurse or certified public health nurse under contract with the county is responsible for

34.26 communicating this recommendation to the commissioner and the recipient. An in-person

34.27 assessment must occur at least annually or when there is a significant change in the

34.28 recipient's condition or when there is a change in the need for personal care assistance

34.29 services. A service update may substitute for the annual face-to-face assessment when

34.30 there is not a significant change in recipient condition or a change in the need for

34.31 personal care assistance service. A service update may be completed by telephone, used

34.32 when there is no need for an increase in personal care assistance services, and used

34.33 for two consecutive assessments if followed by a face-to-face assessment. A service

34.34 update must be completed on a form approved by the commissioner. A service update

34.35 or review for temporary increase includes a review of initial baseline data, evaluation of

35.1 service effectiveness, redetermination of service need, modification of service plan and

35.2 appropriate referrals, update of initial forms, obtaining service authorization, and on going

35.3 consumer education. Assessments or reassessments must be completed on forms provided

35.4 by the commissioner within ~~30~~ 20 days of a request for home care services by a recipient

35.5 or responsible party ~~or personal care provider agency.~~

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

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

37.3 (f) Effective January 1, 2010, a personal care assistant may observe and redirect the

37.4 recipient for episodes where there is a need for redirection due to behaviors. Training of

37.5 the personal care assistant must occur based on the needs of the recipient, the personal

37.6 care assistance care plan, and any other support services provided.

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

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

37.9 read:

37.10 Subd. 3a. **Assessment; defined.** This subdivision is effective until notification

37.11 is given by the commissioner as described under section 256B.0911, subdivision 3a.

37.12 "Assessment" means a review and evaluation of a recipient's need for ~~home~~ personal care

37.13 assistance services conducted in person. Assessments for personal care assistance services

37.14 shall be conducted by the county public health nurse or a certified public health nurse under

37.15 contract with the county except when a long-term care consultation is being conducted

37.16 for the purposes of determining a person's eligibility for home and community-based

37.17 waiver services according to section 256B.0911 and the support plan may include personal

37.18 care assistance services. An in-person assessment must include: documentation of

37.19 health status, determination of need, evaluation of service effectiveness, identification of

37.20 appropriate services, service plan development or modification, coordination of services,

37.21 referrals and follow-up to appropriate payers and community resources, completion of

37.22 required reports, recommendation of service authorization, and consumer education.

37.23 Once the need for personal care assistance services is determined under this section or

37.24 sections 256B.0651, 256B.0653, 256B.0654, and 256B.0656, the county public health

37.25 nurse or certified public health nurse under contract with the county is responsible for

37.26 communicating this recommendation to the commissioner and the recipient. An in-person

37.27 assessment must occur at least annually or when there is a significant change in the

37.28 recipient's condition or when there is a change in the need for personal care assistance

37.29 services. A service update may substitute for the annual face-to-face assessment when

37.30 there is not a significant change in recipient condition or a change in the need for

37.31 personal care assistance service. A service update may be completed by telephone, used

37.32 when there is no need for an increase in personal care assistance services, and used

37.33 for two consecutive assessments if followed by a face-to-face assessment. A service

37.34 update must be completed on a form approved by the commissioner. A service update

37.35 or review for temporary increase includes a review of initial baseline data, evaluation of

38.1 service effectiveness, redetermination of service need, modification of service plan and

38.2 appropriate referrals, update of initial forms, obtaining service authorization, and on going

38.3 consumer education. Assessments or reassessments must be completed on forms provided

38.4 by the commissioner within ~~30~~ 20 days of a request for home care services by a recipient

38.5 or responsible party ~~or personal care provider agency.~~

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

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

35.10 (b) The following limitations apply to the assessment:

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

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

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

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

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

35.23 (1) tube feedings requiring:

35.24 (i) a gastrojejunostomy tube; or

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

35.26 (2) wounds described as:

35.27 (i) stage III or stage IV;

35.28 (ii) multiple wounds;

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

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

35.32 (3) parenteral therapy described as:

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

35.35 (ii) total parenteral nutrition (TPN) daily;

36.1 (4) respiratory interventions, including:

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

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

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

38.10 (b) The following limitations apply to the assessment:

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

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

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

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

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

38.23 (1) tube feedings requiring:

38.24 (i) a gastrojejunostomy tube; or

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

38.26 (2) wounds described as:

38.27 (i) stage III or stage IV;

38.28 (ii) multiple wounds;

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

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

38.32 (3) parenteral therapy described as:

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

38.35 (ii) total parenteral nutrition (TPN) daily;

39.1 (4) respiratory interventions, including:

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

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

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

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

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

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

36.9 (5) insertion and maintenance of catheter₂ including:

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

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

36.13 (iii) bladder irrigations;

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

36.16 (7) neurological intervention₂ including:

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

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

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

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

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

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

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

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

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

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

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

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

39.9 (5) insertion and maintenance of catheter₂ including:

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

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

39.13 (iii) bladder irrigations;

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

39.16 (7) neurological intervention₂ including:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 40.11 ~~telephone assistance and follow-up and to offer a variety of cost-effective alternatives~~
 40.12 ~~to persons with disabilities and elderly persons.~~ The county or tribal lead agency or
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 40.23 services that are available to the individual;

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

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

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

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

37.32 (7) determination of home and community-based waiver and other service eligibility
 37.33 as required under sections 256B.0913, 256B.0915, and 256B.49, including level of care
 37.34 determination for individuals who need an institutional level of care as defined under
 37.35 section 144.0724, subdivision 11, or 256B.092, service eligibility including state plan
 38.1 home care services identified in sections 256B.0625, subdivisions 6, 7, and 19, paragraphs
 38.2 (a) and (c), and 256B.0657, based on assessment and community support plan development
 38.3 with appropriate referrals to obtain necessary diagnostic information, and including the
 38.4 option an eligibility determination for consumer-directed community supports;

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

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

38.9 (b) Upon statewide implementation of lead agency requirements in subdivisions 2b,
 38.10 2c, and 3a, "long-term care consultation services" also means:

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

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

38.13 (ii) section 256B.0657; or

38.14 (iii) consumer support grants under section 256.476;

38.15 (2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024,
 38.16 determination of eligibility for case management services available under sections
 38.17 256B.0621, subdivision 2, paragraph (4), and 256B.0924 and Minnesota Rules, part
 38.18 9525.0016, and also includes obtaining necessary diagnostic information; and

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

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

38.25 (9) assistance to transition people back to community settings after facility
 38.26 admission.

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

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

40.32 (7) determination of home and community-based waiver and other service eligibility
 40.33 as required under sections 256B.0913, 256B.0915, and 256B.49, including level of care
 40.34 determination for individuals who need an institutional level of care as defined under
 40.35 section 144.0724, subdivision 11, or 256B.092, service eligibility including state plan
 41.1 home care services identified in sections 256B.0625, subdivisions 6, 7, and 19, paragraphs
 41.2 (a) and (c), and 256B.0657, based on assessment and community support plan development
 41.3 with appropriate referrals to obtain necessary diagnostic information, and including the
 41.4 option an eligibility determination for consumer-directed community supports;

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

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

41.9 (b) Upon statewide implementation of lead agency requirements in subdivisions 2b,
 41.10 2c, and 3a, "long-term care consultation services" also means:

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

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

41.13 (ii) section 256B.0657; or

41.14 (iii) consumer support grants under section 256.476;

41.15 (2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024,
 41.16 determination of eligibility for case management services available under sections
 41.17 256B.0621, subdivision 2, paragraph (4), and 256B.0924 and Minnesota Rules, part
 41.18 9525.0016, and also includes obtaining necessary diagnostic information; and

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

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

41.25 (9) assistance to transition people back to community settings after facility
 41.26 admission.

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

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

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

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

39.3 Subd. 2b. **Certified assessors.** (a) ~~Beginning January 1, 2011, This section is~~
 39.4 ~~effective upon completion of the training and certification process identified in subdivision~~
 39.5 ~~2c.~~ Each lead agency shall use certified assessors who have completed training and the
 39.6 certification processes determined by the commissioner in subdivision 2c. Certified
 39.7 assessors shall demonstrate best practices in assessment and support planning including
 39.8 person-centered planning principals and have a common set of skills that must ensure
 39.9 consistency and equitable access to services statewide. ~~Assessors must be part of a~~
 39.10 ~~multidisciplinary team of professionals that includes public health nurses, social workers,~~
 39.11 ~~and other professionals as defined in paragraph (b). For persons with complex health care~~
 39.12 ~~needs, a public health nurse or registered nurse from a multidisciplinary team must be~~
 39.13 ~~consulted.~~ A lead agency may choose, according to departmental policies, to contract
 39.14 with a qualified, certified assessor to conduct assessments and reassessments on behalf
 39.15 of the lead agency.

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

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

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

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

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

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

42.3 Subd. 2b. **Certified assessors.** (a) ~~Beginning January 1, 2011, This section is~~
 42.4 ~~effective upon completion of the training and certification process identified in subdivision~~
 42.5 ~~2c.~~ Each lead agency shall use certified assessors who have completed training and the
 42.6 certification processes determined by the commissioner in subdivision 2c. Certified
 42.7 assessors shall demonstrate best practices in assessment and support planning including
 42.8 person-centered planning principals and have a common set of skills that must ensure
 42.9 consistency and equitable access to services statewide. ~~Assessors must be part of a~~
 42.10 ~~multidisciplinary team of professionals that includes public health nurses, social workers,~~
 42.11 ~~and other professionals as defined in paragraph (b). For persons with complex health care~~
 42.12 ~~needs, a public health nurse or registered nurse from a multidisciplinary team must be~~
 42.13 ~~consulted.~~ A lead agency may choose, according to departmental policies, to contract
 42.14 with a qualified, certified assessor to conduct assessments and reassessments on behalf
 42.15 of the lead agency.

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

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

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

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

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

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

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

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

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

40.25 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment,
 40.26 services planning, or other assistance intended to support community-based living,
 40.27 including persons who need assessment in order to determine waiver or alternative care
 40.28 program eligibility, must be visited by a long-term care consultation team within ~~45~~ 20
 40.29 calendar days after the date on which an assessment was requested or recommended.
 40.30 ~~After January 1, 2011~~ Upon statewide implementation of subdivisions 2b, 2c, and 5,
 40.31 ~~these requirements~~ this requirement also apply applies to assessment of persons requesting
 40.32 personal care assistance services, and private duty nursing, and home health agency
 40.33 services, on timelines established in subdivision 5. The commissioner shall provide at
 40.34 least a 90-day notice to lead agencies prior to the effective date of this requirement.
 40.35 Face-to-face assessments must be conducted according to paragraphs (b) to (i).

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

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

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

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

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

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 43.24 read:

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 43.26 services planning, or other assistance intended to support community-based living,
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 43.28 program eligibility, must be visited by a long-term care consultation team within ~~45~~ 20
 43.29 calendar days after the date on which an assessment was requested or recommended.
 43.30 ~~After January 1, 2011~~ Upon statewide implementation of subdivisions 2b, 2c, and 5,
 43.31 ~~these requirements~~ this requirement also apply applies to assessment of persons requesting
 43.32 personal care assistance services, and private duty nursing, and home health agency
 43.33 services, on timelines established in subdivision 5. The commissioner shall provide at
 43.34 least a 90-day notice to lead agencies prior to the effective date of this requirement.
 43.35 Face-to-face assessments must be conducted according to paragraphs (b) to (i).

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

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

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

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

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

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

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

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

41.33 (4) referral information; and

41.34 (5) informal caregiver supports, if applicable.

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

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

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

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

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

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

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

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

44.33 (4) referral information; and

44.34 (5) informal caregiver supports, if applicable.

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

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

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

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

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

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

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

42.26 ~~(2)~~ (4) the role of ~~the~~ long-term care consultation assessment and support planning
 42.27 in ~~waiver and alternative care program~~ eligibility determination for waiver and alternative
 42.28 care programs, and state plan home care, case management, and other services as defined
 42.29 in subdivision 1a, paragraphs (a), clause (7), and (b);

42.30 ~~(3)~~ (5) information about Minnesota health care programs;

42.31 ~~(4)~~ (6) the person's freedom to accept or reject the recommendations of the team;

42.32 ~~(5)~~ (7) the person's right to confidentiality under the Minnesota Government Data
 42.33 Practices Act, chapter 13;

42.34 ~~(6)~~ (8) the ~~long-term care consultant's~~ certified assessor's decision regarding the
 42.35 person's need for institutional level of care as determined under criteria established
 42.36 in section 144.0724, subdivision 11, or 256B.092 and the certified assessor's decision
 43.1 regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs
 43.2 (a), clause (7), and (b); and

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

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

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

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

45.18 (2) documentation that the most cost-effective alternatives available were offered to
 45.19 the individual. For purposes of this clause, "cost-effective" means community services
 45.20 and living arrangements that cost the same as or less than institutional care;

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

45.23 ~~(2)~~ (4) the role of ~~the~~ long-term care consultation assessment and support planning
 45.24 in ~~waiver and alternative care program~~ eligibility determination for waiver and alternative
 45.25 care programs, and state plan home care, case management, and other services as defined
 45.26 in subdivision 1a, paragraph (a), clause (7), and paragraph (b);

45.27 ~~(3)~~ (5) information about Minnesota health care programs;

45.28 ~~(4)~~ (6) the person's freedom to accept or reject the recommendations of the team;

45.29 ~~(5)~~ (7) the person's right to confidentiality under the Minnesota Government Data
 45.30 Practices Act, chapter 13;

45.31 ~~(6)~~ (8) the ~~long-term care consultant's~~ certified assessor's decision regarding the
 45.32 person's need for institutional level of care as determined under criteria established
 45.33 in section 144.0724, subdivision 11, or 256B.092 and the certified assessor's decision
 45.34 regarding eligibility for all services and programs as defined in subdivision 1a, paragraph
 45.35 (a), clause (7) , and paragraph (b); and

43.3 ~~(7)~~(9) the person's right to appeal any certified assessor's decision regarding
 43.4 eligibility for all services and programs as defined in subdivision 1a, paragraph (a), clause
 43.5 ~~(7)~~, and paragraph (b), and incorporating the decision regarding the need for nursing
 43.6 ~~facility~~ institutional level of care or the ~~county's~~ lead agency's final decisions regarding
 43.7 public programs eligibility according to section 256.045, subdivision 3.

43.8 (i) Face-to-face assessment completed as part of eligibility determination for
 43.9 the alternative care, elderly waiver, community alternatives for disabled individuals,
 43.10 community alternative care, and traumatic brain injury waiver programs under sections
 43.11 256B.0913, 256B.0915, 256B.0917, and 256B.49 is valid to establish service eligibility
 43.12 for no more than 60 calendar days after the date of assessment. The effective eligibility
 43.13 start date for these programs can never be prior to the date of assessment. If an assessment
 43.14 was completed more than 60 days before the effective waiver or alternative care program
 43.15 eligibility start date, assessment and support plan information must be updated in a
 43.16 face-to-face visit and documented in the department's Medicaid Management Information
 43.17 System (MMIS). Notwithstanding retroactive medical assistance coverage of state plan
 43.18 services, the effective date of program eligibility in this case for programs included in this
 43.19 item cannot be prior to the date the most recent updated assessment is completed.

43.20 Sec. 11. Minnesota Statutes 2010, section 256B.0911, subdivision 3b, is amended to
 43.21 read:

43.22 Subd. 3b. **Transition assistance.** (a) ~~A long-term care consultation team Lead~~
 43.23 agency certified assessors shall provide assistance to persons residing in a nursing
 43.24 facility, hospital, regional treatment center, or intermediate care facility for persons with
 43.25 developmental disabilities who request or are referred for assistance. Transition assistance
 43.26 must include assessment, community support plan development, referrals to long-term
 43.27 care options counseling under section ~~256B.975~~ 256.975, subdivision ~~40 7~~, for community
 43.28 support plan implementation and to Minnesota health care programs, including home and
 43.29 community-based waiver services and consumer-directed options through the waivers,
 43.30 and referrals to programs that provide assistance with housing. Transition assistance
 43.31 must also include information about the Centers for Independent Living ~~and the Senior~~
 43.32 ~~LinkAge Line, Disability Linkage Line~~, and about other organizations that can provide
 43.33 assistance with relocation efforts, and information about contacting these organizations to
 43.34 obtain their assistance and support.

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

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

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

46.1 ~~(7)~~(9) the person's right to appeal any certified assessor's decision regarding
 46.2 eligibility for all services and programs as defined in subdivision 1a, paragraph (a), clause
 46.3 ~~(7)~~, and paragraph (b), and incorporating the decision regarding the need for nursing
 46.4 ~~facility~~ institutional level of care or the ~~county's~~ lead agency's final decisions regarding
 46.5 public programs eligibility according to section 256.045, subdivision 3.

46.6 (i) Face-to-face assessment completed as part of eligibility determination for
 46.7 the alternative care, elderly waiver, community alternatives for disabled individuals,
 46.8 community alternative care, and traumatic brain injury waiver programs under sections
 46.9 256B.0913, 256B.0915, 256B.0917, and 256B.49 is valid to establish service eligibility
 46.10 for no more than 60 calendar days after the date of assessment. The effective eligibility
 46.11 start date for these programs can never be prior to the date of assessment. If an assessment
 46.12 was completed more than 60 days before the effective waiver or alternative care program
 46.13 eligibility start date, assessment and support plan information must be updated in a
 46.14 face-to-face visit and documented in the department's Medicaid Management Information
 46.15 System (MMIS). Notwithstanding retroactive medical assistance coverage of state plan
 46.16 services, the effective date of program eligibility in this case for programs included in this
 46.17 item cannot be prior to the date the most recent updated assessment is completed.

46.18 Sec. 11. Minnesota Statutes 2010, section 256B.0911, subdivision 3b, is amended to
 46.19 read:

46.20 Subd. 3b. **Transition assistance.** (a) ~~A long-term care consultation team Lead~~
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 46.22 facility, hospital, regional treatment center, or intermediate care facility for persons with
 46.23 developmental disabilities who request or are referred for assistance. Transition assistance
 46.24 must include assessment, community support plan development, referrals to long-term
 46.25 care options counseling under section ~~256B.975~~ 256.975, subdivision ~~40 7~~, for community
 46.26 support plan implementation and to Minnesota health care programs, including home and
 46.27 community-based waiver services and consumer-directed options through the waivers,
 46.28 and referrals to programs that provide assistance with housing. Transition assistance
 46.29 must also include information about the Centers for Independent Living ~~and the Senior~~
 46.30 ~~LinkAge Line, Disability Linkage Line~~, and about other organizations that can provide
 46.31 assistance with relocation efforts, and information about contacting these organizations to
 46.32 obtain their assistance and support.

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

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

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

44.7 ~~(2)~~ (3) the assessment is completed for persons within ~~ten working~~ 20 calendar days
 44.8 of the date of request or recommendation for assessment; ~~and~~

44.9 ~~(3)~~ (4) there is a plan for transition and follow-up for the individual's return to the
 44.10 community. ~~The plan must require, including notification of other local agencies when a~~
 44.11 person who may require assistance is screened by one county for admission to a facility
 44.12 from agencies located in another county; ~~and~~

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

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

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

44.20 Subd. 3c. **Transition to housing with services.** (a) Housing with services
 44.21 establishments offering or providing assisted living under chapter 144G shall inform
 44.22 all prospective residents of the availability of and contact information for transitional
 44.23 consultation services under this subdivision prior to executing a lease or contract with the
 44.24 prospective resident. The purpose of transitional long-term care consultation is to support
 44.25 persons with current or anticipated long-term care needs in making informed choices
 44.26 among options that include the most cost-effective and least restrictive settings, and to
 44.27 delay spenddown to eligibility for publicly funded programs by connecting people to
 44.28 alternative services in their homes before transition to housing with services. Regardless
 44.29 of the consultation, prospective residents maintain the right to choose housing with
 44.30 services or assisted living if that option is their preference.

44.31 (b) Transitional consultation services are provided as determined by the
 44.32 commissioner of human services in partnership with ~~county~~ long-term care consultation
 44.33 units, and the Area Agencies on Aging, and are a combination of telephone-based
 44.34 and in-person assistance provided under models developed by the commissioner. The
 44.35 consultation shall be performed in a manner that provides objective and complete
 45.1 information. Transitional consultation must be provided within five working days of the
 45.2 request of the prospective resident as follows:

45.3 (1) the consultation must be provided by a qualified professional as determined by
 45.4 the commissioner;

45.5 (2) the consultation must include a review of the prospective resident's reasons for
 45.6 considering assisted living, the prospective resident's personal goals, a discussion of the
 45.7 prospective resident's immediate and projected long-term care needs, and alternative
 45.8 community services or assisted living settings that may meet the prospective resident's
 45.9 needs; and

47.5 ~~(2)~~ (3) the assessment is completed for persons within ~~ten working~~ 20 calendar days
 47.6 of the date of request or recommendation for assessment; ~~and~~

47.7 ~~(3)~~ (4) there is a plan for transition and follow-up for the individual's return to the
 47.8 community. ~~The plan must require, including notification of other local agencies when a~~
 47.9 person who may require assistance is screened by one county for admission to a facility
 47.10 from agencies located in another county; ~~and~~

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

47.13 ~~(c) If a person who is eligible for a Minnesota health care program is admitted to a~~
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 47.22 prospective resident. The purpose of transitional long-term care consultation is to support
 47.23 persons with current or anticipated long-term care needs in making informed choices
 47.24 among options that include the most cost-effective and least restrictive settings, and to
 47.25 delay spenddown to eligibility for publicly funded programs by connecting people to
 47.26 alternative services in their homes before transition to housing with services. Regardless
 47.27 of the consultation, prospective residents maintain the right to choose housing with
 47.28 services or assisted living if that option is their preference.

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 47.30 commissioner of human services in partnership with ~~county~~ long-term care consultation
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 47.32 and in-person assistance provided under models developed by the commissioner. The
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 47.34 information. Transitional consultation must be provided within five working days of the
 47.35 request of the prospective resident as follows:

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 48.2 the commissioner;

48.3 (2) the consultation must include a review of the prospective resident's reasons for
 48.4 considering assisted living, the prospective resident's personal goals, a discussion of the
 48.5 prospective resident's immediate and projected long-term care needs, and alternative
 48.6 community services or assisted living settings that may meet the prospective resident's
 48.7 needs; and

45.10 (3) the prospective resident shall be informed of the availability of long-term care
 45.11 consultation services described in subdivision 3a that are available at no charge to the
 45.12 prospective resident to assist the prospective resident in assessment and planning to meet
 45.13 the prospective resident's long-term care needs. The Senior LinkAge Line and long-term
 45.14 care consultation team shall give the highest priority to referrals of individuals who are at
 45.15 highest risk of nursing facility placement or as needed for determining eligibility.

45.16 Sec. 13. Minnesota Statutes 2010, section 256B.0911, subdivision 4a, is amended to
 45.17 read:

45.18 Subd. 4a. **Preadmission screening activities related to nursing facility**

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

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

45.31 The following criteria apply to the preadmission screening:

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

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

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

46.5 (ii) a qualified developmental disability professional, for persons with a primary or
 46.6 secondary diagnosis of developmental disability. For purposes of this requirement, a
 46.7 qualified developmental disability professional must meet the standards for a qualified
 46.8 developmental disability professional under Code of Federal Regulations, title 42, section
 46.9 483.430.

48.8 (3) the prospective resident shall be informed of the availability of long-term care
 48.9 consultation services described in subdivision 3a that are available at no charge to the
 48.10 prospective resident to assist the prospective resident in assessment and planning to meet
 48.11 the prospective resident's long-term care needs. The Senior LinkAge Line and long-term
 48.12 care consultation team shall give the highest priority to referrals of individuals who are at
 48.13 highest risk of nursing facility placement or as needed for determining eligibility.

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 48.22 mental illness and developmental disability as outlined in paragraph (b).

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48.29 The following criteria apply to the preadmission screening:

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 48.31 commissioner to identify persons who require referral for further evaluation and
 48.32 determination of the need for specialized services; and

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 48.34 done by:

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

49.3 (ii) a qualified developmental disability professional, for persons with a primary or
 49.4 secondary diagnosis of developmental disability. For purposes of this requirement, a
 49.5 qualified developmental disability professional must meet the standards for a qualified
 49.6 developmental disability professional under Code of Federal Regulations, title 42, section
 49.7 483.430.

46.10 (c) The local county mental health authority or the state developmental disability
 46.11 authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a
 46.12 nursing facility if the individual does not meet the nursing facility level of care criteria or
 46.13 needs specialized services as defined in Public Law Numbers 100-203 and 101-508. For
 46.14 purposes of this section, "specialized services" for a person with developmental disability
 46.15 means active treatment as that term is defined under Code of Federal Regulations, title
 46.16 42, section 483.440 (a)(1).

46.17 (d) The determination of the need for nursing facility level of care must be made
 46.18 according to criteria established in section 144.0724, subdivision 11, and 256B.092,
 46.19 using forms developed by the commissioner. In assessing a person's needs, consultation
 46.20 team members shall have a physician available for consultation and shall consider the
 46.21 assessment of the individual's attending physician, if any. The individual's physician must
 46.22 be included if the physician chooses to participate. Other personnel may be included on
 46.23 the team as deemed appropriate by the ~~county~~ lead agency.

46.24 Sec. 14. Minnesota Statutes 2010, section 256B.0911, subdivision 4c, is amended to
 46.25 read:

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

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

46.33 (2) the person needs an immediate face-to-face screening interview to determine the
 46.34 need for nursing facility level of care and complete activities required under subdivision
 46.35 4a; or

47.1 (3) the person may be exempt from screening requirements as outlined in subdivision
 47.2 4b, but will need transitional assistance after admission or in-person follow-along after
 47.3 a return home.

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

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

47.8 Sec. 15. Minnesota Statutes 2010, section 256B.0911, subdivision 6, is amended to
 47.9 read:

49.8 (c) The local county mental health authority or the state developmental disability
 49.9 authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a
 49.10 nursing facility if the individual does not meet the nursing facility level of care criteria or
 49.11 needs specialized services as defined in Public Law Numbers 100-203 and 101-508. For
 49.12 purposes of this section, "specialized services" for a person with developmental disability
 49.13 means active treatment as that term is defined under Code of Federal Regulations, title
 49.14 42, section 483.440 (a)(1).

49.15 (d) The determination of the need for nursing facility level of care must be made
 49.16 according to criteria established in section 144.0724, subdivision 11, and 256B.092,
 49.17 using forms developed by the commissioner. In assessing a person's needs, consultation
 49.18 team members shall have a physician available for consultation and shall consider the
 49.19 assessment of the individual's attending physician, if any. The individual's physician must
 49.20 be included if the physician chooses to participate. Other personnel may be included on
 49.21 the team as deemed appropriate by the ~~county~~ lead agency.

49.22 Sec. 14. Minnesota Statutes 2010, section 256B.0911, subdivision 4c, is amended to
 49.23 read:

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

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

49.31 (2) the person needs an immediate face-to-face screening interview to determine the
 49.32 need for nursing facility level of care and complete activities required under subdivision
 49.33 4a; or

50.1 (3) the person may be exempt from screening requirements as outlined in subdivision
 50.2 4b, but will need transitional assistance after admission or in-person follow-along after
 50.3 a return home.

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

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

50.8 Sec. 15. Minnesota Statutes 2010, section 256B.0911, subdivision 6, is amended to
 50.9 read:

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

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

47.21 (c) In the event of the layaway, delicensure and decertification, or removal from
 47.22 layaway of 25 percent or more of the beds in a facility, the commissioner may adjust
 47.23 the per diem payment amount in paragraph (b) and may adjust the monthly payment
 47.24 amount in paragraph (a). The effective date of an adjustment made under this paragraph
 47.25 shall be on or after the first day of the month following the effective date of the layaway,
 47.26 delicensure and decertification, or removal from layaway.

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

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

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

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

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

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

50.21 (c) In the event of the layaway, delicensure and decertification, or removal from
 50.22 layaway of 25 percent or more of the beds in a facility, the commissioner may adjust
 50.23 the per diem payment amount in paragraph (b) and may adjust the monthly payment
 50.24 amount in paragraph (a). The effective date of an adjustment made under this paragraph
 50.25 shall be on or after the first day of the month following the effective date of the layaway,
 50.26 delicensure and decertification, or removal from layaway.

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

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

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

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

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

48.16 Sec. 16. Minnesota Statutes 2010, section 256B.0913, subdivision 7, is amended to
 48.17 read:

48.18 Subd. 7. **Case management.** (a) The provision of case management under the
 48.19 alternative care program is governed by requirements in section 256B.0915, subdivisions
 48.20 1a and 1b.

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

48.23 (c) The case manager is responsible for the cost-effectiveness of the alternative care
 48.24 individual ~~care~~ coordinated services and support plan and must not approve any ~~care~~ plan
 48.25 in which the cost of services funded by alternative care and client contributions exceeds
 48.26 the limit specified in section 256B.0915, subdivision 3, paragraph (b).

48.27 (d) Case manager responsibilities include those in section 256B.0915, subdivision
 48.28 1a, paragraph (g).

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

48.31 Subd. 8. **Requirements for individual ~~care~~ coordinated services and support**
 48.32 **plan.** (a) The case manager shall implement the coordinated services and support plan of
 48.33 ~~care~~ for each alternative care client and ensure that a client's service needs and eligibility
 48.34 are reassessed at least every 12 months. The coordinated services and support plan must
 49.1 meet the requirements in section 256B.0915, subdivision 6. The plan shall include any
 49.2 services prescribed by the individual's attending physician as necessary to allow the
 49.3 individual to remain in a community setting. In developing the individual's care plan, the
 49.4 case manager should include the use of volunteers from families and neighbors, religious
 49.5 organizations, social clubs, and civic and service organizations to support the formal home
 49.6 care services. The lead agency shall be held harmless for damages or injuries sustained
 49.7 through the use of volunteers under this subdivision including workers' compensation
 49.8 liability. The case manager shall provide documentation in each individual's plan of ~~care~~
 49.9 and, if requested, to the commissioner that the most cost-effective alternatives available
 49.10 have been offered to the individual and that the individual was free to choose among
 49.11 available qualified providers, both public and private, including qualified case management
 49.12 or service coordination providers other than those employed by any county; however, the
 49.13 county or tribe maintains responsibility for prior authorizing services in accordance with
 49.14 statutory and administrative requirements. The case manager must give the individual a

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

51.16 Sec. 16. Minnesota Statutes 2010, section 256B.0913, subdivision 7, is amended to
 51.17 read:

51.18 Subd. 7. **Case management.** (a) The provision of case management under the
 51.19 alternative care program is governed by requirements in section 256B.0915, subdivisions
 51.20 1a and 1b.

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

51.23 (c) The case manager is responsible for the cost-effectiveness of the alternative care
 51.24 individual ~~care~~ coordinated services and support plan and must not approve any ~~care~~ plan
 51.25 in which the cost of services funded by alternative care and client contributions exceeds
 51.26 the limit specified in section 256B.0915, subdivision 3, paragraph (b).

51.27 (d) Case manager responsibilities include those in section 256B.0915, subdivision
 51.28 1a, paragraph (g).

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

51.31 Subd. 8. **Requirements for individual ~~care~~ coordinated services and support**
 51.32 **plan.** (a) The case manager shall implement the coordinated services and support plan of
 51.33 ~~care~~ for each alternative care client and ensure that a client's service needs and eligibility
 51.34 are reassessed at least every 12 months. The coordinated services and support plan must
 52.1 meet the requirements in section 256B.0915, subdivision 6. The plan shall include any
 52.2 services prescribed by the individual's attending physician as necessary to allow the
 52.3 individual to remain in a community setting. In developing the individual's care plan, the
 52.4 case manager should include the use of volunteers from families and neighbors, religious
 52.5 organizations, social clubs, and civic and service organizations to support the formal home
 52.6 care services. The lead agency shall be held harmless for damages or injuries sustained
 52.7 through the use of volunteers under this subdivision including workers' compensation
 52.8 liability. The case manager shall provide documentation in each individual's plan of ~~care~~
 52.9 and, if requested, to the commissioner that the most cost-effective alternatives available
 52.10 have been offered to the individual and that the individual was free to choose among
 52.11 available qualified providers, both public and private, including qualified case management
 52.12 or service coordination providers other than those employed by any county; however, the
 52.13 county or tribe maintains responsibility for prior authorizing services in accordance with
 52.14 statutory and administrative requirements. The case manager must give the individual a

49.15 ten-day written notice of any denial, termination, or reduction of alternative care services.

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

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

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

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

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

50.6 (d) Case managers shall be responsible for ongoing monitoring of the provision of
50.7 services included in the individual's plan of care. Case managers shall initiate ~~and oversee~~
50.8 the process of ~~assessment and~~ reassessment of the individual's ~~care~~ coordinated services
50.9 and support plan as defined in subdivision 6 and review the plan of care at intervals
50.10 specified in the federally approved waiver plan.

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

52.15 ten-day written notice of any denial, termination, or reduction of alternative care services.

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

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

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

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

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

53.6 (d) Case managers shall be responsible for ongoing monitoring of the provision of
53.7 services included in the individual's plan of care. Case managers shall initiate ~~and oversee~~
53.8 the process of ~~assessment and~~ reassessment of the individual's ~~care~~ coordinated services
53.9 and support plan as defined in subdivision 6 and review the plan of care at intervals
53.10 specified in the federally approved waiver plan.

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

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

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

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

50.23 (2) informing the individual or the individual's legal guardian or conservator of

50.24 service options, and options for case management services and providers;

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

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

50.27 (5) assisting the person to access services;

50.28 (6) coordination of services; and

50.29 (7) evaluation and monitoring of the services identified in the plan, including at least

50.30 one annual face-to-face visit by the case manager with each person.

50.31 (h) For individuals enrolled in prepaid medical assistance programs under section

50.32 256B.69, subdivisions 6b and 23, the health plan shall provide or arrange to provide

50.33 elderly waiver case management services in paragraph (g), as part of an integrated delivery

50.34 system in accordance with contract requirements established by the commissioner.

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

51.2 read:

51.3 Subd. 1b. **Provider qualifications and standards.** (a) The commissioner must

51.4 enroll qualified providers of ~~elderly~~ case management services under the home and

51.5 community-based waiver for the elderly under section 1915(c) of the Social Security

51.6 Act. The enrollment process shall ensure the provider's ability to meet the qualification

51.7 requirements and standards in this subdivision and other federal and state requirements

51.8 of this service. ~~An elderly~~ A case management provider is an enrolled medical

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

51.10 characteristics:

51.11 (1) the demonstrated capacity and experience to provide the components of

51.12 case management to coordinate and link community resources needed by the eligible

51.13 population;

53.14 (f) Except as described in paragraph (h), case management services must be provided

53.15 by a public or private agency that is enrolled as a medical assistance provider determined

53.16 by the commissioner to meet all of the requirements in subdivision 1b. Case management

53.17 services must not be provided to a recipient by a private agency that has a financial interest

53.18 in the provision of any other services included in the recipient's coordinated service and

53.19 support plan. For purposes of this section, "private agency" means any agency that is not

53.20 identified as a lead agency under section 256B.0911, subdivision 1a, paragraph (e).

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

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

53.23 (2) informing the individual or the individual's legal guardian or conservator of

53.24 service options, and options for case management services and providers;

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

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

53.27 (5) assisting the person to access services;

53.28 (6) coordination of services; and

53.29 (7) evaluation and monitoring of the services identified in the plan, including at least

53.30 one annual face-to-face visit by the case manager with each person.

53.31 (h) For individuals enrolled in prepaid medical assistance programs under section

53.32 256B.69, subdivisions 6b and 23, the health plan will provide or arrange to provide elderly

53.33 waiver case management services in paragraph (g), as part of an integrated delivery system

53.34 in accordance with contract requirements established by the commissioner.

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

54.2 read:

54.3 Subd. 1b. **Provider qualifications and standards.** (a) The commissioner must

54.4 enroll qualified providers of ~~elderly~~ case management services under the home and

54.5 community-based waiver for the elderly under section 1915(c) of the Social Security

54.6 Act. The enrollment process shall ensure the provider's ability to meet the qualification

54.7 requirements and standards in this subdivision and other federal and state requirements

54.8 of this service. ~~An elderly~~ A case management provider is an enrolled medical

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

54.10 characteristics:

54.11 (1) the demonstrated capacity and experience to provide the components of

54.12 case management to coordinate and link community resources needed by the eligible

54.13 population;

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

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

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

51.21 (5) the lead agency may allow a case manager employed by the lead agency to
 51.22 delegate certain aspects of the case management activity to another individual employed
 51.23 by the lead agency provided there is oversight of the individual by the case manager.
 51.24 The case manager may not delegate those aspects which require professional judgment
 51.25 including assessments, reassessments, and ~~care~~ coordinated services and support plan
 51.26 development. Lead agencies include counties, health plans, and federally recognized
 51.27 tribes who authorize services under this section.

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

51.32 Sec. 20. Minnesota Statutes 2010, section 256B.0915, subdivision 3c, is amended to
 51.33 read:

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

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

52.5 Sec. 21. Minnesota Statutes 2010, section 256B.0915, subdivision 6, is amended to
 52.6 read:

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

52.13 (1) is developed and signed by the recipient within ten working days after the case
 52.14 manager receives the community support plan from the certified assessor;

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

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

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

54.21 (5) the lead agency may allow a case manager employed by the lead agency to
 54.22 delegate certain aspects of the case management activity to another individual employed
 54.23 by the lead agency provided there is oversight of the individual by the case manager.
 54.24 The case manager may not delegate those aspects which require professional judgment
 54.25 including assessments, reassessments, and ~~care~~ coordinated services and support plan
 54.26 development. Lead agencies include counties, health plans, and federally recognized
 54.27 tribes who authorize services under this section.

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

54.32 Sec. 20. Minnesota Statutes 2010, section 256B.0915, subdivision 3c, is amended to
 54.33 read:

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

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

55.5 Sec. 21. Minnesota Statutes 2010, section 256B.0915, subdivision 6, is amended to
 55.6 read:

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

55.13 (1) is developed and signed by the recipient within ten working days after the case
 55.14 manager receives the community support plan from the certified assessor;

52.15 (2) includes the results of the assessment information on the person's need for
 52.16 service and identification of service needs that will be or that are met by the person's
 52.17 relatives, friends, and others, as well as community services used by the general public;
 52.18 (3) reasonably ensures the health and safety of the recipient;
 52.19 (4) identifies the person's preferences for services as stated by the person or the
 52.20 person's legal guardian or conservator;
 52.21 (5) reflects the person's informed choice between institutional and community-based
 52.22 services, as well as choice of services, supports, and providers, including available case
 52.23 manager providers;
 52.24 (6) identifies long and short-range goals for the person;
 52.25 (7) identifies specific services and the amount, frequency, duration, and cost of the
 52.26 services to be provided to the person based on assessed needs, preferences, and available
 52.27 resources; and
 52.28 (8) includes information about the right to appeal decisions under section 256.045;
 52.29 (b) In developing the coordinated services and support plan, the case manager should
 52.30 also include the use of volunteers, religious organizations, social clubs, and civic and
 52.31 service organizations to support the individual in the community. The lead agency must be
 52.32 held harmless for damages or injuries sustained through the use of volunteers and agencies
 52.33 under this paragraph, including workers' compensation liability.

53.1 Sec. 22. Minnesota Statutes 2010, section 256B.0915, subdivision 10, is amended to
 53.2 read:

53.3 Subd. 10. **Waiver payment rates; managed care organizations.** The
 53.4 commissioner shall adjust the elderly waiver capitation payment rates for managed
 53.5 care organizations paid under section 256B.69, subdivisions ~~6a~~ 6b and 23, to reflect the
 53.6 maximum service rate limits for customized living services and 24-hour customized
 53.7 living services under subdivisions 3e and 3h for the contract period beginning October
 53.8 1, 2009. Medical assistance rates paid to customized living providers by managed
 53.9 care organizations under this section shall not exceed the maximum service rate limits
 53.10 determined by the commissioner under subdivisions 3e and 3h.

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

55.15 (2) includes the results of the assessment information on the person's need for
 55.16 service and identification of service needs that will be or that are met by the person's
 55.17 relatives, friends, and others, as well as community services used by the general public;
 55.18 (3) reasonably ensures the health and safety of the recipient;
 55.19 (4) identifies the person's preferences for services as stated by the person or the
 55.20 person's legal guardian or conservator;
 55.21 (5) reflects the person's informed choice between institutional and community-based
 55.22 services, as well as choice of services, supports, and providers, including available case
 55.23 manager providers;
 55.24 (6) identifies long and short-range goals for the person;
 55.25 (7) identifies specific services and the amount, frequency, duration, and cost of the
 55.26 services to be provided to the person based on assessed needs, preferences, and available
 55.27 resources; and
 55.28 (8) includes information about the right to appeal decisions under section 256.045;
 55.29 (b) In developing the coordinated services and support plan, the case manager should
 55.30 also include the use of volunteers, religious organizations, social clubs, and civic and
 55.31 service organizations to support the individual in the community. The lead agency must be
 55.32 held harmless for damages or injuries sustained through the use of volunteers and agencies
 55.33 under this paragraph, including workers' compensation liability.

56.1 Sec. 22. Minnesota Statutes 2010, section 256B.0915, subdivision 10, is amended to
 56.2 read:

56.3 Subd. 10. **Waiver payment rates; managed care organizations.** The
 56.4 commissioner shall adjust the elderly waiver capitation payment rates for managed
 56.5 care organizations paid under section 256B.69, subdivisions ~~6a~~ 6b and 23, to reflect the
 56.6 maximum service rate limits for customized living services and 24-hour customized
 56.7 living services under subdivisions 3e and 3h for the contract period beginning October
 56.8 1, 2009. Medical assistance rates paid to customized living providers by managed
 56.9 care organizations under this section shall not exceed the maximum service rate limits
 56.10 determined by the commissioner under subdivisions 3e and 3h.

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

53.12 Subdivision 1. **County of financial responsibility; duties.** Before any services
 53.13 shall be rendered to persons with developmental disabilities who are in need of social
 53.14 service and medical assistance, the county of financial responsibility shall conduct or
 53.15 arrange for a diagnostic evaluation in order to determine whether the person has or may
 53.16 have a developmental disability or has or may have a related condition. If the county
 53.17 of financial responsibility determines that the person has a developmental disability,
 53.18 the county shall inform the person of case management services available under this
 53.19 section. Except as provided in subdivision 1g or 4b, if a person is diagnosed as having a
 53.20 developmental disability, the county of financial responsibility shall conduct or arrange for
 53.21 a needs assessment by a certified assessor, and develop or arrange for an individual service
 53.22 a community support plan according to section 256B.0911, provide or arrange for ongoing
 53.23 case management services at the level identified in the individual service plan, provide
 53.24 or arrange for case management administration, and authorize services identified in the
 53.25 person's individual service coordinated services and support plan developed according to
 53.26 subdivision 1b. Diagnostic information, obtained by other providers or agencies, may be
 53.27 used by the county agency in determining eligibility for case management. Nothing in this
 53.28 section shall be construed as requiring: (1) assessment in areas agreed to as unnecessary
 53.29 by the case manager a certified assessor and the person, or the person's legal guardian or
 53.30 conservator, or the parent if the person is a minor, or (2) assessments in areas where there
 53.31 has been a functional assessment completed in the previous 12 months for which the
 53.32 case manager certified assessor and the person or person's guardian or conservator, or the
 53.33 parent if the person is a minor, agree that further assessment is not necessary. For persons
 53.34 under state guardianship, the case manager certified assessor shall seek authorization from
 53.35 the public guardianship office for waiving any assessment requirements. Assessments
 54.1 related to health, safety, and protection of the person for the purpose of identifying service
 54.2 type, amount, and frequency or assessments required to authorize services may not be
 54.3 waived. To the extent possible, for wards of the commissioner the county shall consider
 54.4 the opinions of the parent of the person with a developmental disability when developing
 54.5 the person's individual service community support plan and coordinated services and
 54.6 support plan.

54.7 Sec. 24. Minnesota Statutes 2010, section 256B.092, subdivision 1a, is amended to
 54.8 read:

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

54.13 (1) review of eligibility for services;

54.14 (2) screening;

54.15 (3) intake;

56.12 Subdivision 1. **County of financial responsibility; duties.** Before any services
 56.13 shall be rendered to persons with developmental disabilities who are in need of social
 56.14 service and medical assistance, the county of financial responsibility shall conduct or
 56.15 arrange for a diagnostic evaluation in order to determine whether the person has or may
 56.16 have a developmental disability or has or may have a related condition. If the county
 56.17 of financial responsibility determines that the person has a developmental disability,
 56.18 the county shall inform the person of case management services available under this
 56.19 section. Except as provided in subdivision 1g or 4b, if a person is diagnosed as having a
 56.20 developmental disability, the county of financial responsibility shall conduct or arrange for
 56.21 a needs assessment by a certified assessor, and develop or arrange for an individual service
 56.22 a community support plan according to section 256B.0911, provide or arrange for ongoing
 56.23 case management services at the level identified in the individual service plan, provide
 56.24 or arrange for case management administration, and authorize services identified in the
 56.25 person's individual service coordinated services and support plan developed according to
 56.26 subdivision 1b. Diagnostic information, obtained by other providers or agencies, may be
 56.27 used by the county agency in determining eligibility for case management. Nothing in this
 56.28 section shall be construed as requiring: (1) assessment in areas agreed to as unnecessary
 56.29 by the case manager a certified assessor and the person, or the person's legal guardian or
 56.30 conservator, or the parent if the person is a minor, or (2) assessments in areas where there
 56.31 has been a functional assessment completed in the previous 12 months for which the
 56.32 case manager certified assessor and the person or person's guardian or conservator, or the
 56.33 parent if the person is a minor, agree that further assessment is not necessary. For persons
 56.34 under state guardianship, the case manager certified assessor shall seek authorization from
 56.35 the public guardianship office for waiving any assessment requirements. Assessments
 57.1 related to health, safety, and protection of the person for the purpose of identifying service
 57.2 type, amount, and frequency or assessments required to authorize services may not be
 57.3 waived. To the extent possible, for wards of the commissioner the county shall consider
 57.4 the opinions of the parent of the person with a developmental disability when developing
 57.5 the person's individual service community support plan and coordinated services and
 57.6 support plan.

57.7 Sec. 24. Minnesota Statutes 2010, section 256B.092, subdivision 1a, is amended to
 57.8 read:

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

57.13 (1) review of eligibility for services;

57.14 (2) screening;

57.15 (3) intake;

54.16 ~~(4) diagnosis;~~
 54.17 ~~(5) the review and authorization of services based upon an individualized service~~
 54.18 ~~plan; and~~
 54.19 ~~(6) responding to requests for conciliation conferences and appeals according to~~
 54.20 ~~section 256.045 made by the person, the person's legal guardian or conservator, or the~~
 54.21 ~~parent if the person is a minor.~~
 54.22 (b) Case management service activities provided to or arranged for a person include:
 54.23 (1) development of the ~~individual service~~ coordinated services and support plan
 54.24 under subdivision 1b;
 54.25 (2) informing the individual or the individual's legal guardian or conservator, or
 54.26 parent if the person is a minor, of service options;
 54.27 (3) consulting with relevant medical experts or service providers;
 54.28 (4) assisting the person in the identification of potential providers;
 54.29 (5) assisting the person to access services and assisting in appeals under section
 54.30 256.045;
 54.31 (6) coordination of services, if coordination is not provided by another service
 54.32 provider;
 54.33 (7) evaluation and monitoring of the services identified in the coordinated services
 54.34 and support plan, which must incorporate at least one annual face-to-face visit by the case
 54.35 manager with each person; and
 55.1 ~~(8) annual reviews of service plans and services provided~~ review and provide the
 55.2 lead agency with recommendations for service authorization based upon the individual's
 55.3 needs identified in the coordinated services and support plan.
 55.4 (c) Case management ~~administration and~~ service activities that are provided to the
 55.5 person with a developmental disability shall be provided directly by county agencies or
 55.6 under contract. Case management services must be provided by a public or private agency
 55.7 that is enrolled as a medical assistance provider determined by the commissioner to meet
 55.8 all of the requirements in the approved federal waiver plans. Case management services
 55.9 must not be provided to a recipient by a private agency that has a financial interest in the
 55.10 provision of any other services included in the recipient's coordinated services and support
 55.11 plan. For purposes of this section, "private agency" means any agency that is not identified
 55.12 as a lead agency under section 256B.0911, subdivision 1a, paragraph (d).

57.16 ~~(4) diagnosis;~~
 57.17 ~~(5) the review and authorization of services based upon an individualized service~~
 57.18 ~~plan; and~~
 57.19 ~~(6) responding to requests for conciliation conferences and appeals according to~~
 57.20 ~~section 256.045 made by the person, the person's legal guardian or conservator, or the~~
 57.21 ~~parent if the person is a minor.~~
 57.22 (b) Case management service activities provided to or arranged for a person include:
 57.23 (1) development of the ~~individual service~~ coordinated services and support plan
 57.24 under subdivision 1b;
 57.25 (2) informing the individual or the individual's legal guardian or conservator, or
 57.26 parent if the person is a minor, of service options;
 57.27 (3) consulting with relevant medical experts or service providers;
 57.28 (4) assisting the person in the identification of potential providers;
 57.29 (5) assisting the person to access services and assisting in appeals under section
 57.30 256.045;
 57.31 (6) coordination of services, if coordination is not provided by another service
 57.32 provider;
 57.33 (7) evaluation and monitoring of the services identified in the coordinated services
 57.34 and support plan, which must incorporate at least one annual face-to-face visit by the case
 57.35 manager with each person; and
 58.1 ~~(8) annual reviews of service plans and services provided~~ review and provide the
 58.2 lead agency with recommendations for service authorization based upon the individual's
 58.3 needs identified in the coordinated services and support plan.
 58.4 (c) Case management ~~administration and~~ service activities that are provided to the
 58.5 person with a developmental disability shall be provided directly by county agencies or
 58.6 under contract. Case management services must be provided by a public or private agency
 58.7 that is enrolled as a medical assistance provider determined by the commissioner to meet
 58.8 all of the requirements in the approved federal waiver plans. Case management services
 58.9 must not be provided to a recipient by a private agency that has a financial interest in the
 58.10 provision of any other services included in the recipient's coordinated services and support
 58.11 plan. For purposes of this section, "private agency" means any agency that is not identified
 58.12 as a lead agency under section 256B.0911, subdivision 1a, paragraph (d).

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

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

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

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

55.26 (1) is developed and signed by the recipient within ten working days after the case
 55.27 manager receives the community support plan from the certified assessor;

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

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

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

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

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

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

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

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

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

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

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

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

58.26 (1) is developed and signed by the recipient within ten working days after the case
 58.27 manager receives the community support plan from the certified assessor;

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

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

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

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

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

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

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

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

56.16 ~~(7) include~~ (10) includes notice of the right to request a conciliation conference or a
56.17 hearing under section 256.045;

56.18 ~~(8) be~~ (11) is agreed upon and signed by the person, the person's legal guardian
56.19 or conservator, or the parent if the person is a minor, and the authorized county
56.20 representative; and

56.21 ~~(9) be~~ (12) is reviewed by a health professional if the person has overriding medical
56.22 needs that impact the delivery of services.

56.23 ~~Service planning formats developed for interagency planning such as transition,
56.24 vocational, and individual family service plans may be substituted for service planning
56.25 formats developed by county agencies.~~

56.26 (b) In developing the coordinated services and support plan, the case manager is
56.27 encouraged to include the use of volunteers, religious organizations, social clubs, and civic
56.28 and service organizations to support the individual in the community. The lead agency
56.29 must be held harmless for damages or injuries sustained through the use of volunteers and
56.30 agencies under this paragraph, including workers' compensation liability.

56.31 Sec. 26. Minnesota Statutes 2010, section 256B.092, subdivision 1e, is amended to
56.32 read:

56.33 Subd. 1e. **Coordination, evaluation, and monitoring of services.** (a) If the
56.34 ~~individual service~~ coordinated service and support plan identifies the need for individual
56.35 program plans for authorized services, the case manager shall assure that individual
57.1 program plans are developed by the providers according to clauses (2) to (5). The
57.2 providers shall assure that the individual program plans:

57.3 (1) are developed according to the respective state and federal licensing and
57.4 certification requirements;

57.5 (2) are designed to achieve the goals of the ~~individual service~~ coordinated service
57.6 and support plan;

57.7 (3) are consistent with other aspects of the ~~individual service~~ coordinated service
57.8 and support plan;

57.9 (4) assure the health and safety of the person; and

57.10 (5) are developed with consistent and coordinated approaches to services among the
57.11 various service providers.

57.12 (b) The case manager shall monitor the provision of services:

57.13 (1) to assure that the ~~individual service~~ coordinated service and support plan is
57.14 being followed according to paragraph (a);

59.16 ~~(7) include~~ (10) includes notice of the right to request a conciliation conference or a
59.17 hearing under section 256.045;

59.18 ~~(8) be~~ (11) is agreed upon and signed by the person, the person's legal guardian
59.19 or conservator, or the parent if the person is a minor, and the authorized county
59.20 representative; and

59.21 ~~(9) be~~ (12) is reviewed by a health professional if the person has overriding medical
59.22 needs that impact the delivery of services.

59.23 ~~Service planning formats developed for interagency planning such as transition,
59.24 vocational, and individual family service plans may be substituted for service planning
59.25 formats developed by county agencies.~~

59.26 (b) In developing the coordinated services and support plan, the case manager is
59.27 encouraged to include the use of volunteers, religious organizations, social clubs, and civic
59.28 and service organizations to support the individual in the community. The lead agency
59.29 must be held harmless for damages or injuries sustained through the use of volunteers and
59.30 agencies under this paragraph, including workers' compensation liability.

59.31 Sec. 26. Minnesota Statutes 2010, section 256B.092, subdivision 1e, is amended to
59.32 read:

59.33 Subd. 1e. **Coordination, evaluation, and monitoring of services.** (a) If the
59.34 ~~individual service~~ coordinated service and support plan identifies the need for individual
59.35 program plans for authorized services, the case manager shall assure that individual
60.1 program plans are developed by the providers according to clauses (2) to (5). The
60.2 providers shall assure that the individual program plans:

60.3 (1) are developed according to the respective state and federal licensing and
60.4 certification requirements;

60.5 (2) are designed to achieve the goals of the ~~individual service~~ coordinated service
60.6 and support plan;

60.7 (3) are consistent with other aspects of the ~~individual service~~ coordinated service
60.8 and support plan;

60.9 (4) assure the health and safety of the person; and

60.10 (5) are developed with consistent and coordinated approaches to services among the
60.11 various service providers.

60.12 (b) The case manager shall monitor the provision of services:

60.13 (1) to assure that the ~~individual service~~ coordinated service and support plan is
60.14 being followed according to paragraph (a);

57.15 (2) to identify any changes or modifications that might be needed in the ~~individual~~
 57.16 ~~service coordinated service and support~~ plan, including changes resulting from
 57.17 recommendations of current service providers;

57.18 (3) to determine if the person's legal rights are protected, and if not, notify the
 57.19 person's legal guardian or conservator, or the parent if the person is a minor, protection
 57.20 services, or licensing agencies as appropriate; and

57.21 (4) to determine if the person, the person's legal guardian or conservator, or the
 57.22 parent if the person is a minor, is satisfied with the services provided.

57.23 (c) If the provider fails to develop or carry out the individual program plan according
 57.24 to paragraph (a), the case manager shall notify the person's legal guardian or conservator,
 57.25 or the parent if the person is a minor, the provider, the respective licensing and certification
 57.26 agencies, and the county board where the services are being provided. In addition, the
 57.27 case manager shall identify other steps needed to assure the person receives the services
 57.28 identified in the ~~individual-service coordinated service and support~~ plan.

57.29 Sec. 27. Minnesota Statutes 2010, section 256B.092, subdivision 1g, is amended to
 57.30 read:

57.31 Subd. 1g. **Conditions not requiring development of ~~individual-service~~**
 57.32 **coordinated service and support plan.** Unless otherwise required by federal law, the
 57.33 county agency is not required to complete ~~an individual-service~~ a coordinated service and
 57.34 ~~support~~ plan as defined in subdivision 1b for:

58.1 (1) persons whose families are requesting respite care for their family member who
 58.2 resides with them, or whose families are requesting a family support grant and are not
 58.3 requesting purchase or arrangement of habilitative services; and

58.4 (2) persons with developmental disabilities, living independently without authorized
 58.5 services or receiving funding for services at a rehabilitation facility as defined in section
 58.6 268A.01, subdivision 6, and not in need of or requesting additional services.

58.7 Sec. 28. Minnesota Statutes 2010, section 256B.092, subdivision 2, is amended to read:

58.8 Subd. 2. **Medical assistance.** To assure quality case management to those persons
 58.9 who are eligible for medical assistance, the commissioner shall, upon request:

58.10 (1) provide consultation on the case management process;

58.11 (2) assist county agencies in the ~~screening and~~ annual reviews of clients review
 58.12 process to assure that appropriate levels of service are provided to persons;

58.13 (3) provide consultation on service planning and development of services with
 58.14 appropriate options;

58.15 (4) provide training and technical assistance to county case managers; and

60.15 (2) to identify any changes or modifications that might be needed in the ~~individual~~
 60.16 ~~service coordinated service and support~~ plan, including changes resulting from
 60.17 recommendations of current service providers;

60.18 (3) to determine if the person's legal rights are protected, and if not, notify the
 60.19 person's legal guardian or conservator, or the parent if the person is a minor, protection
 60.20 services, or licensing agencies as appropriate; and

60.21 (4) to determine if the person, the person's legal guardian or conservator, or the
 60.22 parent if the person is a minor, is satisfied with the services provided.

60.23 (c) If the provider fails to develop or carry out the individual program plan according
 60.24 to paragraph (a), the case manager shall notify the person's legal guardian or conservator,
 60.25 or the parent if the person is a minor, the provider, the respective licensing and certification
 60.26 agencies, and the county board where the services are being provided. In addition, the
 60.27 case manager shall identify other steps needed to assure the person receives the services
 60.28 identified in the ~~individual-service coordinated service and support~~ plan.

60.29 Sec. 27. Minnesota Statutes 2010, section 256B.092, subdivision 1g, is amended to
 60.30 read:

60.31 Subd. 1g. **Conditions not requiring development of ~~individual-service~~**
 60.32 **coordinated service and support plan.** Unless otherwise required by federal law, the
 60.33 county agency is not required to complete ~~an individual-service~~ a coordinated service and
 60.34 ~~support~~ plan as defined in subdivision 1b for:

61.1 (1) persons whose families are requesting respite care for their family member who
 61.2 resides with them, or whose families are requesting a family support grant and are not
 61.3 requesting purchase or arrangement of habilitative services; and

61.4 (2) persons with developmental disabilities, living independently without authorized
 61.5 services or receiving funding for services at a rehabilitation facility as defined in section
 61.6 268A.01, subdivision 6, and not in need of or requesting additional services.

61.7 Sec. 28. Minnesota Statutes 2010, section 256B.092, subdivision 2, is amended to read:

61.8 Subd. 2. **Medical assistance.** To assure quality case management to those persons
 61.9 who are eligible for medical assistance, the commissioner shall, upon request:

61.10 (1) provide consultation on the case management process;

61.11 (2) assist county agencies in the ~~screening and~~ annual reviews of clients review
 61.12 process to assure that appropriate levels of service are provided to persons;

61.13 (3) provide consultation on service planning and development of services with
 61.14 appropriate options;

61.15 (4) provide training and technical assistance to county case managers; and

58.16 (5) authorize payment for medical assistance services according to this chapter
58.17 and rules implementing it.

58.18 Sec. 29. Minnesota Statutes 2010, section 256B.092, subdivision 3, is amended to read:

58.19 Subd. 3. **Authorization and termination of services.** County agency case
58.20 managers, under rules of the commissioner, shall authorize and terminate services of
58.21 community and regional treatment center providers according to ~~individual service~~
58.22 support plans. Services provided to persons with developmental disabilities may only be
58.23 authorized and terminated by case managers or certified assessors according to (1) rules of
58.24 the commissioner and (2) the ~~individual service~~ support plan as defined in subdivision
58.25 1b and section 256B.0911. Medical assistance services not needed shall not be authorized
58.26 by county agencies or funded by the commissioner. When purchasing or arranging for
58.27 unlicensed respite care services for persons with overriding health needs, the county
58.28 agency shall seek the advice of a health care professional in assessing provider staff
58.29 training needs and skills necessary to meet the medical needs of the person.

58.30 Sec. 30. Minnesota Statutes 2010, section 256B.092, subdivision 5, is amended to read:

58.31 Subd. 5. **Federal waivers.** (a) The commissioner shall apply for any federal
58.32 waivers necessary to secure, to the extent allowed by law, federal financial participation
58.33 under United States Code, title 42, sections 1396 et seq., as amended, for the provision
59.1 of services to persons who, in the absence of the services, would need the level of care
59.2 provided in a regional treatment center or a community intermediate care facility for
59.3 persons with developmental disabilities. The commissioner may seek amendments to the
59.4 waivers or apply for additional waivers under United States Code, title 42, sections 1396
59.5 et seq., as amended, to contain costs. The commissioner shall ensure that payment for
59.6 the cost of providing home and community-based alternative services under the federal
59.7 waiver plan shall not exceed the cost of intermediate care services including day training
59.8 and habilitation services that would have been provided without the waived services.

59.9 The commissioner shall seek an amendment to the 1915c home and
59.10 community-based waiver to allow properly licensed adult foster care homes to provide
59.11 residential services to up to five individuals with developmental disabilities. If the
59.12 amendment to the waiver is approved, adult foster care providers that can accommodate
59.13 five individuals shall increase their capacity to five beds, provided the providers continue
59.14 to meet all applicable licensing requirements.

61.16 (5) authorize payment for medical assistance services according to this chapter
61.17 and rules implementing it.

61.18 Sec. 29. Minnesota Statutes 2010, section 256B.092, subdivision 3, is amended to read:

61.19 Subd. 3. **Authorization and termination of services.** County agency case
61.20 managers, under rules of the commissioner, shall authorize and terminate services of
61.21 community and regional treatment center providers according to ~~individual service~~
61.22 support plans. Services provided to persons with developmental disabilities may only be
61.23 authorized and terminated by case managers or certified assessors according to (1) rules of
61.24 the commissioner and (2) the ~~individual service~~ support plan as defined in subdivision
61.25 1b and section 256B.0911. Medical assistance services not needed shall not be authorized
61.26 by county agencies or funded by the commissioner. When purchasing or arranging for
61.27 unlicensed respite care services for persons with overriding health needs, the county
61.28 agency shall seek the advice of a health care professional in assessing provider staff
61.29 training needs and skills necessary to meet the medical needs of the person.

61.30 Sec. 30. Minnesota Statutes 2010, section 256B.092, subdivision 5, is amended to read:

61.31 Subd. 5. **Federal waivers.** (a) The commissioner shall apply for any federal
61.32 waivers necessary to secure, to the extent allowed by law, federal financial participation
61.33 under United States Code, title 42, sections 1396 et seq., as amended, for the provision
62.1 of services to persons who, in the absence of the services, would need the level of care
62.2 provided in a regional treatment center or a community intermediate care facility for
62.3 persons with developmental disabilities. The commissioner may seek amendments to the
62.4 waivers or apply for additional waivers under United States Code, title 42, sections 1396
62.5 et seq., as amended, to contain costs. The commissioner shall ensure that payment for
62.6 the cost of providing home and community-based alternative services under the federal
62.7 waiver plan shall not exceed the cost of intermediate care services including day training
62.8 and habilitation services that would have been provided without the waived services.

62.9 The commissioner shall seek an amendment to the 1915c home and
62.10 community-based waiver to allow properly licensed adult foster care homes to provide
62.11 residential services to up to five individuals with developmental disabilities. If the
62.12 amendment to the waiver is approved, adult foster care providers that can accommodate
62.13 five individuals shall increase their capacity to five beds, provided the providers continue
62.14 to meet all applicable licensing requirements.

59.15 (b) The commissioner, in administering home and community-based waivers for
 59.16 persons with developmental disabilities, shall ensure that day services for eligible persons
 59.17 are not provided by the person's residential service provider, unless the person or the
 59.18 person's legal representative is offered a choice of providers and agrees in writing to
 59.19 provision of day services by the residential service provider. The ~~individual service~~
 59.20 ~~coordinated service and support~~ plan for individuals who choose to have their residential
 59.21 service provider provide their day services must describe how health, safety, protection,
 59.22 and habilitation needs will be met, including how frequent and regular contact with
 59.23 persons other than the residential service provider will occur. The ~~individualized service~~
 59.24 ~~coordinated service and support~~ plan must address the provision of services during the
 59.25 day outside the residence on weekdays.

59.26 (c) When a ~~county~~ lead agency is evaluating denials, reductions, or terminations
 59.27 of home and community-based services under section 256B.0916 for an individual, the
 59.28 ~~case manager~~ lead agency shall offer to meet with the individual or the individual's
 59.29 guardian in order to discuss the prioritization of service needs within the ~~individualized~~
 59.30 ~~service coordinated service and support~~ plan. The reduction in the authorized services
 59.31 for an individual due to changes in funding for waived services may not exceed the
 59.32 amount needed to ensure medically necessary services to meet the individual's health,
 59.33 safety, and welfare.

59.34 Sec. 31. Minnesota Statutes 2010, section 256B.092, subdivision 7, is amended to read:

60.1 Subd. 7. ~~Screening teams Assessments.~~ (a) Assessments and reassessments shall
 60.2 ~~be conducted by certified assessors according to section 256B.0911, and must incorporate~~
 60.3 ~~appropriate referrals to determine eligibility for case management under subdivision 1a.~~

60.4 (b) For persons with developmental disabilities, ~~screening teams shall be established~~
 60.5 ~~which a certified assessor shall evaluate the need for the level of care provided by~~
 60.6 residential-based habilitation services, residential services, training and habilitation
 60.7 services, and nursing facility services. The ~~evaluation assessment~~ shall address whether
 60.8 home and community-based services are appropriate for persons who are at risk of
 60.9 placement in an intermediate care facility for persons with developmental disabilities, or
 60.10 for whom there is reasonable indication that they might require this level of care. The
 60.11 ~~screening team certified assessor shall make an evaluation of need within 60 working~~
 60.12 ~~days of a request for service by a person with a developmental disability, and within~~
 60.13 five working days of an emergency admission of a person to an intermediate care
 60.14 facility for persons with developmental disabilities. ~~The screening team shall consist of~~
 60.15 ~~the case manager for persons with developmental disabilities, the person, the person's~~
 60.16 ~~legal guardian or conservator, or the parent if the person is a minor, and a qualified~~
 60.17 ~~developmental disability professional, as defined in the Code of Federal Regulations,~~
 60.18 ~~title 42, section 483.430, as amended through June 3, 1988. The case manager may also~~
 60.19 ~~act as the qualified developmental disability professional if the case manager meets~~
 60.20 ~~the federal definition. County social service agencies may contract with a public or~~
 60.21 ~~private agency or individual who is not a service provider for the person for the public~~

62.15 (b) The commissioner, in administering home and community-based waivers for
 62.16 persons with developmental disabilities, shall ensure that day services for eligible persons
 62.17 are not provided by the person's residential service provider, unless the person or the
 62.18 person's legal representative is offered a choice of providers and agrees in writing to
 62.19 provision of day services by the residential service provider. The ~~individual service~~
 62.20 ~~coordinated service and support~~ plan for individuals who choose to have their residential
 62.21 service provider provide their day services must describe how health, safety, protection,
 62.22 and habilitation needs will be met, including how frequent and regular contact with
 62.23 persons other than the residential service provider will occur. The ~~individualized service~~
 62.24 ~~coordinated service and support~~ plan must address the provision of services during the
 62.25 day outside the residence on weekdays.

62.26 (c) When a ~~county~~ lead agency is evaluating denials, reductions, or terminations
 62.27 of home and community-based services under section 256B.0916 for an individual, the
 62.28 ~~case manager~~ lead agency shall offer to meet with the individual or the individual's
 62.29 guardian in order to discuss the prioritization of service needs within the ~~individualized~~
 62.30 ~~service coordinated service and support~~ plan. The reduction in the authorized services
 62.31 for an individual due to changes in funding for waived services may not exceed the
 62.32 amount needed to ensure medically necessary services to meet the individual's health,
 62.33 safety, and welfare.

62.34 Sec. 31. Minnesota Statutes 2010, section 256B.092, subdivision 7, is amended to read:

63.1 Subd. 7. ~~Screening teams Assessments.~~ (a) Assessments and reassessments shall
 63.2 ~~be conducted by certified assessors according to section 256B.0911, and must incorporate~~
 63.3 ~~appropriate referrals to determine eligibility for case management under subdivision 1a.~~

63.4 (b) For persons with developmental disabilities, ~~screening teams shall be established~~
 63.5 ~~which a certified assessor shall evaluate the need for the level of care provided by~~
 63.6 residential-based habilitation services, residential services, training and habilitation
 63.7 services, and nursing facility services. The ~~evaluation assessment~~ shall address whether
 63.8 home and community-based services are appropriate for persons who are at risk of
 63.9 placement in an intermediate care facility for persons with developmental disabilities, or
 63.10 for whom there is reasonable indication that they might require this level of care. The
 63.11 ~~screening team certified assessor shall make an evaluation of need within 60 working~~
 63.12 ~~days of a request for service by a person with a developmental disability, and within~~
 63.13 five working days of an emergency admission of a person to an intermediate care
 63.14 facility for persons with developmental disabilities. ~~The screening team shall consist of~~
 63.15 ~~the case manager for persons with developmental disabilities, the person, the person's~~
 63.16 ~~legal guardian or conservator, or the parent if the person is a minor, and a qualified~~
 63.17 ~~developmental disability professional, as defined in the Code of Federal Regulations,~~
 63.18 ~~title 42, section 483.430, as amended through June 3, 1988. The case manager may also~~
 63.19 ~~act as the qualified developmental disability professional if the case manager meets~~
 63.20 ~~the federal definition. County social service agencies may contract with a public or~~
 63.21 ~~private agency or individual who is not a service provider for the person for the public~~

60.22 guardianship representation required by the screening or individual service planning
 60.23 process. The contract shall be limited to public guardianship representation for the
 60.24 screening and individual service planning activities. The contract shall require compliance
 60.25 with the commissioner's instructions and may be for paid or voluntary services. For
 60.26 persons determined to have overriding health care needs and are seeking admission to a
 60.27 nursing facility or an ICF/MR, or seeking access to home and community-based-waivered
 60.28 services, a registered nurse must be designated as either the case manager or the qualified
 60.29 developmental disability professional. For persons under the jurisdiction of a correctional
 60.30 agency, the case manager must consult with the corrections administrator regarding
 60.31 additional health, safety, and supervision needs. The case manager, with the concurrence
 60.32 of the person, the person's legal guardian or conservator, or the parent if the person is a
 60.33 minor, may invite other individuals to attend meetings of the screening team. No member
 60.34 of the screening team shall have any direct or indirect service provider interest in the case.
 60.35 Nothing in this section shall be construed as requiring the screening team meeting to be
 60.36 separate from the service planning meeting.

61.1 Sec. 32. Minnesota Statutes 2010, section 256B.092, subdivision 8, is amended to read:

61.2 Subd. 8. **Screening team Additional certified assessor duties.** In addition to the
 61.3 responsibilities of certified assessors described in section 256B.0911, for persons with
 61.4 developmental disabilities, the screening team certified assessor shall:

61.5 ~~(1) review diagnostic data;~~

61.6 ~~(2) review health, social, and developmental assessment data using a uniform
 61.7 screening tool specified by the commissioner;~~

61.8 ~~(3) identify the level of services appropriate to maintain the person in the most
 61.9 normal and least restrictive setting that is consistent with the person's treatment needs;~~

61.10 ~~(4)~~ (1) identify other noninstitutional public assistance or social service that may
 61.11 prevent or delay long-term residential placement;

61.12 ~~(5)~~ (2) assess whether a person is in need of long-term residential care;

61.13 ~~(6)~~ (3) make recommendations regarding placement and payment for: (i) social
 61.14 service or public assistance support, or both, to maintain a person in the person's own home
 61.15 or other place of residence; (ii) training and habilitation service, vocational rehabilitation,
 61.16 and employment training activities; (iii) community residential placement; (iv) regional
 61.17 treatment center placement; or (v) a home and community-based service alternative to
 61.18 community residential placement or regional treatment center placement;

61.19 ~~(7)~~ (4) evaluate the availability, location, and quality of the services listed in clause
 61.20 ~~(6)~~ (3), including the impact of placement alternatives on the person's ability to maintain
 61.21 or improve existing patterns of contact and involvement with parents and other family
 61.22 members;

61.23 ~~(8)~~ (5) identify the cost implications of recommendations in clause ~~(6)~~ (3); and

63.22 guardianship representation required by the screening or individual service planning
 63.23 process. The contract shall be limited to public guardianship representation for the
 63.24 screening and individual service planning activities. The contract shall require compliance
 63.25 with the commissioner's instructions and may be for paid or voluntary services. For
 63.26 persons determined to have overriding health care needs and are seeking admission to a
 63.27 nursing facility or an ICF/MR, or seeking access to home and community-based-waivered
 63.28 services, a registered nurse must be designated as either the case manager or the qualified
 63.29 developmental disability professional. For persons under the jurisdiction of a correctional
 63.30 agency, the case manager must consult with the corrections administrator regarding
 63.31 additional health, safety, and supervision needs. The case manager, with the concurrence
 63.32 of the person, the person's legal guardian or conservator, or the parent if the person is a
 63.33 minor, may invite other individuals to attend meetings of the screening team. No member
 63.34 of the screening team shall have any direct or indirect service provider interest in the case.
 63.35 Nothing in this section shall be construed as requiring the screening team meeting to be
 63.36 separate from the service planning meeting.

64.1 Sec. 32. Minnesota Statutes 2010, section 256B.092, subdivision 8, is amended to read:

64.2 Subd. 8. **Screening team Additional certified assessor duties.** In addition to the
 64.3 responsibilities of certified assessors described in section 256B.0911, for persons with
 64.4 developmental disabilities, the screening team certified assessor shall:

64.5 ~~(1) review diagnostic data;~~

64.6 ~~(2) review health, social, and developmental assessment data using a uniform
 64.7 screening tool specified by the commissioner;~~

64.8 ~~(3) identify the level of services appropriate to maintain the person in the most
 64.9 normal and least restrictive setting that is consistent with the person's treatment needs;~~

64.10 ~~(4)~~ (1) identify other noninstitutional public assistance or social service that may
 64.11 prevent or delay long-term residential placement;

64.12 ~~(5)~~ (2) assess whether a person is in need of long-term residential care;

64.13 ~~(6)~~ (3) make recommendations regarding placement and payment for: (i) social
 64.14 service or public assistance support, or both, to maintain a person in the person's own home
 64.15 or other place of residence; (ii) training and habilitation service, vocational rehabilitation,
 64.16 and employment training activities; (iii) community residential placement; (iv) regional
 64.17 treatment center placement; or (v) a home and community-based service alternative to
 64.18 community residential placement or regional treatment center placement;

64.19 ~~(7)~~ (4) evaluate the availability, location, and quality of the services listed in clause
 64.20 ~~(6)~~ (3), including the impact of placement alternatives on the person's ability to maintain
 64.21 or improve existing patterns of contact and involvement with parents and other family
 64.22 members;

64.23 ~~(8)~~ (5) identify the cost implications of recommendations in clause ~~(6)~~ (3); and

61.24 ~~(9)~~ (6) make recommendations to a court as may be needed to assist the court in
 61.25 making decisions regarding commitment of persons with developmental disabilities; ~~and~~
 61.26 ~~(10) inform the person and the person's legal guardian or conservator, or the parent if~~
 61.27 ~~the person is a minor, that appeal may be made to the commissioner pursuant to section~~
 61.28 ~~256.045.~~

61.29 Sec. 33. Minnesota Statutes 2010, section 256B.092, subdivision 8a, is amended to
 61.30 read:

61.31 Subd. 8a. **County concurrence notification.** (a) If the county of financial
 61.32 responsibility wishes to place a person in another county for services, the county of
 61.33 financial responsibility shall ~~seek concurrence from~~ notify the proposed county of service
 61.34 and the placement shall be made cooperatively between the two counties. Arrangements
 61.35 shall be made between the two counties for ongoing social service, including annual
 62.1 reviews of the person's ~~individual service coordinated service and support plan.~~ The county
 62.2 where services are provided may not make changes in the person's service coordinated
 62.3 service and support plan without approval by the county of financial responsibility.

62.4 (b) ~~When a person has been screened and authorized for services in an intermediate~~
 62.5 ~~care facility for persons with developmental disabilities or for home and community-based~~
 62.6 ~~services for persons with developmental disabilities, the case manager shall assist that~~
 62.7 ~~person in identifying a service provider who is able to meet the needs of the person~~
 62.8 ~~according to the person's individual service plan. If the identified service is to be provided~~
 62.9 ~~in a county other than the county of financial responsibility, the county of financial~~
 62.10 ~~responsibility shall request concurrence of the county where the person is requesting to~~
 62.11 ~~receive the identified services. The county of service may refuse to concur shall notify~~
 62.12 the county of financial responsibility if:

62.13 ~~(1) it can demonstrate that the provider is unable to provide the services identified in~~
 62.14 ~~the person's individual service plan as services that are needed and are to be provided; or~~

62.15 ~~(2)~~ ₂ in the case of an intermediate care facility for persons with developmental
 62.16 disabilities, there has been no authorization for admission by the admission review team
 62.17 as required in section 256B.0926.

64.24 ~~(9)~~ (6) make recommendations to a court as may be needed to assist the court in
 64.25 making decisions regarding commitment of persons with developmental disabilities; ~~and~~
 64.26 ~~(10) inform the person and the person's legal guardian or conservator, or the parent if~~
 64.27 ~~the person is a minor, that appeal may be made to the commissioner pursuant to section~~
 64.28 ~~256.045.~~

64.29 Sec. 33. Minnesota Statutes 2010, section 256B.092, subdivision 8a, is amended to
 64.30 read:

64.31 Subd. 8a. **County concurrence notification.** (a) If the county of financial
 64.32 responsibility wishes to place a person in another county for services, the county of
 64.33 financial responsibility shall ~~seek concurrence from~~ notify the proposed county of service
 64.34 and the placement shall be made cooperatively between the two counties. Arrangements
 64.35 shall be made between the two counties for ongoing social service, including annual
 65.1 reviews of the person's ~~individual service coordinated service and support plan.~~ The county
 65.2 where services are provided may not make changes in the person's service coordinated
 65.3 service and support plan without approval by the county of financial responsibility.

65.4 (b) ~~When a person has been screened and authorized for services in an intermediate~~
 65.5 ~~care facility for persons with developmental disabilities or for home and community-based~~
 65.6 ~~services for persons with developmental disabilities, the case manager shall assist that~~
 65.7 ~~person in identifying a service provider who is able to meet the needs of the person~~
 65.8 ~~according to the person's individual service plan. If the identified service is to be provided~~
 65.9 ~~in a county other than the county of financial responsibility, the county of financial~~
 65.10 ~~responsibility shall request concurrence of the county where the person is requesting to~~
 65.11 ~~receive the identified services. The county of service may refuse to concur shall notify~~
 65.12 the county of financial responsibility if:

65.13 ~~(1) it can demonstrate that the provider is unable to provide the services identified in~~
 65.14 ~~the person's individual service plan as services that are needed and are to be provided; or~~

65.15 ~~(2)~~ ₂ in the case of an intermediate care facility for persons with developmental
 65.16 disabilities, there has been no authorization for admission by the admission review team
 65.17 as required in section 256B.0926.

62.18 (c) The county of service shall notify the county of financial responsibility of
 62.19 ~~conurrence or refusal to concur~~ any concerns about the chosen provider's capacity to
 62.20 meet the needs of the person seeking to move to residential services in another county no
 62.21 later than 20 working days following receipt of the written request notification. Unless
 62.22 other mutually acceptable arrangements are made by the involved county agencies, the
 62.23 county of financial responsibility is responsible for costs of social services and the costs
 62.24 associated with the development and maintenance of the placement. The county of
 62.25 service may request that the county of financial responsibility purchase case management
 62.26 services from the county of service or from a contracted provider of case management
 62.27 when the county of financial responsibility is not providing case management as defined
 62.28 in this section and rules adopted under this section, unless other mutually acceptable
 62.29 arrangements are made by the involved county agencies. Standards for payment limits
 62.30 under this section may be established by the commissioner. Financial disputes between
 62.31 counties shall be resolved as provided in section 256G.09. This subdivision also applies to
 62.32 home and community-based waiver services provided under section 256B.49.

62.33 Sec. 34. Minnesota Statutes 2010, section 256B.092, subdivision 9, is amended to read:

62.34 Subd. 9. **Reimbursement.** Payment for services shall not be provided to a
 62.35 service provider for any person placed in an intermediate care facility for persons with
 63.1 developmental disabilities prior to the person ~~being screened by the screening team~~
 63.2 receiving an assessment by a certified assessor. The commissioner shall not deny
 63.3 reimbursement for: (1) a person admitted to an intermediate care facility for persons
 63.4 with developmental disabilities who is assessed to need long-term supportive services,
 63.5 if long-term supportive services other than intermediate care are not available in that
 63.6 community; (2) any person admitted to an intermediate care facility for persons with
 63.7 developmental disabilities under emergency circumstances; (3) any eligible person placed
 63.8 in the intermediate care facility for persons with developmental disabilities pending an
 63.9 appeal of the ~~screening team's certified assessor's~~ decision; or (4) any medical assistance
 63.10 recipient when, after full discussion of all appropriate alternatives including those that
 63.11 are expected to be less costly than intermediate care for persons with developmental
 63.12 disabilities, the person or the person's legal guardian or conservator, or the parent if the
 63.13 person is a minor, insists on intermediate care placement. The screening team certified
 63.14 assessor shall provide documentation that the most cost-effective alternatives available
 63.15 were offered to this individual or the individual's legal guardian or conservator.

63.16 Sec. 35. Minnesota Statutes 2010, section 256B.092, subdivision 11, is amended to
 63.17 read:

65.18 (c) The county of service shall notify the county of financial responsibility of
 65.19 ~~conurrence or refusal to concur~~ any concerns about the chosen provider's capacity to
 65.20 meet the needs of the person seeking to move to residential services in another county no
 65.21 later than 20 working days following receipt of the written request notification. Unless
 65.22 other mutually acceptable arrangements are made by the involved county agencies, the
 65.23 county of financial responsibility is responsible for costs of social services and the costs
 65.24 associated with the development and maintenance of the placement. The county of
 65.25 service may request that the county of financial responsibility purchase case management
 65.26 services from the county of service or from a contracted provider of case management
 65.27 when the county of financial responsibility is not providing case management as defined
 65.28 in this section and rules adopted under this section, unless other mutually acceptable
 65.29 arrangements are made by the involved county agencies. Standards for payment limits
 65.30 under this section may be established by the commissioner. Financial disputes between
 65.31 counties shall be resolved as provided in section 256G.09. This subdivision also applies to
 65.32 home and community-based waiver services provided under section 256B.49.

65.33 Sec. 34. Minnesota Statutes 2010, section 256B.092, subdivision 9, is amended to read:

65.34 Subd. 9. **Reimbursement.** Payment for services shall not be provided to a
 65.35 service provider for any person placed in an intermediate care facility for persons with
 66.1 developmental disabilities prior to the person ~~being screened by the screening team~~
 66.2 receiving an assessment by a certified assessor. The commissioner shall not deny
 66.3 reimbursement for: (1) a person admitted to an intermediate care facility for persons
 66.4 with developmental disabilities who is assessed to need long-term supportive services,
 66.5 if long-term supportive services other than intermediate care are not available in that
 66.6 community; (2) any person admitted to an intermediate care facility for persons with
 66.7 developmental disabilities under emergency circumstances; (3) any eligible person placed
 66.8 in the intermediate care facility for persons with developmental disabilities pending an
 66.9 appeal of the ~~screening team's certified assessor's~~ decision; or (4) any medical assistance
 66.10 recipient when, after full discussion of all appropriate alternatives including those that
 66.11 are expected to be less costly than intermediate care for persons with developmental
 66.12 disabilities, the person or the person's legal guardian or conservator, or the parent if the
 66.13 person is a minor, insists on intermediate care placement. The screening team certified
 66.14 assessor shall provide documentation that the most cost-effective alternatives available
 66.15 were offered to this individual or the individual's legal guardian or conservator.

66.16 Sec. 35. Minnesota Statutes 2010, section 256B.092, subdivision 11, is amended to
 66.17 read:

63.18 Subd. 11. **Residential support services.** (a) Upon federal approval, there is
 63.19 established a new service called residential support that is available on the community
 63.20 alternative care, community alternatives for disabled individuals, developmental
 63.21 disabilities, and traumatic brain injury waivers. Existing waiver service descriptions
 63.22 must be modified to the extent necessary to ensure there is no duplication between
 63.23 other services. Residential support services must be provided by vendors licensed as a
 63.24 community residential setting as defined in section 245A.11, subdivision 8.

63.25 (b) Residential support services must meet the following criteria:

63.26 (1) providers of residential support services must own or control the residential site;

63.27 (2) the residential site must not be the primary residence of the license holder;

63.28 (3) the residential site must have a designated program supervisor responsible for
 63.29 program oversight, development, and implementation of policies and procedures;

63.30 (4) the provider of residential support services must provide supervision, training,
 63.31 and assistance as described in the person's community coordinated services and support
 63.32 plan; and

63.33 (5) the provider of residential support services must meet the requirements of
 63.34 licensure and additional requirements of the person's community coordinated services and
 63.35 support plan.

64.1 (c) Providers of residential support services that meet the definition in paragraph
 64.2 (a) must be registered using a process determined by the commissioner beginning July
 64.3 1, 2009.

64.4 Sec. 36. Minnesota Statutes 2010, section 256B.49, subdivision 13, is amended to read:

64.5 Subd. 13. **Case management.** (a) Each recipient of a home and community-based
 64.6 waiver shall be provided case management services by qualified vendors as described
 64.7 in the federally approved waiver application. The case management service activities
 64.8 provided ~~will~~ must include:

64.9 (1) assessing the needs of the individual within 20 working days of a recipient's
 64.10 request;

64.11 (2) ~~developing~~ finalizing the written ~~individual service coordinated service and~~
 64.12 support plan within ten working days after the assessment is completed case manager
 64.13 receives the plan from the certified assessor;

64.14 (3) informing the recipient or the recipient's legal guardian or conservator of service
 64.15 options;

64.16 (4) assisting the recipient in the identification of potential service providers and
 64.17 available options for case management service and providers;

66.18 Subd. 11. **Residential support services.** (a) Upon federal approval, there is
 66.19 established a new service called residential support that is available on the community
 66.20 alternative care, community alternatives for disabled individuals, developmental
 66.21 disabilities, and traumatic brain injury waivers. Existing waiver service descriptions
 66.22 must be modified to the extent necessary to ensure there is no duplication between
 66.23 other services. Residential support services must be provided by vendors licensed as a
 66.24 community residential setting as defined in section 245A.11, subdivision 8.

66.25 (b) Residential support services must meet the following criteria:

66.26 (1) providers of residential support services must own or control the residential site;

66.27 (2) the residential site must not be the primary residence of the license holder;

66.28 (3) the residential site must have a designated program supervisor responsible for
 66.29 program oversight, development, and implementation of policies and procedures;

66.30 (4) the provider of residential support services must provide supervision, training,
 66.31 and assistance as described in the person's community coordinated services and support
 66.32 plan; and

66.33 (5) the provider of residential support services must meet the requirements of
 66.34 licensure and additional requirements of the person's community coordinated services and
 66.35 support plan.

67.1 (c) Providers of residential support services that meet the definition in paragraph
 67.2 (a) must be registered using a process determined by the commissioner beginning July
 67.3 1, 2009.

67.4 Sec. 36. Minnesota Statutes 2010, section 256B.49, subdivision 13, is amended to read:

67.5 Subd. 13. **Case management.** (a) Each recipient of a home and community-based
 67.6 waiver shall be provided case management services by qualified vendors as described
 67.7 in the federally approved waiver application. The case management service activities
 67.8 provided ~~will~~ must include:

67.9 ~~(1) assessing the needs of the individual within 20 working days of a recipient's~~
 67.10 ~~request;~~

67.11 ~~(2) developing~~ (1) finalizing the written ~~individual service coordinated service and~~
 67.12 support plan within ten working days after the assessment is completed case manager
 67.13 receives the plan from the certified assessor;

67.14 ~~(3)~~ (2) informing the recipient or the recipient's legal guardian or conservator
 67.15 of service options;

67.16 ~~(4)~~ (3) assisting the recipient in the identification of potential service providers and
 67.17 available options for case management service and providers;

64.18 (5) assisting the recipient to access services and assisting with appeals under section
 64.19 256.045; and

64.20 (6) coordinating, evaluating, and monitoring of the services identified in the service
 64.21 plan;

64.22 ~~(7) completing the annual reviews of the service plan; and~~

64.23 ~~(8) informing the recipient or legal representative of the right to have assessments~~
 64.24 ~~completed and service plans developed within specified time periods, and to appeal county~~
 64.25 ~~action or inaction under section 256.045, subdivision 3, including the determination of~~
 64.26 ~~nursing facility level of care.~~

64.27 (b) The case manager may delegate certain aspects of the case management service
 64.28 activities to another individual provided there is oversight by the case manager. The case
 64.29 manager may not delegate those aspects which require professional judgment including
 64.30 assessments, reassessments, and care plan development;

64.31 (1) finalizing the coordinated service and support plan;

64.32 (2) ongoing assessment and monitoring of the person's needs and adequacy of the
 64.33 approved coordinated service and support plan; and

64.34 (3) adjustments to the coordinated service and support plan.

65.1 (c) Case management services must be provided by a public or private agency that
 65.2 is enrolled as a medical assistance provider determined by the commissioner to meet all
 65.3 of the requirements in the approved federal waiver plans. Case management services
 65.4 must not be provided to a recipient by a private agency that has any financial interest in
 65.5 the provision of any other services included in the recipient's coordinated services and
 65.6 support plan. For purposes of this section, "private agency" means any agency that is not
 65.7 identified as a lead agency under section 256B.0911, subdivision 1a, paragraph (d).

65.8 Sec. 37. Minnesota Statutes 2010, section 256B.49, subdivision 14, is amended to read:

65.9 Subd. 14. **Assessment and reassessment.** (a) Assessments of each recipient's
 65.10 strengths, informal support systems, and need for services shall be completed within
 65.11 20 working days of the recipient's request. Reassessment of each recipient's strengths,
 65.12 support systems, and need for services shall be conducted at least every 12 months and at
 65.13 other times when there has been a significant change in the recipient's functioning and
 65.14 reassessments shall be conducted by certified assessors according to section 256B.0911,
 65.15 subdivision 2b.

65.16 (b) There must be a determination that the client requires a hospital level of care or a
 65.17 nursing facility level of care as defined in section 144.0724, subdivision 11, at initial and
 65.18 subsequent assessments to initiate and maintain participation in the waiver program.

67.18 ~~(5)~~ (4) assisting the recipient to access services and assisting with appeals under
 67.19 section 256.045; and

67.20 ~~(6)~~ (5) coordinating, evaluating, and monitoring of the services identified in the
 67.21 service plan;

67.22 ~~(7) completing the annual reviews of the service plan; and~~

67.23 ~~(8) informing the recipient or legal representative of the right to have assessments~~
 67.24 ~~completed and service plans developed within specified time periods, and to appeal county~~
 67.25 ~~action or inaction under section 256.045, subdivision 3, including the determination of~~
 67.26 ~~nursing facility level of care.~~

67.27 (b) The case manager may delegate certain aspects of the case management service
 67.28 activities to another individual provided there is oversight by the case manager. The case
 67.29 manager may not delegate those aspects which require professional judgment including
 67.30 assessments, reassessments, and care plan development;

67.31 (1) finalizing the coordinated service and support plan;

67.32 (2) ongoing assessment and monitoring of the person's needs and adequacy of the
 67.33 approved coordinated service and support plan; and

67.34 (3) adjustments to the coordinated service and support plan.

68.1 (c) Case management services must be provided by a public or private agency that
 68.2 is enrolled as a medical assistance provider determined by the commissioner to meet all
 68.3 of the requirements in the approved federal waiver plans. Case management services
 68.4 must not be provided to a recipient by a private agency that has any financial interest in
 68.5 the provision of any other services included in the recipient's coordinated services and
 68.6 support plan. For purposes of this section, "private agency" means any agency that is not
 68.7 identified as a lead agency under section 256B.0911, subdivision 1a, paragraph (d).

68.8 Sec. 37. Minnesota Statutes 2010, section 256B.49, subdivision 14, is amended to read:

68.9 Subd. 14. **Assessment and reassessment.** (a) Assessments of each recipient's
 68.10 strengths, informal support systems, and need for services shall be completed within
 68.11 20 working days of the recipient's request. Reassessment of each recipient's strengths,
 68.12 support systems, and need for services shall be conducted at least every 12 months and at
 68.13 other times when there has been a significant change in the recipient's functioning and
 68.14 reassessments shall be conducted by certified assessors according to section 256B.0911,
 68.15 subdivision 2b.

68.16 (b) There must be a determination that the client requires a hospital level of care or a
 68.17 nursing facility level of care as defined in section 144.0724, subdivision 11, at initial and
 68.18 subsequent assessments to initiate and maintain participation in the waiver program.

65.19 (c) Regardless of other assessments identified in section 144.0724, subdivision 4, as
 65.20 appropriate to determine nursing facility level of care for purposes of medical assistance
 65.21 payment for nursing facility services, only face-to-face assessments conducted according
 65.22 to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care
 65.23 determination or a nursing facility level of care determination must be accepted for
 65.24 purposes of initial and ongoing access to waiver services payment.

~~65.25 (d) Persons with developmental disabilities who apply for services under the nursing
 65.26 facility-level waiver programs shall be screened for the appropriate level of care according
 65.27 to section 256B.092.~~

65.28 ~~(e)~~ (d) Recipients who are found eligible for home and community-based services
 65.29 under this section before their 65th birthday may remain eligible for these services after
 65.30 their 65th birthday if they continue to meet all other eligibility factors.

65.31 Sec. 38. Minnesota Statutes 2010, section 256B.49, subdivision 15, is amended to read:

65.32 Subd. 15. **Individualized Coordinated service and support plan.** (a) Each
 65.33 recipient of home and community-based waived services shall be provided a copy of the
 65.34 written ~~service~~ coordinated service and support plan which-

66.1 ~~(1) is developed and signed by the recipient within ten working days of the
 66.2 completion of the assessment;~~

66.3 ~~(2) meets the assessed needs of the recipient;~~

66.4 ~~(3) reasonably ensures the health and safety of the recipient;~~

66.5 ~~(4) promotes independence;~~

66.6 ~~(5) allows for services to be provided in the most integrated settings; and~~

66.7 ~~(6) provides for an informed choice, as defined in section 256B.77, subdivision
 66.8 2, paragraph (p), of service and support providers meets the requirements in section
 66.9 256B.092, subdivision 1b.~~

66.10 (b) When a county is evaluating denials, reductions, or terminations of home and
 66.11 community-based services under section 256B.49 for an individual, the case manager
 66.12 shall offer to meet with the individual or the individual's guardian in order to discuss the
 66.13 prioritization of service needs within the ~~individualized service coordinated services and
 66.14 support~~ plan. The reduction in the authorized services for an individual due to changes
 66.15 in funding for waived services may not exceed the amount needed to ensure medically
 66.16 necessary services to meet the individual's health, safety, and welfare.

66.17 Sec. 39. Minnesota Statutes 2010, section 256G.02, subdivision 6, is amended to read:

66.18 Subd. 6. **Excluded time.** "Excluded time" means:

68.19 (c) Regardless of other assessments identified in section 144.0724, subdivision 4, as
 68.20 appropriate to determine nursing facility level of care for purposes of medical assistance
 68.21 payment for nursing facility services, only face-to-face assessments conducted according
 68.22 to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care
 68.23 determination or a nursing facility level of care determination must be accepted for
 68.24 purposes of initial and ongoing access to waiver services payment.

~~68.25 (d) Persons with developmental disabilities who apply for services under the nursing
 68.26 facility-level waiver programs shall be screened for the appropriate level of care according
 68.27 to section 256B.092.~~

68.28 ~~(e)~~ (d) Recipients who are found eligible for home and community-based services
 68.29 under this section before their 65th birthday may remain eligible for these services after
 68.30 their 65th birthday if they continue to meet all other eligibility factors.

68.31 Sec. 38. Minnesota Statutes 2010, section 256B.49, subdivision 15, is amended to read:

68.32 Subd. 15. **Individualized Coordinated service and support plan.** (a) Each
 68.33 recipient of home and community-based waived services shall be provided a copy of the
 68.34 written ~~service~~ coordinated service and support plan which-

69.1 ~~(1) is developed and signed by the recipient within ten working days of the
 69.2 completion of the assessment;~~

69.3 ~~(2) meets the assessed needs of the recipient;~~

69.4 ~~(3) reasonably ensures the health and safety of the recipient;~~

69.5 ~~(4) promotes independence;~~

69.6 ~~(5) allows for services to be provided in the most integrated settings; and~~

69.7 ~~(6) provides for an informed choice, as defined in section 256B.77, subdivision
 69.8 2, paragraph (p), of service and support providers meets the requirements in section
 69.9 256B.092, subdivision 1b.~~

69.10 (b) When a county is evaluating denials, reductions, or terminations of home and
 69.11 community-based services under section 256B.49 for an individual, the case manager
 69.12 shall offer to meet with the individual or the individual's guardian in order to discuss the
 69.13 prioritization of service needs within the ~~individualized service coordinated services and
 69.14 support~~ plan. The reduction in the authorized services for an individual due to changes
 69.15 in funding for waived services may not exceed the amount needed to ensure medically
 69.16 necessary services to meet the individual's health, safety, and welfare.

69.17 Sec. 39. Minnesota Statutes 2010, section 256G.02, subdivision 6, is amended to read:

69.18 Subd. 6. **Excluded time.** "Excluded time" means:

66.19 ~~(a)~~ (1) any period an applicant spends in a hospital, sanitarium, nursing home,
 66.20 shelter other than an emergency shelter, halfway house, foster home, semi-independent
 66.21 living domicile or services program, residential facility offering care, board and lodging
 66.22 facility or other institution for the hospitalization or care of human beings, as defined in
 66.23 section 144.50, 144A.01, or 245A.02, subdivision 14; maternity home, battered women's
 66.24 shelter, or correctional facility; or any facility based on an emergency hold under sections
 66.25 253B.05, subdivisions 1 and 2, and 253B.07, subdivision 6;

66.26 ~~(b)~~ (2) any period an applicant spends on a placement basis in a training and
 66.27 habilitation program, including: a rehabilitation facility or work or employment program
 66.28 as defined in section 268A.01; ~~or receiving personal care assistance services pursuant to~~
 66.29 ~~section 256B.0659~~; semi-independent living services provided under section 252.275, and
 66.30 Minnesota Rules, parts 9525.0500 to 9525.0660; ~~or day training and habilitation programs~~
 66.31 and assisted living services; and

66.32 ~~(e)~~ (3) any placement for a person with an indeterminate commitment, including
 66.33 independent living.

67.1 Sec. 40. **RECOMMENDATIONS FOR FURTHER CASE MANAGEMENT**
 67.2 **REDESIGN.**

67.3 By February 1, 2012, the commissioner of human services shall develop a legislative
 67.4 report with specific recommendations and language for proposed legislation to be effective
 67.5 July 1, 2012, for the following:

67.6 (a) definitions of service and consolidation of standards and rates to the extent
 67.7 appropriate for all types of medical assistance case management service services, including
 67.8 targeted case management under Minnesota Statutes, sections 256B.0621, 256B.0924, and
 67.9 256B.094, and all types of home and community-based waiver case management and case
 67.10 management under Minnesota Rules, parts 9525.0004 to 9525.0036. This work must be
 67.11 completed in collaboration with efforts under Minnesota Statutes, section 256B.4912;

67.12 (b) recommendations on county of financial responsibility requirements and quality
 67.13 assurance measures for case management; and

67.14 (c) identification of county administrative functions that may remain entwined in
 67.15 case management service delivery models.

67.16 **ARTICLE 4**
 67.17 **NURSING FACILITIES**

67.18 Section 1. Minnesota Statutes 2010, section 144A.071, subdivision 3, is amended to
 67.19 read:

69.19 ~~(a)~~ (1) any period an applicant spends in a hospital, sanitarium, nursing home,
 69.20 shelter other than an emergency shelter, halfway house, foster home, semi-independent
 69.21 living domicile or services program, residential facility offering care, board and lodging
 69.22 facility or other institution for the hospitalization or care of human beings, as defined in
 69.23 section 144.50, 144A.01, or 245A.02, subdivision 14; maternity home, battered women's
 69.24 shelter, or correctional facility; or any facility based on an emergency hold under sections
 69.25 253B.05, subdivisions 1 and 2, and 253B.07, subdivision 6;

69.26 ~~(b)~~ (2) any period an applicant spends on a placement basis in a training and
 69.27 habilitation program, including: a rehabilitation facility or work or employment program
 69.28 as defined in section 268A.01; ~~or receiving personal care assistance services pursuant to~~
 69.29 ~~section 256B.0659~~; semi-independent living services provided under section 252.275, and
 69.30 Minnesota Rules, parts 9525.0500 to 9525.0660; ~~or day training and habilitation programs~~
 69.31 and assisted living services; and

69.32 ~~(e)~~ (3) any placement for a person with an indeterminate commitment, including
 69.33 independent living.

70.1 Sec. 40. **RECOMMENDATIONS FOR FURTHER CASE MANAGEMENT**
 70.2 **REDESIGN.**

70.3 By February 1, 2012, the commissioner of human services shall develop a legislative
 70.4 report with specific recommendations and language for proposed legislation to be effective
 70.5 July 1, 2012, for the following:

70.6 (a) definitions of service and consolidation of standards and rates to the extent
 70.7 appropriate for all types of medical assistance case management service services, including
 70.8 targeted case management under Minnesota Statutes, sections 256B.0621, 256B.0924, and
 70.9 256B.094, and all types of home and community-based waiver case management and case
 70.10 management under Minnesota Rules, parts 9525.0004 to 9525.0036. This work must be
 70.11 completed in collaboration with efforts under Minnesota Statutes, section 256B.4912;

70.12 (b) recommendations on county of financial responsibility requirements and quality
 70.13 assurance measures for case management; and

70.14 (c) identification of county administrative functions that may remain entwined in
 70.15 case management service delivery models.

70.16 **ARTICLE 4**
 70.17 **NURSING FACILITIES**

70.18 Section 1. Minnesota Statutes 2010, section 144A.071, subdivision 3, is amended to
 70.19 read:

67.20 Subd. 3. **Exceptions authorizing increase in beds; hardship areas.** (a) The
 67.21 commissioner of health, in coordination with the commissioner of human services, may
 67.22 approve the addition of a new ~~certified bed or the addition of a new~~ licensed and Medicare
 67.23 and Medicaid-certified nursing home bed beds, ~~under using the following conditions:~~
 67.24 ~~criteria and process in this subdivision.~~

67.25 ~~(a) to license or certify a new bed in place of one decertified after July 1, 1993, as~~
 67.26 ~~long as the number of certified plus newly certified or recertified beds does not exceed the~~
 67.27 ~~number of beds licensed or certified on July 1, 1993, or to address an extreme hardship~~
 67.28 ~~situation, in a particular county that, together with all contiguous Minnesota counties, has~~
 67.29 ~~fewer nursing home beds per 1,000 elderly than the number that is ten percent higher than~~
 67.30 ~~the national average of nursing home beds per 1,000 elderly individuals. For the purposes~~
 67.31 ~~of this section, the national average of nursing home beds shall be the most recent figure~~
 67.32 ~~that can be supplied by the federal Centers for Medicare and Medicaid Services and the~~
 67.33 ~~number of elderly in the county or the nation shall be determined by the most recent~~
 67.34 ~~federal census or the most recent estimate of the state demographer as of July 1, of each~~
 67.35 ~~year of persons age 65 and older, whichever is the most recent at the time of the request for~~
 68.1 ~~replacement. An extreme hardship situation can only be found after the county documents~~
 68.2 ~~the existence of unmet medical needs that cannot be addressed by any other alternatives;~~

68.3 (b) The commissioner, in cooperation with the commissioner of human services,
 68.4 shall consider the following criteria when determining that an area of the state is a
 68.5 hardship area with regard to access to nursing facility services:

68.6 (1) a low number of beds per 1,000 in a specified area using as a standard beds
 68.7 per 1,000 persons age 65 and older, in five-year age groups, using data from the most
 68.8 recent census and population projections, weighted by each group's most recent nursing
 68.9 home utilization, of the county at the 20th percentile, as determined by the commissioner
 68.10 of human services;

68.11 (2) a high level of out-migration for nursing facility services associated with a
 68.12 described area from the county or counties of residence to other Minnesota counties, as
 68.13 determined by the commissioner of human services, using as a standard an amount greater
 68.14 than the out-migration of the county ranked at the 50th percentile;

68.15 (3) an adequate level of availability of noninstitutional long-term care services
 68.16 measured as public spending for home and community-based long-term care services per
 68.17 individual age 65 and older, in five-year age groups, using data from the most recent
 68.18 census and population projections, weighted by each group's most recent nursing home
 68.19 utilization, as determined by the commissioner of human services, using as a standard an
 68.20 amount greater than the 50th percentile of counties;

68.21 (4) there must be a declaration of hardship resulting from insufficient access to
 68.22 nursing home beds by local county agencies and area agencies on aging; and

68.23 (5) other factors that may demonstrate the need to add new nursing facility beds.

70.20 Subd. 3. **Exceptions authorizing increase in beds; hardship areas.** (a) The
 70.21 commissioner of health, in coordination with the commissioner of human services, may
 70.22 approve the addition of a new ~~certified bed or the addition of a new~~ licensed and Medicare
 70.23 and Medicaid-certified nursing home bed beds, ~~under using the following conditions:~~
 70.24 ~~criteria and process in this subdivision.~~

70.25 ~~(a) to license or certify a new bed in place of one decertified after July 1, 1993, as~~
 70.26 ~~long as the number of certified plus newly certified or recertified beds does not exceed the~~
 70.27 ~~number of beds licensed or certified on July 1, 1993, or to address an extreme hardship~~
 70.28 ~~situation, in a particular county that, together with all contiguous Minnesota counties, has~~
 70.29 ~~fewer nursing home beds per 1,000 elderly than the number that is ten percent higher than~~
 70.30 ~~the national average of nursing home beds per 1,000 elderly individuals. For the purposes~~
 70.31 ~~of this section, the national average of nursing home beds shall be the most recent figure~~
 70.32 ~~that can be supplied by the federal Centers for Medicare and Medicaid Services and the~~
 70.33 ~~number of elderly in the county or the nation shall be determined by the most recent~~
 70.34 ~~federal census or the most recent estimate of the state demographer as of July 1, of each~~
 70.35 ~~year of persons age 65 and older, whichever is the most recent at the time of the request for~~
 71.1 ~~replacement. An extreme hardship situation can only be found after the county documents~~
 71.2 ~~the existence of unmet medical needs that cannot be addressed by any other alternatives;~~

71.3 (b) The commissioner, in cooperation with the commissioner of human services,
 71.4 shall consider the following criteria when determining that an area of the state is a
 71.5 hardship area with regard to access to nursing facility services:

71.6 (1) a low number of beds per 1,000 in a specified area using as a standard beds
 71.7 per 1,000 persons age 65 and older, in five-year age groups, using data from the most
 71.8 recent census and population projections, weighted by each group's most recent nursing
 71.9 home utilization, of the county at the 20th percentile, as determined by the commissioner
 71.10 of human services;

71.11 (2) a high level of out-migration for nursing facility services associated with a
 71.12 described area from the county or counties of residence to other Minnesota counties, as
 71.13 determined by the commissioner of human services, using as a standard an amount greater
 71.14 than the out-migration of the county ranked at the 50th percentile;

71.15 (3) an adequate level of availability of noninstitutional long-term care services
 71.16 measured as public spending for home and community-based long-term care services per
 71.17 individual age 65 and older, in five-year age groups, using data from the most recent
 71.18 census and population projections, weighted by each group's most recent nursing home
 71.19 utilization, as determined by the commissioner of human services, using as a standard an
 71.20 amount greater than the 50th percentile of counties;

71.21 (4) there must be a declaration of hardship resulting from insufficient access to
 71.22 nursing home beds by local county agencies and area agencies on aging; and

71.23 (5) other factors that may demonstrate the need to add new nursing facility beds.

68.24 (c) On August 15 of odd-numbered years, the commissioner, in cooperation with
 68.25 the commissioner of human services, may publish in the State Register a request for
 68.26 information in which interested parties, using the data provided under section 144A.351,
 68.27 along with any other relevant data, demonstrate that a specified area is a hardship area
 68.28 with regard to access to nursing facility services. For a response to be considered, the
 68.29 commissioner must receive it by November 15. The commissioner shall make responses
 68.30 to the request for information available to the public and shall allow 30 days for comment.
 68.31 The commissioner shall review responses and comments and determine if any areas of
 68.32 the state are to be declared hardship areas.

68.33 (d) For each designated hardship area determined in paragraph (c), the commissioner
 68.34 shall publish a request for proposals in accordance with section 144A.073 and Minnesota
 68.35 Rules, parts 4655.1070 to 4655.1098. The request for proposals must be published in the
 68.36 State Register by March 15 following receipt of responses to the request for information.
 69.1 The request for proposals must specify the number of new beds which may be added
 69.2 in the designated hardship area, which must not exceed the number which, if added to
 69.3 the existing number of beds in the area, including beds in layaway status, would have
 69.4 prevented it from being determined to be a hardship area under paragraph (b), clause
 69.5 (1). Beginning July 1, 2011, the number of new beds approved must not exceed 200
 69.6 beds statewide per biennium. After June 30, 2019, the number of new beds that may be
 69.7 approved in a biennium must not exceed 300 statewide. For a proposal to be considered,
 69.8 the commissioner must receive it within six months of the publication of the request for
 69.9 proposals. The commissioner shall review responses to the request for proposals and
 69.10 shall approve or disapprove each proposal by the following July 15, in accordance with
 69.11 section 144A.073 and Minnesota Rules, parts 4655.1070 to 4655.1098. The commissioner
 69.12 shall base approvals or disapprovals on a comparison and ranking of proposals using
 69.13 only the criteria in subdivision 4a. Approval of a proposal expires after 18 months
 69.14 unless the facility has added the new beds using existing space, subject to approval
 69.15 by the commissioner, or has commenced construction as defined in section 144A.071,
 69.16 subdivision 1a, paragraph (d). If fewer than 50 percent of the beds in a facility are newly
 69.17 licensed, after the beds have been added, the operating payment rates previously in effect
 69.18 shall remain. If 50 percent or more of the beds in a facility are newly licensed after the
 69.19 approved beds have been added, then determination of operating payment rates shall
 69.20 be done according to Minnesota Rules, part 9549.0057, using limits determined under
 69.21 section 256B.441. Determination of external fixed payment rates must be done according
 69.22 to section 256B.441, subdivision 53. Determinations of property payment rates for
 69.23 facilities with beds added under this subdivision must be done in the same manner as rate
 69.24 determinations resulting from projects approved and completed under section 144A.073.

69.25 ~~(b)~~ (e) The commissioner may:

71.24 (c) On August 15 of odd-numbered years, the commissioner, in cooperation with
 71.25 the commissioner of human services, may publish in the State Register a request for
 71.26 information in which interested parties, using the data provided under section 144A.351,
 71.27 along with any other relevant data, demonstrate that a specified area is a hardship area
 71.28 with regard to access to nursing facility services. For a response to be considered, the
 71.29 commissioner must receive it by November 15. The commissioner shall make responses
 71.30 to the request for information available to the public and shall allow 30 days for comment.
 71.31 The commissioner shall review responses and comments and determine if any areas of
 71.32 the state are to be declared hardship areas.

71.33 (d) For each designated hardship area determined in paragraph (c), the commissioner
 71.34 shall publish a request for proposals in accordance with section 144A.073 and Minnesota
 71.35 Rules, parts 4655.1070 to 4655.1098. The request for proposals must be published in the
 71.36 State Register by March 15 following receipt of responses to the request for information.
 72.1 The request for proposals must specify the number of new beds which may be added
 72.2 in the designated hardship area, which must not exceed the number which, if added to
 72.3 the existing number of beds in the area, including beds in layaway status, would have
 72.4 prevented it from being determined to be a hardship area under paragraph (b), clause
 72.5 (1). Beginning July 1, 2011, the number of new beds approved must not exceed 200
 72.6 beds statewide per biennium. After June 30, 2019, the number of new beds that may be
 72.7 approved in a biennium must not exceed 300 statewide. For a proposal to be considered,
 72.8 the commissioner must receive it within six months of the publication of the request for
 72.9 proposals. The commissioner shall review responses to the request for proposals and
 72.10 shall approve or disapprove each proposal by the following July 15, in accordance with
 72.11 section 144A.073 and Minnesota Rules, parts 4655.1070 to 4655.1098. The commissioner
 72.12 shall base approvals or disapprovals on a comparison and ranking of proposals using
 72.13 only the criteria in subdivision 4a. Approval of a proposal expires after 18 months
 72.14 unless the facility has added the new beds using existing space, subject to approval
 72.15 by the commissioner, or has commenced construction as defined in section 144A.071,
 72.16 subdivision 1a, paragraph (d). If fewer than 50 percent of the beds in a facility are newly
 72.17 licensed, after the beds have been added, the operating payment rates previously in effect
 72.18 shall remain. If 50 percent or more of the beds in a facility are newly licensed after the
 72.19 approved beds have been added, then determination of operating payment rates shall
 72.20 be done according to Minnesota Rules, part 9549.0057, using limits determined under
 72.21 section 256B.441. Determination of external fixed payment rates must be done according
 72.22 to section 256B.441, subdivision 53. Determinations of property payment rates for
 72.23 facilities with beds added under this subdivision must be done in the same manner as rate
 72.24 determinations resulting from projects approved and completed under section 144A.073.

72.25 ~~(b)~~ (e) The commissioner may:

69.26 (1) certify or license new beds in a new facility that is to be operated by the
 69.27 commissioner of veterans affairs or when the costs of constructing and operating the new
 69.28 beds are to be reimbursed by the commissioner of veterans affairs or the United States
 69.29 Veterans Administration; and

69.30 ~~(e) to~~ (2) license or certify beds in a facility that has been involuntarily delicensed or
 69.31 decertified for participation in the medical assistance program, provided that an application
 69.32 for relicensure or recertification is submitted to the commissioner by an organization that
 69.33 is not a related organization as defined in section 256B.441, subdivision 34, to the prior
 69.34 licensee within 120 days after delicensure or decertification;

70.1 ~~(d) to certify two existing beds in a facility with 66 licensed beds on January 1, 1994,~~
 70.2 ~~that had an average occupancy rate of 98 percent or higher in both calendar years 1992 and~~
 70.3 ~~1993, and which began construction of four attached assisted living units in April 1993; or~~

70.4 ~~(e) to certify four existing beds in a facility in Winona with 139 beds, of which 129~~
 70.5 ~~beds are certified.~~

70.6 Sec. 2. Minnesota Statutes 2010, section 144D.08, is amended to read:

70.7 **144D.08 UNIFORM CONSUMER INFORMATION GUIDE.**

70.8 All housing with services establishments shall make available to all prospective
 70.9 and current residents information consistent with the uniform format and the required
 70.10 components adopted by the commissioner under section 144G.06. This section does not
 70.11 apply to an establishment registered under section 144D.025, serving the homeless.

70.12 Sec. 3. Minnesota Statutes 2010, section 256B.19, subdivision 1e, is amended to read:

72.26 (1) certify or license new beds in a new facility that is to be operated by the
 72.27 commissioner of veterans affairs or when the costs of constructing and operating the new
 72.28 beds are to be reimbursed by the commissioner of veterans affairs or the United States
 72.29 Veterans Administration; and

72.30 ~~(e) to~~ (2) license or certify beds in a facility that has been involuntarily delicensed or
 72.31 decertified for participation in the medical assistance program, provided that an application
 72.32 for relicensure or recertification is submitted to the commissioner by an organization that
 72.33 is not a related organization as defined in section 256B.441, subdivision 34, to the prior
 72.34 licensee within 120 days after delicensure or decertification;

73.1 ~~(d) to certify two existing beds in a facility with 66 licensed beds on January 1, 1994,~~
 73.2 ~~that had an average occupancy rate of 98 percent or higher in both calendar years 1992 and~~
 73.3 ~~1993, and which began construction of four attached assisted living units in April 1993; or~~

73.4 ~~(e) to certify four existing beds in a facility in Winona with 139 beds, of which 129~~
 73.5 ~~beds are certified.~~

73.6 Sec. 2. Minnesota Statutes 2010, section 144A.073, subdivision 3c, is amended to read:

73.7 Subd. 3c. **Cost neutral relocation projects.** (a) Notwithstanding subdivision 3, the
 73.8 commissioner may at any time accept proposals, or amendments to proposals previously
 73.9 approved under this section, for relocations that are cost neutral with respect to state costs
 73.10 as defined in section 144A.071, subdivision 5a. The commissioner, in consultation with
 73.11 the commissioner of human services, shall evaluate proposals according to subdivision
 73.12 ~~4 4a, clauses (1), (2), (3), and (9) (4), (5), (6), and (8), and other criteria established in~~
 73.13 rule- or law. The commissioner of human services shall determine the allowable payment
 73.14 rates of the facility receiving the beds in accordance with section 256B.441, subdivision
 73.15 60. The commissioner shall approve or disapprove a project within 90 days. Proposals
 73.16 and amendments approved under this subdivision are not subject to the six-mile limit
 73.17 in subdivision 5, paragraph (e).

73.18 (b) For the purposes of paragraph (a), cost neutrality shall be measured over the first
 73.19 three 12-month periods of operation after completion of the project.

73.20 Sec. 3. Minnesota Statutes 2010, section 144D.08, is amended to read:

73.21 **144D.08 UNIFORM CONSUMER INFORMATION GUIDE.**

73.22 All housing with services establishments shall make available to all prospective
 73.23 and current residents information consistent with the uniform format and the required
 73.24 components adopted by the commissioner under section 144G.06. This section does not
 73.25 apply to an establishment registered under section 144D.025, serving the homeless.

73.26 Sec. 4. Minnesota Statutes 2010, section 256B.19, subdivision 1e, is amended to read:

70.13 Subd. 1e. **Additional local share of certain nursing facility costs.** Beginning on
 70.14 the latter of January 1, 2011, or the first day of the month beginning no less than 45 days
 70.15 following federal approval, local government entities that own the physical plant or are
 70.16 the license holders of nursing facilities receiving rate adjustments under section 256B.441,
 70.17 subdivision 55a, shall be responsible for paying the portion of nonfederal costs calculated
 70.18 under section 256B.441, subdivision 55a, paragraph (d). This responsibility remains in
 70.19 effect through the day before the phase-in under section 256B.441, subdivision 55, is
 70.20 complete. Beginning the day when the phase-in under section 256B.441, subdivision 55,
 70.21 is complete, local government entities that own the physical plant or are the license holders
 70.22 of nursing facilities receiving rate adjustments under section 256B.441, subdivision 55a,
 70.23 shall be responsible for paying the portion of nonfederal costs calculated under section
 70.24 256B.441, subdivision 55a, paragraph (e). Payments of the nonfederal share shall be
 70.25 made monthly to the commissioner in amounts determined in accordance with section
 70.26 256B.441, subdivision 55a, paragraph ~~(d)~~ (e). Payments for each month beginning ~~in~~
 70.27 ~~January 2011 through September 2015~~ on the effective date of the rate adjustment shall be
 70.28 due by the 15th day of the following month. If any provider obligated to pay an amount
 70.29 under this subdivision is more than ~~two months~~ 30 days delinquent in the timely payment
 70.30 of the monthly installment, the commissioner may ~~withhold payments, penalties, and~~
 70.31 ~~interest in accordance with the methods outlined in section 256.9657, subdivision 7a~~
 70.32 revoke participation under this subdivision and end payments determined under section
 70.33 256B.441, subdivision 55a, to the participating nursing facility effective on the first day
 70.34 of the month following the month in which such notice was mailed. In the event of
 71.1 revocation, any amounts paid by private residents under this subdivision for days of
 71.2 service on or after the first day of the month following the month in which such notice was
 71.3 mailed must be refunded.

71.4 Sec. 4. Minnesota Statutes 2010, section 256B.431, subdivision 2t, is amended to read:

71.5 Subd. 2t. **Payment limitation.** For services rendered on or after July 1, 2003,
 71.6 for facilities reimbursed under this ~~section or section 256B.434~~ chapter, the Medicaid
 71.7 program shall only pay a co-payment during a Medicare-covered skilled nursing facility
 71.8 stay if the Medicare rate less the resident's co-payment responsibility is less than the
 71.9 Medicaid RUG-III case-mix payment rate, or, beginning January 1, 2012, the Medicaid
 71.10 RUG-IV case-mix payment rate. The amount that shall be paid by the Medicaid program
 71.11 is equal to the amount by which the Medicaid RUG-III or RUG-IV case-mix payment
 71.12 rate exceeds the Medicare rate less the co-payment responsibility. Health plans paying
 71.13 for nursing home services under section 256B.69, subdivision 6a, may limit payments as
 71.14 allowed under this subdivision.

71.15 Sec. 5. Minnesota Statutes 2010, section 256B.438, subdivision 1, is amended to read:

73.27 Subd. 1e. **Additional local share of certain nursing facility costs.** Beginning on
 73.28 the latter of January 1, 2011, or the first day of the month beginning no less than 45 days
 73.29 following federal approval, local government entities that own the physical plant or are
 73.30 the license holders of nursing facilities receiving rate adjustments under section 256B.441,
 73.31 subdivision 55a, shall be responsible for paying the portion of nonfederal costs calculated
 73.32 under section 256B.441, subdivision 55a, paragraph (d). This responsibility remains in
 73.33 effect through the day before the phase-in under section 256B.441, subdivision 55, is
 74.1 complete. Beginning the day when the phase-in under section 256B.441, subdivision 55,
 74.2 is complete, local government entities that own the physical plant or are the license holders
 74.3 of nursing facilities receiving rate adjustments under section 256B.441, subdivision 55a,
 74.4 shall be responsible for paying the portion of nonfederal costs calculated under section
 74.5 256B.441, subdivision 55a, paragraph (e). Payments of the nonfederal share shall be
 74.6 made monthly to the commissioner in amounts determined in accordance with section
 74.7 256B.441, subdivision 55a, paragraph ~~(d)~~ (e). Payments for each month beginning ~~in~~
 74.8 ~~January 2011 through September 2015~~ on the effective date of the rate adjustment shall be
 74.9 due by the 15th day of the following month. If any provider obligated to pay an amount
 74.10 under this subdivision is more than ~~two months~~ 30 days delinquent in the timely payment
 74.11 of the monthly installment, the commissioner may ~~withhold payments, penalties, and~~
 74.12 ~~interest in accordance with the methods outlined in section 256.9657, subdivision 7a~~
 74.13 revoke participation under this subdivision and end payments determined under section
 74.14 256B.441, subdivision 55a, to the participating nursing facility effective on the first day
 74.15 of the month following the month in which such notice was mailed. In the event of
 74.16 revocation, any amounts paid by private residents under this subdivision for days of
 74.17 service on or after the first day of the month following the month in which such notice was
 74.18 mailed must be refunded.

74.19 Sec. 5. Minnesota Statutes 2010, section 256B.431, subdivision 2t, is amended to read:

74.20 Subd. 2t. **Payment limitation.** For services rendered on or after July 1, 2003,
 74.21 for facilities reimbursed under this ~~section or section 256B.434~~ chapter, the Medicaid
 74.22 program shall only pay a co-payment during a Medicare-covered skilled nursing facility
 74.23 stay if the Medicare rate less the resident's co-payment responsibility is less than the
 74.24 Medicaid RUG-III case-mix payment rate, or, beginning January 1, 2012, the Medicaid
 74.25 RUG-IV case-mix payment rate. The amount that shall be paid by the Medicaid program
 74.26 is equal to the amount by which the Medicaid RUG-III or RUG-IV case-mix payment
 74.27 rate exceeds the Medicare rate less the co-payment responsibility. Health plans paying
 74.28 for nursing home services under section 256B.69, subdivision 6a, may limit payments as
 74.29 allowed under this subdivision.

74.30 Sec. 6. Minnesota Statutes 2010, section 256B.438, subdivision 1, is amended to read:

71.16 Subdivision 1. **Scope.** This section establishes the method and criteria used to
 71.17 determine resident reimbursement classifications based upon the assessments of residents
 71.18 of nursing homes and boarding care homes whose payment rates are established under
 71.19 section 256B.431, 256B.434, or ~~256B.435~~ 256B.441 or any other section. Resident
 71.20 reimbursement classifications shall be established according to the 34 group, resource
 71.21 utilization groups, version III or RUG-III model as described in section 144.0724.
 71.22 Reimbursement classifications established under this section shall be implemented
 71.23 after June 30, 2002, but no later than January 1, 2003. Reimbursement classifications
 71.24 established under this section shall be implemented no earlier than six weeks after the
 71.25 commissioner mails notices of payment rates to the facilities. Effective January 1, 2012,
 71.26 resident reimbursement classifications shall be established according to the 48 group,
 71.27 resource utilization groups, RUG-IV model under section 144.0724.

71.28 Sec. 6. Minnesota Statutes 2010, section 256B.438, subdivision 3, is amended to read:

71.29 Subd. 3. **Case mix indices.** (a) The commissioner of human services shall assign a
 71.30 case mix index to each resident class based on the Centers for Medicare and Medicaid
 71.31 Services staff time measurement study and adjusted for Minnesota-specific wage indices.
 71.32 The case mix indices assigned to each resident class shall be published in the Minnesota
 72.1 State Register at least 120 days prior to the implementation of the 34 group, RUG-III
 72.2 resident classification system.

72.3 (b) An index maximization approach shall be used to classify residents.

72.4 (c) After implementation of the revised case mix system, the commissioner of
 72.5 human services may annually rebase case mix indices and base rates using more current
 72.6 data on average wage rates and staff time measurement studies. This rebasing shall be
 72.7 calculated under subdivision 7, paragraph (b). The commissioner shall publish in the
 72.8 Minnesota State Register adjusted case mix indices at least 45 days prior to the effective
 72.9 date of the adjusted case mix indices.

72.10 (d) Upon implementation of the 48-group RUG-IV resident classification system, the
 72.11 commissioner of human services shall assign a case mix index to each resident class based
 72.12 on the Centers for Medicare and Medicaid Services staff time measurement study. The
 72.13 case mix indices assigned to each resident class shall be published in the State Register at
 72.14 least 120 days prior to the implementation of the RUG-IV resident classification system.

72.15 Sec. 7. Minnesota Statutes 2010, section 256B.438, subdivision 4, is amended to read:

72.16 Subd. 4. **Resident assessment schedule.** (a) Nursing facilities shall conduct and
 72.17 submit case mix assessments according to the schedule established by the commissioner
 72.18 of health under section 144.0724, subdivisions 4 and 5.

74.31 Subdivision 1. **Scope.** This section establishes the method and criteria used to
 74.32 determine resident reimbursement classifications based upon the assessments of residents
 74.33 of nursing homes and boarding care homes whose payment rates are established under
 74.34 section 256B.431, 256B.434, or ~~256B.435~~ 256B.441 or any other section. Resident
 75.1 reimbursement classifications shall be established according to the 34 group, resource
 75.2 utilization groups, version III or RUG-III model as described in section 144.0724.
 75.3 Reimbursement classifications established under this section shall be implemented
 75.4 after June 30, 2002, but no later than January 1, 2003. Reimbursement classifications
 75.5 established under this section shall be implemented no earlier than six weeks after the
 75.6 commissioner mails notices of payment rates to the facilities. Effective January 1, 2012,
 75.7 resident reimbursement classifications shall be established according to the 48 group,
 75.8 resource utilization groups, RUG-IV model under section 144.0724.

75.9 Sec. 7. Minnesota Statutes 2010, section 256B.438, subdivision 3, is amended to read:

75.10 Subd. 3. **Case mix indices.** (a) The commissioner of human services shall assign a
 75.11 case mix index to each resident class based on the Centers for Medicare and Medicaid
 75.12 Services staff time measurement study and adjusted for Minnesota-specific wage indices.
 75.13 The case mix indices assigned to each resident class shall be published in the Minnesota
 75.14 State Register at least 120 days prior to the implementation of the 34 group, RUG-III
 75.15 resident classification system.

75.16 (b) An index maximization approach shall be used to classify residents.

75.17 (c) After implementation of the revised case mix system, the commissioner of
 75.18 human services may annually rebase case mix indices and base rates using more current
 75.19 data on average wage rates and staff time measurement studies. This rebasing shall be
 75.20 calculated under subdivision 7, paragraph (b). The commissioner shall publish in the
 75.21 Minnesota State Register adjusted case mix indices at least 45 days prior to the effective
 75.22 date of the adjusted case mix indices.

75.23 (d) Upon implementation of the 48-group RUG-IV resident classification system, the
 75.24 commissioner of human services shall assign a case mix index to each resident class based
 75.25 on the Centers for Medicare and Medicaid Services staff time measurement study. The
 75.26 case mix indices assigned to each resident class shall be published in the State Register at
 75.27 least 120 days prior to the implementation of the RUG-IV resident classification system.

75.28 Sec. 8. Minnesota Statutes 2010, section 256B.438, subdivision 4, is amended to read:

75.29 Subd. 4. **Resident assessment schedule.** (a) Nursing facilities shall conduct and
 75.30 submit case mix assessments according to the schedule established by the commissioner
 75.31 of health under section 144.0724, subdivisions 4 and 5.

72.19 (b) The resident reimbursement classifications established under section 144.0724, 72.20 subdivision 3, shall be effective the day of admission for new admission assessments.
72.21 The effective date for significant change assessments shall be the assessment reference 72.22 date. The effective date for annual and quarterly assessments shall be the first day of the 72.23 month following assessment reference date.

72.24 (c) Effective October 1, 2006, the commissioner shall rebase payment rates 72.25 to account for the change in the resident assessment schedule in section 144.0724, 72.26 subdivision 4, paragraph (b), clause (4), in a facility specific budget neutral manner, 72.27 according to subdivision 7, paragraph (b).

72.28 (d) Effective January 1, 2012, the commissioner shall determine payment rates 72.29 to account for the transition to RUG-IV, in a facility-specific, revenue-neutral manner, 72.30 according to subdivision 8, paragraph (b).

72.31 Sec. 8. Minnesota Statutes 2010, section 256B.438, is amended by adding a 72.32 subdivision to read:

72.33 Subd. 8. Rate determination upon transition to RUG-IV payment rates. (a) The
72.34 commissioner of human services shall determine payment rates at the time of transition
73.1 to the RUG-IV-based payment model in a facility-specific, revenue-neutral manner. To
73.2 transition from the current calculation methodology to the RUG-IV-based methodology,
73.3 nursing facilities shall report to the commissioner of human services the private pay
73.4 and Medicaid resident days classified according to the categories defined in subdivision
73.5 3, paragraphs (a) and (d), for the six-month reporting period ending June 30, 2011. This
73.6 report must be submitted to the commissioner, in a form prescribed by the commissioner,
73.7 by August 15, 2011. The commissioner of human services shall use this data to compute
73.8 the standardized days for the RUG-III and RUG-IV classification systems.

73.9 (b) The commissioner of human services shall determine the case mix adjusted
73.10 component for the January 1, 2012, rate as follows:

73.11 (1) using the September 30, 2010, cost report, determine the case mix portion of the
73.12 operating cost for each facility;

73.13 (2) multiply the 36 operating payment rates in effect on December 31, 2011, by the
73.14 number of private pay and Medicaid resident days assigned to each group for the reporting
73.15 period ending June 30, 2011, and compute the total;

73.16 (3) compute the product of the amounts in clauses (1) and (2);

73.17 (4) determine the private pay and Medicaid RUG standardized days for the reporting
73.18 period ending June 30, 2011, using the new indices calculated under subdivision 3,
73.19 paragraph (d);

73.20 (5) divide the amount determined in clause (3) by the amount in clause (4), which
73.21 shall be the default rate (DDF) unadjusted case mix component of the rate under the
73.22 RUG-IV method; and

75.32 (b) The resident reimbursement classifications established under section 144.0724, 75.33 subdivision 3, shall be effective the day of admission for new admission assessments.
75.34 The effective date for significant change assessments shall be the assessment reference 76.1 date. The effective date for annual and quarterly assessments shall be the first day of the 76.2 month following assessment reference date.

76.3 (c) Effective October 1, 2006, the commissioner shall rebase payment rates 76.4 to account for the change in the resident assessment schedule in section 144.0724, 76.5 subdivision 4, paragraph (b), clause (4), in a facility specific budget neutral manner, 76.6 according to subdivision 7, paragraph (b).

76.7 (d) Effective January 1, 2012, the commissioner shall determine payment rates 76.8 to account for the transition to RUG-IV, in a facility-specific, revenue-neutral manner, 76.9 according to subdivision 8, paragraph (b).

76.10 Sec. 9. Minnesota Statutes 2010, section 256B.438, is amended by adding a 76.11 subdivision to read:

76.12 Subd. 8. Rate determination upon transition to RUG-IV payment rates. (a) The
76.13 commissioner of human services shall determine payment rates at the time of transition
76.14 to the RUG-IV-based payment model in a facility-specific, revenue-neutral manner. To
76.15 transition from the current calculation methodology to the RUG-IV-based methodology,
76.16 nursing facilities shall report to the commissioner of human services the private pay
76.17 and Medicaid resident days classified according to the categories defined in subdivision
76.18 3, paragraphs (a) and (d), for the six-month reporting period ending June 30, 2011. This
76.19 report must be submitted to the commissioner, in a form prescribed by the commissioner,
76.20 by August 15, 2011. The commissioner of human services shall use this data to compute
76.21 the standardized days for the RUG-III and RUG-IV classification systems.

76.22 (b) The commissioner of human services shall determine the case mix adjusted
76.23 component for the January 1, 2012, rate as follows:

76.24 (1) using the September 30, 2010, cost report, determine the case mix portion of the
76.25 operating cost for each facility;

76.26 (2) multiply the 36 operating payment rates in effect on December 31, 2011, by the
76.27 number of private pay and Medicaid resident days assigned to each group for the reporting
76.28 period ending June 30, 2011, and compute the total;

76.29 (3) compute the product of the amounts in clauses (1) and (2);

76.30 (4) determine the private pay and Medicaid RUG standardized days for the reporting
76.31 period ending June 30, 2011, using the new indices calculated under subdivision 3,
76.32 paragraph (d);

76.33 (5) divide the amount determined in clause (3) by the amount in clause (4), which
76.34 shall be the default rate (DDF) unadjusted case mix component of the rate under the
76.35 RUG-IV method; and

73.23 (6) determine the case mix adjusted component of each operating rate by multiplying
 73.24 the default rate (DDF) unadjusted case mix component by the case mix weight in
 73.25 subdivision 3, paragraph (d), for each RUG-IV group.

73.26 (c) The noncase mix components will be allocated to each RUG group as a constant
 73.27 amount to determine the operating payment rate.

73.28 Sec. 9. Minnesota Statutes 2010, section 256B.441, subdivision 55a, is amended to
 73.29 read:

73.30 Subd. 55a. **Alternative to phase-in for publicly owned nursing facilities.** (a) For
 73.31 operating payment rates implemented between ~~January 1, 2011, and September 30, 2015,~~
 73.32 the first day of the month beginning no less than 45 days following federal approval,
 73.33 and the day before the phase-in under subdivision 55 is complete, the commissioner
 73.34 shall allow nursing facilities whose physical plant is owned or whose license is held by a
 73.35 city, county, or hospital district to apply for a higher payment rate under this section if
 74.1 the local government entity agrees to pay a specified portion of the nonfederal share
 74.2 of medical assistance costs. Nursing facilities that apply shall be eligible to select an
 74.3 operating payment rate, with a weight of 1.00, up to the rate calculated in subdivision 54,
 74.4 without application of the phase-in under subdivision 55. The rates for the other RUG's
 74.5 ~~levels~~ RUGS shall be computed as provided under subdivision 54.

74.6 (b) For operating payment rates implemented beginning the day when the phase-in
 74.7 under subdivision 55 is complete, the commissioner shall allow nursing facilities whose
 74.8 physical plant is owned or whose license is held by a city, county, or hospital district to
 74.9 apply for a higher payment rate under this section if the local government entity agrees
 74.10 to pay a specified portion of the nonfederal share of medical assistance costs. Nursing
 74.11 facilities that apply are eligible to select an operating payment rate, with a weight of 1.00,
 74.12 up to an amount determined by the commissioner to be allowable under the Medicare upper
 74.13 payment limit test. The rates for the other RUGS shall be computed under subdivision 54.

74.14 ~~(b)~~ (c) Rates determined under this subdivision shall take effect beginning on the
 74.15 latter of January 1, 2011, or the first day of the month beginning no less than 45 days
 74.16 following federal approval, based on cost reports for the rate year ending September 30,
 74.17 2009, and in future rate years, rates determined for nursing facilities participating under
 74.18 this subdivision shall take effect on October 1 of each year, based on the most recent
 74.19 available cost report.

74.20 ~~(e)~~ (d) Eligible nursing facilities that wish to participate under this subdivision shall
 74.21 make an application to the commissioner by September 30, 2010, or by June 30 of any
 74.22 subsequent year. Participation under this subdivision is irrevocable. If paragraph (a) does
 74.23 not result in a rate greater than what would have been provided without application of this
 74.24 subdivision, a facility's rates shall be calculated as otherwise provided and no payment by
 74.25 the local government entity shall be required under paragraph (d).

77.1 (6) determine the case mix adjusted component of each operating rate by multiplying
 77.2 the default rate (DDF) unadjusted case mix component by the case mix weight in
 77.3 subdivision 3, paragraph (d), for each RUG-IV group.

77.4 (c) The noncase mix components will be allocated to each RUG group as a constant
 77.5 amount to determine the operating payment rate.

77.6 Sec. 10. Minnesota Statutes 2010, section 256B.441, subdivision 55a, is amended to
 77.7 read:

77.8 Subd. 55a. **Alternative to phase-in for publicly owned nursing facilities.** (a) For
 77.9 operating payment rates implemented between ~~January 1, 2011, and September 30, 2015,~~
 77.10 the first day of the month beginning no less than 45 days following federal approval,
 77.11 and the day before the phase-in under subdivision 55 is complete, the commissioner
 77.12 shall allow nursing facilities whose physical plant is owned or whose license is held by a
 77.13 city, county, or hospital district to apply for a higher payment rate under this section if
 77.14 the local government entity agrees to pay a specified portion of the nonfederal share
 77.15 of medical assistance costs. Nursing facilities that apply shall be eligible to select an
 77.16 operating payment rate, with a weight of 1.00, up to the rate calculated in subdivision 54,
 77.17 without application of the phase-in under subdivision 55. The rates for the other RUG's
 77.18 ~~levels~~ RUGS shall be computed as provided under subdivision 54.

77.19 (b) For operating payment rates implemented beginning the day when the phase-in
 77.20 under subdivision 55 is complete, the commissioner shall allow nursing facilities whose
 77.21 physical plant is owned or whose license is held by a city, county, or hospital district to
 77.22 apply for a higher payment rate under this section if the local government entity agrees
 77.23 to pay a specified portion of the nonfederal share of medical assistance costs. Nursing
 77.24 facilities that apply are eligible to select an operating payment rate, with a weight of 1.00,
 77.25 up to an amount determined by the commissioner to be allowable under the Medicare upper
 77.26 payment limit test. The rates for the other RUGS shall be computed under subdivision 54.

77.27 ~~(b)~~ (c) Rates determined under this subdivision shall take effect beginning on the
 77.28 latter of January 1, 2011, or the first day of the month beginning no less than 45 days
 77.29 following federal approval, based on cost reports for the rate year ending September 30,
 77.30 2009, and in future rate years, rates determined for nursing facilities participating under
 77.31 this subdivision shall take effect on October 1 of each year, based on the most recent
 77.32 available cost report.

77.33 ~~(e)~~ (d) Eligible nursing facilities that wish to participate under this subdivision shall
 77.34 make an application to the commissioner by September 30, 2010, or by June 30 of any
 77.35 subsequent year. Participation under this subdivision is irrevocable. If paragraph (a) does
 78.1 not result in a rate greater than what would have been provided without application of this
 78.2 subdivision, a facility's rates shall be calculated as otherwise provided and no payment by
 78.3 the local government entity shall be required under paragraph (d).

74.26 ~~(d)~~ (e) For each participating nursing facility, the public entity that owns the physical
 74.27 plant or is the license holder of the nursing facility shall pay to the state the entire
 74.28 nonfederal share of medical assistance payments received as a result of the difference
 74.29 between the nursing facility's payment rate under ~~subdivision 54~~, paragraph (a) or (b),
 74.30 and the rates that the nursing facility would otherwise be paid without application of this
 74.31 subdivision under subdivision 54 or 55 as determined by the commissioner.

74.32 ~~(e)~~ (f) The commissioner may, at any time, reduce the payments under this
 74.33 subdivision based on the commissioner's determination that the payments shall cause
 74.34 nursing facility rates to exceed the state's Medicare upper payment limit or any other
 74.35 federal limitation. If the commissioner determines a reduction is necessary, the
 74.36 commissioner shall reduce all payment rates for participating nursing facilities by a
 75.1 percentage applied to the amount of increase they would otherwise receive under this
 75.2 subdivision and shall notify participating facilities of the reductions. If payments to a
 75.3 nursing facility are reduced, payments under section 256B.19, subdivision 1e, shall be
 75.4 reduced accordingly.

75.5 Sec. 10. **REPEALER.**

75.6 Minnesota Statutes 2010, section 144A.073, subdivisions 4 and 5, are repealed.

75.7 **ARTICLE 5**
 75.8 **TECHNICAL**

75.9 Section 1. Minnesota Statutes 2010, section 144A.071, subdivision 5a, is amended to
 75.10 read:

75.11 Subd. 5a. **Cost estimate of a moratorium exception project.** (a) For the
 75.12 purposes of this section and section 144A.073, the cost estimate of a moratorium
 75.13 exception project shall include the effects of the proposed project on the costs of the state
 75.14 subsidy for community-based services, nursing services, and housing in institutional
 75.15 and noninstitutional settings. The commissioner of health, in cooperation with the
 75.16 commissioner of human services, shall define the method for estimating these costs in the
 75.17 permanent rule implementing section 144A.073. The commissioner of human services
 75.18 shall prepare an estimate of the total state annual long-term costs of each moratorium
 75.19 exception proposal.

78.4 ~~(d)~~ (e) For each participating nursing facility, the public entity that owns the physical
 78.5 plant or is the license holder of the nursing facility shall pay to the state the entire
 78.6 nonfederal share of medical assistance payments received as a result of the difference
 78.7 between the nursing facility's payment rate under ~~subdivision 54~~, paragraph (a) or (b),
 78.8 and the rates that the nursing facility would otherwise be paid without application of this
 78.9 subdivision under subdivision 54 or 55 as determined by the commissioner.

78.10 ~~(e)~~ (f) The commissioner may, at any time, reduce the payments under this
 78.11 subdivision based on the commissioner's determination that the payments shall cause
 78.12 nursing facility rates to exceed the state's Medicare upper payment limit or any other
 78.13 federal limitation. If the commissioner determines a reduction is necessary, the
 78.14 commissioner shall reduce all payment rates for participating nursing facilities by a
 78.15 percentage applied to the amount of increase they would otherwise receive under this
 78.16 subdivision and shall notify participating facilities of the reductions. If payments to a
 78.17 nursing facility are reduced, payments under section 256B.19, subdivision 1e, shall be
 78.18 reduced accordingly.

78.19 Sec. 11. **REPEALER.**

78.20 Minnesota Statutes 2010, section 144A.073, subdivisions 4 and 5, are repealed.

78.21 **ARTICLE 5**
 78.22 **TECHNICAL**

78.23 Section 1. Minnesota Statutes 2010, section 144A.071, subdivision 5a, is amended to
 78.24 read:

78.25 Subd. 5a. **Cost estimate of a moratorium exception project.** (a) For the
 78.26 purposes of this section and section 144A.073, the cost estimate of a moratorium
 78.27 exception project shall include the effects of the proposed project on the costs of the state
 78.28 subsidy for community-based services, nursing services, and housing in institutional
 78.29 and noninstitutional settings. The commissioner of health, in cooperation with the
 78.30 commissioner of human services, shall define the method for estimating these costs in the
 78.31 permanent rule implementing section 144A.073. The commissioner of human services
 78.32 shall prepare an estimate of the total state annual long-term costs of each moratorium
 78.33 exception proposal.

75.20 (b) The interest rate to be used for estimating the cost of each moratorium exception
75.21 project proposal shall be the lesser of either the prime rate plus two percentage points, or
75.22 the posted yield for standard conventional fixed rate mortgages of the Federal Home Loan
75.23 Mortgage Corporation plus two percentage points as published in the Wall Street Journal
75.24 and in effect 56 days prior to the application deadline. If the applicant's proposal uses this
75.25 interest rate, the commissioner of human services, in determining the facility's actual
75.26 property-related payment rate to be established upon completion of the project must use
75.27 the actual interest rate obtained by the facility for the project's permanent financing up to
75.28 the maximum permitted under ~~subdivision 6~~ Minnesota Rules, part 9549.0060, subpart 6.
75.29 The applicant may choose an alternate interest rate for estimating the project's cost.
75.30 If the applicant makes this election, the commissioner of human services, in determining
75.31 the facility's actual property-related payment rate to be established upon completion of the
75.32 project, must use the lesser of the actual interest rate obtained for the project's permanent
75.33 financing or the interest rate which was used to estimate the proposal's project cost. For
76.1 succeeding rate years, the applicant is at risk for financing costs in excess of the interest
76.2 rate selected.

79.1 (b) The interest rate to be used for estimating the cost of each moratorium exception
79.2 project proposal shall be the lesser of either the prime rate plus two percentage points, or
79.3 the posted yield for standard conventional fixed rate mortgages of the Federal Home Loan
79.4 Mortgage Corporation plus two percentage points as published in the Wall Street Journal
79.5 and in effect 56 days prior to the application deadline. If the applicant's proposal uses this
79.6 interest rate, the commissioner of human services, in determining the facility's actual
79.7 property-related payment rate to be established upon completion of the project must use
79.8 the actual interest rate obtained by the facility for the project's permanent financing up to
79.9 the maximum permitted under ~~subdivision 6~~ Minnesota Rules, part 9549.0060, subpart 6.
79.10 The applicant may choose an alternate interest rate for estimating the project's cost.
79.11 If the applicant makes this election, the commissioner of human services, in determining
79.12 the facility's actual property-related payment rate to be established upon completion of the
79.13 project, must use the lesser of the actual interest rate obtained for the project's permanent
79.14 financing or the interest rate which was used to estimate the proposal's project cost. For
79.15 succeeding rate years, the applicant is at risk for financing costs in excess of the interest
79.16 rate selected.