



STATE OF MINNESOTA

Office of Governor Mark Dayton

130 State Capitol ♦ 75 Rev. Dr. Martin Luther King Jr. Boulevard ♦ Saint Paul, MN 55155

May 30, 2017

The Honorable Michelle L. Fischbach
President of the Senate
Room 2113, Minnesota Senate Building
St. Paul, Minnesota 55155

Dear Madam President:

On the advice of my General Counsel, to ensure there are no legal challenges, I am signing Chapter 6, Senate File 2 rather than allowing it to become law without my signature.

I am signing the Omnibus Health and Human Services budget bill even though I believe it fails to sufficiently fund the urgent and ongoing needs in our state. In order to balance out the Legislative majority's unsustainable tax bill, leaders insisted on a drastic cut of \$463 million from Health and Human Services budget for Fiscal Years (FY) 2018-2019. This budget target meant that many bipartisan priorities such as early childhood, dental care, community health centers, home care workers, and child protection were not sufficiently funded.

Despite this challenging target, I am pleased that this bill includes some critical investments including additional resources for the Minnesota Security Hospital (MSH) in Saint Peter which serves individuals from across the state who struggle with serious mental illness. Along with the funding for MSH that is included in the bonding bill, this investment will bring the facility up to national standards for clinical care, providing a more therapeutic environment for patients and a safer workplace for staff. This bill also fully funds my proposal to improve oversight and investigations of alleged abuse of vulnerable adults in nursing homes and other care settings.

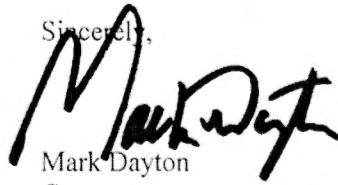
I am disappointed that while Legislative leaders have touted the importance of targeting resources to high-need families, they have not applied this same standard to low-income Minnesotans who receive services through the Minnesota Department of Human Services or the Minnesota Department of Health. As a result, there were not sufficient dollars in the Health and Human Services budget to fully fund two of my top priorities for our youngest Minnesotans: the Child Care Assistance Program (CCAP) and family home visiting for high-risk families. The bill does include \$18 million to improve child care quality and stability for low-income families as well as home visiting for an additional 2,300 families. However, with more funds we could have reduced barriers to child care access by raising the CCAP reimbursement rate for child care providers and improved long-term health by providing home visiting to all teen parents statewide.

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Returning the state to strong fiscal standing has been my top priority. I was disappointed that Legislative leaders refused to fix an issue with the forecasted costs of the Disability Waiver Rate Setting program. Without the change that I recommended in my Supplemental Budget, the bottom line in the November 2017 forecast for FY 2018-2019 will be reduced by more than \$30 million and the FY 2020-2021 forecast will be reduced by over \$113 million. The Legislature's decision to ignore this concern puts the state's future fiscal health at unnecessary risk.

Lastly, I think it is a grave mistake that this bill fails to make a meaningful improvement in dental care for more than one million children and adults who rely on Medical Assistance and MinnesotaCare. There is only minimal new funding for dental services and the bill includes a policy that will seriously undermine access to dental care in Greater Minnesota. The bill weakens the provision that requires dental providers who participate in the State Health Employee Health Insurance Program (SEGIP) to also serve Minnesotans covered by Medical Assistance and MinnesotaCare. I encourage the Legislature to revisit this important issue in the next Legislative Session.

Sincerely,



Mark Dayton
Governor

cc: Senator Paul E. Gazelka, Senate Majority Leader
Senator Thomas M. Bakk, Senate Minority Leader
Senator Michelle Benson, Minnesota Senate
Representative Kurt Daudt, Speaker of the House
Representative Melissa Hortman, House Minority Leader
Representative Matt Dean, House of Representatives
The Honorable Steve Simon, Secretary of State
Mr. Cal R. Ludeman, Secretary of the Senate
Mr. Patrick Murphy, Chief Clerk of the House of Representatives
Mr. Paul Marinac, Revisor of Statutes

AN ACT

1.1
1.2 relating to state government; establishing the health and human services budget;
1.3 modifying provisions governing community supports, housing, continuing care,
1.4 health care, health insurance, direct care and treatment, children and families,
1.5 chemical and mental health services, Department of Human Services operations,
1.6 Health Department, health licensing boards, opiate abuse prevention, managed
1.7 care organizations, and child care development block grant compliance; making
1.8 technical changes; modifying terminology and definitions; establishing licensing
1.9 fix-it tickets; requiring reports; establishing moratorium on conversion transactions;
1.10 modifying fees; making forecast adjustments; appropriating money; amending
1.11 Minnesota Statutes 2016, sections 3.972, by adding subdivisions; 13.32, by adding
1.12 a subdivision; 13.46, subdivisions 1, 2; 13.84, subdivision 5; 62A.04, subdivision
1.13 1; 62A.21, subdivision 2a; 62A.3075; 62D.105; 62E.04, subdivision 11; 62E.05,
1.14 subdivision 1; 62E.06, by adding a subdivision; 62K.15; 62U.02; 103I.005,
1.15 subdivisions 2, 2a, 12, 20a, 21, by adding subdivisions; 103I.101, subdivisions 2,
1.16 5, 6; 103I.105; 103I.111, subdivisions 6, 8; 103I.205, subdivisions 1, 2, 3, 4, 5, 6;
1.17 103I.208, subdivisions 1, 2; 103I.235, by adding a subdivision; 103I.301,
1.18 subdivisions 1, 2; 103I.315, subdivision 1; 103I.501; 103I.505, subdivisions 1, 2;
1.19 103I.515; 103I.525, subdivisions 1, 2, 5, 6, 8; 103I.531, subdivisions 2, 5; 103I.535,
1.20 subdivisions 2, 6; 103I.541, subdivisions 1, 2, 2a, 2b, 2c, 2e, 3, 4, 5; 103I.545;
1.21 103I.601, subdivisions 2, 4; 103I.711, subdivision 1; 103I.715, subdivision 2;
1.22 119B.011, subdivisions 20, 20a; 119B.025, subdivision 1, by adding subdivisions;
1.23 119B.03, subdivision 3; 119B.05, subdivision 1; 119B.09, subdivisions 1, 4;
1.24 119B.10, subdivision 1, by adding a subdivision; 119B.12, subdivision 2; 119B.13,
1.25 subdivisions 1, 6; 144.0722, subdivision 1, as amended; 144.0724, subdivisions
1.26 4, 6; 144.122; 144.1501, subdivision 2; 144.4961, subdivisions 3, 4, 5; 144.551,
1.27 subdivision 1; 144.562, subdivision 2; 144.99, subdivision 1; 144A.071,
1.28 subdivisions 3, as amended, 4a, as amended, 4c, as amended, 4d, as amended;
1.29 144A.10, subdivision 4, as amended; 144A.351, subdivision 1; 144A.472,
1.30 subdivision 7; 144A.4799, subdivision 3; 144A.70, subdivision 6, by adding a
1.31 subdivision; 144A.74; 144D.04, subdivision 2, by adding a subdivision; 144D.06;
1.32 145.4131, subdivision 1; 145.4716, subdivision 2; 145.928, subdivision 13; 145.986,
1.33 subdivision 1a; 146B.02, subdivisions 2, 3, 5, 8, by adding subdivisions; 146B.03,
1.34 subdivisions 6, 7, as amended; 146B.07, subdivision 2; 146B.10, subdivisions 1,
1.35 2, by adding a subdivision; 147.01, subdivision 7; 147.02, subdivision 1; 147.03,
1.36 subdivision 1; 147B.08, by adding a subdivision; 147C.40, by adding a subdivision;
1.37 148.514, subdivision 1; 148.519, subdivisions 1, 2; 148.5194, subdivisions 2, 3,
1.38 4, 7, by adding a subdivision; 148.5195, subdivision 2; 148.6402, subdivision 4;
1.39 148.6405; 148.6408, subdivision 2; 148.6410, subdivision 2; 148.6412, subdivision

2.1 2; 148.6415; 148.6418, subdivisions 1, 2, 4, 5; 148.6420, subdivisions 1, 3, 5;
2.2 148.6423; 148.6425, subdivisions 2, 3; 148.6428; 148.6443, subdivisions 5, 6, 7,
2.3 8; 148.6445, subdivisions 1, 10; 148.6448; 148.881; 148.89; 148.90, subdivisions
2.4 1, 2; 148.905, subdivision 1; 148.907, subdivisions 1, 2; 148.9105, subdivisions
2.5 1, 4, 5; 148.916, subdivisions 1, 1a; 148.925; 148.96, subdivision 3; 148.997,
2.6 subdivision 1; 148B.53, subdivision 1; 150A.06, subdivisions 3, 8; 150A.10,
2.7 subdivision 4; 151.212, subdivision 2; 152.11, by adding a subdivision; 152.25,
2.8 subdivision 1, by adding subdivisions; 152.28, by adding a subdivision; 152.33,
2.9 by adding a subdivision; 153A.14, subdivisions 1, 2; 153A.17; 157.16, subdivisions
2.10 1, 3, 3a; 214.01, subdivision 2; 245.462, subdivision 9; 245.467, subdivision 2;
2.11 245.4871, by adding subdivisions; 245.4876, subdivision 2; 245.4889, subdivision
2.12 1; 245.814, by adding a subdivision; 245.91, subdivisions 4, 6; 245.94, subdivision
2.13 1; 245.97, subdivision 6; 245A.02, subdivisions 2b, 5a, by adding subdivisions;
2.14 245A.03, subdivisions 2, 7; 245A.04, subdivisions 4, 14; 245A.06, subdivisions
2.15 2, 8, by adding a subdivision; 245A.07, subdivision 3; 245A.09, subdivision 7;
2.16 245A.10, subdivision 2; 245A.11, by adding subdivisions; 245A.14, by adding a
2.17 subdivision; 245A.16, subdivision 1, by adding a subdivision; 245A.191; 245A.40,
2.18 by adding a subdivision; 245A.50, subdivision 5; 245C.02, by adding a subdivision;
2.19 245C.03, subdivision 1, by adding a subdivision; 245C.04, subdivisions 1, 8;
2.20 245C.05, subdivisions 2b, 4, 5, 7; 245C.08, subdivisions 1, 2, 4; 245C.09, by
2.21 adding a subdivision; 245C.10, subdivision 9, by adding subdivisions; 245C.11,
2.22 subdivision 3; 245C.15; 245C.16, subdivision 1; 245C.17, subdivision 6; 245C.21,
2.23 subdivision 1; 245C.22, subdivisions 5, 7; 245C.23; 245C.24, subdivision 3;
2.24 245C.25; 245C.30, subdivision 2; 245D.03, subdivision 1; 245D.04, subdivision
2.25 3; 246.18, subdivision 4, by adding a subdivision; 252.27, subdivision 2a; 252.41,
2.26 subdivision 3; 252.50, subdivision 5; 253B.10, subdivision 1; 254A.01; 254A.02,
2.27 subdivisions 2, 3, 5, 6, 8, 10, by adding subdivisions; 254A.03; 254A.035,
2.28 subdivision 1; 254A.04; 254A.08; 254A.09; 254A.19, subdivision 3; 254B.01,
2.29 subdivision 3, by adding a subdivision; 254B.03, subdivision 2; 254B.04,
2.30 subdivisions 1, 2b; 254B.05, subdivisions 1, 1a, 5; 254B.051; 254B.07; 254B.08;
2.31 254B.09; 254B.12, subdivision 2, by adding a subdivision; 254B.13, subdivision
2.32 2a; 256.01, by adding a subdivision; 256.045, subdivisions 3, 3a; 256.9657,
2.33 subdivision 1; 256.9685, subdivisions 1, 1a; 256.9686, subdivision 8; 256.969,
2.34 subdivisions 1, 2b, 3a, 8, 8c, 9, 12; 256.9695, subdivision 1; 256.975, subdivision
2.35 7, by adding a subdivision; 256B.04, subdivisions 12, 24; 256B.056, subdivisions
2.36 3b, 3c, 5c; 256B.0561, subdivisions 2, 4; 256B.057, subdivision 9, as amended;
2.37 256B.059, subdivision 6, as amended; 256B.0621, subdivision 10; 256B.0625,
2.38 subdivisions 1, 3b, 6a, 7, 17, 17b, 18h, 20, 31, 45a, 64, by adding subdivisions;
2.39 256B.0644; 256B.0653, subdivisions 2, 3, 4, as amended, 5, 6, by adding a
2.40 subdivision; 256B.072; 256B.0755, subdivisions 1, 3, 4, by adding a subdivision;
2.41 256B.0911, subdivisions 1a, 2b, 3a, 4d, as amended, 5, 6, as amended, by adding
2.42 a subdivision; 256B.0915, subdivisions 1, 3a, 3e, 3h, 5, by adding subdivisions;
2.43 256B.092, subdivision 4; 256B.0921; 256B.0924, by adding a subdivision;
2.44 256B.0943, subdivision 13; 256B.0945, subdivisions 2, 4; 256B.196, subdivisions
2.45 2, 3, 4; 256B.35, subdivision 4, as amended; 256B.431, subdivisions 10, 16, 30;
2.46 256B.434, subdivisions 4, 4f; 256B.49, subdivisions 11, 15; 256B.4913, subdivision
2.47 4a, by adding a subdivision; 256B.4914, subdivisions 2, 3, 5, 6, 7, 8, 9, 10, 16, by
2.48 adding a subdivision; 256B.493, subdivisions 1, 2, by adding a subdivision;
2.49 256B.50, subdivision 1b; 256B.5012, by adding subdivisions; 256B.69, subdivision
2.50 9e, by adding subdivisions; 256B.75; 256B.76, subdivisions 1, as amended, 2;
2.51 256B.761; 256B.763; 256B.766; 256C.21; 256C.23, subdivisions 1, 2, by adding
2.52 subdivisions; 256C.233, subdivisions 1, 2, 4; 256C.24; 256C.25, subdivision 1;
2.53 256C.261; 256C.30; 256D.44, subdivisions 4, as amended, 5, as amended; 256E.30,
2.54 subdivision 2; 256I.03, subdivision 8; 256I.04, subdivisions 1, 2d, 2g, 3; 256I.05,
2.55 subdivisions 1a, 1c, 1e, 1j, 1m, by adding subdivisions; 256I.06, subdivisions 2,
2.56 8; 256J.45, subdivision 2; 256L.03, subdivisions 1, 1a, 5; 256L.11, subdivision 7,
2.57 by adding a subdivision; 256L.15, subdivision 2; 256P.06, subdivision 2; 256P.07,
2.58 subdivisions 3, 6; 256R.02, subdivisions 4, 17, 18, 19, 22, 42, 52, by adding

subdivisions; 256R.06, subdivision 5; 256R.07, by adding a subdivision; 256R.10, by adding a subdivision; 256R.37; 256R.40, subdivisions 1, 5; 256R.41; 256R.47; 256R.49, subdivision 1; 260C.451, subdivision 6; 327.15, subdivision 3; 364.09; 609.5315, subdivision 5c; 626.556, subdivisions 2, 3, 3c, 4, 10d, 10e, 10f, 10i; Laws 2009, chapter 101, article 1, section 12; Laws 2012, chapter 247, article 4, section 47, as amended; article 6, section 2, subdivision 2; Laws 2013, chapter 108, article 15, section 2, subdivision 2; Laws 2015, chapter 71, article 14, section 3, subdivision 2, as amended; Laws 2017, chapter 2, article 1, sections 2, subdivision 3; 5; 7; Laws 2017, chapter 13, article 1, section 15; proposing coding for new law in Minnesota Statutes, chapters 103I; 119B; 137; 144; 147A; 148; 245; 245A; 256; 256B; 256I; 256N; 256R; proposing coding for new law as Minnesota Statutes, chapters 144H; 245G; repealing Minnesota Statutes 2016, sections 13.468; 103I.005, subdivisions 8, 14, 15; 103I.451; 119B.07; 144.0571; 144A.351, subdivision 2; 147A.21; 147B.08, subdivisions 1, 2, 3; 147C.40, subdivisions 1, 2, 3, 4; 148.6402, subdivision 2; 148.6450; 148.906; 148.907; subdivision 5; 148.908; 148.909, subdivision 7; 148.96, subdivisions 4, 5; 245A.1915; 245A.192; 254A.02, subdivision 4; 256B.19, subdivision 1c; 256B.4914, subdivision 16; 256B.64; 256B.7631; Laws 2012, chapter 247, article 4, section 47, as amended; Laws 2015, chapter 71, article 7, section 54; Minnesota Rules, parts 5600.2500; 9500.1140, subparts 3, 4, 5, 6; 9530.6405, subparts 1, 1a, 2, 3, 4, 5, 6, 7, 7a, 8, 9, 10, 11, 12, 13, 14, 14a, 15, 15a, 16, 17, 17a, 17b, 17c, 18, 20, 21; 9530.6410; 9530.6415; 9530.6420; 9530.6422; 9530.6425; 9530.6430; 9530.6435; 9530.6440; 9530.6445; 9530.6450; 9530.6455; 9530.6460; 9530.6465; 9530.6470; 9530.6475; 9530.6480; 9530.6485; 9530.6490; 9530.6495; 9530.6500; 9530.6505.

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

ARTICLE 1

COMMUNITY SUPPORTS

Section 1. Minnesota Statutes 2016, section 144A.351, subdivision 1, is amended to read:

Subdivision 1. Report requirements. The commissioners of health and human services, with the cooperation of counties and in consultation with stakeholders, including persons who need or are using long-term care services and supports, lead agencies, regional entities, senior, disability, and mental health organization representatives, service providers, and community members shall prepare a report to the legislature by August 15, 2013, and biennially thereafter, regarding the status of the full range of long-term care services and supports for the elderly and children and adults with disabilities and mental illnesses in Minnesota. Any amounts appropriated for this report are available in either year of the biennium. The report shall address:

(1) demographics and need for long-term care services and supports in Minnesota;

(2) summary of county and regional reports on long-term care gaps, surpluses, imbalances, and corrective action plans;

(3) status of long-term care services and related mental health services, housing options, and supports by county and region including:

- 4.1 (i) changes in availability of the range of long-term care services and housing options;
- 4.2 (ii) access problems, including access to the least restrictive and most integrated services
- 4.3 and settings, regarding long-term care services; and
- 4.4 (iii) comparative measures of long-term care services availability, including serving
- 4.5 people in their home areas near family, and changes over time; and
- 4.6 (4) recommendations regarding goals for the future of long-term care services and
- 4.7 supports, policy and fiscal changes, and resource development and transition needs.

4.8 Sec. 2. Minnesota Statutes 2016, section 245D.03, subdivision 1, is amended to read:

4.9 Subdivision 1. **Applicability.** (a) The commissioner shall regulate the provision of home

4.10 and community-based services to persons with disabilities and persons age 65 and older

4.11 pursuant to this chapter. The licensing standards in this chapter govern the provision of

4.12 basic support services and intensive support services.

4.13 (b) Basic support services provide the level of assistance, supervision, and care that is

4.14 necessary to ensure the health and welfare of the person and do not include services that

4.15 are specifically directed toward the training, treatment, habilitation, or rehabilitation of the

4.16 person. Basic support services include:

4.17 (1) in-home and out-of-home respite care services as defined in section 245A.02,

4.18 subdivision 15, and under the brain injury, community alternative care, community access

4.19 for disability inclusion, developmental disability, and elderly waiver plans, excluding

4.20 out-of-home respite care provided to children in a family child foster care home licensed

4.21 under Minnesota Rules, parts 2960.3000 to 2960.3100, when the child foster care license

4.22 holder complies with the requirements under section 245D.06, subdivisions 5, 6, 7, and 8,

4.23 or successor provisions; and section 245D.061 or successor provisions, which must be

4.24 stipulated in the statement of intended use required under Minnesota Rules, part 2960.3000,

4.25 subpart 4;

4.26 (2) adult companion services as defined under the brain injury, community access for

4.27 disability inclusion, and elderly waiver plans, excluding adult companion services provided

4.28 under the Corporation for National and Community Services Senior Companion Program

4.29 established under the Domestic Volunteer Service Act of 1973, Public Law 98-288;

4.30 (3) personal support as defined under the developmental disability waiver plan;

4.31 (4) 24-hour emergency assistance, personal emergency response as defined under the

4.32 community access for disability inclusion and developmental disability waiver plans;

- 5.1 (5) night supervision services as defined under the brain injury waiver plan; and
- 5.2 (6) homemaker services as defined under the community access for disability inclusion,
- 5.3 brain injury, community alternative care, developmental disability, and elderly waiver plans,
- 5.4 excluding providers licensed by the Department of Health under chapter 144A and those
- 5.5 providers providing cleaning services only; and
- 5.6 (7) individual community living support under section 256B.0915, subdivision 3j.
- 5.7 (c) Intensive support services provide assistance, supervision, and care that is necessary
- 5.8 to ensure the health and welfare of the person and services specifically directed toward the
- 5.9 training, habilitation, or rehabilitation of the person. Intensive support services include:
- 5.10 (1) intervention services, including:
- 5.11 (i) behavioral support services as defined under the brain injury and community access
- 5.12 for disability inclusion waiver plans;
- 5.13 (ii) in-home or out-of-home crisis respite services as defined under the developmental
- 5.14 disability waiver plan; and
- 5.15 (iii) specialist services as defined under the current developmental disability waiver
- 5.16 plan;
- 5.17 (2) in-home support services, including:
- 5.18 (i) in-home family support and supported living services as defined under the
- 5.19 developmental disability waiver plan;
- 5.20 (ii) independent living services training as defined under the brain injury and community
- 5.21 access for disability inclusion waiver plans; and
- 5.22 (iii) semi-independent living services; and
- 5.23 (iv) individualized home supports services as defined under the brain injury, community
- 5.24 alternative care, and community access for disability inclusion waiver plans;
- 5.25 (3) residential supports and services, including:
- 5.26 (i) supported living services as defined under the developmental disability waiver plan
- 5.27 provided in a family or corporate child foster care residence, a family adult foster care
- 5.28 residence, a community residential setting, or a supervised living facility;
- 5.29 (ii) foster care services as defined in the brain injury, community alternative care, and
- 5.30 community access for disability inclusion waiver plans provided in a family or corporate

6.1 child foster care residence, a family adult foster care residence, or a community residential
6.2 setting; and

6.3 (iii) residential services provided to more than four persons with developmental
6.4 disabilities in a supervised living facility, including ICFs/DD;

6.5 (4) day services, including:

6.6 (i) structured day services as defined under the brain injury waiver plan;

6.7 (ii) day training and habilitation services under sections 252.41 to 252.46, and as defined
6.8 under the developmental disability waiver plan; and

6.9 (iii) prevocational services as defined under the brain injury and community access for
6.10 disability inclusion waiver plans; and

6.11 (5) ~~supported employment as defined under the brain injury, developmental disability,~~
6.12 ~~and community access for disability inclusion waiver plans~~ employment exploration services
6.13 as defined under the brain injury, community alternative care, community access for disability
6.14 inclusion, and developmental disability waiver plans;

6.15 (6) employment development services as defined under the brain injury, community
6.16 alternative care, community access for disability inclusion, and developmental disability
6.17 waiver plans; and

6.18 (7) employment support services as defined under the brain injury, community alternative
6.19 care, community access for disability inclusion, and developmental disability waiver plans.

6.20 **EFFECTIVE DATE.** (a) The amendment to paragraphs (b) and (c), clause (2), is
6.21 effective the day following final enactment.

6.22 (b) The amendments to paragraph (c), clauses (5) to (7), are effective upon federal
6.23 approval. The commissioner of human services shall notify the revisor of statutes when
6.24 federal approval is obtained.

6.25 Sec. 3. Minnesota Statutes 2016, section 252.41, subdivision 3, is amended to read:

6.26 Subd. 3. **Day training and habilitation services for adults with developmental**
6.27 **disabilities.** (a) "Day training and habilitation services for adults with developmental
6.28 disabilities" means services that:

6.29 (1) include supervision, training, assistance, ~~and supported employment,~~ center-based
6.30 work-related activities, or other community-integrated activities designed and implemented
6.31 in accordance with the individual service and individual habilitation plans required under

7.1 Minnesota Rules, parts 9525.0004 to 9525.0036, to help an adult reach and maintain the
7.2 highest possible level of independence, productivity, and integration into the community;
7.3 and

7.4 (2) are provided by a vendor licensed under sections 245A.01 to 245A.16 and 252.28,
7.5 subdivision 2, to provide day training and habilitation services.

7.6 (b) Day training and habilitation services reimbursable under this section do not include
7.7 special education and related services as defined in the Education of the Individuals with
7.8 Disabilities Act, United States Code, title 20, chapter 33, section 1401, clauses (6) and (17),
7.9 or vocational services funded under section 110 of the Rehabilitation Act of 1973, United
7.10 States Code, title 29, section 720, as amended.

7.11 (c) Day training and habilitation services do not include employment exploration,
7.12 employment development, or employment support services as defined in the home and
7.13 community-based services waivers for people with disabilities authorized under sections
7.14 256B.092 and 256B.49.

7.15 EFFECTIVE DATE. This section is effective upon federal approval. The commissioner
7.16 of human services shall notify the revisor of statutes when federal approval is obtained.

7.17 Sec. 4. [256.477] SELF-ADVOCACY GRANTS.

7.18 (a) The commissioner shall make available a grant for the purposes of establishing and
7.19 maintaining a statewide self-advocacy network for persons with intellectual and
7.20 developmental disabilities. The self-advocacy network shall:

7.21 (1) ensure that persons with intellectual and developmental disabilities are informed of
7.22 their rights in employment, housing, transportation, voting, government policy, and other
7.23 issues pertinent to the intellectual and developmental disability community;

7.24 (2) provide public education and awareness of the civil and human rights issues persons
7.25 with intellectual and developmental disabilities face;

7.26 (3) provide funds, technical assistance, and other resources for self-advocacy groups
7.27 across the state; and

7.28 (4) organize systems of communications to facilitate an exchange of information between
7.29 self-advocacy groups.

7.30 (b) An organization receiving a grant under paragraph (a) must be an organization
7.31 governed by people with intellectual and developmental disabilities that administers a
7.32 statewide network of disability groups in order to maintain and promote self-advocacy

8.1 services and supports for persons with intellectual and developmental disabilities throughout
8.2 the state.

8.3 Sec. 5. Minnesota Statutes 2016, section 256B.0625, subdivision 6a, is amended to read:

8.4 Subd. 6a. **Home health services.** Home health services are those services specified in
8.5 Minnesota Rules, part 9505.0295 and sections 256B.0651 and 256B.0653. Medical assistance
8.6 covers home health services at a recipient's home residence or in the community where
8.7 normal life activities take the recipient. Medical assistance does not cover home health
8.8 services for residents of a hospital, nursing facility, or intermediate care facility, unless the
8.9 commissioner of human services has authorized skilled nurse visits for less than 90 days
8.10 for a resident at an intermediate care facility for persons with developmental disabilities,
8.11 to prevent an admission to a hospital or nursing facility or unless a resident who is otherwise
8.12 eligible is on leave from the facility and the facility either pays for the home health services
8.13 or forgoes the facility per diem for the leave days that home health services are used. Home
8.14 health services must be provided by a Medicare certified home health agency. All nursing
8.15 and home health aide services must be provided according to sections 256B.0651 to
8.16 256B.0653.

8.17 Sec. 6. Minnesota Statutes 2016, section 256B.0625, subdivision 31, is amended to read:

8.18 Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical
8.19 supplies and equipment. Separate payment outside of the facility's payment rate shall be
8.20 made for wheelchairs and wheelchair accessories for recipients who are residents of
8.21 intermediate care facilities for the developmentally disabled. Reimbursement for wheelchairs
8.22 and wheelchair accessories for ICF/DD recipients shall be subject to the same conditions
8.23 and limitations as coverage for recipients who do not reside in institutions. A wheelchair
8.24 purchased outside of the facility's payment rate is the property of the recipient.

8.25 (b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies
8.26 must enroll as a Medicare provider.

8.27 (c) When necessary to ensure access to durable medical equipment, prosthetics, orthotics,
8.28 or medical supplies, the commissioner may exempt a vendor from the Medicare enrollment
8.29 requirement if:

8.30 (1) the vendor supplies only one type of durable medical equipment, prosthetic, orthotic,
8.31 or medical supply;

8.32 (2) the vendor serves ten or fewer medical assistance recipients per year;

9.1 (3) the commissioner finds that other vendors are not available to provide same or similar
9.2 durable medical equipment, prosthetics, orthotics, or medical supplies; and

9.3 (4) the vendor complies with all screening requirements in this chapter and Code of
9.4 Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from
9.5 the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare
9.6 and Medicaid Services approved national accreditation organization as complying with the
9.7 Medicare program's supplier and quality standards and the vendor serves primarily pediatric
9.8 patients.

9.9 (d) Durable medical equipment means a device or equipment that:

9.10 (1) can withstand repeated use;

9.11 (2) is generally not useful in the absence of an illness, injury, or disability; and

9.12 (3) is provided to correct or accommodate a physiological disorder or physical condition
9.13 or is generally used primarily for a medical purpose.

9.14 (e) Electronic tablets may be considered durable medical equipment if the electronic
9.15 tablet will be used as an augmentative and alternative communication system as defined
9.16 under subdivision 31a, paragraph (a). To be covered by medical assistance, the device must
9.17 be locked in order to prevent use not related to communication.

9.18 (f) Notwithstanding the requirement in paragraph (e) that an electronic tablet must be
9.19 locked to prevent use not as an augmentative communication device, a recipient of waiver
9.20 services may use an electronic tablet for a use not related to communication when the
9.21 recipient has been authorized under the waiver to receive one or more additional applications
9.22 that can be loaded onto the electronic tablet, such that allowing the additional use prevents
9.23 the purchase of a separate electronic tablet with waiver funds.

9.24 (g) An order or prescription for medical supplies, equipment, or appliances must meet
9.25 the requirements in Code of Federal Regulations, title 42, part 440.70.

9.26 Sec. 7. Minnesota Statutes 2016, section 256B.0653, subdivision 2, is amended to read:

9.27 Subd. 2. **Definitions.** For the purposes of this section, the following terms have the
9.28 meanings given.

9.29 (a) "Assessment" means an evaluation of the recipient's medical need for home health
9.30 agency services by a registered nurse or appropriate therapist that is conducted within 30
9.31 days of a request.

10.1 (b) "Home care therapies" means occupational, physical, and respiratory therapy and
10.2 speech-language pathology services provided in the home by a Medicare certified home
10.3 health agency.

10.4 (c) "Home health agency services" means services delivered ~~in the recipient's home~~
10.5 ~~residence, except as specified in section 256B.0625,~~ by a home health agency to a recipient
10.6 with medical needs due to illness, disability, or physical conditions in settings permitted
10.7 under section 256B.0625, subdivision 6a.

10.8 (d) "Home health aide" means an employee of a home health agency who completes
10.9 medically oriented tasks written in the plan of care for a recipient.

10.10 (e) "Home health agency" means a home care provider agency that is Medicare-certified.

10.11 (f) "Occupational therapy services" mean the services defined in Minnesota Rules, part
10.12 9505.0390.

10.13 (g) "Physical therapy services" mean the services defined in Minnesota Rules, part
10.14 9505.0390.

10.15 (h) "Respiratory therapy services" mean the services defined in chapter 147C.

10.16 (i) "Speech-language pathology services" mean the services defined in Minnesota Rules,
10.17 part 9505.0390.

10.18 (j) "Skilled nurse visit" means a professional nursing visit to complete nursing tasks
10.19 required due to a recipient's medical condition that can only be safely provided by a
10.20 professional nurse to restore and maintain optimal health.

10.21 (k) "Store-and-forward technology" means telehomecare services that do not occur in
10.22 real time via synchronous transmissions such as diabetic and vital sign monitoring.

10.23 (l) "Telehomecare" means the use of telecommunications technology via live, two-way
10.24 interactive audiovisual technology which may be augmented by store-and-forward
10.25 technology.

10.26 (m) "Telehomecare skilled nurse visit" means a visit by a professional nurse to deliver
10.27 a skilled nurse visit to a recipient located at a site other than the site where the nurse is
10.28 located and is used in combination with face-to-face skilled nurse visits to adequately meet
10.29 the recipient's needs.

11.1 Sec. 8. Minnesota Statutes 2016, section 256B.0653, subdivision 3, is amended to read:

11.2 Subd. 3. **Home health aide visits.** (a) Home health aide visits must be provided by a
11.3 certified home health aide using a written plan of care that is updated in compliance with
11.4 Medicare regulations. A home health aide shall provide hands-on personal care, perform
11.5 simple procedures as an extension of therapy or nursing services, and assist in instrumental
11.6 activities of daily living as defined in section 256B.0659, including assuring that the person
11.7 gets to medical appointments if identified in the written plan of care. Home health aide
11.8 visits ~~must~~ may be provided in the recipient's home or in the community where normal life
11.9 activities take the recipient.

11.10 (b) All home health aide visits must have authorization under section 256B.0652. The
11.11 commissioner shall limit home health aide visits to no more than one visit per day per
11.12 recipient.

11.13 (c) Home health aides must be supervised by a registered nurse or an appropriate therapist
11.14 when providing services that are an extension of therapy.

11.15 Sec. 9. Minnesota Statutes 2016, section 256B.0653, subdivision 4, as amended by Laws
11.16 2017, chapter 59, section 10, is amended to read:

11.17 Subd. 4. **Skilled nurse visit services.** (a) Skilled nurse visit services must be provided
11.18 by a registered nurse or a licensed practical nurse under the supervision of a registered nurse,
11.19 according to the written plan of care and accepted standards of medical and nursing practice
11.20 according to chapter 148. Skilled nurse visit services must be ordered by a physician,
11.21 advanced practice registered nurse, or physician assistant and documented in a plan of care
11.22 that is reviewed and approved by the ordering physician, advanced practice registered nurse,
11.23 or physician assistant at least once every 60 days. All skilled nurse visits must be medically
11.24 necessary and provided in the recipient's home residence or in the community where normal
11.25 life activities take the recipient, except as allowed under section 256B.0625, subdivision
11.26 6a.

11.27 (b) Skilled nurse visits include face-to-face and telehomecare visits with a limit of up
11.28 to two visits per day per recipient. All visits must be based on assessed needs.

11.29 (c) Telehomecare skilled nurse visits are allowed when the recipient's health status can
11.30 be accurately measured and assessed without a need for a face-to-face, hands-on encounter.
11.31 All telehomecare skilled nurse visits must have authorization and are paid at the same
11.32 allowable rates as face-to-face skilled nurse visits.

12.1 (d) The provision of telehomecare must be made via live, two-way interactive audiovisual
12.2 technology and may be augmented by utilizing store-and-forward technologies. Individually
12.3 identifiable patient data obtained through real-time or store-and-forward technology must
12.4 be maintained as health records according to sections 144.291 to 144.298. If the video is
12.5 used for research, training, or other purposes unrelated to the care of the patient, the identity
12.6 of the patient must be concealed.

12.7 (e) Authorization for skilled nurse visits must be completed under section 256B.0652.
12.8 A total of nine face-to-face skilled nurse visits per calendar year do not require authorization.
12.9 All telehomecare skilled nurse visits require authorization.

12.10 Sec. 10. Minnesota Statutes 2016, section 256B.0653, subdivision 5, is amended to read:

12.11 Subd. 5. **Home care therapies.** (a) Home care therapies include the following: physical
12.12 therapy, occupational therapy, respiratory therapy, and speech and language pathology
12.13 therapy services.

12.14 (b) Home care therapies must be:

12.15 (1) provided in the recipient's residence or in the community where normal life activities
12.16 take the recipient after it has been determined the recipient is unable to access outpatient
12.17 therapy;

12.18 (2) prescribed, ordered, or referred by a physician and documented in a plan of care and
12.19 reviewed, according to Minnesota Rules, part 9505.0390;

12.20 (3) assessed by an appropriate therapist; and

12.21 (4) provided by a Medicare-certified home health agency enrolled as a Medicaid provider
12.22 agency.

12.23 (c) Restorative and specialized maintenance therapies must be provided according to
12.24 Minnesota Rules, part 9505.0390. Physical and occupational therapy assistants may be used
12.25 as allowed under Minnesota Rules, part 9505.0390, subpart 1, item B.

12.26 (d) For both physical and occupational therapies, the therapist and the therapist's assistant
12.27 may not both bill for services provided to a recipient on the same day.

12.28 Sec. 11. Minnesota Statutes 2016, section 256B.0653, subdivision 6, is amended to read:

12.29 Subd. 6. **Noncovered home health agency services.** The following are not eligible for
12.30 payment under medical assistance as a home health agency service:

13.1 (1) telehomecare skilled nurses services that is communication between the home care
13.2 nurse and recipient that consists solely of a telephone conversation, facsimile, electronic
13.3 mail, or a consultation between two health care practitioners;

13.4 (2) the following skilled nurse visits:

13.5 (i) for the purpose of monitoring medication compliance with an established medication
13.6 program for a recipient;

13.7 (ii) administering or assisting with medication administration, including injections,
13.8 prefilling syringes for injections, or oral medication setup of an adult recipient, when, as
13.9 determined and documented by the registered nurse, the need can be met by an available
13.10 pharmacy or the recipient or a family member is physically and mentally able to
13.11 self-administer or prefill a medication;

13.12 (iii) services done for the sole purpose of supervision of the home health aide or personal
13.13 care assistant;

13.14 (iv) services done for the sole purpose to train other home health agency workers;

13.15 (v) services done for the sole purpose of blood samples or lab draw when the recipient
13.16 is able to access these services outside the home; and

13.17 (vi) Medicare evaluation or administrative nursing visits required by Medicare;

13.18 (3) home health aide visits when the following activities are the sole purpose for the
13.19 visit: companionship, socialization, household tasks, transportation, and education; and

13.20 (4) home care therapies provided in other settings such as a clinic, ~~day program~~, or as
13.21 an inpatient or when the recipient can access therapy outside of the recipient's residence;
13.22 and

13.23 (5) home health agency services without qualifying documentation of a face-to-face
13.24 encounter as specified in subdivision 7.

13.25 Sec. 12. Minnesota Statutes 2016, section 256B.0653, is amended by adding a subdivision
13.26 to read:

13.27 Subd. 7. **Face-to-face encounter.** (a) A face-to-face encounter by a qualifying provider
13.28 must be completed for all home health services regardless of the need for prior authorization,
13.29 except when providing a onetime perinatal visit by skilled nursing. The face-to-face encounter
13.30 may occur through telemedicine as defined in section 256B.0625, subdivision 3b. The
13.31 encounter must be related to the primary reason the recipient requires home health services
13.32 and must occur within the 90 days before or the 30 days after the start of services. The

14.1 face-to-face encounter may be conducted by one of the following practitioners, licensed in
14.2 Minnesota:

14.3 (1) a physician;

14.4 (2) a nurse practitioner or clinical nurse specialist;

14.5 (3) a certified nurse midwife; or

14.6 (4) a physician assistant.

14.7 (b) The allowed nonphysician practitioner, as described in this subdivision, performing
14.8 the face-to-face encounter must communicate the clinical findings of that face-to-face
14.9 encounter to the ordering physician. Those clinical findings must be incorporated into a
14.10 written or electronic document included in the recipient's medical record. To assure clinical
14.11 correlation between the face-to-face encounter and the associated home health services, the
14.12 physician responsible for ordering the services must:

14.13 (1) document that the face-to-face encounter, which is related to the primary reason the
14.14 recipient requires home health services, occurred within the required time period; and

14.15 (2) indicate the practitioner who conducted the encounter and the date of the encounter.

14.16 (c) For home health services requiring authorization, including prior authorization, home
14.17 health agencies must retain the qualifying documentation of a face-to-face encounter as part
14.18 of the recipient health service record, and submit the qualifying documentation to the
14.19 commissioner or the commissioner's designee upon request.

14.20 Sec. 13. Minnesota Statutes 2016, section 256B.0911, subdivision 1a, is amended to read:

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

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

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

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

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

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

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

15.4 (6) determination of home and community-based waiver and other service eligibility as
15.5 required under sections 256B.0913, 256B.0915, and 256B.49, including level of care
15.6 determination for individuals who need an institutional level of care as determined under
15.7 subdivision 4e, based on assessment and community support plan development, appropriate
15.8 referrals to obtain necessary diagnostic information, and including an eligibility determination
15.9 for consumer-directed community supports;

15.10 (7) providing recommendations for institutional placement when there are no
15.11 cost-effective community services available;

15.12 (8) providing access to assistance to transition people back to community settings after
15.13 institutional admission; and

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

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

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

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

15.26 (ii) consumer support grants under section 256.476; or

15.27 (iii) section 256B.85;

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

15.31 (3) determination of institutional level of care, home and community-based service
15.32 waiver, and other service eligibility as required under section 256B.092, determination of

16.1 eligibility for family support grants under section 252.32, semi-independent living services
16.2 under section 252.275, and day training and habilitation services under section 256B.092;
16.3 and

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

16.6 (c) "Long-term care options counseling" means the services provided by the linkage
16.7 lines as mandated by sections 256.01, subdivision 24, and 256.975, subdivision 7, and also
16.8 includes telephone assistance and follow up once a long-term care consultation assessment
16.9 has been completed.

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

16.12 (e) "Lead agencies" means counties administering or tribes and health plans under
16.13 contract with the commissioner to administer long-term care consultation assessment and
16.14 support planning services.

16.15 (f) "Person-centered planning" is a process that includes the active participation of a
16.16 person in the planning of the person's services, including in making meaningful and informed
16.17 choices about the person's own goals, talents, and objectives, as well as making meaningful
16.18 and informed choices about the services the person receives. For the purposes of this section,
16.19 "informed choice" means a voluntary choice of services by a person from all available
16.20 service options based on accurate and complete information concerning all available service
16.21 options and concerning the person's own preferences, abilities, goals, and objectives. In
16.22 order for a person to make an informed choice, all available options must be developed and
16.23 presented to the person to empower the person to make decisions.

16.24 Sec. 14. Minnesota Statutes 2016, section 256B.0911, subdivision 2b, is amended to read:

16.25 Subd. 2b. **MnCHOICES certified assessors.** (a) Each lead agency shall use certified
16.26 assessors who have completed MnCHOICES training and the certification processes
16.27 determined by the commissioner in subdivision 2c. Certified assessors shall demonstrate
16.28 best practices in assessment and support planning including person-centered planning
16.29 principles and have a common set of skills that must ensure consistency and
16.30 equitable access to services statewide. A lead agency may choose, according to departmental
16.31 policies, to contract with a qualified, certified assessor to conduct assessments and
16.32 reassessments on behalf of the lead agency. Certified assessors must use person-centered
16.33 planning principles to conduct an interview that identifies what is important to the person,

17.1 the person's needs for supports, health and safety concerns, and the person's abilities, interests,
17.2 and goals.

17.3 Certified assessors are responsible for:

17.4 (1) ensuring persons are offered objective, unbiased access to resources;

17.5 (2) ensuring persons have the needed information to support informed choice, including
17.6 where and how they choose to live and the opportunity to pursue desired employment;

17.7 (3) determining level of care and eligibility for long-term services and supports;

17.8 (4) using the information gathered from the interview to develop a person-centered
17.9 community support plan that reflects identified needs and support options within the context
17.10 of values, interests, and goals important to the person; and

17.11 (5) providing the person with a community support plan that summarizes the person's
17.12 assessment findings, support options, and agreed-upon next steps.

17.13 (b) MnCHOICES certified assessors are persons with a minimum of a bachelor's degree
17.14 in social work, nursing with a public health nursing certificate, or other closely related field
17.15 with at least one year of home and community-based experience, or a registered nurse with
17.16 at least two years of home and community-based experience who has received training and
17.17 certification specific to assessment and consultation for long-term care services in the state.

17.18 Sec. 15. Minnesota Statutes 2016, section 256B.0911, is amended by adding a subdivision
17.19 to read:

17.20 Subd. 3f. **Long-term care reassessments and community support plan updates.**

17.21 Reassessments must be tailored using the professional judgment of the assessor to the
17.22 person's known needs, strengths, preferences, and circumstances. Reassessments provide
17.23 information to support the person's informed choice and opportunities to express choice
17.24 regarding activities that contribute to quality of life, as well as information and opportunity
17.25 to identify goals related to desired employment, community activities, and preferred living
17.26 environment. Reassessments allow for a review of the current support plan's effectiveness,
17.27 monitoring of services, and the development of an updated person-centered community
17.28 support plan. Reassessments verify continued eligibility or offer alternatives as warranted
17.29 and provide an opportunity for quality assurance of service delivery. Face-to-face assessments
17.30 must be conducted annually or as required by federal and state laws and rules.

18.1 Sec. 16. Minnesota Statutes 2016, section 256B.0911, subdivision 4d, as amended by
18.2 Laws 2017, chapter 40, article 1, section 69, is amended to read:

18.3 Subd. 4d. **Preadmission screening of individuals under 65 years of age.** (a) It is the
18.4 policy of the state of Minnesota to ensure that individuals with disabilities or chronic illness
18.5 are served in the most integrated setting appropriate to their needs and have the necessary
18.6 information to make informed choices about home and community-based service options.

18.7 (b) Individuals under 65 years of age who are admitted to a Medicaid-certified nursing
18.8 facility must be screened prior to admission according to the requirements outlined in section
18.9 256.975, subdivisions 7a to 7c. This shall be provided by the Senior LinkAge Line as
18.10 required under section 256.975, subdivision 7.

18.11 (c) Individuals under 65 years of age who are admitted to nursing facilities with only a
18.12 telephone screening must receive a face-to-face assessment from the long-term care
18.13 consultation team member of the county in which the facility is located or from the recipient's
18.14 county case manager within ~~40 calendar days of admission~~ the timeline established by the
18.15 commissioner, based on review of data.

18.16 (d) At the face-to-face assessment, the long-term care consultation team member or
18.17 county case manager must perform the activities required under subdivision 3b.

18.18 (e) For individuals under 21 years of age, a screening interview which recommends
18.19 nursing facility admission must be face-to-face and approved by the commissioner before
18.20 the individual is admitted to the nursing facility.

18.21 (f) In the event that an individual under 65 years of age is admitted to a nursing facility
18.22 on an emergency basis, the Senior LinkAge Line must be notified of the admission on the
18.23 next working day, and a face-to-face assessment as described in paragraph (c) must be
18.24 conducted within ~~40 calendar days of admission~~ the timeline established by the commissioner,
18.25 based on review of data.

18.26 (g) At the face-to-face assessment, the long-term care consultation team member or the
18.27 case manager must present information about home and community-based options, including
18.28 consumer-directed options, so the individual can make informed choices. If the individual
18.29 chooses home and community-based services, the long-term care consultation team member
18.30 or case manager must complete a written relocation plan within 20 working days of the
18.31 visit. The plan shall describe the services needed to move out of the facility and a time line
18.32 for the move which is designed to ensure a smooth transition to the individual's home and
18.33 community.

19.1 (h) An individual under 65 years of age residing in a nursing facility shall receive a
19.2 face-to-face assessment at least every 12 months to review the person's service choices and
19.3 available alternatives unless the individual indicates, in writing, that annual visits are not
19.4 desired. In this case, the individual must receive a face-to-face assessment at least once
19.5 every 36 months for the same purposes.

19.6 (i) Notwithstanding the provisions of subdivision 6, the commissioner may pay county
19.7 agencies directly for face-to-face assessments for individuals under 65 years of age who
19.8 are being considered for placement or residing in a nursing facility.

19.9 (j) Funding for preadmission screening follow-up shall be provided to the Disability
19.10 Linkage Line for the under-60 population by the Department of Human Services to cover
19.11 options counseling salaries and expenses to provide the services described in subdivisions
19.12 7a to 7c. The Disability Linkage Line shall employ, or contract with other agencies to
19.13 employ, within the limits of available funding, sufficient personnel to provide preadmission
19.14 screening follow-up services and shall seek to maximize federal funding for the service as
19.15 provided under section 256.01, subdivision 2, paragraph (aa).

19.16 Sec. 17. Minnesota Statutes 2016, section 256B.0911, subdivision 5, is amended to read:

19.17 Subd. 5. **Administrative activity.** (a) The commissioner shall streamline the processes,
19.18 including timelines for when assessments need to be completed, required to provide the
19.19 services in this section and shall implement integrated solutions to automate the business
19.20 processes to the extent necessary for community support plan approval, reimbursement,
19.21 program planning, evaluation, and policy development.

19.22 (b) The commissioner of human services shall work with lead agencies responsible for
19.23 conducting long-term consultation services to modify the MnCHOICES application and
19.24 assessment policies to create efficiencies while ensuring federal compliance with medical
19.25 assistance and long-term services and supports eligibility criteria.

19.26 Sec. 18. Minnesota Statutes 2016, section 256B.0911, subdivision 6, as amended by Laws
19.27 2017, chapter 40, article 1, section 70, is amended to read:

19.28 Subd. 6. **Payment for long-term care consultation services.** (a) Until September 30,
19.29 2013, payment for long-term care consultation face-to-face assessment shall be made as
19.30 described in this subdivision.

19.31 (b) The total payment for each county must be paid monthly by certified nursing facilities
19.32 in the county. The monthly amount to be paid by each nursing facility for each fiscal year

20.1 must be determined by dividing the county's annual allocation for long-term care consultation
20.2 services by 12 to determine the monthly payment and allocating the monthly payment to
20.3 each nursing facility based on the number of licensed beds in the nursing facility. Payments
20.4 to counties in which there is no certified nursing facility must be made by increasing the
20.5 payment rate of the two facilities located nearest to the county seat.

20.6 (c) The commissioner shall include the total annual payment determined under paragraph
20.7 (b) for each nursing facility reimbursed under section 256B.431, 256B.434, or chapter 256R.

20.8 (d) In the event of the layaway, delicensure and decertification, or removal from layaway
20.9 of 25 percent or more of the beds in a facility, the commissioner may adjust the per diem
20.10 payment amount in paragraph (c) and may adjust the monthly payment amount in paragraph
20.11 (b). The effective date of an adjustment made under this paragraph shall be on or after the
20.12 first day of the month following the effective date of the layaway, delicensure and
20.13 decertification, or removal from layaway.

20.14 (e) Payments for long-term care consultation services are available to the county or
20.15 counties to cover staff salaries and expenses to provide the services described in subdivision
20.16 1a. The county shall employ, or contract with other agencies to employ, within the limits
20.17 of available funding, sufficient personnel to provide long-term care consultation services
20.18 while meeting the state's long-term care outcomes and objectives as defined in subdivision
20.19 1. The county shall be accountable for meeting local objectives as approved by the
20.20 commissioner in the biennial home and community-based services quality assurance plan
20.21 on a form provided by the commissioner.

20.22 (f) Notwithstanding section 256B.0641, overpayments attributable to payment of the
20.23 screening costs under the medical assistance program may not be recovered from a facility.

20.24 (g) The commissioner of human services shall amend the Minnesota medical assistance
20.25 plan to include reimbursement for the local consultation teams.

20.26 (h) Until the alternative payment methodology in paragraph (i) is implemented, the
20.27 county may bill, as case management services, assessments, support planning, and
20.28 follow-along provided to persons determined to be eligible for case management under
20.29 Minnesota health care programs. No individual or family member shall be charged for an
20.30 initial assessment or initial support plan development provided under subdivision 3a or 3b.

20.31 (i) The commissioner shall develop an alternative payment methodology, effective on
20.32 October 1, 2013, for long-term care consultation services that includes the funding available
20.33 under this subdivision, and for assessments authorized under sections 256B.092 and
20.34 256B.0659. In developing the new payment methodology, the commissioner shall consider

21.1 the maximization of other funding sources, including federal administrative reimbursement
21.2 through federal financial participation funding, for all long-term care consultation activity.
21.3 The alternative payment methodology shall include the use of the appropriate time studies
21.4 and the state financing of nonfederal share as part of the state's medical assistance program.
21.5 Between July 1, 2017, and June 30, 2019, the state shall pay 84.3 percent of the nonfederal
21.6 share as reimbursement to the counties. Beginning July 1, 2019, the state shall pay 81.9
21.7 percent of the nonfederal share as reimbursement to the counties.

21.8 Sec. 19. Minnesota Statutes 2016, section 256B.0921, is amended to read:

21.9 **256B.0921 HOME AND COMMUNITY-BASED SERVICES INCENTIVE POOL.**

21.10 The commissioner of human services shall develop an initiative to provide incentives
21.11 for innovation in: (1) achieving integrated competitive employment; (2) achieving integrated
21.12 competitive employment for youth under age 25 upon their graduation from school; (3)
21.13 living in the most integrated setting; and (4) other outcomes determined by the commissioner.
21.14 The commissioner shall seek requests for proposals and shall contract with one or more
21.15 entities to provide incentive payments for meeting identified outcomes. ~~The initial requests~~
21.16 ~~for proposals must be issued by October 1, 2016.~~

21.17 Sec. 20. Minnesota Statutes 2016, section 256B.4913, subdivision 4a, is amended to read:

21.18 Subd. 4a. **Rate stabilization adjustment.** (a) For purposes of this subdivision,
21.19 "implementation period" means the period beginning January 1, 2014, and ending on the
21.20 last day of the month in which the rate management system is populated with the data
21.21 necessary to calculate rates for substantially all individuals receiving home and
21.22 community-based waiver services under sections 256B.092 and 256B.49. "Banding period"
21.23 means the time period beginning on January 1, 2014, and ending upon the expiration of the
21.24 12-month period defined in paragraph (c), clause (5).

21.25 (b) For purposes of this subdivision, the historical rate for all service recipients means
21.26 the individual reimbursement rate for a recipient in effect on December 1, 2013, except
21.27 that:

21.28 (1) for a day service recipient who was not authorized to receive these waiver services
21.29 prior to January 1, 2014; added a new service or services on or after January 1, 2014; or
21.30 changed providers on or after January 1, 2014, the historical rate must be the weighted
21.31 average authorized rate for the provider number in the county of service, effective December
21.32 1, 2013; or

22.1 (2) for a unit-based service with programming or a unit-based service without
22.2 programming recipient who was not authorized to receive these waiver services prior to
22.3 January 1, 2014; added a new service or services on or after January 1, 2014; or changed
22.4 providers on or after January 1, 2014, the historical rate must be the weighted average
22.5 authorized rate for each provider number in the county of service, effective December 1,
22.6 2013; or

22.7 (3) for residential service recipients who change providers on or after January 1, 2014,
22.8 the historical rate must be set by each lead agency within their county aggregate budget
22.9 using their respective methodology for residential services effective December 1, 2013, for
22.10 determining the provider rate for a similarly situated recipient being served by that provider.

22.11 (c) The commissioner shall adjust individual reimbursement rates determined under this
22.12 section so that the unit rate is no higher or lower than:

22.13 (1) 0.5 percent from the historical rate for the implementation period;

22.14 (2) 0.5 percent from the rate in effect in clause (1), for the 12-month period immediately
22.15 following the time period of clause (1);

22.16 (3) 0.5 percent from the rate in effect in clause (2), for the 12-month period immediately
22.17 following the time period of clause (2);

22.18 (4) 1.0 percent from the rate in effect in clause (3), for the 12-month period immediately
22.19 following the time period of clause (3);

22.20 (5) 1.0 percent from the rate in effect in clause (4), for the 12-month period immediately
22.21 following the time period of clause (4); ~~and~~

22.22 (6) no adjustment to the rate in effect in clause (5) for the 12-month period immediately
22.23 following the time period of clause (5). During this banding rate period, the commissioner
22.24 shall not enforce any rate decrease or increase that would otherwise result from the end of
22.25 the banding period. The commissioner shall, upon enactment, seek federal approval for the
22.26 addition of this banding period; and

22.27 (7) one percent from the rate in effect in clause (6) for the 12-month period immediately
22.28 following the time period of clause (6).

22.29 (d) The commissioner shall review all changes to rates that were in effect on December
22.30 1, 2013, to verify that the rates in effect produce the equivalent level of spending and service
22.31 unit utilization on an annual basis as those in effect on October 31, 2013.

23.1 (e) By December 31, 2014, the commissioner shall complete the review in paragraph
23.2 (d), adjust rates to provide equivalent annual spending, and make appropriate adjustments.

23.3 (f) During the banding period, the Medicaid Management Information System (MMIS)
23.4 service agreement rate must be adjusted to account for change in an individual's need. The
23.5 commissioner shall adjust the Medicaid Management Information System (MMIS) service
23.6 agreement rate by:

23.7 (1) calculating a service rate under section 256B.4914, subdivision 6, 7, 8, or 9, for the
23.8 individual with variables reflecting the level of service in effect on December 1, 2013;

23.9 (2) calculating a service rate under section 256B.4914, subdivision 6, 7, 8, or 9, for the
23.10 individual with variables reflecting the updated level of service at the time of application;
23.11 and

23.12 (3) adding to or subtracting from the Medicaid Management Information System (MMIS)
23.13 service agreement rate, the difference between the values in clauses (1) and (2).

23.14 (g) This subdivision must not apply to rates for recipients served by providers new to a
23.15 given county after January 1, 2014. Providers of personal supports services who also acted
23.16 as fiscal support entities must be treated as new providers as of January 1, 2014.

23.17 **EFFECTIVE DATE.** (a) The amendment to paragraph (b) is effective the day following
23.18 final enactment.

23.19 (b) The amendment to paragraph (c) is effective upon federal approval. The commissioner
23.20 of human services shall notify the revisor of statutes when federal approval is obtained.

23.21 Sec. 21. Minnesota Statutes 2016, section 256B.4913, is amended by adding a subdivision
23.22 to read:

23.23 Subd. 7. New services. A service added to section 256B.4914 after January 1, 2014, is
23.24 not subject to rate stabilization adjustment in this section.

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

23.26 Sec. 22. Minnesota Statutes 2016, section 256B.4914, subdivision 2, is amended to read:

23.27 Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the
23.28 meanings given them, unless the context clearly indicates otherwise.

23.29 (b) "Commissioner" means the commissioner of human services.

24.1 (c) "Component value" means underlying factors that are part of the cost of providing
24.2 services that are built into the waiver rates methodology to calculate service rates.

24.3 (d) "Customized living tool" means a methodology for setting service rates that delineates
24.4 and documents the amount of each component service included in a recipient's customized
24.5 living service plan.

24.6 (e) "Disability waiver rates system" means a statewide system that establishes rates that
24.7 are based on uniform processes and captures the individualized nature of waiver services
24.8 and recipient needs.

24.9 (f) "Individual staffing" means the time spent as a one-to-one interaction specific to an
24.10 individual recipient by staff to provide direct support and assistance with activities of daily
24.11 living, instrumental activities of daily living, and training to participants, and is based on
24.12 the requirements in each individual's coordinated service and support plan under section
24.13 245D.02, subdivision 4b; any coordinated service and support plan addendum under section
24.14 245D.02, subdivision 4c; and an assessment tool. Provider observation of an individual's
24.15 needs must also be considered.

24.16 (g) "Lead agency" means a county, partnership of counties, or tribal agency charged
24.17 with administering waived services under sections 256B.092 and 256B.49.

24.18 (h) "Median" means the amount that divides distribution into two equal groups, one-half
24.19 above the median and one-half below the median.

24.20 (i) "Payment or rate" means reimbursement to an eligible provider for services provided
24.21 to a qualified individual based on an approved service authorization.

24.22 (j) "Rates management system" means a Web-based software application that uses a
24.23 framework and component values, as determined by the commissioner, to establish service
24.24 rates.

24.25 (k) "Recipient" means a person receiving home and community-based services funded
24.26 under any of the disability waivers.

24.27 (l) "Shared staffing" means time spent by employees, not defined under paragraph (f),
24.28 providing or available to provide more than one individual with direct support and assistance
24.29 with activities of daily living as defined under section 256B.0659, subdivision 1, paragraph
24.30 (b); instrumental activities of daily living as defined under section 256B.0659, subdivision
24.31 1, paragraph (i); ancillary activities needed to support individual services; and training to
24.32 participants, and is based on the requirements in each individual's coordinated service and
24.33 support plan under section 245D.02, subdivision 4b; any coordinated service and support

25.1 plan addendum under section 245D.02, subdivision 4c; an assessment tool; and provider
25.2 observation of an individual's service need. Total shared staffing hours are divided
25.3 proportionally by the number of individuals who receive the shared service provisions.

25.4 (m) "Staffing ratio" means the number of recipients a service provider employee supports
25.5 during a unit of service based on a uniform assessment tool, provider observation, case
25.6 history, and the recipient's services of choice, and not based on the staffing ratios under
25.7 section 245D.31.

25.8 (n) "Unit of service" means the following:

25.9 (1) for residential support services under subdivision 6, a unit of service is a day. Any
25.10 portion of any calendar day, within allowable Medicaid rules, where an individual spends
25.11 time in a residential setting is billable as a day;

25.12 (2) for day services under subdivision 7:

25.13 (i) for day training and habilitation services, a unit of service is either:

25.14 (A) a day unit of service is defined as six or more hours of time spent providing direct
25.15 services and transportation; or

25.16 (B) a partial day unit of service is defined as fewer than six hours of time spent providing
25.17 direct services and transportation; and

25.18 (C) for new day service recipients after January 1, 2014, 15 minute units of service must
25.19 be used for fewer than six hours of time spent providing direct services and transportation;

25.20 (ii) for adult day and structured day services, a unit of service is a day or 15 minutes. A
25.21 day unit of service is six or more hours of time spent providing direct services;

25.22 (iii) for prevocational services, a unit of service is a day or an hour. A day unit of service
25.23 is six or more hours of time spent providing direct service;

25.24 (3) for unit-based services with programming under subdivision 8:

25.25 (i) for supported living services, a unit of service is a day or 15 minutes. When a day
25.26 rate is authorized, any portion of a calendar day where an individual receives services is
25.27 billable as a day; and

25.28 (ii) for all other services, a unit of service is 15 minutes; and

25.29 (4) for unit-based services without programming under subdivision 9:

26.1 (i) for respite services, a unit of service is a day or 15 minutes. When a day rate is
26.2 authorized, any portion of a calendar day when an individual receives services is billable
26.3 as a day; and

26.4 (ii) for all other services, a unit of service is 15 minutes.

26.5 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
26.6 of human services shall notify the revisor of statutes when federal approval is obtained.

26.7 Sec. 23. Minnesota Statutes 2016, section 256B.4914, subdivision 3, is amended to read:

26.8 Subd. 3. **Applicable services.** Applicable services are those authorized under the state's
26.9 home and community-based services waivers under sections 256B.092 and 256B.49,
26.10 including the following, as defined in the federally approved home and community-based
26.11 services plan:

- 26.12 (1) 24-hour customized living;
- 26.13 (2) adult day care;
- 26.14 (3) adult day care bath;
- 26.15 (4) behavioral programming;
- 26.16 (5) companion services;
- 26.17 (6) customized living;
- 26.18 (7) day training and habilitation;
- 26.19 (8) housing access coordination;
- 26.20 (9) independent living skills;
- 26.21 (10) in-home family support;
- 26.22 (11) night supervision;
- 26.23 (12) personal support;
- 26.24 (13) prevocational services;
- 26.25 (14) residential care services;
- 26.26 (15) residential support services;
- 26.27 (16) respite services;
- 26.28 (17) structured day services;

- 27.1 (18) supported employment services;
- 27.2 (19) supported living services;
- 27.3 (20) transportation services; and
- 27.4 (21) individualized home supports;
- 27.5 (22) independent living skills specialist services;
- 27.6 (23) employment exploration services;
- 27.7 (24) employment development services;
- 27.8 (25) employment support services; and
- 27.9 ~~(21)~~ (26) other services as approved by the federal government in the state home and
- 27.10 community-based services plan.

27.11 **EFFECTIVE DATE.** (a) Clause (21) is effective the day following final enactment.

27.12 (b) Clauses (22) to (25) are effective upon federal approval. The commissioner of human

27.13 services shall notify the revisor of statutes when federal approval is obtained.

27.14 (c) Clause (18) expires upon federal approval. The commissioner of human services

27.15 shall notify the revisor of statutes when federal approval is obtained.

27.16 Sec. 24. Minnesota Statutes 2016, section 256B.4914, subdivision 5, is amended to read:

27.17 Subd. 5. **Base wage index and standard component values.** (a) The base wage index

27.18 is established to determine staffing costs associated with providing services to individuals

27.19 receiving home and community-based services. For purposes of developing and calculating

27.20 the proposed base wage, Minnesota-specific wages taken from job descriptions and standard

27.21 occupational classification (SOC) codes from the Bureau of Labor Statistics as defined in

27.22 the most recent edition of the Occupational Handbook must be used. The base wage index

27.23 must be calculated as follows:

27.24 (1) for residential direct care staff, the sum of:

27.25 (i) 15 percent of the subtotal of 50 percent of the median wage for personal and home

27.26 health aide (SOC code 39-9021); 30 percent of the median wage for nursing ~~aide~~ assistant

27.27 (SOC code ~~31-1012~~ 31-1014); and 20 percent of the median wage for social and human

27.28 services aide (SOC code 21-1093); and

27.29 (ii) 85 percent of the subtotal of 20 percent of the median wage for home health aide

27.30 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide

28.1 (SOC code 39-9021); 20 percent of the median wage for nursing aide assistant (SOC code
28.2 ~~31-1012~~ 31-1014); 20 percent of the median wage for psychiatric technician (SOC code
28.3 29-2053); and 20 percent of the median wage for social and human services aide (SOC code
28.4 21-1093);

28.5 (2) for day services, 20 percent of the median wage for nursing aide assistant (SOC code
28.6 ~~31-1012~~ 31-1014); 20 percent of the median wage for psychiatric technician (SOC code
28.7 29-2053); and 60 percent of the median wage for social and human services aide (SOC code
28.8 21-1093);

28.9 (3) for residential asleep-overnight staff, the wage ~~will be \$7.66 per hour~~ is the minimum
28.10 wage in Minnesota for large employers, except in a family foster care setting, the wage is
28.11 ~~\$2.80 per hour~~ 36 percent of the minimum wage in Minnesota for large employers;

28.12 (4) for behavior program analyst staff, 100 percent of the median wage for mental health
28.13 counselors (SOC code 21-1014);

28.14 (5) for behavior program professional staff, 100 percent of the median wage for clinical
28.15 counseling and school psychologist (SOC code 19-3031);

28.16 (6) for behavior program specialist staff, 100 percent of the median wage for psychiatric
28.17 technicians (SOC code 29-2053);

28.18 (7) for supportive living services staff, 20 percent of the median wage for nursing aide
28.19 assistant (SOC code ~~31-1012~~ 31-1014); 20 percent of the median wage for psychiatric
28.20 technician (SOC code 29-2053); and 60 percent of the median wage for social and human
28.21 services aide (SOC code 21-1093);

28.22 (8) for housing access coordination staff, ~~50~~ 100 percent of the median wage for
28.23 community and social services specialist (SOC code 21-1099); ~~and 50 percent of the median~~
28.24 ~~wage for social and human services aide (SOC code 21-1093);~~

28.25 (9) for in-home family support staff, 20 percent of the median wage for nursing aide
28.26 (SOC code 31-1012); 30 percent of the median wage for community social service specialist
28.27 (SOC code 21-1099); 40 percent of the median wage for social and human services aide
28.28 (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC
28.29 code 29-2053);

28.30 (10) for individualized home supports services staff, 40 percent of the median wage for
28.31 community social service specialist (SOC code 21-1099); 50 percent of the median wage
28.32 for social and human services aide (SOC code 21-1093); and ten percent of the median
28.33 wage for psychiatric technician (SOC code 29-2053);

29.1 (11) for independent living skills staff, 40 percent of the median wage for community
29.2 social service specialist (SOC code 21-1099); 50 percent of the median wage for social and
29.3 human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric
29.4 technician (SOC code 29-2053);

29.5 (12) for independent living skills specialist staff, 100 percent of mental health and
29.6 substance abuse social worker (SOC code 21-1023);

29.7 ~~(11)~~ (13) for supported employment staff, 20 percent of the median wage for nursing
29.8 aide assistant (SOC code 31-1012 31-1014); 20 percent of the median wage for psychiatric
29.9 technician (SOC code 29-2053); and 60 percent of the median wage for social and human
29.10 services aide (SOC code 21-1093);

29.11 (14) for employment support services staff, 50 percent of the median wage for
29.12 rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for
29.13 community and social services specialist (SOC code 21-1099);

29.14 (15) for employment exploration services staff, 50 percent of the median wage for
29.15 rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for
29.16 community and social services specialist (SOC code 21-1099);

29.17 (16) for employment development services staff, 50 percent of the median wage for
29.18 education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent
29.19 of the median wage for community and social services specialist (SOC code 21-1099);

29.20 ~~(12)~~ (17) for adult companion staff, 50 percent of the median wage for personal and
29.21 home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides,
29.22 orderlies, and attendants assistant (SOC code 31-1012 31-1014);

29.23 ~~(13)~~ (18) for night supervision staff, 20 percent of the median wage for home health
29.24 aide (SOC code 31-1011); 20 percent of the median wage for personal and home health
29.25 aide (SOC code 39-9021); 20 percent of the median wage for nursing aide assistant (SOC
29.26 code 31-1012 31-1014); 20 percent of the median wage for psychiatric technician (SOC
29.27 code 29-2053); and 20 percent of the median wage for social and human services aide (SOC
29.28 code 21-1093);

29.29 (14) (19) for respite staff, 50 percent of the median wage for personal and home care
29.30 aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides, orderlies,
29.31 and attendants assistant (SOC code 31-1012 31-1014);

30.1 ~~(15)~~ (20) for personal support staff, 50 percent of the median wage for personal and
30.2 home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides;
30.3 ~~orderlies, and attendants~~ assistant (SOC code ~~31-1012~~ 31-1014);

30.4 ~~(16)~~ (21) for supervisory staff, ~~the basic wage is \$17.43 per hour,~~ 100 percent of the
30.5 median wage for community and social services specialist (SOC code 21-1099), with the
30.6 exception of the supervisor of behavior professional, behavior analyst, and behavior
30.7 specialists, which must be \$30.75 per hour is 100 percent of the median wage for clinical
30.8 counseling and school psychologist (SOC code 19-3031);

30.9 ~~(17)~~ (22) for registered nurse staff, ~~the basic wage is \$30.82 per hour,~~ 100 percent of
30.10 the median wage for registered nurses (SOC code 29-1141); and

30.11 ~~(18)~~ (23) for licensed practical nurse staff, ~~the basic wage is \$18.64 per hour~~ 100 percent
30.12 of the median wage for licensed practical nurses (SOC code 29-2061).

30.13 (b) Component values for residential support services are:

30.14 (1) supervisory span of control ratio: 11 percent;

30.15 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;

30.16 (3) employee-related cost ratio: 23.6 percent;

30.17 (4) general administrative support ratio: 13.25 percent;

30.18 (5) program-related expense ratio: 1.3 percent; and

30.19 (6) absence and utilization factor ratio: 3.9 percent.

30.20 (c) Component values for family foster care are:

30.21 (1) supervisory span of control ratio: 11 percent;

30.22 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;

30.23 (3) employee-related cost ratio: 23.6 percent;

30.24 (4) general administrative support ratio: 3.3 percent;

30.25 (5) program-related expense ratio: 1.3 percent; and

30.26 (6) absence factor: 1.7 percent.

30.27 (d) Component values for day services for all services are:

30.28 (1) supervisory span of control ratio: 11 percent;

30.29 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;

- 31.1 (3) employee-related cost ratio: 23.6 percent;
- 31.2 (4) program plan support ratio: 5.6 percent;
- 31.3 (5) client programming and support ratio: ten percent;
- 31.4 (6) general administrative support ratio: 13.25 percent;
- 31.5 (7) program-related expense ratio: 1.8 percent; and
- 31.6 (8) absence and utilization factor ratio: ~~3.9~~ 9.4 percent.
- 31.7 (e) Component values for unit-based services with programming are:
- 31.8 (1) supervisory span of control ratio: 11 percent;
- 31.9 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 31.10 (3) employee-related cost ratio: 23.6 percent;
- 31.11 (4) program plan supports ratio: ~~3.1~~ 15.5 percent;
- 31.12 (5) client programming and supports ratio: ~~8.6~~ 4.7 percent;
- 31.13 (6) general administrative support ratio: 13.25 percent;
- 31.14 (7) program-related expense ratio: 6.1 percent; and
- 31.15 (8) absence and utilization factor ratio: 3.9 percent.
- 31.16 (f) Component values for unit-based services without programming except respite are:
- 31.17 (1) supervisory span of control ratio: 11 percent;
- 31.18 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 31.19 (3) employee-related cost ratio: 23.6 percent;
- 31.20 (4) program plan support ratio: ~~3.1~~ 7.0 percent;
- 31.21 (5) client programming and support ratio: ~~8.6~~ 2.3 percent;
- 31.22 (6) general administrative support ratio: 13.25 percent;
- 31.23 (7) program-related expense ratio: ~~6.1~~ 2.9 percent; and
- 31.24 (8) absence and utilization factor ratio: 3.9 percent.
- 31.25 (g) Component values for unit-based services without programming for respite are:
- 31.26 (1) supervisory span of control ratio: 11 percent;
- 31.27 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;

- 32.1 (3) employee-related cost ratio: 23.6 percent;
- 32.2 (4) general administrative support ratio: 13.25 percent;
- 32.3 (5) program-related expense ratio: ~~6.1~~ 2.9 percent; and
- 32.4 (6) absence and utilization factor ratio: 3.9 percent.

32.5 (h) On July 1, 2017, the commissioner shall update the base wage index in paragraph

32.6 (a) based on the wage data by standard occupational code (SOC) from the Bureau of Labor

32.7 Statistics available on December 31, 2016. The commissioner shall publish these updated

32.8 values and load them into the rate management system. ~~This adjustment occurs every five~~

32.9 ~~years. For adjustments in 2021 and beyond, the commissioner shall use the data available~~

32.10 ~~on December 31 of the calendar year five years prior. On July 1, 2022, and every five years~~

32.11 thereafter, the commissioner shall update the base wage index in paragraph (a) based on

32.12 the most recently available wage data by SOC from the Bureau of Labor Statistics. The

32.13 commissioner shall publish these updated values and load them into the rate management

32.14 system.

32.15 (i) On July 1, 2017, the commissioner shall update the framework components in

32.16 paragraphs (b) to (g) paragraph (d), clause (5); paragraph (e), clause (5); and paragraph (f),

32.17 clause (5); subdivision 6, clauses (8) and (9); and subdivision 7, clauses (10), (16), and (17),

32.18 for changes in the Consumer Price Index. The commissioner will adjust these values higher

32.19 or lower by the percentage change in the Consumer Price Index-All Items, United States

32.20 city average (CPI-U) from January 1, 2014, to January 1, 2017. The commissioner shall

32.21 publish these updated values and load them into the rate management system. ~~This adjustment~~

32.22 ~~occurs every five years. For adjustments in 2021 and beyond, the commissioner shall use~~

32.23 ~~the data available on January 1 of the calendar year four years prior and January 1 of the~~

32.24 ~~current calendar year. On July 1, 2022, and every five years thereafter, the commissioner~~

32.25 shall update the framework components in paragraph (d), clause (5); paragraph (e), clause

32.26 (5); and paragraph (f), clause (5); subdivision 6, clauses (8) and (9); and subdivision 7,

32.27 clauses (10), (16), and (17), for changes in the Consumer Price Index. The commissioner

32.28 shall adjust these values higher or lower by the percentage change in the CPI-U from the

32.29 date of the previous update to the date of the data most recently available prior to the

32.30 scheduled update. The commissioner shall publish these updated values and load them into

32.31 the rate management system.

32.32 (j) In this subdivision, if Bureau of Labor Statistics occupational codes or Consumer

32.33 Price Index items are unavailable in the future, the commissioner shall recommend to the

32.34 legislature codes or items to update and replace missing component values.

33.1 **EFFECTIVE DATE.** (a) The amendments to paragraphs (a) to (g) are effective January
33.2 1, 2018, except the amendment to paragraph (a), clauses (3), (21), and (22), and paragraph
33.3 (d), clause (8), which are effective January 1, 2019, and the amendment to paragraph (a),
33.4 clause (10), which is effective the day following final enactment.

33.5 (b) The amendments to paragraphs (h) to (j) are effective the day following final
33.6 enactment.

33.7 (c) Paragraph (a), clause (13), expires upon federal approval. The commissioner of
33.8 human services shall notify the revisor of statutes when federal approval is obtained.

33.9 Sec. 25. Minnesota Statutes 2016, section 256B.4914, subdivision 6, is amended to read:

33.10 Subd. 6. **Payments for residential support services.** (a) Payments for residential support
33.11 services, as defined in sections 256B.092, subdivision 11, and 256B.49, subdivision 22,
33.12 must be calculated as follows:

33.13 (1) determine the number of shared staffing and individual direct staff hours to meet a
33.14 recipient's needs provided on site or through monitoring technology;

33.15 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
33.16 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
33.17 5. This is defined as the direct-care rate;

33.18 (3) for a recipient requiring customization for deaf and hard-of-hearing language
33.19 accessibility under subdivision 12, add the customization rate provided in subdivision 12
33.20 to the result of clause (2). This is defined as the customized direct-care rate;

33.21 (4) multiply the number of shared and individual direct staff hours provided on site or
33.22 through monitoring technology and nursing hours by the appropriate staff wages in
33.23 subdivision 5, paragraph (a), or the customized direct-care rate;

33.24 (5) multiply the number of shared and individual direct staff hours provided on site or
33.25 through monitoring technology and nursing hours by the product of the supervision span
33.26 of control ratio in subdivision 5, paragraph (b), clause (1), and the appropriate supervision
33.27 wage in subdivision 5, paragraph (a), clause ~~(16)~~ (21);

33.28 (6) combine the results of clauses (4) and (5), excluding any shared and individual direct
33.29 staff hours provided through monitoring technology, and multiply the result by one plus
33.30 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b),
33.31 clause (2). This is defined as the direct staffing cost;

34.1 (7) for employee-related expenses, multiply the direct staffing cost, excluding any shared
34.2 and individual direct staff hours provided through monitoring technology, by one plus the
34.3 employee-related cost ratio in subdivision 5, paragraph (b), clause (3);

34.4 (8) for client programming and supports, the commissioner shall add \$2,179; and

34.5 (9) for transportation, if provided, the commissioner shall add \$1,680, or \$3,000 if
34.6 customized for adapted transport, based on the resident with the highest assessed need.

34.7 (b) The total rate must be calculated using the following steps:

34.8 (1) subtotal paragraph (a), clauses (7) to (9), and the direct staffing cost of any shared
34.9 and individual direct staff hours provided through monitoring technology that was excluded
34.10 in clause (7);

34.11 (2) sum the standard general and administrative rate, the program-related expense ratio,
34.12 and the absence and utilization ratio;

34.13 (3) divide the result of clause (1) by one minus the result of clause (2). This is the total
34.14 payment amount; and

34.15 (4) adjust the result of clause (3) by a factor to be determined by the commissioner to
34.16 adjust for regional differences in the cost of providing services.

34.17 (c) The payment methodology for customized living, 24-hour customized living, and
34.18 residential care services must be the customized living tool. Revisions to the customized
34.19 living tool must be made to reflect the services and activities unique to disability-related
34.20 recipient needs.

34.21 (d) For individuals enrolled prior to January 1, 2014, the days of service authorized must
34.22 meet or exceed the days of service used to convert service agreements in effect on December
34.23 1, 2013, and must not result in a reduction in spending or service utilization due to conversion
34.24 during the implementation period under section 256B.4913, subdivision 4a. If during the
34.25 implementation period, an individual's historical rate, including adjustments required under
34.26 section 256B.4913, subdivision 4a, paragraph (c), is equal to or greater than the rate
34.27 determined in this subdivision, the number of days authorized for the individual is 365.

34.28 (e) The number of days authorized for all individuals enrolling after January 1, 2014,
34.29 in residential services must include every day that services start and end.

- 35.1 Sec. 26. Minnesota Statutes 2016, section 256B.4914, subdivision 7, is amended to read:
- 35.2 Subd. 7. **Payments for day programs.** Payments for services with day programs
- 35.3 including adult day care, day treatment and habilitation, prevocational services, and structured
- 35.4 day services must be calculated as follows:
- 35.5 (1) determine the number of units of service and staffing ratio to meet a recipient's needs:
- 35.6 (i) the staffing ratios for the units of service provided to a recipient in a typical week
- 35.7 must be averaged to determine an individual's staffing ratio; and
- 35.8 (ii) the commissioner, in consultation with service providers, shall develop a uniform
- 35.9 staffing ratio worksheet to be used to determine staffing ratios under this subdivision;
- 35.10 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
- 35.11 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
- 35.12 5;
- 35.13 (3) for a recipient requiring customization for deaf and hard-of-hearing language
- 35.14 accessibility under subdivision 12, add the customization rate provided in subdivision 12
- 35.15 to the result of clause (2). This is defined as the customized direct-care rate;
- 35.16 (4) multiply the number of day program direct staff hours and nursing hours by the
- 35.17 appropriate staff wage in subdivision 5, paragraph (a), or the customized direct-care rate;
- 35.18 (5) multiply the number of day direct staff hours by the product of the supervision span
- 35.19 of control ratio in subdivision 5, paragraph (d), clause (1), and the appropriate supervision
- 35.20 wage in subdivision 5, paragraph (a), clause ~~(16)~~ (21);
- 35.21 (6) combine the results of clauses (4) and (5), and multiply the result by one plus the
- 35.22 employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (d), clause
- 35.23 (2). This is defined as the direct staffing rate;
- 35.24 (7) for program plan support, multiply the result of clause (6) by one plus the program
- 35.25 plan support ratio in subdivision 5, paragraph (d), clause (4);
- 35.26 (8) for employee-related expenses, multiply the result of clause (7) by one plus the
- 35.27 employee-related cost ratio in subdivision 5, paragraph (d), clause (3);
- 35.28 (9) for client programming and supports, multiply the result of clause (8) by one plus
- 35.29 the client programming and support ratio in subdivision 5, paragraph (d), clause (5);
- 35.30 (10) for program facility costs, add \$19.30 per week with consideration of staffing ratios
- 35.31 to meet individual needs;

- 36.1 (11) for adult day bath services, add \$7.01 per 15 minute unit;
- 36.2 (12) this is the subtotal rate;
- 36.3 (13) sum the standard general and administrative rate, the program-related expense ratio,
36.4 and the absence and utilization factor ratio;
- 36.5 (14) divide the result of clause (12) by one minus the result of clause (13). This is the
36.6 total payment amount;
- 36.7 (15) adjust the result of clause (14) by a factor to be determined by the commissioner
36.8 to adjust for regional differences in the cost of providing services;
- 36.9 (16) for transportation provided as part of day training and habilitation for an individual
36.10 who does not require a lift, add:
- 36.11 (i) \$10.50 for a trip between zero and ten miles for a nonshared ride in a vehicle without
36.12 a lift, \$8.83 for a shared ride in a vehicle without a lift, and \$9.25 for a shared ride in a
36.13 vehicle with a lift;
- 36.14 (ii) \$15.75 for a trip between 11 and 20 miles for a nonshared ride in a vehicle without
36.15 a lift, \$10.58 for a shared ride in a vehicle without a lift, and \$11.88 for a shared ride in a
36.16 vehicle with a lift;
- 36.17 (iii) \$25.75 for a trip between 21 and 50 miles for a nonshared ride in a vehicle without
36.18 a lift, \$13.92 for a shared ride in a vehicle without a lift, and \$16.88 for a shared ride in a
36.19 vehicle with a lift; or
- 36.20 (iv) \$33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a lift,
36.21 \$16.50 for a shared ride in a vehicle without a lift, and \$20.75 for a shared ride in a vehicle
36.22 with a lift;
- 36.23 (17) for transportation provided as part of day training and habilitation for an individual
36.24 who does require a lift, add:
- 36.25 (i) \$19.05 for a trip between zero and ten miles for a nonshared ride in a vehicle with a
36.26 lift, and \$15.05 for a shared ride in a vehicle with a lift;
- 36.27 (ii) \$32.16 for a trip between 11 and 20 miles for a nonshared ride in a vehicle with a
36.28 lift, and \$28.16 for a shared ride in a vehicle with a lift;
- 36.29 (iii) \$58.76 for a trip between 21 and 50 miles for a nonshared ride in a vehicle with a
36.30 lift, and \$58.76 for a shared ride in a vehicle with a lift; or

37.1 (iv) \$80.93 for a trip of 51 miles or more for a nonshared ride in a vehicle with a lift,
37.2 and \$80.93 for a shared ride in a vehicle with a lift.

37.3 Sec. 27. Minnesota Statutes 2016, section 256B.4914, subdivision 8, is amended to read:

37.4 Subd. 8. **Payments for unit-based services with programming.** Payments for unit-based
37.5 services with programming, including behavior programming, housing access coordination,
37.6 in-home family support, independent living skills training, independent living skills specialist
37.7 services, individualized home supports, hourly supported living services, employment
37.8 exploration services, employment development services, supported employment, and
37.9 supported employment support services provided to an individual outside of any day or
37.10 residential service plan must be calculated as follows, unless the services are authorized
37.11 separately under subdivision 6 or 7:

37.12 (1) determine the number of units of service to meet a recipient's needs;

37.13 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
37.14 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision
37.15 5;

37.16 (3) for a recipient requiring customization for deaf and hard-of-hearing language
37.17 accessibility under subdivision 12, add the customization rate provided in subdivision 12
37.18 to the result of clause (2). This is defined as the customized direct-care rate;

37.19 (4) multiply the number of direct staff hours by the appropriate staff wage in subdivision
37.20 5, paragraph (a), or the customized direct-care rate;

37.21 (5) multiply the number of direct staff hours by the product of the supervision span of
37.22 control ratio in subdivision 5, paragraph (e), clause (1), and the appropriate supervision
37.23 wage in subdivision 5, paragraph (a), clause ~~(16)~~ (21);

37.24 (6) combine the results of clauses (4) and (5), and multiply the result by one plus the
37.25 employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (e), clause
37.26 (2). This is defined as the direct staffing rate;

37.27 (7) for program plan support, multiply the result of clause (6) by one plus the program
37.28 plan supports ratio in subdivision 5, paragraph (e), clause (4);

37.29 (8) for employee-related expenses, multiply the result of clause (7) by one plus the
37.30 employee-related cost ratio in subdivision 5, paragraph (e), clause (3);

37.31 (9) for client programming and supports, multiply the result of clause (8) by one plus
37.32 the client programming and supports ratio in subdivision 5, paragraph (e), clause (5);

38.1 (10) this is the subtotal rate;

38.2 (11) sum the standard general and administrative rate, the program-related expense ratio,
38.3 and the absence and utilization factor ratio;

38.4 (12) divide the result of clause (10) by one minus the result of clause (11). This is the
38.5 total payment amount;

38.6 (13) for supported employment provided in a shared manner, divide the total payment
38.7 amount in clause (12) by the number of service recipients, not to exceed three. For
38.8 employment support services provided in a shared manner, divide the total payment amount
38.9 in clause (12) by the number of service recipients, not to exceed six. For independent living
38.10 skills training and individualized home supports provided in a shared manner, divide the
38.11 total payment amount in clause (12) by the number of service recipients, not to exceed two;
38.12 and

38.13 (14) adjust the result of clause (13) by a factor to be determined by the commissioner
38.14 to adjust for regional differences in the cost of providing services.

38.15 **EFFECTIVE DATE.** This section is effective the day following final enactment.
38.16 Supported employment services in this subdivision expire upon federal approval. The
38.17 commissioner of human services shall notify the revisor of statutes when federal approval
38.18 is obtained.

38.19 Sec. 28. Minnesota Statutes 2016, section 256B.4914, subdivision 9, is amended to read:

38.20 Subd. 9. **Payments for unit-based services without programming.** Payments for
38.21 unit-based services without programming, including night supervision, personal support,
38.22 respite, and companion care provided to an individual outside of any day or residential
38.23 service plan must be calculated as follows unless the services are authorized separately
38.24 under subdivision 6 or 7:

38.25 (1) for all services except respite, determine the number of units of service to meet a
38.26 recipient's needs;

38.27 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
38.28 Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

38.29 (3) for a recipient requiring customization for deaf and hard-of-hearing language
38.30 accessibility under subdivision 12, add the customization rate provided in subdivision 12
38.31 to the result of clause (2). This is defined as the customized direct care rate;

39.1 (4) multiply the number of direct staff hours by the appropriate staff wage in subdivision
39.2 5 or the customized direct care rate;

39.3 (5) multiply the number of direct staff hours by the product of the supervision span of
39.4 control ratio in subdivision 5, paragraph (f), clause (1), and the appropriate supervision
39.5 wage in subdivision 5, paragraph (a), clause ~~(16)~~ (21);

39.6 (6) combine the results of clauses (4) and (5), and multiply the result by one plus the
39.7 employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (f), clause
39.8 (2). This is defined as the direct staffing rate;

39.9 (7) for program plan support, multiply the result of clause (6) by one plus the program
39.10 plan support ratio in subdivision 5, paragraph (f), clause (4);

39.11 (8) for employee-related expenses, multiply the result of clause (7) by one plus the
39.12 employee-related cost ratio in subdivision 5, paragraph (f), clause (3);

39.13 (9) for client programming and supports, multiply the result of clause (8) by one plus
39.14 the client programming and support ratio in subdivision 5, paragraph (f), clause (5);

39.15 (10) this is the subtotal rate;

39.16 (11) sum the standard general and administrative rate, the program-related expense ratio,
39.17 and the absence and utilization factor ratio;

39.18 (12) divide the result of clause (10) by one minus the result of clause (11). This is the
39.19 total payment amount;

39.20 (13) for respite services, determine the number of day units of service to meet an
39.21 individual's needs;

39.22 (14) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
39.23 Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;

39.24 (15) for a recipient requiring deaf and hard-of-hearing customization under subdivision
39.25 12, add the customization rate provided in subdivision 12 to the result of clause (14). This
39.26 is defined as the customized direct care rate;

39.27 (16) multiply the number of direct staff hours by the appropriate staff wage in subdivision
39.28 5, paragraph (a);

39.29 (17) multiply the number of direct staff hours by the product of the supervisory span of
39.30 control ratio in subdivision 5, paragraph (g), clause (1), and the appropriate supervision
39.31 wage in subdivision 5, paragraph (a), clause ~~(16)~~ (21);

(18) combine the results of clauses (16) and (17), and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (g), clause (2). This is defined as the direct staffing rate;

(19) for employee-related expenses, multiply the result of clause (18) by one plus the employee-related cost ratio in subdivision 5, paragraph (g), clause (3);

(20) this is the subtotal rate;

(21) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(22) divide the result of clause (20) by one minus the result of clause (21). This is the total payment amount; and

(23) adjust the result of clauses (12) and (22) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

Sec. 29. Minnesota Statutes 2016, section 256B.4914, subdivision 10, is amended to read:

Subd. 10. Updating payment values and additional information. (a) From January 1, 2014, through December 31, 2017, the commissioner shall develop and implement uniform procedures to refine terms and adjust values used to calculate payment rates in this section.

(b) No later than July 1, 2014, the commissioner shall, within available resources, begin to conduct research and gather data and information from existing state systems or other outside sources on the following items:

(1) differences in the underlying cost to provide services and care across the state; and

(2) mileage, vehicle type, lift requirements, incidents of individual and shared rides, and units of transportation for all day services, which must be collected from providers using the rate management worksheet and entered into the rates management system; and

(3) the distinct underlying costs for services provided by a license holder under sections 245D.05, 245D.06, 245D.07, 245D.071, 245D.081, and 245D.09, and for services provided by a license holder certified under section 245D.33.

(c) Beginning January 1, 2014, through December 31, 2018, using a statistically valid set of rates management system data, the commissioner, in consultation with stakeholders, shall analyze for each service the average difference in the rate on December 31, 2013, and the framework rate at the individual, provider, lead agency, and state levels. The commissioner shall issue semiannual reports to the stakeholders on the difference in rates by service and by county during the banding period under section 256B.4913, subdivision

41.1 4a. The commissioner shall issue the first report by October 1, 2014, and the final report
41.2 shall be issued by December 31, 2018.

41.3 (d) No later than July 1, 2014, the commissioner, in consultation with stakeholders, shall
41.4 begin the review and evaluation of the following values already in subdivisions 6 to 9, or
41.5 issues that impact all services, including, but not limited to:

41.6 (1) values for transportation rates ~~for day services;~~

41.7 ~~(2) values for transportation rates in residential services;~~

41.8 ~~(3)~~ (2) values for services where monitoring technology replaces staff time;

41.9 ~~(4)~~ (3) values for indirect services;

41.10 ~~(5)~~ (4) values for nursing;

41.11 ~~(6) component values for independent living skills;~~

41.12 ~~(7) component values for family foster care that reflect licensing requirements;~~

41.13 ~~(8) adjustments to other components to replace the budget neutrality factor;~~

41.14 ~~(9) remote monitoring technology for nonresidential services;~~

41.15 ~~(10) values for basic and intensive services in residential services;~~

41.16 ~~(11)~~ (5) values for the facility use rate in day services, and the weightings used in the
41.17 day service ratios and adjustments to those weightings;

41.18 ~~(12)~~ (6) values for workers' compensation as part of employee-related expenses;

41.19 ~~(13)~~ (7) values for unemployment insurance as part of employee-related expenses;

41.20 ~~(14) a component value to reflect costs for individuals with rates previously adjusted~~
41.21 ~~for the inclusion of group residential housing rate 3 costs, only for any individual enrolled~~
41.22 ~~as of December 31, 2013; and~~

41.23 ~~(15)~~ (8) any changes in state or federal law with ~~an~~ a direct impact on the underlying
41.24 cost of providing home and community-based services; and

41.25 (9) outcome measures, determined by the commissioner, for home and community-based
41.26 services rates determined under this section.

41.27 (e) The commissioner shall report to the chairs and the ranking minority members of
41.28 the legislative committees and divisions with jurisdiction over health and human services
41.29 policy and finance with the information and data gathered under paragraphs (b) to (d) on
41.30 the following dates:

42.1 (1) January 15, 2015, with preliminary results and data;
42.2 (2) January 15, 2016, with a status implementation update, and additional data and
42.3 summary information;

42.4 (3) January 15, 2017, with the full report; and

42.5 (4) January 15, 2019 2020, with another full report, and a full report once every four
42.6 years thereafter.

42.7 ~~(f) Based on the commissioner's evaluation of the information and data collected in~~
42.8 ~~paragraphs (b) to (d), the commissioner shall make recommendations to the legislature by~~
42.9 ~~January 15, 2015, to address any issues identified during the first year of implementation.~~
42.10 ~~After January 15, 2015, the commissioner may make recommendations to the legislature~~
42.11 ~~to address potential issues.~~

42.12 ~~(g)~~ (f) The commissioner shall implement a regional adjustment factor to all rate
42.13 calculations in subdivisions 6 to 9, effective no later than January 1, 2015. Beginning July
42.14 1, 2017, the commissioner shall renew analysis and implement changes to the regional
42.15 adjustment factors when adjustments required under subdivision 5, paragraph (h), occur.
42.16 Prior to implementation, the commissioner shall consult with stakeholders on the
42.17 methodology to calculate the adjustment.

42.18 ~~(h)~~ (g) The commissioner shall provide a public notice via LISTSERV in October of
42.19 each year beginning October 1, 2014, containing information detailing legislatively approved
42.20 changes in:

42.21 (1) calculation values including derived wage rates and related employee and
42.22 administrative factors;

42.23 (2) service utilization;

42.24 (3) county and tribal allocation changes; and

42.25 (4) information on adjustments made to calculation values and the timing of those
42.26 adjustments.

42.27 The information in this notice must be effective January 1 of the following year.

42.28 ~~(i) No later than July 1, 2016, the commissioner shall develop and implement, in~~
42.29 ~~consultation with stakeholders, a methodology sufficient to determine the shared staffing~~
42.30 ~~levels necessary to meet, at a minimum, health and welfare needs of individuals who will~~
42.31 ~~be living together in shared residential settings, and the required shared staffing activities~~
42.32 ~~described in subdivision 2, paragraph (l). This determination methodology must ensure~~

43.1 ~~staffing levels are adaptable to meet the needs and desired outcomes for current and~~
43.2 ~~prospective residents in shared residential settings.~~

43.3 ~~(j) (h)~~ When the available shared staffing hours in a residential setting are insufficient
43.4 to meet the needs of an individual who enrolled in residential services after January 1, 2014,
43.5 or insufficient to meet the needs of an individual with a service agreement adjustment
43.6 described in section 256B.4913, subdivision 4a, paragraph (f), then individual staffing hours
43.7 shall be used.

43.8 (i) The commissioner shall study the underlying cost of absence and utilization for day
43.9 services. Based on the commissioner's evaluation of the data collected under this paragraph,
43.10 the commissioner shall make recommendations to the legislature by January 15, 2018, for
43.11 changes, if any, to the absence and utilization factor ratio component value for day services.

43.12 (j) Beginning July 1, 2017, the commissioner shall collect transportation and trip
43.13 information for all day services through the rates management system.

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

43.15 Sec. 30. Minnesota Statutes 2016, section 256B.4914, is amended by adding a subdivision
43.16 to read:

43.17 Subd. 10a. **Reporting and analysis of cost data.** (a) The commissioner must ensure
43.18 that wage values and component values in subdivisions 5 to 9 reflect the cost to provide the
43.19 service. As determined by the commissioner, in consultation with stakeholders identified
43.20 in section 256B.4913, subdivision 5, a provider enrolled to provide services with rates
43.21 determined under this section must submit requested cost data to the commissioner to support
43.22 research on the cost of providing services that have rates determined by the disability waiver
43.23 rates system. Requested cost data may include, but is not limited to:

43.24 (1) worker wage costs;

43.25 (2) benefits paid;

43.26 (3) supervisor wage costs;

43.27 (4) executive wage costs;

43.28 (5) vacation, sick, and training time paid;

43.29 (6) taxes, workers' compensation, and unemployment insurance costs paid;

43.30 (7) administrative costs paid;

43.31 (8) program costs paid;

44.1 (9) transportation costs paid;

44.2 (10) vacancy rates; and

44.3 (11) other data relating to costs required to provide services requested by the
44.4 commissioner.

44.5 (b) At least once in any five-year period, a provider must submit cost data for a fiscal
44.6 year that ended not more than 18 months prior to the submission date. The commissioner
44.7 shall provide each provider a 90-day notice prior to its submission due date. If a provider
44.8 fails to submit required reporting data, the commissioner shall provide notice to providers
44.9 that have not provided required data 30 days after the required submission date, and a second
44.10 notice for providers who have not provided required data 60 days after the required
44.11 submission date. The commissioner shall temporarily suspend payments to the provider if
44.12 cost data is not received 90 days after the required submission date. Withheld payments
44.13 shall be made once data is received by the commissioner.

44.14 (c) The commissioner shall conduct a random validation of data submitted under
44.15 paragraph (a) to ensure data accuracy. The commissioner shall analyze cost documentation
44.16 in paragraph (a) and provide recommendations for adjustments to cost components.

44.17 (d) The commissioner shall analyze cost documentation in paragraph (a) and, in
44.18 consultation with stakeholders identified in section 256B.4913, subdivision 5, may submit
44.19 recommendations on component values and inflationary factor adjustments to the chairs
44.20 and ranking minority members of the legislative committees with jurisdiction over human
44.21 services every four years beginning January 1, 2020. The commissioner shall make
44.22 recommendations in conjunction with reports submitted to the legislature according to
44.23 subdivision 10, paragraph (e). The commissioner shall release cost data in an aggregate
44.24 form, and cost data from individual providers shall not be released except as provided for
44.25 in current law.

44.26 (e) The commissioner, in consultation with stakeholders identified in section 256B.4913,
44.27 subdivision 5, shall develop and implement a process for providing training and technical
44.28 assistance necessary to support provider submission of cost documentation required under
44.29 paragraph (a).

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

44.31 Sec. 31. Minnesota Statutes 2016, section 256B.4914, subdivision 16, is amended to read:

44.32 Subd. 16. **Budget neutrality adjustments.** (a) The commissioner shall use the following
44.33 adjustments to the rate generated by the framework to assure budget neutrality until the rate

45.1 information is available to implement paragraph (b). The rate generated by the framework
45.2 shall be multiplied by the appropriate factor, as designated below:

45.3 (1) for residential services: 1.003;

45.4 (2) for day services: 1.000;

45.5 (3) for unit-based services with programming: 0.941; and

45.6 (4) for unit-based services without programming: 0.796.

45.7 (b) Within 12 months of January 1, 2014, the commissioner shall compare estimated
45.8 spending for all home and community-based waiver services under the new payment rates
45.9 defined in subdivisions 6 to 9 with estimated spending for the same recipients and services
45.10 under the rates in effect on July 1, 2013. This comparison must distinguish spending under
45.11 each of subdivisions 6, 7, 8, and 9. The comparison must be based on actual recipients and
45.12 services for one or more service months after the new rates have gone into effect. The
45.13 commissioner shall consult with the commissioner of management and budget on this
45.14 analysis to ensure budget neutrality. If estimated spending under the new rates for services
45.15 under one or more subdivisions differs in this comparison by 0.3 percent or more, the
45.16 commissioner shall assure aggregate budget neutrality across all service areas by adjusting
45.17 the budget neutrality factor in paragraph (a) in each subdivision so that total estimated
45.18 spending for each subdivision under the new rates matches estimated spending under the
45.19 rates in effect on July 1, 2013.

45.20 (c) A service rate developed using values in subdivision 5, paragraph (a), clause (10),
45.21 is not subject to budget neutrality adjustments.

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

45.23 Sec. 32. Minnesota Statutes 2016, section 256C.23, is amended by adding a subdivision
45.24 to read:

45.25 Subd. 1a. **Culturally affirmative.** "Culturally affirmative" describes services that are
45.26 designed and delivered within the context of the culture, language, and life experiences of
45.27 a person who is deaf, a person who is deafblind, and a person who is hard-of-hearing.

45.28 Sec. 33. Minnesota Statutes 2016, section 256C.23, subdivision 2, is amended to read:

45.29 Subd. 2. **Deaf.** "Deaf" means a hearing loss of such severity that the individual must
45.30 depend primarily on visual communication such as American Sign Language or other signed

46.1 language, visual and manual means of communication such as signing systems in English
46.2 or Cued Speech, writing, lip speech reading, manual communication, and gestures.

46.3 Sec. 34. Minnesota Statutes 2016, section 256C.23, is amended by adding a subdivision
46.4 to read:

46.5 Subd. 2c. **Interpreting services.** "Interpreting services" means services that include:

46.6 (1) interpreting between a spoken language, such as English, and a visual language, such
46.7 as American Sign Language;

46.8 (2) interpreting between a spoken language and a visual representation of a spoken
46.9 language, such as Cued Speech and signing systems in English;

46.10 (3) interpreting within one language where the interpreter uses natural gestures and
46.11 silently repeats the spoken message, replacing some words or phrases to give higher visibility
46.12 on the lips;

46.13 (4) interpreting using low vision or tactile methods for persons who have a combined
46.14 hearing and vision loss or are deafblind; and

46.15 (5) interpreting from one communication mode or language into another communication
46.16 mode or language that is linguistically and culturally appropriate for the participants in the
46.17 communication exchange.

46.18 Sec. 35. Minnesota Statutes 2016, section 256C.23, is amended by adding a subdivision
46.19 to read:

46.20 Subd. 6. **Real-time captioning.** "Real-time captioning" means a method of captioning
46.21 in which a caption is simultaneously prepared and displayed or transmitted at the time of
46.22 origination by specially trained real-time captioners.

46.23 Sec. 36. Minnesota Statutes 2016, section 256C.233, subdivision 1, is amended to read:

46.24 Subdivision 1. **Deaf and Hard-of-Hearing Services Division.** The commissioners of
46.25 human services, education, employment and economic development, and health shall create
46.26 a distinct and separate organizational unit to be known as advise the commissioner of human
46.27 services on the activities of the Deaf and Hard-of-Hearing Services Division to address.
46.28 This division addresses the developmental, social, educational, and occupational and
46.29 social-emotional needs of persons who are deaf, persons who are deafblind, and persons
46.30 who are hard-of-hearing persons through a statewide network of collaborative services and
46.31 by coordinating the promulgation of public policies, regulations, legislation, and programs

47.1 affecting advocates on behalf of and provides information and training about how to best
47.2 serve persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing
47.3 persons. An interdepartmental management team shall advise the activities of the Deaf and
47.4 Hard-of-Hearing Services Division. The commissioner of human services shall coordinate
47.5 the work of the interagency management team advisers and receive legislative appropriations
47.6 for the division.

47.7 Sec. 37. Minnesota Statutes 2016, section 256C.233, subdivision 2, is amended to read:

47.8 Subd. 2. **Responsibilities.** The Deaf and Hard-of-Hearing Services Division shall:

47.9 (1) establish and maintain a statewide network of regional service centers culturally
47.10 affirmative services for Minnesotans who are deaf, Minnesotans who are deafblind, and
47.11 Minnesotans who are hard-of-hearing Minnesotans;

47.12 (2) assist work across divisions within the Departments Department of Human Services,
47.13 Education, and Employment and Economic Development to coordinate the promulgation
47.14 and implementation of public policies, regulations, legislation, programs, and services
47.15 affecting as well as with other agencies and counties, to ensure that there is an understanding
47.16 of:

47.17 (i) the communication challenges faced by persons who are deaf, persons who are
47.18 deafblind, and persons who are hard-of-hearing persons;

47.19 (ii) the best practices for accommodating and mitigating communication challenges;
47.20 and

47.21 (iii) the legal requirements for providing access to and effective communication with
47.22 persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing; and

47.23 (3) provide a coordinated system of assess the supply and demand statewide interpreting
47.24 or for interpreter referral services; and real-time captioning services, implement strategies
47.25 to provide greater access to these services in areas without sufficient supply, and build the
47.26 base of service providers across the state;

47.27 (4) maintain a statewide information resource that includes contact information and
47.28 professional certification credentials of interpreting service providers and real-time captioning
47.29 service providers;

47.30 (5) provide culturally affirmative mental health services to persons who are deaf, persons
47.31 who are deafblind, and persons who are hard-of-hearing who:

- 48.1 (i) use a visual language such as American Sign Language or a tactile form of a language;
48.2 or
- 48.3 (ii) otherwise need culturally affirmative therapeutic services;
- 48.4 (6) research and develop best practices and recommendations for emerging issues;
- 48.5 (7) provide as much information as practicable on the division's stand-alone Web site
48.6 in American Sign Language; and
- 48.7 (8) report to the chairs and ranking minority members of the legislative committees with
48.8 jurisdiction over human services biennially, beginning on January 1, 2019, on the following:
- 48.9 (i) the number of regional service center staff, the location of the office of each staff
48.10 person, other service providers with which they are colocated, the number of people served
48.11 by each staff person and a breakdown of whether each person was served on-site or off-site,
48.12 and for those served off-site, a list of locations where services were delivered and the number
48.13 who were served in-person and the number who were served via technology;
- 48.14 (ii) the amount and percentage of the division budget spent on reasonable
48.15 accommodations for staff;
- 48.16 (iii) the number of people who use demonstration equipment and consumer evaluations
48.17 of the experience;
- 48.18 (iv) the number of training sessions provided by division staff, the topics covered, the
48.19 number of participants, and consumer evaluations, including a breakdown by delivery
48.20 method such as in-person or via technology;
- 48.21 (v) the number of training sessions hosted at a division location provided by another
48.22 service provider, the topics covered, the number of participants, and consumer evaluations,
48.23 including a breakdown by delivery method such as in-person or via technology;
- 48.24 (vi) for each grant awarded, the amount awarded to the grantee and a summary of the
48.25 grantee's results, including consumer evaluations of the services or products provided;
- 48.26 (vii) the number of people on waiting lists for any services provided by division staff
48.27 or for services or equipment funded through grants awarded by the division;
- 48.28 (viii) the amount of time staff spent driving to appointments to deliver direct one-to-one
48.29 client services in locations outside of the regional service centers; and
- 48.30 (ix) the regional needs and feedback on addressing service gaps identified by the advisory
48.31 committees.

49.1 Sec. 38. Minnesota Statutes 2016, section 256C.24, subdivision 1, is amended to read:

49.2 Subdivision 1. **Location.** The Deaf and Hard-of-Hearing Services Division shall establish
49.3 ~~up to eight~~ at least six regional service centers for persons who are deaf and persons who
49.4 are hard-of-hearing persons. The centers shall be distributed regionally to provide access
49.5 for persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing
49.6 persons in all parts of the state.

49.7 Sec. 39. Minnesota Statutes 2016, section 256C.24, subdivision 2, is amended to read:

49.8 Subd. 2. **Responsibilities.** Each regional service center shall:

49.9 (1) ~~serve as a central entry point for~~ establish connections and collaborations and explore
49.10 co-locating with other public and private entities providing services to persons who are
49.11 deaf, persons who are deafblind, and persons who are hard-of-hearing persons in need of
49.12 services and make referrals to the services needed in the region;

49.13 (2) for those in need of services, assist in coordinating services between service providers
49.14 and persons who are deaf, persons who are deafblind, and persons who are hard-of-hearing,
49.15 and the persons' families, and make referrals to the services needed;

49.16 (2) ~~(3)~~ employ staff trained to work with persons who are deaf, persons who are deafblind,
49.17 and persons who are hard-of-hearing persons;

49.18 (3) ~~(4)~~ if adequate services are not available from another public or private service
49.19 provider in the region, provide to all individual assistance to persons who are deaf, persons
49.20 who are deafblind, and persons who are hard-of-hearing persons access to interpreter services
49.21 which are necessary to help them obtain services, and the persons' families. Individual
49.22 culturally affirmative assistance may be provided using technology only in areas of the state
49.23 where a person has access to sufficient quality telecommunications or broadband services
49.24 to allow effective communication. When a person who is deaf, a person who is deafblind,
49.25 or a person who is hard-of-hearing does not have access to sufficient telecommunications
49.26 or broadband service, individual assistance shall be available in person;

49.27 (5) identify regional training needs, work with deaf and hard-of-hearing services training
49.28 staff, and collaborate with others to deliver training for persons who are deaf, persons who
49.29 are deafblind, and persons who are hard-of-hearing, and the persons' families, and other
49.30 service providers about subjects including the persons' rights under the law, American Sign
49.31 Language, and the impact of hearing loss and options for accommodating it;

49.32 (4) ~~implement a plan to provide loaned equipment and resource materials to deaf,~~
49.33 ~~deafblind, and hard-of-hearing~~ (6) have a mobile or permanent lab where persons who are

50.1 deaf, persons who are deafblind, and persons who are hard-of-hearing can try a selection
50.2 of modern assistive technology and equipment to determine what would best meet the
50.3 persons' needs;

50.4 ~~(5) cooperate with responsible departments and administrative authorities to provide~~
50.5 ~~access for deaf, deafblind, and hard-of-hearing persons to services provided by state, county,~~
50.6 ~~and regional agencies;~~

50.7 ~~(6)~~ (7) collaborate with the Resource Center for the Deaf and Hard-of-Hearing Persons,
50.8 other divisions of the Department of Education, and local school districts to develop and
50.9 deliver programs and services for families with children who are deaf, children who are
50.10 deafblind, or children who are hard-of-hearing children and to support school personnel
50.11 serving these children;

50.12 ~~(7) when possible, (8)~~ provide training to the social service or income maintenance staff
50.13 employed by counties or by organizations with whom counties contract for services to
50.14 ensure that communication barriers which prevent persons who are deaf, persons who are
50.15 deafblind, and persons who are hard-of-hearing persons from using services are removed;

50.16 ~~(8) when possible, (9)~~ provide training to ~~state and regional~~ human service agencies in
50.17 the region regarding program access for persons who are deaf, persons who are deafblind,
50.18 and persons who are hard-of-hearing persons; and

50.19 ~~(9)~~ (10) assess the ongoing need and supply of services for persons who are deaf, persons
50.20 who are deafblind, and persons who are hard-of-hearing persons in all parts of the state,
50.21 annually consult with the division's advisory committees to identify regional needs and
50.22 solicit feedback on addressing service gaps, and cooperate with public and private service
50.23 providers to develop these services;

50.24 (11) provide culturally affirmative mental health services to persons who are deaf,
50.25 persons who are deafblind, and persons who are hard-of-hearing who:

50.26 (i) use a visual language such as American Sign Language or a tactile form of a language;
50.27 or

50.28 (ii) otherwise need culturally affirmative therapeutic services; and

50.29 (12) establish partnerships with state and regional entities statewide that have the
50.30 technological capacity to provide Minnesotans with virtual access to the division's services
50.31 and division-sponsored training via technology.

51.1 Sec. 40. Minnesota Statutes 2016, section 256C.24, subdivision 3, is amended to read:

51.2 Subd. 3. **Advisory committee.** The director of the Deaf and Hard-of-Hearing Services
51.3 Division shall appoint ~~an advisory committee~~ eight advisory committees of up to nine
51.4 ~~persons for each regional service area~~ per advisory committee. Each committee shall represent
51.5 a specific region of the state. The director shall determine the boundaries of each advisory
51.6 committee region. The committees shall advise the director on the needs of persons who
51.7 are deaf, persons who are deafblind, and persons who are hard-of-hearing and service gaps
51.8 in the region of the state the committee represents. Members shall include persons who are
51.9 deaf, persons who are deafblind, and persons who are hard-of-hearing, persons who have
51.10 communication disabilities, parents of children who are deaf and parents of children who
51.11 are hard-of-hearing, parents of children who have communication disabilities, and
51.12 representatives of county and regional human services, including representatives of private
51.13 service providers. At least 50 percent of the members must be deaf or deafblind or
51.14 hard-of-hearing or have a communication disability. Committee members shall serve for a
51.15 three-year term and shall serve no more than two consecutive terms, and may be appointed
51.16 to consecutive terms. Each advisory committee shall elect a chair. The director of the Deaf
51.17 and Hard-of-Hearing Services Division shall assign staff to serve as nonvoting members of
51.18 the committee. Members shall not receive a per diem. Otherwise, the compensation, removal
51.19 of members, and filling of vacancies on the committee shall be as provided in section
51.20 15.0575.

51.21 Sec. 41. Minnesota Statutes 2016, section 256C.261, is amended to read:

51.22 **256C.261 SERVICES FOR PERSONS WHO ARE DEAFBLIND PERSONS.**

51.23 (a) The commissioner of human services shall ~~combine the existing biennial base level~~
51.24 ~~funding for deafblind services into a single grant program. At least 35 percent of the total~~
51.25 ~~funding is awarded for services and other supports to deafblind children and their families~~
51.26 ~~and at least 25 percent is awarded for services and other supports to deafblind adults. use~~
51.27 at least 35 percent of the deafblind services biennial base level grant funding for services
51.28 and other supports for a child who is deafblind and the child's family. The commissioner
51.29 shall use at least 25 percent of the deafblind services biennial base level grant funding for
51.30 services and other supports for an adult who is deafblind.

51.31 The commissioner shall award grants for the purposes of:

51.32 (1) providing services and supports to ~~individuals~~ persons who are deafblind; and

52.1 (2) developing and providing training to counties and the network of senior citizen
52.2 service providers. The purpose of the training grants is to teach counties how to use existing
52.3 programs that capture federal financial participation to meet the needs of eligible persons
52.4 who are deafblind persons and to build capacity of senior service programs to meet the
52.5 needs of seniors with a dual sensory hearing and vision loss.

52.6 (b) The commissioner may make grants:

52.7 (1) for services and training provided by organizations; and

52.8 (2) to develop and administer consumer-directed services.

52.9 (c) Consumer-directed services shall be provided in whole by grant-funded providers.

52.10 The deaf and hard-of-hearing regional service centers shall not provide any aspect of a

52.11 grant-funded consumer-directed services program.

52.12 ~~(e)~~ (d) Any entity that is able to satisfy the grant criteria is eligible to receive a grant
52.13 under paragraph (a).

52.14 ~~(d)~~ (e) Deafblind service providers may, but are not required to, provide intervenor
52.15 services as part of the service package provided with grant funds under this section.

52.16 Sec. 42. Minnesota Statutes 2016, section 256C.30, is amended to read:

52.17 **256C.30 DUTIES OF HUMAN SERVICES COMMISSIONER.**

52.18 (a) As described in this section, the commissioner of human services must enter into
52.19 grant agreements with television stations to make live local news programming accessible
52.20 to persons who are deaf, persons who are hard-of-hearing, and persons who are deafblind
52.21 persons as defined in section 256C.23.

52.22 (b) The grant agreements must provide for:

52.23 (1) real-time captioning services for broadcasting that is not emergency broadcasting
52.24 subject to Code of Federal Regulations, title 47, section 79.2;

52.25 (2) real-time captioning services for commercial broadcasters in areas of Minnesota
52.26 where commercial broadcasters are not subject to the live programming closed-captioning
52.27 requirements of Code of Federal Regulations, title 47, section 79.1(d); and

52.28 (3) real-time captioning for large-market noncommercial broadcasters who produce live
52.29 news programming.

(c) For the purposes of this section, "real-time captioning" means a method of captioning in which captions are simultaneously prepared and transmitted at the time of origination by specially trained real-time captioners.

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

Sec. 43. Laws 2012, chapter 247, article 4, section 47, as amended by Laws 2014, chapter 312, article 27, section 72, and Laws 2016, chapter 144, section 1, the effective date, is amended to read:

EFFECTIVE DATE. ~~The amendments to this section are effective on June 1, 2016, and expire on the date Laws 2015, chapter 71, article 7, section 54, becomes effective. The commissioner of human services shall notify the revisor of statutes when Laws 2015, chapter 71, article 7, section 54, becomes effective.~~ Notwithstanding any other law to the contrary, the exception in this section is effective until the exception under section 44 or under Laws 2015, chapter 71, article 7, section 54, becomes effective, whichever occurs first. The commissioner of human services shall notify the revisor of statutes when section 44 or Laws 2015, chapter 71, article 7, section 54, is effective.

Sec. 44. **EXPANSION OF CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET METHODOLOGY EXCEPTION.**

(a) No later than September 30, 2017, if necessary, the commissioner of human services shall submit an amendment to the Centers for Medicare and Medicaid Services for the home and community-based services waivers authorized under Minnesota Statutes, sections 256B.092 and 256B.49, to expand the exception to the consumer-directed community supports budget methodology under Laws 2015, chapter 71, article 7, section 54, to provide up to 30 percent more funds for either:

(1) consumer-directed community supports participants who have a coordinated service and support plan which identifies the need for an increased amount of services or supports under consumer-directed community supports than the amount they are currently receiving under the consumer-directed community supports budget methodology:

(i) to increase the amount of time a person works or otherwise improves employment opportunities;

(ii) to plan a transition to, move to, or live in a setting described in Minnesota Statutes, section 256D.44, subdivision 5, paragraph (f), clause (1), item (ii), or paragraph (g); or

(iii) to develop and implement a positive behavior support plan; or

54.1 (2) home and community-based waiver participants who are currently using licensed
54.2 providers for (i) employment supports or services during the day; or (ii) residential services,
54.3 either of which cost more annually than the person would spend under a consumer-directed
54.4 community supports plan for any or all of the supports needed to meet the goals identified
54.5 in paragraph (a), clause (1), items (i), (ii), and (iii).

54.6 (b) The exception under paragraph (a), clause (1), is limited to those persons who can
54.7 demonstrate that they will have to discontinue using consumer-directed community supports
54.8 and accept other non-self-directed waiver services because their supports needed for the
54.9 goals described in paragraph (a), clause (1), items (i), (ii), and (iii), cannot be met within
54.10 the consumer-directed community supports budget limits.

54.11 (c) The exception under paragraph (a), clause (2), is limited to those persons who can
54.12 demonstrate that, upon choosing to become a consumer-directed community supports
54.13 participant, the total cost of services, including the exception, will be less than the cost of
54.14 current waiver services.

54.15 **EFFECTIVE DATE.** The exception under this section is effective October 1, 2017, or
54.16 upon federal approval, whichever is later. Notwithstanding any other law to the contrary,
54.17 the exception in Laws 2016, chapter 144, section 1, remains in effect until the exception
54.18 under Laws 2015, chapter 71, article 7, section 54, or under this section becomes effective,
54.19 whichever occurs first. The commissioner of human services shall notify the revisor of
54.20 statutes when federal approval is obtained.

54.21 Sec. 45. **CONSUMER-DIRECTED COMMUNITY SUPPORTS BUDGET**
54.22 **METHODOLOGY EXCEPTION FOR PERSONS LEAVING INSTITUTIONS AND**
54.23 **CRISIS RESIDENTIAL SETTINGS.**

54.24 (a) By September 30, 2017, the commissioner shall establish an institutional and crisis
54.25 bed consumer-directed community supports budget exception process in the home and
54.26 community-based services waivers under Minnesota Statutes, sections 256B.092 and
54.27 256B.49. This budget exception process shall be available for any individual who:

54.28 (1) is not offered available and appropriate services within 60 days since approval for
54.29 discharge from the individual's current institutional setting; and

54.30 (2) requires services that are more expensive than appropriate services provided in a
54.31 noninstitutional setting using the consumer-directed community supports option.

54.32 (b) Institutional settings for purposes of this exception include intermediate care facilities
54.33 for persons with developmental disabilities; nursing facilities; acute care hospitals; Anoka

55.1 Metro Regional Treatment Center; Minnesota Security Hospital; and crisis beds. The budget
55.2 exception shall be limited to no more than the amount of appropriate services provided in
55.3 a noninstitutional setting as determined by the lead agency managing the individual's home
55.4 and community-based services waiver. The lead agency shall notify the Department of
55.5 Human Services of the budget exception.

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

55.7 Sec. 46. **CONSUMER-DIRECTED COMMUNITY SUPPORTS REVISED BUDGET**
55.8 **METHODOLOGY REPORT.**

55.9 (a) The commissioner of human services, in consultation with stakeholders and others
55.10 including representatives of lead agencies, home and community-based services waiver
55.11 participants using consumer-directed community supports, advocacy groups, state agencies,
55.12 the Institute on Community Integration at the University of Minnesota, and service and
55.13 financial management providers, shall develop a revised consumer-directed community
55.14 supports budget methodology. The new methodology shall be based on (1) the costs of
55.15 providing services as reflected by the wage and other relevant components incorporated in
55.16 the disability waiver rate formulas under Minnesota Statutes, chapter 256B, and (2)
55.17 state-to-county waiver-funding methodologies. The new methodology should develop
55.18 individual consumer-directed community supports budgets comparable to those provided
55.19 for similar needs individuals if paying for non-consumer-directed community supports
55.20 waiver services.

55.21 (b) By December 15, 2018, the commissioner shall report a revised consumer-directed
55.22 community supports budget methodology, including proposed legislation and funding
55.23 necessary to implement the new methodology, to the chairs and ranking minority members
55.24 of the house of representatives and senate committees with jurisdiction over health and
55.25 human services.

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

55.27 Sec. 47. **FEDERAL WAIVER AMENDMENTS.**

55.28 The commissioner of human services shall submit necessary waiver amendments to the
55.29 Centers for Medicare and Medicaid Services to add employment exploration services,
55.30 employment development services, and employment support services to the home and
55.31 community-based services waivers authorized under Minnesota Statutes, sections 256B.092
55.32 and 256B.49. The commissioner shall also submit necessary waiver amendments to remove
55.33 community-based employment services from day training and habilitation and prevocational

56.1 services. The commissioner shall submit all necessary waiver amendments by October 1,
56.2 2017.

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

56.4 Sec. 48. **TRANSPORTATION STUDY.**

56.5 The commissioner of human services, with cooperation from lead agencies and in
56.6 consultation with stakeholders, shall conduct a study to identify opportunities to increase
56.7 access to transportation services for an individual who receives home and community-based
56.8 services. The commissioner shall submit a report with recommendations to the chairs and
56.9 ranking minority members of the legislative committees with jurisdiction over human
56.10 services by January 15, 2019. The report shall:

56.11 (1) study all aspects of the current transportation service network, including the fleet
56.12 available, the different rate-setting methods currently used, methods that an individual uses
56.13 to access transportation, and the diversity of available provider agencies;

56.14 (2) identify current barriers for an individual accessing transportation and for a provider
56.15 providing waiver services transportation in the marketplace;

56.16 (3) identify efficiencies and collaboration opportunities to increase available
56.17 transportation, including transportation funded by medical assistance, and available regional
56.18 transportation and transit options;

56.19 (4) study transportation solutions in other states for delivering home and community-based
56.20 services;

56.21 (5) study provider costs required to administer transportation services;

56.22 (6) make recommendations for coordinating and increasing transportation accessibility
56.23 across the state; and

56.24 (7) make recommendations for the rate setting of waived transportation.

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

56.26 Sec. 49. **DIRECTION TO COMMISSIONER; TELECOMMUNICATION**
56.27 **EQUIPMENT PROGRAM.**

56.28 The commissioner of human services shall work in consultation with the Commission
56.29 of Deaf, Deafblind, and Hard-of-Hearing Minnesotans to provide recommendations by
56.30 January 15, 2018, to the chairs and ranking minority members of the house of representatives

57.1 and senate committees with jurisdiction over human services to modernize the
57.2 telecommunication equipment program. The recommendations must address:

57.3 (1) types of equipment and supports the program should provide to ensure people with
57.4 communication difficulties have equitable access to telecommunications services;

57.5 (2) additional services the program should provide, such as education about technology
57.6 options that can improve a person's access to telecommunications services; and

57.7 (3) how the current program's service delivery structure might be improved to better
57.8 meet the needs of people with communication disabilities.

57.9 The commissioner shall also provide draft legislative language to accomplish the
57.10 recommendations. Final recommendations, the final report, and draft legislative language
57.11 must be approved by both the commissioner and the chair of the Commission of Deaf,
57.12 Deafblind, and Hard-of-Hearing Minnesotans.

57.13 **Sec. 50. DIRECTION TO COMMISSIONER; BILLING FOR MENTAL HEALTH**
57.14 **SERVICES.**

57.15 By January 1, 2018, the commissioner of human services shall report to the chairs and
57.16 ranking minority members of the house of representatives and senate committees with
57.17 jurisdiction over deaf and hard-of-hearing services on the potential costs and benefits of the
57.18 Deaf and Hard-of-Hearing Services Division billing for the cost of providing mental health
57.19 services.

57.20 **Sec. 51. DIRECTION TO COMMISSIONER; MnCHOICES ASSESSMENT TOOL.**

57.21 The commissioner of human services shall work with lead agencies responsible for
57.22 conducting long-term consultation services under Minnesota Statutes, section 256B.0911,
57.23 to modify the MnCHOICES assessment tool and related policies to:

- 57.24 (1) reduce assessment times;
- 57.25 (2) create efficiencies within the tool and within practice and policy for conducting
57.26 assessments and support planning;
- 57.27 (3) implement policy changes reducing the frequency and depth of assessment and
57.28 reassessment, while ensuring federal compliance with medical assistance and disability
57.29 waiver eligibility requirements; and
- 57.30 (4) evaluate alternative payment methods.

58.1 **Sec. 52. RANDOM MOMENT TIME STUDY EVALUATION REQUIRED.**

58.2 The commissioner of human services shall implement administrative efficiencies and
58.3 evaluate the random moment time study methodology for reimbursement of costs associated
58.4 with county duties required under Minnesota Statutes, section 256B.0911. The evaluation
58.5 must determine whether random moment is efficient and effective in supporting functions
58.6 of assessment and support planning and the purpose under Minnesota Statutes, section
58.7 256B.0911, subdivision 1. The commissioner shall submit a report to the chairs and ranking
58.8 minority members of the house of representatives and senate committees with jurisdiction
58.9 over health and human services by January 15, 2019.

58.10 **Sec. 53. RATE INCREASE FOR SELF-DIRECTED WORKFORCE**
58.11 **NEGOTIATIONS.**

58.12 (a) Notwithstanding any other law or rule to the contrary, effective July 1, 2017, and
58.13 within available appropriations, the commissioner of human services shall have the authority
58.14 to implement rate adjustments to comply with wages and benefits negotiated in the labor
58.15 agreement between the state of Minnesota and the Service Employees International Union
58.16 (SEIU) Healthcare Minnesota for the period between July 1, 2017, and June 30, 2019.

58.17 (b) The rate changes described in this section apply to direct support services provided
58.18 through a covered program, as defined by Minnesota Statutes, section 256B.0711, subdivision
58.19 1, paragraph (b).

58.20 **Sec. 54. REPEALER.**

58.21 (a) Minnesota Statutes 2016, section 144A.351, subdivision 2, is repealed.

58.22 (b) Minnesota Statutes 2016, section 256B.4914, subdivision 16, is repealed effective
58.23 January 1, 2018.

58.24 (c) Laws 2012, chapter 247, article 4, section 47, as amended by Laws 2014, chapter
58.25 312, article 27, section 72, Laws 2015, chapter 71, article 7, section 58, Laws 2016, chapter
58.26 144, section 1; and Laws 2015, chapter 71, article 7, section 54, are repealed upon the
58.27 effective date of section 44.

58.28 (d) Minnesota Statutes 2016, sections 256C.23, subdivision 3; 256C.233, subdivision
58.29 4; and 256C.25, subdivisions 1 and 2, are repealed.

ARTICLE 2
HOUSING

Section 1. Minnesota Statutes 2016, section 144D.04, subdivision 2, is amended to read:

Subd. 2. **Contents of contract.** A housing with services contract, which need not be entitled as such to comply with this section, shall include at least the following elements in itself or through supporting documents or attachments:

- (1) the name, street address, and mailing address of the establishment;
- (2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners is not a natural person, identification of the type of business entity of the owner or owners;
- (3) the name and mailing address of the managing agent, through management agreement or lease agreement, of the establishment, if different from the owner or owners;
- (4) the name and address of at least one natural person who is authorized to accept service of process on behalf of the owner or owners and managing agent;
- (5) a statement describing the registration and licensure status of the establishment and any provider providing health-related or supportive services under an arrangement with the establishment;
- (6) the term of the contract;
- (7) a description of the services to be provided to the resident in the base rate to be paid by resident, including a delineation of the portion of the base rate that constitutes rent and a delineation of charges for each service included in the base rate;
- (8) a description of any additional services, including home care services, available for an additional fee from the establishment directly or through arrangements with the establishment, and a schedule of fees charged for these services;
- (9) a description of the process through which the contract may be modified, amended, or terminated, including whether a move to a different room or sharing a room would be required in the event that the tenant can no longer pay the current rent;
- (10) a description of the establishment's complaint resolution process available to residents including the toll-free complaint line for the Office of Ombudsman for Long-Term Care;
- (11) the resident's designated representative, if any;
- (12) the establishment's referral procedures if the contract is terminated;

60.1 (13) requirements of residency used by the establishment to determine who may reside
60.2 or continue to reside in the housing with services establishment;

60.3 (14) billing and payment procedures and requirements;

60.4 (15) a statement regarding the ability of residents a resident to receive services from
60.5 service providers with whom the establishment does not have an arrangement;

60.6 (16) a statement regarding the availability of public funds for payment for residence or
60.7 services in the establishment; and

60.8 (17) a statement regarding the availability of and contact information for long-term care
60.9 consultation services under section 256B.0911 in the county in which the establishment is
60.10 located.

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

60.12 Sec. 2. Minnesota Statutes 2016, section 144D.04, is amended by adding a subdivision to
60.13 read:

60.14 **Subd. 2a. Additional contract requirements.** (a) For a resident receiving one or more
60.15 health-related services from the establishment's arranged home care provider, as defined in
60.16 section 144D.01, subdivision 6, the contract must include the requirements in paragraph
60.17 (b). A restriction of a resident's rights under this subdivision is allowed only if determined
60.18 necessary for health and safety reasons identified by the home care provider's registered
60.19 nurse in an initial assessment or reassessment, as defined under section 144A.4791,
60.20 subdivision 8, and documented in the written service plan under section 144A.4791,
60.21 subdivision 9. Any restrictions of those rights for people served under sections 256B.0915
60.22 and 256B.49 must be documented in the resident's coordinated service and support plan
60.23 (CSSP), as defined under sections 256B.0915, subdivision 6 and 256B.49, subdivision 15.

60.24 (b) The contract must include a statement:

60.25 (1) regarding the ability of a resident to furnish and decorate the resident's unit within
60.26 the terms of the lease;

60.27 (2) regarding the resident's right to access food at any time;

60.28 (3) regarding a resident's right to choose the resident's visitors and times of visits;

60.29 (4) regarding the resident's right to choose a roommate if sharing a unit; and

60.30 (5) notifying the resident of the resident's right to have and use a lockable door to the
60.31 resident's unit. The landlord shall provide the locks on the unit. Only a staff member with

61.1 a specific need to enter the unit shall have keys, and advance notice must be given to the
61.2 resident before entrance, when possible.

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

61.4 Sec. 3. Minnesota Statutes 2016, section 245A.03, subdivision 7, is amended to read:

61.5 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license
61.6 for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult
61.7 foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter
61.8 for a physical location that will not be the primary residence of the license holder for the
61.9 entire period of licensure. If a license is issued during this moratorium, and the license
61.10 holder changes the license holder's primary residence away from the physical location of
61.11 the foster care license, the commissioner shall revoke the license according to section
61.12 245A.07. The commissioner shall not issue an initial license for a community residential
61.13 setting licensed under chapter 245D. When approving an exception under this paragraph,
61.14 the commissioner shall consider the resource need determination process in paragraph (h),
61.15 the availability of foster care licensed beds in the geographic area in which the licensee
61.16 seeks to operate, the results of a person's choices during their annual assessment and service
61.17 plan review, and the recommendation of the local county board. The determination by the
61.18 commissioner is final and not subject to appeal. Exceptions to the moratorium include:

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

61.20 (2) foster care licenses replacing foster care licenses in existence on May 15, 2009, or
61.21 community residential setting licenses replacing adult foster care licenses in existence on
61.22 December 31, 2013, and determined to be needed by the commissioner under paragraph
61.23 (b);

61.24 (3) new foster care licenses or community residential setting licenses determined to be
61.25 needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD,
61.26 or regional treatment center; restructuring of state-operated services that limits the capacity
61.27 of state-operated facilities; or allowing movement to the community for people who no
61.28 longer require the level of care provided in state-operated facilities as provided under section
61.29 256B.092, subdivision 13, or 256B.49, subdivision 24;

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

62.1 (5) new foster care licenses or community residential setting licenses determined to be
62.2 needed by the commissioner for the transition of people from personal care assistance to
62.3 the home and community-based services;

62.4 (6) new foster care licenses or community residential setting licenses determined to be
62.5 needed by the commissioner for the transition of people from the residential care waiver
62.6 services to foster care services. This exception applies only when:

62.7 (i) the person's case manager provided the person with information about the choice of
62.8 service, service provider, and location of service to help the person make an informed choice;
62.9 and

62.10 (ii) the person's foster care services are less than or equal to the cost of the person's
62.11 services delivered in the residential care waiver service setting as determined by the lead
62.12 agency; or

62.13 (7) new foster care licenses or community residential setting licenses for people receiving
62.14 services under chapter 245D and residing in an unlicensed setting before May 1, 2017, and
62.15 for which a license is required. This exception does not apply to people living in their own
62.16 home. For purposes of this clause, there is a presumption that a foster care or community
62.17 residential setting license is required for services provided to three or more people in a
62.18 dwelling unit when the setting is controlled by the provider. A license holder subject to this
62.19 exception may rebut the presumption that a license is required by seeking a reconsideration
62.20 of the commissioner's determination. The commissioner's disposition of a request for
62.21 reconsideration is final and not subject to appeal under chapter 14. The exception is available
62.22 until June 30, 2018. This exception is available when:

62.23 (i) the person's case manager provided the person with information about the choice of
62.24 service, service provider, and location of service, including in the person's home, to help
62.25 the person make an informed choice; and

62.26 (ii) the person's services provided in the licensed foster care or community residential
62.27 setting are less than or equal to the cost of the person's services delivered in the unlicensed
62.28 setting as determined by the lead agency.

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

(c) When an adult resident served by the program moves out of a foster home that is not the primary residence of the license holder according to section 256B.49, subdivision 15, paragraph (f), or the adult community residential setting, the county shall immediately inform the Department of Human Services Licensing Division. The department shall may decrease the statewide licensed capacity for adult foster care settings ~~where the physical location is not the primary residence of the license holder, or for adult community residential settings, if the voluntary changes described in paragraph (e) are not sufficient to meet the savings required by reductions in licensed bed capacity under Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40, paragraph (f), and maintain statewide long-term care residential services capacity within budgetary limits. Implementation of the statewide licensed capacity reduction shall begin on July 1, 2013. The commissioner shall delicense up to 128 beds by June 30, 2014, using the needs determination process. Prior to any involuntary reduction of licensed capacity, the commissioner shall consult with lead agencies and license holders to determine which adult foster care settings, where the physical location is not the primary residence of the license holder, or community residential settings, are licensed for up to five beds, but have operated at less than full capacity for 12 or more months as of March 1, 2014. The settings that meet these criteria must be the first to be considered for an involuntary decrease in statewide licensed capacity, up to a maximum of 35 beds. If more than 35 beds are identified that meet these criteria, the commissioner shall prioritize the selection of those beds to be closed based on the length of time the beds have been vacant. The longer a bed has been vacant, the higher priority it must be given for closure. Under this paragraph, the commissioner has the authority to reduce unused licensed capacity of a current foster care program, or the community residential settings, to accomplish the consolidation or closure of settings. Under this paragraph, the commissioner has the authority to manage statewide capacity, including adjusting the capacity available to each county and adjusting statewide available capacity, to meet the statewide needs identified through the process in paragraph (e). A decreased licensed capacity according to this paragraph is not subject to appeal under this chapter.~~

(d) Residential settings that would otherwise be subject to the decreased license capacity established in paragraph (c) shall be exempt if the license holder's beds are occupied by residents whose primary diagnosis is mental illness and the license holder is certified under the requirements in subdivision 6a or section 245D.33.

(e) A resource need determination process, managed at the state level, using the available reports required by section 144A.351, and other data and information shall be used to determine where the reduced capacity required determined under paragraph (e) section

64.1 256B.493 will be implemented. The commissioner shall consult with the stakeholders
64.2 described in section 144A.351, and employ a variety of methods to improve the state's
64.3 capacity to meet the informed decisions of those people who want to move out of corporate
64.4 foster care or community residential settings, long-term care service needs within budgetary
64.5 limits, including seeking proposals from service providers or lead agencies to change service
64.6 type, capacity, or location to improve services, increase the independence of residents, and
64.7 better meet needs identified by the long-term care services and supports reports and statewide
64.8 data and information. ~~By February 1, 2013, and August 1, 2014, and each following year,~~
64.9 ~~the commissioner shall provide information and data on the overall capacity of licensed~~
64.10 ~~long-term care services, actions taken under this subdivision to manage statewide long-term~~
64.11 ~~care services and supports resources, and any recommendations for change to the legislative~~
64.12 ~~committees with jurisdiction over health and human services budget.~~

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

64.21 (g) License holders of foster care homes identified under paragraph (f) that are not the
64.22 primary residence of the license holder and that also provide services in the foster care home
64.23 that are covered by a federally approved home and community-based services waiver, as
64.24 authorized under section 256B.0915, 256B.092, or 256B.49, must inform the human services
64.25 licensing division that the license holder provides or intends to provide these waiver-funded
64.26 services.

64.27 (h) The commissioner may adjust capacity to address needs identified in section
64.28 144A.351. Under this authority, the commissioner may approve new licensed settings or
64.29 delicense existing settings. Delicensing of settings will be accomplished through a process
64.30 identified in section 256B.493. Annually, by August 1, the commissioner shall provide
64.31 information and data on capacity of licensed long-term services and supports, actions taken
64.32 under the subdivision to manage statewide long-term services and supports resources, and
64.33 any recommendations for change to the legislative committees with jurisdiction over the
64.34 health and human services budget.

(i) The commissioner must notify a license holder when its corporate foster care or community residential setting licensed beds are reduced under this section. The notice of reduction of licensed beds must be in writing and delivered to the license holder by certified mail or personal service. The notice must state why the licensed beds are reduced and must inform the license holder of its right to request reconsideration by the commissioner. The license holder's request for reconsideration must be in writing. If mailed, the request for reconsideration must be postmarked and sent to the commissioner within 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds. If a request for reconsideration is made by personal service, it must be received by the commissioner within 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

(j) The commissioner shall not issue an initial license for children's residential treatment services licensed under Minnesota Rules, parts 2960.0580 to 2960.0700, under this chapter for a program that Centers for Medicare and Medicaid Services would consider an institution for mental diseases. Facilities that serve only private pay clients are exempt from the moratorium described in this paragraph. The commissioner has the authority to manage existing statewide capacity for children's residential treatment services subject to the moratorium under this paragraph and may issue an initial license for such facilities if the initial license would not increase the statewide capacity for children's residential treatment services subject to the moratorium under this paragraph.

Sec. 4. Minnesota Statutes 2016, section 245A.04, subdivision 14, is amended to read:

Subd. 14. Policies and procedures for program administration required and enforceable. (a) The license holder shall develop program policies and procedures necessary to maintain compliance with licensing requirements under Minnesota Statutes and Minnesota Rules.

(b) The license holder shall:

(1) provide training to program staff related to their duties in implementing the program's policies and procedures developed under paragraph (a);

(2) document the provision of this training; and

(3) monitor implementation of policies and procedures by program staff.

(c) The license holder shall keep program policies and procedures readily accessible to staff and index the policies and procedures with a table of contents or another method approved by the commissioner.

(d) An adult foster care license holder that provides foster care services to a resident under section 256B.0915 must annually provide a copy of the resident termination policy under section 245A.11, subdivision 11, to a resident covered by the policy.

Sec. 5. Minnesota Statutes 2016, section 245A.11, is amended by adding a subdivision to read:

Subd. 9. **Adult foster care bedrooms.** (a) A resident receiving services must have a choice of roommate. Each roommate must consent in writing to sharing a bedroom with one another. The license holder is responsible for notifying a resident of the resident's right to request a change of roommate.

(b) The license holder must provide a lock for each resident's bedroom door, unless otherwise indicated for the resident's health, safety, or well-being. A restriction on the use of the lock must be documented and justified in the resident's individual abuse prevention plan required by sections 245A.65, subdivision 2, paragraph (b), and 626.557, subdivision 14. For a resident served under section 256B.0915, the case manager must be part of the interdisciplinary team under section 245A.65, subdivision 2, paragraph (b).

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

Sec. 6. Minnesota Statutes 2016, section 245A.11, is amended by adding a subdivision to read:

Subd. 10. **Adult foster care resident rights.** (a) The license holder shall ensure that a resident and a resident's legal representative are given, at admission:

(1) an explanation and copy of the resident's rights specified in paragraph (b);

(2) a written summary of the Vulnerable Adults Protection Act prepared by the department; and

(3) the name, address, and telephone number of the local agency to which a resident or a resident's legal representative may submit an oral or written complaint.

(b) Adult foster care resident rights include the right to:

(1) have daily, private access to and use of a non-coin-operated telephone for local and long-distance telephone calls made collect or paid for by the resident;

(2) receive and send, without interference, uncensored, unopened mail or electronic correspondence or communication;

- 67.1 (3) have use of and free access to common areas in the residence and the freedom to
67.2 come and go from the residence at will;
- 67.3 (4) have privacy for visits with the resident's spouse, next of kin, legal counsel, religious
67.4 adviser, or others, according to section 363A.09 of the Human Rights Act, including privacy
67.5 in the resident's bedroom;
- 67.6 (5) keep, use, and access the resident's personal clothing and possessions as space permits,
67.7 unless this right infringes on the health, safety, or rights of another resident or household
67.8 member, including the right to access the resident's personal possessions at any time;
- 67.9 (6) choose the resident's visitors and time of visits and participate in activities of
67.10 commercial, religious, political, and community groups without interference if the activities
67.11 do not infringe on the rights of another resident or household member;
- 67.12 (7) if married, privacy for visits by the resident's spouse, and, if both spouses are residents
67.13 of the adult foster home, the residents have the right to share a bedroom and bed;
- 67.14 (8) privacy, including use of the lock on the resident's bedroom door or unit door. A
67.15 resident's privacy must be respected by license holders, caregivers, household members,
67.16 and volunteers by knocking on the door of a resident's bedroom or bathroom and seeking
67.17 consent before entering, except in an emergency;
- 67.18 (9) furnish and decorate the resident's bedroom or living unit;
- 67.19 (10) engage in chosen activities and have an individual schedule supported by the license
67.20 holder that meets the resident's preferences;
- 67.21 (11) freedom and support to access food at any time;
- 67.22 (12) have personal, financial, service, health, and medical information kept private, and
67.23 be advised of disclosure of this information by the license holder;
- 67.24 (13) access records and recorded information about the resident according to applicable
67.25 state and federal law, regulation, or rule;
- 67.26 (14) be free from maltreatment;
- 67.27 (15) be treated with courtesy and respect and receive respectful treatment of the resident's
67.28 property;
- 67.29 (16) reasonable observance of cultural and ethnic practice and religion;
- 67.30 (17) be free from bias and harassment regarding race, gender, age, disability, spirituality,
67.31 and sexual orientation;

68.1 (18) be informed of and use the license holder's grievance policy and procedures,
68.2 including how to contact the highest level of authority in the program;

68.3 (19) assert the resident's rights personally, or have the rights asserted by the resident's
68.4 family, authorized representative, or legal representative, without retaliation; and

68.5 (20) give or withhold written informed consent to participate in any research or
68.6 experimental treatment.

68.7 (c) A restriction of a resident's rights under paragraph (b), clauses (1) to (4), (6), (8),
68.8 (10), and (11), is allowed only if determined necessary to ensure the health, safety, and
68.9 well-being of the resident. Any restriction of a resident's right must be documented and
68.10 justified in the resident's individual abuse prevention plan required by sections 245A.65,
68.11 subdivision 2, paragraph (b) and 626.557, subdivision 14. For a resident served under section
68.12 256B.0915, the case manager must be part of the interdisciplinary team under section
68.13 245A.65, subdivision 2, paragraph (b). The restriction must be implemented in the least
68.14 restrictive manner necessary to protect the resident and provide support to reduce or eliminate
68.15 the need for the restriction.

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

68.17 Sec. 7. Minnesota Statutes 2016, section 245A.11, is amended by adding a subdivision to
68.18 read:

68.19 Subd. 11. **Adult foster care service termination for elderly waiver participants.** (a)
68.20 This subdivision applies to foster care services for a resident served under section 256B.0915.

68.21 (b) The foster care license holder must establish policies and procedures for service
68.22 termination that promote continuity of care and service coordination with the resident and
68.23 the case manager and with another licensed caregiver, if any, who also provides support to
68.24 the resident. The policy must include the requirements specified in paragraphs (c) to (h).

68.25 (c) The license holder must allow a resident to remain in the program and cannot terminate
68.26 services unless:

68.27 (1) the termination is necessary for the resident's health, safety, and well-being and the
68.28 resident's needs cannot be met in the facility;

68.29 (2) the safety of the resident or another resident in the program is endangered and positive
68.30 support strategies were attempted and have not achieved and effectively maintained safety
68.31 for the resident or another resident in the program;

69.1 (3) the health, safety, and well-being of the resident or another resident in the program
69.2 would otherwise be endangered;

69.3 (4) the program was not paid for services;

69.4 (5) the program ceases to operate; or

69.5 (6) the resident was terminated by the lead agency from waiver eligibility.

69.6 (d) Before giving notice of service termination, the license holder must document the
69.7 action taken to minimize or eliminate the need for termination. The action taken by the
69.8 license holder must include, at a minimum:

69.9 (1) consultation with the resident's interdisciplinary team to identify and resolve issues
69.10 leading to a notice of service termination; and

69.11 (2) a request to the case manager or other professional consultation or intervention
69.12 services to support the resident in the program. This requirement does not apply to a notice
69.13 of service termination issued under paragraph (c), clause (4) or (5).

69.14 (e) If, based on the best interests of the resident, the circumstances at the time of notice
69.15 were such that the license holder was unable to take the action specified in paragraph (d),
69.16 the license holder must document the specific circumstances and the reason the license
69.17 holder was unable to take the action.

69.18 (f) The license holder must notify the resident or the resident's legal representative and
69.19 the case manager in writing of the intended service termination. The notice must include:

69.20 (1) the reason for the action;

69.21 (2) except for service termination under paragraph (c), clause (4) or (5), a summary of
69.22 the action taken to minimize or eliminate the need for termination and the reason the action
69.23 failed to prevent the termination;

69.24 (3) the resident's right to appeal the service termination under section 256.045, subdivision
69.25 3, paragraph (a); and

69.26 (4) the resident's right to seek a temporary order staying the service termination according
69.27 to the procedures in section 256.045, subdivision 4a, or subdivision 6, paragraph (c).

69.28 (g) Notice of the proposed service termination must be given at least 30 days before
69.29 terminating a resident's service.

69.30 (h) After the resident receives the notice of service termination and before the services
69.31 are terminated, the license holder must:

70.1 (1) work with the support team or expanded support team to develop reasonable
70.2 alternatives to support continuity of care and to protect the resident;

70.3 (2) provide information requested by the resident or case manager; and

70.4 (3) maintain information about the service termination, including the written notice of
70.5 service termination, in the resident's record.

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

70.7 Sec. 8. Minnesota Statutes 2016, section 245D.04, subdivision 3, is amended to read:

70.8 Subd. 3. **Protection-related rights.** (a) A person's protection-related rights include the
70.9 right to:

70.10 (1) have personal, financial, service, health, and medical information kept private, and
70.11 be advised of disclosure of this information by the license holder;

70.12 (2) access records and recorded information about the person in accordance with
70.13 applicable state and federal law, regulation, or rule;

70.14 (3) be free from maltreatment;

70.15 (4) be free from restraint, time out, seclusion, restrictive intervention, or other prohibited
70.16 procedure identified in section 245D.06, subdivision 5, or successor provisions, except for:

70.17 (i) emergency use of manual restraint to protect the person from imminent danger to self
70.18 or others according to the requirements in section 245D.061 or successor provisions; or (ii)
70.19 the use of safety interventions as part of a positive support transition plan under section
70.20 245D.06, subdivision 8, or successor provisions;

70.21 (5) receive services in a clean and safe environment when the license holder is the owner,
70.22 lessor, or tenant of the service site;

70.23 (6) be treated with courtesy and respect and receive respectful treatment of the person's
70.24 property;

70.25 (7) reasonable observance of cultural and ethnic practice and religion;

70.26 (8) be free from bias and harassment regarding race, gender, age, disability, spirituality,
70.27 and sexual orientation;

70.28 (9) be informed of and use the license holder's grievance policy and procedures, including
70.29 knowing how to contact persons responsible for addressing problems and to appeal under
70.30 section 256.045;

71.1 (10) know the name, telephone number, and the Web site, e-mail, and street addresses
71.2 of protection and advocacy services, including the appropriate state-appointed ombudsman,
71.3 and a brief description of how to file a complaint with these offices;

71.4 (11) assert these rights personally, or have them asserted by the person's family,
71.5 authorized representative, or legal representative, without retaliation;

71.6 (12) give or withhold written informed consent to participate in any research or
71.7 experimental treatment;

71.8 (13) associate with other persons of the person's choice;

71.9 (14) personal privacy; and

71.10 (15) engage in chosen activities.

71.11 (b) For a person residing in a residential site licensed according to chapter 245A, or
71.12 where the license holder is the owner, lessor, or tenant of the residential service site,
71.13 protection-related rights also include the right to:

71.14 (1) have daily, private access to and use of a non-coin-operated telephone for local calls
71.15 and long-distance calls made collect or paid for by the person;

71.16 (2) receive and send, without interference, uncensored, unopened mail or electronic
71.17 correspondence or communication;

71.18 (3) have use of and free access to common areas in the residence; and

71.19 (4) privacy for visits with the person's spouse, next of kin, legal counsel, religious adviser
71.20 adviser, or others, in accordance with section 363A.09 of the Human Rights Act, including
71.21 privacy in the person's bedroom; and

71.22 (5) have access to three nutritionally balanced meals and nutritious snacks between
71.23 meals each day.

71.24 (c) Restriction of a person's rights under paragraph (a), clauses (13) to (15), or paragraph
71.25 (b) is allowed only if determined necessary to ensure the health, safety, and well-being of
71.26 the person. Any restriction of those rights must be documented in the person's coordinated
71.27 service and support plan or coordinated service and support plan addendum. The restriction
71.28 must be implemented in the least restrictive alternative manner necessary to protect the
71.29 person and provide support to reduce or eliminate the need for the restriction in the most
71.30 integrated setting and inclusive manner. The documentation must include the following
71.31 information:

72.1 (1) the justification for the restriction based on an assessment of the person's vulnerability
72.2 related to exercising the right without restriction;

72.3 (2) the objective measures set as conditions for ending the restriction;

72.4 (3) a schedule for reviewing the need for the restriction based on the conditions for
72.5 ending the restriction to occur semiannually from the date of initial approval, at a minimum,
72.6 or more frequently if requested by the person, the person's legal representative, if any, and
72.7 case manager; and

72.8 (4) signed and dated approval for the restriction from the person, or the person's legal
72.9 representative, if any. A restriction may be implemented only when the required approval
72.10 has been obtained. Approval may be withdrawn at any time. If approval is withdrawn, the
72.11 right must be immediately and fully restored.

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

72.13 Sec. 9. Minnesota Statutes 2016, section 256.045, subdivision 3, is amended to read:

72.14 Subd. 3. **State agency hearings.** (a) State agency hearings are available for the following:

72.15 (1) any person applying for, receiving or having received public assistance, medical
72.16 care, or a program of social services granted by the state agency or a county agency or the
72.17 federal Food Stamp Act whose application for assistance is denied, not acted upon with
72.18 reasonable promptness, or whose assistance is suspended, reduced, terminated, or claimed
72.19 to have been incorrectly paid;

72.20 (2) any patient or relative aggrieved by an order of the commissioner under section
72.21 252.27;

72.22 (3) a party aggrieved by a ruling of a prepaid health plan;

72.23 (4) except as provided under chapter 245C, any individual or facility determined by a
72.24 lead investigative agency to have maltreated a vulnerable adult under section 626.557 after
72.25 they have exercised their right to administrative reconsideration under section 626.557;

72.26 (5) any person whose claim for foster care payment according to a placement of the
72.27 child resulting from a child protection assessment under section 626.556 is denied or not
72.28 acted upon with reasonable promptness, regardless of funding source;

72.29 (6) any person to whom a right of appeal according to this section is given by other
72.30 provision of law;

73.1 (7) an applicant aggrieved by an adverse decision to an application for a hardship waiver
73.2 under section 256B.15;

73.3 (8) an applicant aggrieved by an adverse decision to an application or redetermination
73.4 for a Medicare Part D prescription drug subsidy under section 256B.04, subdivision 4a;

73.5 (9) except as provided under chapter 245A, an individual or facility determined to have
73.6 maltreated a minor under section 626.556, after the individual or facility has exercised the
73.7 right to administrative reconsideration under section 626.556;

73.8 (10) except as provided under chapter 245C, an individual disqualified under sections
73.9 245C.14 and 245C.15, following a reconsideration decision issued under section 245C.23,
73.10 on the basis of serious or recurring maltreatment; a preponderance of the evidence that the
73.11 individual has committed an act or acts that meet the definition of any of the crimes listed
73.12 in section 245C.15, subdivisions 1 to 4; or for failing to make reports required under section
73.13 626.556, subdivision 3, or 626.557, subdivision 3. Hearings regarding a maltreatment
73.14 determination under clause (4) or (9) and a disqualification under this clause in which the
73.15 basis for a disqualification is serious or recurring maltreatment, shall be consolidated into
73.16 a single fair hearing. In such cases, the scope of review by the human services judge shall
73.17 include both the maltreatment determination and the disqualification. The failure to exercise
73.18 the right to an administrative reconsideration shall not be a bar to a hearing under this section
73.19 if federal law provides an individual the right to a hearing to dispute a finding of
73.20 maltreatment;

73.21 (11) any person with an outstanding debt resulting from receipt of public assistance,
73.22 medical care, or the federal Food Stamp Act who is contesting a setoff claim by the
73.23 Department of Human Services or a county agency. The scope of the appeal is the validity
73.24 of the claimant agency's intention to request a setoff of a refund under chapter 270A against
73.25 the debt;

73.26 (12) a person issued a notice of service termination under section 245D.10, subdivision
73.27 3a, from residential supports and services as defined in section 245D.03, subdivision 1,
73.28 paragraph (c), clause (3), that is not otherwise subject to appeal under subdivision 4a; or

73.29 (13) an individual disability waiver recipient based on a denial of a request for a rate
73.30 exception under section 256B.4914; or

73.31 (14) a person issued a notice of service termination under section 245A.11, subdivision
73.32 11, that is not otherwise subject to appeal under subdivision 4a.

(b) The hearing for an individual or facility under paragraph (a), clause (4), (9), or (10), is the only administrative appeal to the final agency determination specifically, including a challenge to the accuracy and completeness of data under section 13.04. Hearings requested under paragraph (a), clause (4), apply only to incidents of maltreatment that occur on or after October 1, 1995. Hearings requested by nursing assistants in nursing homes alleged to have maltreated a resident prior to October 1, 1995, shall be held as a contested case proceeding under the provisions of chapter 14. Hearings requested under paragraph (a), clause (9), apply only to incidents of maltreatment that occur on or after July 1, 1997. A hearing for an individual or facility under paragraph (a), clauses (4), (9), and (10), is only available when there is no district court action pending. If such action is filed in district court while an administrative review is pending that arises out of some or all of the events or circumstances on which the appeal is based, the administrative review must be suspended until the judicial actions are completed. If the district court proceedings are completed, dismissed, or overturned, the matter may be considered in an administrative hearing.

(c) For purposes of this section, bargaining unit grievance procedures are not an administrative appeal.

(d) The scope of hearings involving claims to foster care payments under paragraph (a), clause (5), shall be limited to the issue of whether the county is legally responsible for a child's placement under court order or voluntary placement agreement and, if so, the correct amount of foster care payment to be made on the child's behalf and shall not include review of the propriety of the county's child protection determination or child placement decision.

(e) The scope of hearings under paragraph (a), ~~elause~~ clauses (12) and (14), shall be limited to whether the proposed termination of services is authorized under section 245D.10, subdivision 3a, paragraph (b), or 245A.11, subdivision 11, and whether the requirements of section 245D.10, subdivision 3a, ~~paragraph paragraphs (c) to (e)~~, or 245A.11, subdivision 2a, paragraphs (d) to (f), were met. If the appeal includes a request for a temporary stay of termination of services, the scope of the hearing shall also include whether the case management provider has finalized arrangements for a residential facility, a program, or services that will meet the assessed needs of the recipient by the effective date of the service termination.

(f) A vendor of medical care as defined in section 256B.02, subdivision 7, or a vendor under contract with a county agency to provide social services is not a party and may not request a hearing under this section, except if assisting a recipient as provided in subdivision 4.

75.1 (g) An applicant or recipient is not entitled to receive social services beyond the services
75.2 prescribed under chapter 256M or other social services the person is eligible for under state
75.3 law.

75.4 (h) The commissioner may summarily affirm the county or state agency's proposed
75.5 action without a hearing when the sole issue is an automatic change due to a change in state
75.6 or federal law.

75.7 (i) Unless federal or Minnesota law specifies a different time frame in which to file an
75.8 appeal, an individual or organization specified in this section may contest the specified
75.9 action, decision, or final disposition before the state agency by submitting a written request
75.10 for a hearing to the state agency within 30 days after receiving written notice of the action,
75.11 decision, or final disposition, or within 90 days of such written notice if the applicant,
75.12 recipient, patient, or relative shows good cause, as defined in section 256.0451, subdivision
75.13 13, why the request was not submitted within the 30-day time limit. The individual filing
75.14 the appeal has the burden of proving good cause by a preponderance of the evidence.

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

75.16 **Sec. 10. [256B.051] HOUSING SUPPORT SERVICES.**

75.17 **Subdivision 1. Purpose.** Housing support services are established to provide housing
75.18 support services to an individual with a disability that limits the individual's ability to obtain
75.19 or maintain stable housing. The services support an individual's transition to housing in the
75.20 community and increase long-term stability in housing, to avoid future periods of being at
75.21 risk of homelessness or institutionalization.

75.22 **Subd. 2. Definitions.** (a) For the purposes of this section, the terms defined in this
75.23 subdivision have the meanings given.

75.24 (b) "At-risk of homelessness" means (1) an individual that is faced with a set of
75.25 circumstances likely to cause the individual to become homeless, or (2) an individual
75.26 previously homeless, who will be discharged from a correctional, medical, mental health,
75.27 or treatment center, who lacks sufficient resources to pay for housing and does not have a
75.28 permanent place to live.

75.29 (c) "Commissioner" means the commissioner of human services.

75.30 (d) "Homeless" means an individual or family lacking a fixed, adequate nighttime
75.31 residence.

75.32 (e) "Individual with a disability" means:

76.1 (1) an individual who is aged, blind, or disabled as determined by the criteria used by
76.2 the title 11 program of the Social Security Act, United States Code, title 42, section 416,
76.3 paragraph (i), item (1); or

76.4 (2) an individual who meets a category of eligibility under section 256D.05, subdivision
76.5 1, paragraph (a), clauses (1), (3), (5) to (9), or (14).

76.6 (f) "Institution" means a setting as defined in section 256B.0621, subdivision 2, clause
76.7 (3), and the Minnesota Security Hospital as defined in section 253.20.

76.8 Subd. 3. **Eligibility.** An individual with a disability is eligible for housing support services
76.9 if the individual:

76.10 (1) is 18 years of age or older;

76.11 (2) is enrolled in medical assistance;

76.12 (3) has an assessment of functional need that determines a need for services due to
76.13 limitations caused by the individual's disability;

76.14 (4) resides in or plans to transition to a community-based setting as defined in Code of
76.15 Federal Regulations, title 42, section 441.301(c); and

76.16 (5) has housing instability evidenced by:

76.17 (i) being homeless or at-risk of homelessness;

76.18 (ii) being in the process of transitioning from, or having transitioned in the past six
76.19 months from, an institution or licensed or registered setting;

76.20 (iii) being eligible for waiver services under section 256B.0915, 256B.092, or 256B.49;

76.21 or

76.22 (iv) having been identified by a long-term care consultation under section 256B.0911
76.23 as at risk of institutionalization.

76.24 Subd. 4. **Assessment requirements.** (a) An individual's assessment of functional need
76.25 must be conducted by one of the following methods:

76.26 (1) an assessor according to the criteria established in section 256B.0911, subdivision
76.27 3a, using a format established by the commissioner;

76.28 (2) documented need for services as verified by a professional statement of need as
76.29 defined in section 256I.03, subdivision 12; or

77.1 (3) according to the continuum of care coordinated assessment system established in
77.2 Code of Federal Regulations, title 24, section 578.3, using a format established by the
77.3 commissioner.

77.4 (b) An individual must be reassessed within one year of initial assessment, and annually
77.5 thereafter.

77.6 Subd. 5. **Housing support services.** (a) Housing support services include housing
77.7 transition services and housing and tenancy sustaining services.

77.8 (b) Housing transition services are defined as:

77.9 (1) tenant screening and housing assessment;

77.10 (2) assistance with the housing search and application process;

77.11 (3) identifying resources to cover onetime moving expenses;

77.12 (4) ensuring a new living arrangement is safe and ready for move-in;

77.13 (5) assisting in arranging for and supporting details of a move; and

77.14 (6) developing a housing support crisis plan.

77.15 (c) Housing and tenancy sustaining services include:

77.16 (1) prevention and early identification of behaviors that may jeopardize continued stable
77.17 housing;

77.18 (2) education and training on roles, rights, and responsibilities of the tenant and the
77.19 property manager;

77.20 (3) coaching to develop and maintain key relationships with property managers and
77.21 neighbors;

77.22 (4) advocacy and referral to community resources to prevent eviction when housing is
77.23 at risk;

77.24 (5) assistance with housing recertification process;

77.25 (6) coordination with the tenant to regularly review, update, and modify housing support
77.26 and crisis plan; and

77.27 (7) continuing training on being a good tenant, lease compliance, and household
77.28 management.

77.29 (d) A housing support service may include person-centered planning for people who are
77.30 not eligible to receive person-centered planning through any other service, if the

78.1 person-centered planning is provided by a consultation service provider that is under contract
78.2 with the department and enrolled as a Minnesota health care program.

78.3 Subd. 6. **Provider qualifications and duties.** A provider eligible for reimbursement
78.4 under this section shall:

78.5 (1) enroll as a medical assistance Minnesota health care program provider and meet all
78.6 applicable provider standards and requirements;

78.7 (2) demonstrate compliance with federal and state laws and policies for housing support
78.8 services as determined by the commissioner;

78.9 (3) comply with background study requirements under chapter 245C and maintain
78.10 documentation of background study requests and results; and

78.11 (4) directly provide housing support services and not use a subcontractor or reporting
78.12 agent.

78.13 Subd. 7. **Housing support supplemental service rates.** Supplemental service rates for
78.14 individuals in settings according to sections 144D.025, 256I.04, subdivision 3, paragraph
78.15 (a), clause (3), and 256I.05, subdivision 1g, shall be reduced by one-half over a two-year
78.16 period. This reduction only applies to supplemental service rates for individuals eligible for
78.17 housing support services under this section.

78.18 **EFFECTIVE DATE.** (a) Subdivisions 1 to 6 are contingent upon federal approval. The
78.19 commissioner of human services shall notify the revisor of statutes when federal approval
78.20 is obtained.

78.21 (b) Subdivision 7 is contingent upon federal approval of subdivisions 1 to 6. The
78.22 commissioner of human services shall notify the revisor of statutes when federal approval
78.23 is obtained.

78.24 Sec. 11. Minnesota Statutes 2016, section 256B.0911, subdivision 3a, is amended to read:

78.25 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services
78.26 planning, or other assistance intended to support community-based living, including persons
78.27 who need assessment in order to determine waiver or alternative care program eligibility,
78.28 must be visited by a long-term care consultation team within 20 calendar days after the date
78.29 on which an assessment was requested or recommended. Upon statewide implementation
78.30 of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person
78.31 requesting personal care assistance services and home care nursing. The commissioner shall

79.1 provide at least a 90-day notice to lead agencies prior to the effective date of this requirement.

79.2 Face-to-face assessments must be conducted according to paragraphs (b) to (i).

79.3 (b) Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified
79.4 assessors to conduct the assessment. For a person with complex health care needs, a public
79.5 health or registered nurse from the team must be consulted.

79.6 (c) The MnCHOICES assessment provided by the commissioner to lead agencies must
79.7 be used to complete a comprehensive, person-centered assessment. The assessment must
79.8 include the health, psychological, functional, environmental, and social needs of the
79.9 individual necessary to develop a community support plan that meets the individual's needs
79.10 and preferences.

79.11 (d) The assessment must be conducted in a face-to-face interview with the person being
79.12 assessed and the person's legal representative. At the request of the person, other individuals
79.13 may participate in the assessment to provide information on the needs, strengths, and
79.14 preferences of the person necessary to develop a community support plan that ensures the
79.15 person's health and safety. Except for legal representatives or family members invited by
79.16 the person, persons participating in the assessment may not be a provider of service or have
79.17 any financial interest in the provision of services. For persons who are to be assessed for
79.18 elderly waiver customized living services under section 256B.0915, with the permission of
79.19 the person being assessed or the person's designated or legal representative, the client's
79.20 current or proposed provider of services may submit a copy of the provider's nursing
79.21 assessment or written report outlining its recommendations regarding the client's care needs.
79.22 The person conducting the assessment must notify the provider of the date by which this
79.23 information is to be submitted. This information shall be provided to the person conducting
79.24 the assessment prior to the assessment. For a person who is to be assessed for waiver services
79.25 under section 256B.092 or 256B.49, with the permission of the person being assessed or
79.26 the person's designated legal representative, the person's current provider of services may
79.27 submit a written report outlining recommendations regarding the person's care needs prepared
79.28 by a direct service employee with at least 20 hours of service to that client. The person
79.29 conducting the assessment or reassessment must notify the provider of the date by which
79.30 this information is to be submitted. This information shall be provided to the person
79.31 conducting the assessment and the person or the person's legal representative, and must be
79.32 considered prior to the finalization of the assessment or reassessment.

79.33 (e) The person or the person's legal representative must be provided with a written
79.34 community support plan within 40 calendar days of the assessment visit, regardless of

80.1 whether the individual is eligible for Minnesota health care programs. The written community
80.2 support plan must include:

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

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

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

80.8 (4) referral information; and

80.9 (5) informal caregiver supports, if applicable.

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

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

80.18 (g) The person has the right to make the final decision between institutional placement
80.19 and community placement after the recommendations have been provided, except as provided
80.20 in section 256.975, subdivision 7a, paragraph (d).

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

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

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

81.1 (3) the need for and purpose of preadmission screening conducted by long-term care
81.2 options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects
81.3 nursing facility placement. If the individual selects nursing facility placement, the lead
81.4 agency shall forward information needed to complete the level of care determinations and
81.5 screening for developmental disability and mental illness collected during the assessment
81.6 to the long-term care options counselor using forms provided by the commissioner;

81.7 (4) the role of long-term care consultation assessment and support planning in eligibility
81.8 determination for waiver and alternative care programs, and state plan home care, case
81.9 management, and other services as defined in subdivision 1a, paragraphs (a), clause (6),
81.10 and (b);

81.11 (5) information about Minnesota health care programs;

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

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

81.15 (8) the certified assessor's decision regarding the person's need for institutional level of
81.16 care as determined under criteria established in subdivision 4e and the certified assessor's
81.17 decision regarding eligibility for all services and programs as defined in subdivision 1a,
81.18 paragraphs (a), clause (6), and (b); and

81.19 (9) the person's right to appeal the certified assessor's decision regarding eligibility for
81.20 all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and
81.21 (8), and (b), and incorporating the decision regarding the need for institutional level of care
81.22 or the lead agency's final decisions regarding public programs eligibility according to section
81.23 256.045, subdivision 3.

81.24 (i) Face-to-face assessment completed as part of eligibility determination for the
81.25 alternative care, elderly waiver, community access for disability inclusion, community
81.26 alternative care, and brain injury waiver programs under sections 256B.0913, 256B.0915,
81.27 and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after
81.28 the date of assessment.

81.29 (j) The effective eligibility start date for programs in paragraph (i) can never be prior to
81.30 the date of assessment. If an assessment was completed more than 60 days before the
81.31 effective waiver or alternative care program eligibility start date, assessment and support
81.32 plan information must be updated and documented in the department's Medicaid Management
81.33 Information System (MMIS). Notwithstanding retroactive medical assistance coverage of

82.1 state plan services, the effective date of eligibility for programs included in paragraph (i)
82.2 cannot be prior to the date the most recent updated assessment is completed.

82.3 (k) At the time of reassessment, the certified assessor shall assess each person receiving
82.4 waiver services currently residing in a community residential setting, or licensed adult foster
82.5 care home that is not the primary residence of the license holder, or in which the license
82.6 holder is not the primary caregiver, to determine if that person would prefer to be served in
82.7 a community-living settings as defined in section 256B.49, subdivision 23. The certified
82.8 assessor shall offer the person, through a person-centered planning process, the option to
82.9 receive alternative housing and service options.

82.10 Sec. 12. Minnesota Statutes 2016, section 256B.0915, subdivision 1, is amended to read:

82.11 Subdivision 1. **Authority.** (a) The commissioner is authorized to apply for a home and
82.12 community-based services waiver for the elderly, authorized under section 1915(c) of the
82.13 Social Security Act, in order to obtain federal financial participation to expand the availability
82.14 of services for persons who are eligible for medical assistance. The commissioner may
82.15 apply for additional waivers or pursue other federal financial participation which is
82.16 advantageous to the state for funding home care services for the frail elderly who are eligible
82.17 for medical assistance. The provision of waived services to elderly and disabled medical
82.18 assistance recipients must comply with the criteria for service definitions and provider
82.19 standards approved in the waiver.

82.20 (b) The commissioner shall comply with the requirements in the federally approved
82.21 transition plan for the home and community-based services waivers authorized under this
82.22 section.

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

82.24 Sec. 13. Minnesota Statutes 2016, section 256B.092, subdivision 4, is amended to read:

82.25 Subd. 4. **Home and community-based services for developmental disabilities.** (a)
82.26 The commissioner shall make payments to approved vendors participating in the medical
82.27 assistance program to pay costs of providing home and community-based services, including
82.28 case management service activities provided as an approved home and community-based
82.29 service, to medical assistance eligible persons with developmental disabilities who have
82.30 been screened under subdivision 7 and according to federal requirements. Federal
82.31 requirements include those services and limitations included in the federally approved
82.32 application for home and community-based services for persons with developmental
82.33 disabilities and subsequent amendments.

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

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

(d) The commissioner shall comply with the requirements in the federally approved transition plan for the home and community-based services waivers for the elderly authorized under this section.

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

Sec. 14. Minnesota Statutes 2016, section 256B.49, subdivision 11, is amended to read:

Subd. 11. **Authority.** (a) The commissioner is authorized to apply for home and community-based service waivers, as authorized under section 1915(c) of the Social Security Act to serve persons under the age of 65 who are determined to require the level of care provided in a nursing home and persons who require the level of care provided in a hospital. The commissioner shall apply for the home and community-based waivers in order to:

- (1) promote the support of persons with disabilities in the most integrated settings;
- (2) expand the availability of services for persons who are eligible for medical assistance;
- (3) promote cost-effective options to institutional care; and
- (4) obtain federal financial participation.

84.1 (b) The provision of waived services to medical assistance recipients with disabilities
84.2 shall comply with the requirements outlined in the federally approved applications for home
84.3 and community-based services and subsequent amendments, including provision of services
84.4 according to a service plan designed to meet the needs of the individual. For purposes of
84.5 this section, the approved home and community-based application is considered the necessary
84.6 federal requirement.

84.7 (c) The commissioner shall provide interested persons serving on agency advisory
84.8 committees, task forces, the Centers for Independent Living, and others who request to be
84.9 on a list to receive, notice of, and an opportunity to comment on, at least 30 days before
84.10 any effective dates, (1) any substantive changes to the state's disability services program
84.11 manual, or (2) changes or amendments to the federally approved applications for home and
84.12 community-based waivers, prior to their submission to the federal Centers for Medicare
84.13 and Medicaid Services.

84.14 (d) The commissioner shall seek approval, as authorized under section 1915(c) of the
84.15 Social Security Act, to allow medical assistance eligibility under this section for children
84.16 under age 21 without deeming of parental income or assets.

84.17 (e) The commissioner shall seek approval, as authorized under section 1915(c) of the
84.18 Social Act, to allow medical assistance eligibility under this section for individuals under
84.19 age 65 without deeming the spouse's income or assets.

84.20 (f) The commissioner shall comply with the requirements in the federally approved
84.21 transition plan for the home and community-based services waivers authorized under this
84.22 section.

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

84.24 Sec. 15. Minnesota Statutes 2016, section 256B.49, subdivision 15, is amended to read:

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

84.29 (b) In developing the comprehensive transitional service plan, the individual receiving
84.30 services, the case manager, and the guardian, if applicable, will identify the transitional
84.31 service plan fundamental service outcome and anticipated timeline to achieve this outcome.
84.32 Within the first 20 days following a recipient's request for an assessment or reassessment,
84.33 the transitional service planning team must be identified. A team leader must be identified

85.1 who will be responsible for assigning responsibility and communicating with team members
85.2 to ensure implementation of the transition plan and ongoing assessment and communication
85.3 process. The team leader should be an individual, such as the case manager or guardian,
85.4 who has the opportunity to follow the recipient to the next level of service.

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

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

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

85.24 (c) Counties and other agencies responsible for funding community placement and
85.25 ongoing community supportive services are responsible for the implementation of the
85.26 comprehensive transitional service plans. Oversight responsibilities include both ensuring
85.27 effective transitional service delivery and efficient utilization of funding resources.

85.28 (d) Following one year of transitional services, the transitional services planning team
85.29 will make a determination as to whether or not the individual receiving services requires
85.30 the current level of continuous and consistent support in order to maintain the recipient's
85.31 current level of functioning. Recipients who are determined to have not had a significant
85.32 change in functioning for 12 months must move from a transitional to a maintenance service
85.33 plan. Recipients on a maintenance service plan must be reassessed to determine if the
85.34 recipient would benefit from a transitional service plan at least every 12 months and at other

times when there has been a significant change in the recipient's functioning. This assessment should consider any changes to technological or natural community supports.

(e) When a county is evaluating denials, reductions, or terminations of home and community-based services under this section for an individual, the case manager shall offer to meet with the individual or the individual's guardian in order to discuss the prioritization of service needs within the coordinated service and support plan, comprehensive transitional service plan, or maintenance service plan. The reduction in the authorized services for an individual due to changes in funding for waived services may not exceed the amount needed to ensure medically necessary services to meet the individual's health, safety, and welfare.

~~(f) At the time of reassessment, local agency case managers shall assess each recipient of community access for disability inclusion or brain injury waived services currently residing in a licensed adult foster home that is not the primary residence of the license holder, or in which the license holder is not the primary caregiver, to determine if that recipient could appropriately be served in a community living setting. If appropriate for the recipient, the case manager shall offer the recipient, through a person-centered planning process, the option to receive alternative housing and service options. In the event that the recipient chooses to transfer from the adult foster home, the vacated bed shall not be filled with another recipient of waiver services and group residential housing and the licensed capacity shall be reduced accordingly, unless the savings required by the licensed bed closure reductions under Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40, paragraph (f), for foster care settings where the physical location is not the primary residence of the license holder are met through voluntary changes described in section 245A.03, subdivision 7, paragraph (e), or as provided under paragraph (a), clauses (3) and (4). If the adult foster home becomes no longer viable due to these transfers, the county agency, with the assistance of the department, shall facilitate a consolidation of settings or closure. This reassessment process shall be completed by July 1, 2013.~~

Sec. 16. Minnesota Statutes 2016, section 256B.493, subdivision 1, is amended to read:

Subdivision 1. **Commissioner's duties; report.** The commissioner of human services shall solicit proposals for the conversion of services provided for persons with disabilities in settings licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, or community residential settings licensed under chapter 245D, to other types of community settings in conjunction with the closure of identified licensed adult foster care settings has the authority to manage statewide licensed corporate foster care or community residential settings capacity,

87.1 including the reduction and realignment of licensed capacity of a current foster care or
87.2 community residential settings to accomplish the consolidation or closure of settings. The
87.3 commissioner shall implement a program for planned closure of licensed corporate adult
87.4 foster care or community residential settings, necessary as a preferred method to: (1) respond
87.5 to the informed decisions of those individuals who want to move out of these settings into
87.6 other types of community settings; and (2) achieve necessary budgetary savings required
87.7 in section 245A.03, subdivision 7, paragraphs (c) and (d).

87.8 Sec. 17. Minnesota Statutes 2016, section 256B.493, subdivision 2, is amended to read:

87.9 Subd. 2. **Planned closure process needs determination.** ~~The commissioner shall~~
87.10 ~~announce and implement a program for planned closure of adult foster care homes. Planned~~
87.11 ~~closure shall be the preferred method for achieving necessary budgetary savings required~~
87.12 ~~by the licensed bed closure budget reduction in section 245A.03, subdivision 7, paragraph~~
87.13 ~~(c). If additional closures are required to achieve the necessary savings, the commissioner~~
87.14 ~~shall use the process and priorities in section 245A.03, subdivision 7, paragraph (c) A~~
87.15 resource need determination process, managed at the state level, using available reports
87.16 required by section 144A.351 and other data and information shall be used by the
87.17 commissioner to align capacity where needed.

87.18 Sec. 18. Minnesota Statutes 2016, section 256B.493, is amended by adding a subdivision
87.19 to read:

87.20 Subd. 2a. **Closure process.** (a) The commissioner shall work with stakeholders to
87.21 establish a process for the application, review, approval, and implementation of setting
87.22 closures. Voluntary proposals from license holders for consolidation and closure of adult
87.23 foster care or community residential settings are encouraged. Whether voluntary or
87.24 involuntary, all closure plans must include:

87.25 (1) a description of the proposed closure plan, identifying the home or homes and
87.26 occupied beds;

87.27 (2) the proposed timetable for the proposed closure, including the proposed dates for
87.28 notification to people living there and the affected lead agencies, commencement of closure,
87.29 and completion of closure;

87.30 (3) the proposed relocation plan jointly developed by the counties of financial
87.31 responsibility, the people living there and their legal representatives, if any, who wish to
87.32 continue to receive services from the provider, and the providers for current residents of
87.33 any adult foster care home designated for closure; and

88.1 (4) documentation from the provider in a format approved by the commissioner that all
88.2 the adult foster care homes or community residential settings receiving a planned closure
88.3 rate adjustment under the plan have accepted joint and severable for recovery of
88.4 overpayments under section 256B.0641, subdivision 2, for the facilities designated for
88.5 closure under this plan.

88.6 (b) The commissioner shall give first priority to closure plans which:

88.7 (1) target counties and geographic areas which have:

88.8 (i) need for other types of services;

88.9 (ii) need for specialized services;

88.10 (iii) higher than average per capita use of licensed corporate foster care or community
88.11 residential settings; or

88.12 (iv) residents not living in the geographic area of their choice;

88.13 (2) demonstrate savings of medical assistance expenditures; and

88.14 (3) demonstrate that alternative services are based on the recipient's choice of provider
88.15 and are consistent with federal law, state law, and federally approved waiver plans.

88.16 The commissioner shall also consider any information provided by people using services,
88.17 their legal representatives, family members, or the lead agency on the impact of the planned
88.18 closure on people and the services they need.

88.19 (c) For each closure plan approved by the commissioner, a contract must be established
88.20 between the commissioner, the counties of financial responsibility, and the participating
88.21 license holder.

88.22 Sec. 19. Minnesota Statutes 2016, section 256D.44, subdivision 4, as amended by Laws
88.23 2017, chapter 59, section 12, is amended to read:

88.24 Subd. 4. **Temporary absence due to illness.** For the purposes of this subdivision, "home"
88.25 means a residence owned or rented by a recipient or the recipient's spouse. ~~Home does not~~
88.26 ~~include a group residential housing facility.~~ Assistance payments for recipients who are
88.27 temporarily absent from their home due to hospitalization for illness must continue at the
88.28 same level of payment during their absence if the following criteria are met:

88.29 (1) a physician, advanced practice registered nurse, or physician assistant certifies that
88.30 the absence is not expected to continue for more than three months;

89.1 (2) a physician, advanced practice registered nurse, or physician assistant certifies that
89.2 the recipient will be able to return to independent living; and

89.3 (3) the recipient has expenses associated with maintaining a residence in the community.

89.4 Sec. 20. Minnesota Statutes 2016, section 256D.44, subdivision 5, as amended by Laws
89.5 2017, chapter 40, article 1, section 84, and Laws 2017, chapter 59, section 13, is amended
89.6 to read:

89.7 Subd. 5. **Special needs.** (a) In addition to the state standards of assistance established
89.8 in subdivisions 1 to 4, payments are allowed for the following special needs of recipients
89.9 of Minnesota supplemental aid who are not residents of a nursing home, a regional treatment
89.10 center, or a group residential setting authorized to receive housing facility support payments
89.11 under chapter 256I.

89.12 (a) (b) The county agency shall pay a monthly allowance for medically prescribed diets
89.13 if the cost of those additional dietary needs cannot be met through some other maintenance
89.14 benefit. The need for special diets or dietary items must be prescribed by a licensed physician,
89.15 advanced practice registered nurse, or physician assistant. Costs for special diets shall be
89.16 determined as percentages of the allotment for a one-person household under the thrifty
89.17 food plan as defined by the United States Department of Agriculture. The types of diets and
89.18 the percentages of the thrifty food plan that are covered are as follows:

89.19 (1) high protein diet, at least 80 grams daily, 25 percent of thrifty food plan;

89.20 (2) controlled protein diet, 40 to 60 grams and requires special products, 100 percent of
89.21 thrifty food plan;

89.22 (3) controlled protein diet, less than 40 grams and requires special products, 125 percent
89.23 of thrifty food plan;

89.24 (4) low cholesterol diet, 25 percent of thrifty food plan;

89.25 (5) high residue diet, 20 percent of thrifty food plan;

89.26 (6) pregnancy and lactation diet, 35 percent of thrifty food plan;

89.27 (7) gluten-free diet, 25 percent of thrifty food plan;

89.28 (8) lactose-free diet, 25 percent of thrifty food plan;

89.29 (9) antidumping diet, 15 percent of thrifty food plan;

89.30 (10) hypoglycemic diet, 15 percent of thrifty food plan; or

89.31 (11) ketogenic diet, 25 percent of thrifty food plan.

90.1 ~~(b)~~ (c) Payment for nonrecurring special needs must be allowed for necessary home
90.2 repairs or necessary repairs or replacement of household furniture and appliances using the
90.3 payment standard of the AFDC program in effect on July 16, 1996, for these expenses, as
90.4 long as other funding sources are not available.

90.5 ~~(e)~~ (d) A fee for guardian or conservator service is allowed at a reasonable rate negotiated
90.6 by the county or approved by the court. This rate shall not exceed five percent of the
90.7 assistance unit's gross monthly income up to a maximum of \$100 per month. If the guardian
90.8 or conservator is a member of the county agency staff, no fee is allowed.

90.9 ~~(d)~~ (e) The county agency shall continue to pay a monthly allowance of \$68 for restaurant
90.10 meals for a person who was receiving a restaurant meal allowance on June 1, 1990, and
90.11 who eats two or more meals in a restaurant daily. The allowance must continue until the
90.12 person has not received Minnesota supplemental aid for one full calendar month or until
90.13 the person's living arrangement changes and the person no longer meets the criteria for the
90.14 restaurant meal allowance, whichever occurs first.

90.15 ~~(e)~~ (f) A fee of ten percent of the recipient's gross income or \$25, whichever is less, is
90.16 allowed for representative payee services provided by an agency that meets the requirements
90.17 under SSI regulations to charge a fee for representative payee services. This special need
90.18 is available to all recipients of Minnesota supplemental aid regardless of their living
90.19 arrangement.

90.20 ~~(f)~~ (g) (1) Notwithstanding the language in this subdivision, an amount equal to one-half
90.21 of the maximum allotment authorized by the federal Food Stamp Program for a federal
90.22 Supplemental Security Income payment amount for a single individual which is in effect
90.23 on the first day of July of each year will be added to the standards of assistance established
90.24 in subdivisions 1 to 4 for adults under the age of 65 who qualify as shelter-needy in need
90.25 of housing assistance and are:

90.26 (i) relocating from an institution, a setting authorized to receive housing support under
90.27 chapter 256I, or an adult mental health residential treatment program under section
90.28 256B.0622; or

90.29 (ii) eligible for personal care assistance under section 256B.0659; or

90.30 (iii) home and community-based waiver recipients living in their own home or rented
90.31 or leased apartment.

90.32 (2) Notwithstanding subdivision 3, paragraph (c), an individual eligible for the shelter
90.33 needy benefit under this paragraph is considered a household of one. An eligible individual

91.1 who receives this benefit prior to age 65 may continue to receive the benefit after the age
91.2 of 65.

91.3 (3) "~~Shelter-needy~~ Housing assistance" means that the assistance unit incurs monthly
91.4 shelter costs that exceed 40 percent of the assistance unit's gross income before the application
91.5 of this special needs standard. "Gross income" for the purposes of this section is the
91.6 applicant's or recipient's income as defined in section 256D.35, subdivision 10, or the
91.7 standard specified in subdivision 3, paragraph (a) or (b), whichever is greater. A recipient
91.8 of a federal or state housing subsidy, that limits shelter costs to a percentage of gross income,
91.9 shall not be considered ~~shelter-needy~~ in need of housing assistance for purposes of this
91.10 paragraph.

91.11 **EFFECTIVE DATE.** Paragraphs (a) to (f) are effective July 1, 2017. Paragraph (g),
91.12 clause (1), is effective July 1, 2020, except paragraph (g), clause (1), items (ii) and (iii), are
91.13 effective July 1, 2017.

91.14 Sec. 21. Minnesota Statutes 2016, section 256I.03, subdivision 8, is amended to read:

91.15 Subd. 8. **Supplementary services.** "Supplementary services" means housing support
91.16 services provided to residents of group residential housing providers individuals in addition
91.17 to room and board including, but not limited to, oversight and up to 24-hour supervision,
91.18 medication reminders, assistance with transportation, arranging for meetings and
91.19 appointments, and arranging for medical and social services.

91.20 Sec. 22. Minnesota Statutes 2016, section 256I.04, subdivision 1, is amended to read:

91.21 Subdivision 1. **Individual eligibility requirements.** An individual is eligible for and
91.22 entitled to a ~~group residential~~ housing support payment to be made on the individual's behalf
91.23 if the agency has approved the ~~individual's residence in a group residential setting where~~
91.24 the individual will receive housing setting support and the individual meets the requirements
91.25 in paragraph (a) ~~or~~ (b), or (c).

91.26 (a) The individual is aged, blind, or is over 18 years of age and disabled as determined
91.27 under the criteria used by the title II program of the Social Security Act, and meets the
91.28 resource restrictions and standards of section 256P.02, and the individual's countable income
91.29 after deducting the (1) exclusions and disregards of the SSI program, (2) the medical
91.30 assistance personal needs allowance under section 256B.35, and (3) an amount equal to the
91.31 income actually made available to a community spouse by an elderly waiver participant
91.32 under the provisions of sections 256B.0575, paragraph (a), clause (4), and 256B.058,

92.1 subdivision 2, is less than the monthly rate specified in the agency's agreement with the
92.2 provider of ~~group residential~~ housing support in which the individual resides.

92.3 (b) The individual meets a category of eligibility under section 256D.05, subdivision 1,
92.4 paragraph (a), clauses (1), (3), (5) to (9), and (14), and paragraph (b), if applicable, and the
92.5 individual's resources are less than the standards specified by section 256P.02, and the
92.6 individual's countable income as determined under section 256P.06, less the medical
92.7 assistance personal needs allowance under section 256B.35 is less than the monthly rate
92.8 specified in the agency's agreement with the provider of ~~group residential~~ housing support
92.9 in which the individual resides.

92.10 (c) The individual receives licensed residential crisis stabilization services under section
92.11 256B.0624, subdivision 7, and is receiving medical assistance. The individual may receive
92.12 concurrent housing support payments if receiving licensed residential crisis stabilization
92.13 services under section 256B.0624, subdivision 7.

92.14 **EFFECTIVE DATE.** Paragraph (c) is effective October 1, 2017.

92.15 Sec. 23. Minnesota Statutes 2016, section 256I.04, subdivision 2d, is amended to read:

92.16 Subd. 2d. **Conditions of payment; commissioner's right to suspend or terminate**
92.17 **agreement.** (a) ~~Group residential Housing or supplementary services~~ support must be
92.18 provided to the satisfaction of the commissioner, as determined at the sole discretion of the
92.19 commissioner's authorized representative, and in accordance with all applicable federal,
92.20 state, and local laws, ordinances, rules, and regulations, including business registration
92.21 requirements of the Office of the Secretary of State. A provider shall not receive payment
92.22 for room and board or supplementary services ~~or housing~~ found by the commissioner to be
92.23 performed or provided in violation of federal, state, or local law, ordinance, rule, or
92.24 regulation.

92.25 (b) The commissioner has the right to suspend or terminate the agreement immediately
92.26 when the commissioner determines the health or welfare of the housing or service recipients
92.27 is endangered, or when the commissioner has reasonable cause to believe that the provider
92.28 has breached a material term of the agreement under subdivision 2b.

92.29 (c) Notwithstanding paragraph (b), if the commissioner learns of a curable material
92.30 breach of the agreement by the provider, the commissioner shall provide the provider with
92.31 a written notice of the breach and allow ten days to cure the breach. If the provider does
92.32 not cure the breach within the time allowed, the provider shall be in default of the agreement
92.33 and the commissioner may terminate the agreement immediately thereafter. If the provider

93.1 has breached a material term of the agreement and cure is not possible, the commissioner
93.2 may immediately terminate the agreement.

93.3 Sec. 24. Minnesota Statutes 2016, section 256I.04, subdivision 2g, is amended to read:

93.4 Subd. 2g. **Crisis shelters.** Secure crisis shelters for battered women and their children
93.5 designated by the Minnesota Department of Corrections are not ~~group residences~~ eligible
93.6 for housing support under this chapter.

93.7 Sec. 25. Minnesota Statutes 2016, section 256I.04, subdivision 3, is amended to read:

93.8 Subd. 3. **Moratorium on development of ~~group residential~~ housing support beds.**

93.9 (a) Agencies shall not enter into agreements for new ~~group residential~~ housing support beds
93.10 with total rates in excess of the MSA equivalent rate except:

93.11 (1) for ~~group residential housing~~ establishments licensed under chapter 245D provided
93.12 the facility is needed to meet the census reduction targets for persons with developmental
93.13 disabilities at regional treatment centers;

93.14 (2) up to 80 beds in a single, specialized facility located in Hennepin County that will
93.15 provide housing for chronic inebriates who are repetitive users of detoxification centers and
93.16 are refused placement in emergency shelters because of their state of intoxication, and
93.17 planning for the specialized facility must have been initiated before July 1, 1991, in
93.18 anticipation of receiving a grant from the Housing Finance Agency under section 462A.05,
93.19 subdivision 20a, paragraph (b);

93.20 (3) notwithstanding the provisions of subdivision 2a, for up to ~~190~~ 226 supportive
93.21 housing units in Anoka, Dakota, Hennepin, or Ramsey County for homeless adults with a
93.22 mental illness, a history of substance abuse, or human immunodeficiency virus or acquired
93.23 immunodeficiency syndrome. For purposes of this section, "homeless adult" means a person
93.24 who is living on the street or in a shelter or discharged from a regional treatment center,
93.25 community hospital, or residential treatment program and has no appropriate housing
93.26 available and lacks the resources and support necessary to access appropriate housing. At
93.27 least 70 percent of the supportive housing units must serve homeless adults with mental
93.28 illness, substance abuse problems, or human immunodeficiency virus or acquired
93.29 immunodeficiency syndrome who are about to be or, within the previous six months, has
93.30 been discharged from a regional treatment center, or a state-contracted psychiatric bed in
93.31 a community hospital, or a residential mental health or chemical dependency treatment
93.32 program. If a person meets the requirements of subdivision 1, paragraph (a), and receives
93.33 a federal or state housing subsidy, the ~~group residential~~ housing support rate for that person

94.1 is limited to the supplementary rate under section 256I.05, subdivision 1a, and is determined
94.2 by subtracting the amount of the person's countable income that exceeds the MSA equivalent
94.3 rate from the ~~group-residential~~ housing support supplementary service rate. A resident in a
94.4 demonstration project site who no longer participates in the demonstration program shall
94.5 retain eligibility for a ~~group-residential~~ housing support payment in an amount determined
94.6 under section 256I.06, subdivision 8, using the MSA equivalent rate. Service funding under
94.7 section 256I.05, subdivision 1a, will end June 30, 1997, if federal matching funds are
94.8 available and the services can be provided through a managed care entity. If federal matching
94.9 funds are not available, then service funding will continue under section 256I.05, subdivision
94.10 1a;

94.11 (4) for an additional two beds, resulting in a total of 32 beds, for a facility located in
94.12 Hennepin County providing services for recovering and chemically dependent men that has
94.13 had a ~~group-residential~~ housing support contract with the county and has been licensed as
94.14 a board and lodge facility with special services since 1980;

94.15 (5) for a ~~group-residential~~ housing support provider located in the city of St. Cloud, or
94.16 a county contiguous to the city of St. Cloud, that operates a 40-bed facility, that received
94.17 financing through the Minnesota Housing Finance Agency Ending Long-Term Homelessness
94.18 Initiative and serves chemically dependent clientele, providing 24-hour-a-day supervision;

94.19 (6) for a new 65-bed facility in Crow Wing County that will serve chemically dependent
94.20 persons, operated by a ~~group-residential~~ housing support provider that currently operates a
94.21 304-bed facility in Minneapolis, and a 44-bed facility in Duluth;

94.22 (7) for a ~~group-residential~~ housing support provider that operates two ten-bed facilities,
94.23 one located in Hennepin County and one located in Ramsey County, that provide community
94.24 support and 24-hour-a-day supervision to serve the mental health needs of individuals who
94.25 have chronically lived unsheltered; and

94.26 (8) for a ~~group-residential~~ facility authorized for recipients of housing support in Hennepin
94.27 County with a capacity of up to 48 beds that has been licensed since 1978 as a board and
94.28 lodging facility and that until August 1, 2007, operated as a licensed chemical dependency
94.29 treatment program.

94.30 (b) An agency may enter into a ~~group-residential~~ housing support agreement for beds
94.31 with rates in excess of the MSA equivalent rate in addition to those currently covered under
94.32 a ~~group-residential~~ housing support agreement if the additional beds are only a replacement
94.33 of beds with rates in excess of the MSA equivalent rate which have been made available
94.34 due to closure of a setting, a change of licensure or certification which removes the beds

95.1 from group residential housing support payment, or as a result of the downsizing of a group
95.2 ~~residential housing~~ setting authorized for recipients of housing support. The transfer of
95.3 available beds from one agency to another can only occur by the agreement of both agencies.

95.4 Sec. 26. Minnesota Statutes 2016, section 256I.05, subdivision 1a, is amended to read:

95.5 Subd. 1a. **Supplementary service rates.** (a) Subject to the provisions of section 256I.04,
95.6 subdivision 3, the county agency may negotiate a payment not to exceed \$426.37 for other
95.7 services necessary to provide room and board ~~provided by the group residence~~ if the residence
95.8 is licensed by or registered by the Department of Health, or licensed by the Department of
95.9 Human Services to provide services in addition to room and board, and if the provider of
95.10 services is not also concurrently receiving funding for services for a recipient under a home
95.11 and community-based waiver under title XIX of the Social Security Act; or funding from
95.12 the medical assistance program under section 256B.0659, for personal care services for
95.13 residents in the setting; or residing in a setting which receives funding under section 245.73.
95.14 If funding is available for other necessary services through a home and community-based
95.15 waiver, or personal care services under section 256B.0659, then the GRH housing support
95.16 rate is limited to the rate set in subdivision 1. Unless otherwise provided in law, in no case
95.17 may the supplementary service rate exceed \$426.37. The registration and licensure
95.18 requirement does not apply to establishments which are exempt from state licensure because
95.19 they are located on Indian reservations and for which the tribe has prescribed health and
95.20 safety requirements. Service payments under this section may be prohibited under rules to
95.21 prevent the supplanting of federal funds with state funds. The commissioner shall pursue
95.22 the feasibility of obtaining the approval of the Secretary of Health and Human Services to
95.23 provide home and community-based waiver services under title XIX of the Social Security
95.24 Act for residents who are not eligible for an existing home and community-based waiver
95.25 due to a primary diagnosis of mental illness or chemical dependency and shall apply for a
95.26 waiver if it is determined to be cost-effective.

95.27 (b) The commissioner is authorized to make cost-neutral transfers from the GRH housing
95.28 support fund for beds under this section to other funding programs administered by the
95.29 department after consultation with the county or counties in which the affected beds are
95.30 located. The commissioner may also make cost-neutral transfers from the GRH housing
95.31 support fund to county human service agencies for beds permanently removed from the
95.32 GRH housing support census under a plan submitted by the county agency and approved
95.33 by the commissioner. The commissioner shall report the amount of any transfers under this
95.34 provision annually to the legislature.

96.1 (c) Counties must not negotiate supplementary service rates with providers of group
96.2 ~~residential housing support~~ that are licensed as board and lodging with special services and
96.3 that do not encourage a policy of sobriety on their premises and make referrals to available
96.4 community services for volunteer and employment opportunities for residents.

96.5 Sec. 27. Minnesota Statutes 2016, section 256I.05, subdivision 1c, is amended to read:

96.6 Subd. 1c. **Rate increases.** An agency may not increase the rates negotiated for group
96.7 ~~residential housing support~~ above those in effect on June 30, 1993, except as provided in
96.8 paragraphs (a) to (f).

96.9 (a) An agency may increase the rates for ~~group residential housing settings~~ room and
96.10 board to the MSA equivalent rate for those settings whose current rate is below the MSA
96.11 equivalent rate.

96.12 (b) An agency may increase the rates for residents in adult foster care whose difficulty
96.13 of care has increased. The total ~~group residential housing support~~ rate for these residents
96.14 must not exceed the maximum rate specified in subdivisions 1 and 1a. Agencies must not
96.15 include nor increase ~~group residential housing~~ difficulty of care rates for adults in foster
96.16 care whose difficulty of care is eligible for funding by home and community-based waiver
96.17 programs under title XIX of the Social Security Act.

96.18 (c) The room and board rates will be increased each year when the MSA equivalent rate
96.19 is adjusted for SSI cost-of-living increases by the amount of the annual SSI increase, less
96.20 the amount of the increase in the medical assistance personal needs allowance under section
96.21 256B.35.

96.22 (d) When a ~~group residential housing rate is used to pay~~ support pays for an individual's
96.23 room and board, or other costs necessary to provide room and board, the rate payable to the
96.24 residence must continue for up to 18 calendar days per incident that the person is temporarily
96.25 absent from the residence, not to exceed 60 days in a calendar year, if the absence or absences
96.26 have received the prior approval of the county agency's social service staff. Prior approval
96.27 is not required for emergency absences due to crisis, illness, or injury.

96.28 (e) For facilities meeting substantial change criteria within the prior year. Substantial
96.29 change criteria exists if the ~~group residential housing~~ establishment experiences a 25 percent
96.30 increase or decrease in the total number of its beds, if the net cost of capital additions or
96.31 improvements is in excess of 15 percent of the current market value of the residence, or if
96.32 the residence physically moves, or changes its licensure, and incurs a resulting increase in
96.33 operation and property costs.

97.1 (f) Until June 30, 1994, an agency may increase by up to five percent the total rate paid
97.2 for recipients of assistance under sections 256D.01 to 256D.21 or 256D.33 to 256D.54 who
97.3 reside in residences that are licensed by the commissioner of health as a boarding care home,
97.4 but are not certified for the purposes of the medical assistance program. However, an increase
97.5 under this clause must not exceed an amount equivalent to 65 percent of the 1991 medical
97.6 assistance reimbursement rate for nursing home resident class A, in the geographic grouping
97.7 in which the facility is located, as established under Minnesota Rules, parts 9549.0051 to
97.8 9549.0058.

97.9 Sec. 28. Minnesota Statutes 2016, section 256I.05, subdivision 1e, is amended to read:

97.10 Subd. 1e. **Supplementary rate for certain facilities.** (a) Notwithstanding the provisions
97.11 of subdivisions 1a and 1c, beginning July 1, 2005, a county agency shall negotiate a
97.12 supplementary rate in addition to the rate specified in subdivision 1, not to exceed \$700 per
97.13 month, including any legislatively authorized inflationary adjustments, for a ~~group residential~~
97.14 housing support provider that:

97.15 (1) is located in Hennepin County and has had a ~~group residential~~ housing support
97.16 contract with the county since June 1996;

97.17 (2) operates in three separate locations a 75-bed facility, a 50-bed facility, and a 26-bed
97.18 facility; and

97.19 (3) serves a chemically dependent clientele, providing 24 hours per day supervision and
97.20 limiting a resident's maximum length of stay to 13 months out of a consecutive 24-month
97.21 period.

97.22 (b) Notwithstanding subdivisions 1a and 1c, a county agency shall negotiate a
97.23 supplementary rate in addition to the rate specified in subdivision 1, not to exceed \$700 per
97.24 month, including any legislatively authorized inflationary adjustments, of a ~~group residential~~
97.25 housing support provider that:

97.26 (1) is located in St. Louis County and has had a ~~group residential~~ housing support contract
97.27 with the county since 2006;

97.28 (2) operates a 62-bed facility; and

97.29 (3) serves a chemically dependent adult male clientele, providing 24 hours per day
97.30 supervision and limiting a resident's maximum length of stay to 13 months out of a
97.31 consecutive 24-month period.

98.1 (c) Notwithstanding subdivisions 1a and 1c, beginning July 1, 2013, a county agency
98.2 shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not
98.3 to exceed \$700 per month, including any legislatively authorized inflationary adjustments,
98.4 for the ~~group residential~~ provider described under paragraphs (a) and (b), not to exceed an
98.5 additional 115 beds.

98.6 Sec. 29. Minnesota Statutes 2016, section 256I.05, subdivision 1j, is amended to read:

98.7 Subd. 1j. **Supplementary rate for certain facilities; Crow Wing County.**

98.8 Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2007, a county
98.9 agency shall negotiate a supplementary rate in addition to the rate specified in subdivision
98.10 1, not to exceed \$700 per month, including any legislatively authorized inflationary
98.11 adjustments, for a new 65-bed facility in Crow Wing County that will serve chemically
98.12 dependent persons operated by a ~~group residential~~ housing support provider that currently
98.13 operates a 304-bed facility in Minneapolis and a 44-bed facility in Duluth which opened in
98.14 January of 2006.

98.15 Sec. 30. Minnesota Statutes 2016, section 256I.05, subdivision 1m, is amended to read:

98.16 Subd. 1m. **Supplemental rate for certain facilities; Hennepin and Ramsey Counties.**

98.17 ~~(a)~~ Notwithstanding the provisions of this section, beginning July 1, 2007, a county agency
98.18 shall negotiate a supplemental service rate in addition to the rate specified in subdivision
98.19 1, not to exceed ~~\$700 per month~~ the maximum rate in subdivision 1a or the existing monthly
98.20 rate, whichever is higher, including any legislatively authorized inflationary adjustments,
98.21 for a ~~group residential~~ housing support provider that operates two ten-bed facilities, one
98.22 located in Hennepin County and one located in Ramsey County, which provide community
98.23 support and serve the mental health needs of individuals who have chronically lived
98.24 unsheltered, providing 24-hour-per-day supervision.

98.25 ~~(b) An individual who has lived in one of the facilities under paragraph (a), who is being~~
98.26 ~~transitioned to independent living as part of the program plan continues to be eligible for~~
98.27 ~~group residential housing and the supplemental service rate negotiated with the county under~~
98.28 ~~paragraph (a).~~

98.29 Sec. 31. Minnesota Statutes 2016, section 256I.05, is amended by adding a subdivision
98.30 to read:

98.31 Subd. 1p. **Supplementary rate; St. Louis County.** Notwithstanding the provisions of
98.32 subdivisions 1a and 1c, beginning July 1, 2017, a county agency shall negotiate a

99.1 supplementary rate in addition to the rate specified in subdivision 1, not to exceed \$700 per
99.2 month, including any legislatively authorized inflationary adjustments, for a housing support
99.3 provider that:

99.4 (1) is located in St. Louis County and has had a housing support contract with the county
99.5 since July 2016;

99.6 (2) operates a 35-bed facility;

99.7 (3) serves women who are chemically dependent, mentally ill, or both;

99.8 (4) provides 24-hour per day supervision;

99.9 (5) provides on-site support with skilled professionals, including a licensed practical
99.10 nurse, registered nurses, peer specialists, and resident counselors; and

99.11 (6) provides independent living skills training and assistance with family reunification.

99.12 Sec. 32. Minnesota Statutes 2016, section 256I.05, is amended by adding a subdivision
99.13 to read:

99.14 Subd. 1q. **Supplemental rate; Olmsted County.** Notwithstanding the provisions of
99.15 subdivisions 1a and 1c, beginning July 1, 2017, a county agency shall negotiate a
99.16 supplementary rate in addition to the rate specified in subdivision 1, not to exceed \$750 per
99.17 month, including any legislatively authorized inflationary adjustments, for a housing support
99.18 provider located in Olmsted County that operates long-term residential facilities with a total
99.19 of 104 beds that serve chemically dependent men and women and provide 24-hour-a-day
99.20 supervision and other support services.

99.21 Sec. 33. Minnesota Statutes 2016, section 256I.05, is amended by adding a subdivision
99.22 to read:

99.23 Subd. 1r. **Supplemental rate; Anoka County.** Notwithstanding the provisions in this
99.24 section, a county agency shall negotiate a supplemental rate for 42 beds in addition to the
99.25 rate specified in subdivision 1, not to exceed the maximum rate allowed under subdivision
99.26 1a, including any legislatively authorized inflationary adjustments, for a housing support
99.27 provider that is located in Anoka County and provides emergency housing on the former
99.28 Anoka Regional Treatment Center campus.

100.1 Sec. 34. Minnesota Statutes 2016, section 256I.05, is amended by adding a subdivision
100.2 to read:

100.3 Subd. 11. **Transfer of emergency shelter funds.** (a) The commissioner shall make a
100.4 cost-neutral transfer of funding from the housing support fund to county human service
100.5 agencies for emergency shelter beds removed from the housing support census under a
100.6 biennial plan submitted by the county and approved by the commissioner. The plan must
100.7 describe: (1) anticipated and actual outcomes for persons experiencing homelessness in
100.8 emergency shelters; (2) improved efficiencies in administration; (3) requirements for
100.9 individual eligibility; and (4) plans for quality assurance monitoring and quality assurance
100.10 outcomes. The commissioner shall review the county plan to monitor implementation and
100.11 outcomes at least biennially, and more frequently if the commissioner deems necessary.

100.12 (b) The funding under paragraph (a) may be used for the provision of room and board
100.13 or supplemental services according to section 256I.03, subdivisions 2 and 8. Providers must
100.14 meet the requirements of section 256I.04, subdivisions 2a to 2f. Funding must be allocated
100.15 annually, and the room and board portion of the allocation shall be adjusted according to
100.16 the percentage change in the housing support room and board rate. The room and board
100.17 portion of the allocation shall be determined at the time of transfer. The commissioner or
100.18 county may return beds to the housing support fund with 180 days' notice, including financial
100.19 reconciliation.

100.20 **EFFECTIVE DATE.** This section is effective July 1, 2017.

100.21 Sec. 35. Minnesota Statutes 2016, section 256I.06, subdivision 2, is amended to read:

100.22 Subd. 2. **Time of payment.** A county agency may make payments to a group residencee
100.23 in advance for an individual whose stay in the group residencee is expected to last beyond
100.24 the calendar month for which the payment is made. Group residential Housing support
100.25 payments made by a county agency on behalf of an individual who is not expected to remain
100.26 in the group residence beyond the month for which payment is made must be made
100.27 subsequent to the individual's departure from the group residence.

100.28 **EFFECTIVE DATE.** This section is effective July 1, 2017.

100.29 Sec. 36. Minnesota Statutes 2016, section 256I.06, subdivision 8, is amended to read:

100.30 Subd. 8. **Amount of group residential housing support payment.** (a) The amount of
100.31 a group residential housing room and board payment to be made on behalf of an eligible
100.32 individual is determined by subtracting the individual's countable income under section

101.1 256I.04, subdivision 1, for a whole calendar month from the ~~group residential housing~~
101.2 ~~charge room and board rate~~ for that same month. The ~~group residential housing charge~~
101.3 support payment is determined by multiplying the ~~group residential housing support rate~~
101.4 times the period of time the individual was a resident or temporarily absent under section
101.5 256I.05, subdivision 1c, paragraph (d).

101.6 (b) For an individual with earned income under paragraph (a), prospective budgeting
101.7 must be used to determine the amount of the individual's payment for the following six-month
101.8 period. An increase in income shall not affect an individual's eligibility or payment amount
101.9 until the month following the reporting month. A decrease in income shall be effective the
101.10 first day of the month after the month in which the decrease is reported.

101.11 (c) For an individual who receives licensed residential crisis stabilization services under
101.12 section 256B.0624, subdivision 7, the amount of housing support payment is determined
101.13 by multiplying the housing support rate times the period of time the individual was a resident.

101.14 **EFFECTIVE DATE.** Paragraph (c) is effective October 1, 2017.

101.15 Sec. 37. **[256I.09] COMMUNITY LIVING INFRASTRUCTURE.**

101.16 The commissioner shall award grants to agencies through an annual competitive process.
101.17 Grants awarded under this section may be used for: (1) outreach to locate and engage people
101.18 who are homeless or residing in segregated settings to screen for basic needs and assist with
101.19 referral to community living resources; (2) building capacity to provide technical assistance
101.20 and consultation on housing and related support service resources for persons with both
101.21 disabilities and low income; or (3) streamlining the administration and monitoring activities
101.22 related to housing support funds. Agencies may collaborate and submit a joint application
101.23 for funding under this section.

101.24 Sec. 38. **GROUP RESIDENTIAL HOUSING; HOUSING SUPPORT SERVICES**
101.25 **PLAN TO REVIEW SUPPLEMENTAL SERVICE RATES.**

101.26 (a) Since 1993, group residential housing supplementary service rates have been
101.27 established in statute without a standard rate setting methodology, nor information about
101.28 or an analysis of the actual cost the provider will sustain to provide the services. There are
101.29 approximately 200 providers that receive more than 65 different monthly supplemental rates
101.30 ranging from \$44 to \$5,000. Further, there are wide discrepancies between the services that
101.31 are provided for the supplemental rate payment.

102.1 (b) The commissioner of human services shall develop: (1) a plan to review all
102.2 supplemental rates over a sufficient time period, to be determined by the commissioner; (2)
102.3 a process to modify the rate if it is either inadequate or excessive; and (3) a process to review
102.4 supplemental rates prospectively, so the legislature has the foundation necessary in which
102.5 to make a decision as to whether to approve the request for a supplemental rate. The
102.6 information must be provided in a report to the senate and house of representatives
102.7 committees with jurisdiction over group residential housing issues, along with proposed
102.8 legislation to effectuate the plan and processes and a fiscal estimate by December 1, 2018.

102.9 Sec. 39. REVISOR'S INSTRUCTION.

102.10 In each section of Minnesota Statutes referred to in column A, the revisor of statutes
102.11 shall change the phrase in column B to the phrase in column C. The revisor may make
102.12 technical and other necessary changes to sentence structure to preserve the meaning of the
102.13 text. The revisor shall make other changes in chapter titles; section, subdivision, part, and
102.14 subpart headnotes; and in other terminology necessary as a result of the enactment of this
102.15 section.

102.16	<u>Column A</u>	<u>Column B</u>	<u>Column C</u>
102.17	<u>144A.071, subdivision 4d</u>	<u>group residential housing</u>	<u>housing support under chapter</u>
102.18			<u>256I</u>
102.19	<u>201.061, subdivision 3</u>	<u>group residential housing</u>	<u>setting authorized to provide</u>
102.20			<u>housing support</u>
102.21	<u>244.052, subdivision 4c</u>	<u>group residential housing</u>	<u>licensed setting authorized to</u>
102.22		<u>facility</u>	<u>provide housing support</u>
102.23			<u>under section 256I.04</u>
102.24	<u>245.466, subdivision 7</u>	<u>under group residential</u>	<u>by housing support under</u>
102.25		<u>housing</u>	<u>chapter 256I</u>
102.26	<u>245.466, subdivision 7</u>	<u>from group residential housing</u>	<u>from housing support</u>
102.27	<u>245.4661, subdivision 6</u>	<u>group residential housing</u>	<u>housing support under chapter</u>
102.28			<u>256I</u>
102.29	<u>245C.10, subdivision 11</u>	<u>group residential housing or</u>	<u>housing support</u>
102.30		<u>supplementary services</u>	
102.31	<u>256.01, subdivision 18</u>	<u>group residential housing</u>	<u>housing support under chapter</u>
102.32			<u>256I</u>
102.33	<u>256.017, subdivision 1</u>	<u>group residential housing</u>	<u>housing support</u>
102.34	<u>256.98, subdivision 8</u>	<u>group residential housing</u>	<u>housing support under chapter</u>
102.35			<u>256I</u>
102.36	<u>256B.49, subdivision 15</u>	<u>group residential housing</u>	<u>housing support under chapter</u>
102.37			<u>256I</u>
102.38	<u>256B.4914, subdivision 10</u>	<u>group residential housing rate</u>	<u>housing support rate 3 costs</u>
102.39		<u>3 costs</u>	<u>under chapter 256I</u>

103.1	<u>256B.501, subdivision 4b</u>	<u>group residential housing</u>	<u>housing support</u>
103.2	<u>256B.77, subdivision 12</u>	<u>residential services covered</u>	<u>housing support services</u>
103.3		<u>under the group residential</u>	<u>under chapter 256I</u>
103.4		<u>housing program</u>	
103.5	<u>256D.44, subdivision 2</u>	<u>group residential housing</u>	<u>setting authorized to provide</u>
103.6		<u>facility</u>	<u>housing support</u>
103.7	<u>256G.01, subdivision 3</u>	<u>group residential housing</u>	<u>housing support under chapter</u>
103.8			<u>256I</u>
103.9	<u>256I.01</u>	<u>Group Residential Housing</u>	<u>Housing Support</u>
103.10	<u>256I.02</u>	<u>Group Residential Housing</u>	<u>Housing Support</u>
103.11	<u>256I.03, subdivision 2</u>	<u>"Group residential housing"</u>	<u>"Room and board"</u>
103.12	<u>256I.03, subdivision 2</u>	<u>Group residential housing</u>	<u>The room and board</u>
103.13	<u>256I.03, subdivision 3</u>	<u>"Group residential housing"</u>	<u>"Housing support"</u>
103.14	<u>256I.03, subdivision 6</u>	<u>group residential housing</u>	<u>room and board</u>
103.15	<u>256I.03, subdivisions 7 and 9</u>	<u>group residential housing</u>	<u>housing support</u>
103.16	<u>256I.04, subdivisions 1a, 1b,</u>	<u>group residential housing</u>	<u>housing support</u>
103.17	<u>1c, and 2</u>		
103.18	<u>256I.04, subdivision 2a</u>	<u>provide group residential</u>	<u>provide housing support</u>
103.19		<u>housing</u>	
103.20	<u>256I.04, subdivision 2a</u>	<u>of group residential housing</u>	<u>of housing support</u>
103.21		<u>or supplementary services</u>	
103.22	<u>256I.04, subdivision 2a</u>	<u>complete group residential</u>	<u>complete housing support</u>
103.23		<u>housing</u>	
103.24	<u>256I.04, subdivision 2b</u>	<u>group residential housing or</u>	<u>housing support</u>
103.25		<u>supplementary services</u>	
103.26	<u>256I.04, subdivision 2b</u>	<u>provision of group residential</u>	<u>provision of housing support</u>
103.27		<u>housing</u>	
103.28	<u>256I.04, subdivision 2c</u>	<u>group residential housing or</u>	<u>housing support</u>
103.29		<u>supplementary services</u>	
103.30	<u>256I.04, subdivision 2e</u>	<u>group residential housing or</u>	<u>housing support</u>
103.31		<u>supplementary services</u>	
103.32	<u>256I.04, subdivision 4</u>	<u>group residential housing</u>	<u>room and board rate</u>
103.33		<u>payment for room and board</u>	
103.34	<u>256I.05, subdivision 1</u>	<u>living in group residential</u>	<u>receiving housing support</u>
103.35		<u>housing</u>	
103.36	<u>256I.05, subdivisions 1h, 1k,</u>	<u>group residential housing</u>	<u>housing support</u>
103.37	<u>1l, 7b, and 7c</u>		
103.38	<u>256I.05, subdivision 2</u>	<u>group residential housing</u>	<u>room and board</u>
103.39	<u>256I.05, subdivision 3</u>	<u>group residential housing</u>	<u>room and board</u>
103.40	<u>256I.05, subdivision 6</u>	<u>reside in group residential</u>	<u>receive housing support</u>
103.41		<u>housing</u>	
103.42	<u>256I.06, subdivisions 1, 3, 4,</u>	<u>group residential housing</u>	<u>housing support</u>
103.43	<u>and 6</u>		
103.44	<u>256I.06, subdivision 7</u>	<u>group residential housing</u>	<u>the housing support</u>

104.1	<u>256I.08</u>	<u>group residential housing</u>	<u>housing support</u>
104.2	<u>256P.03, subdivision 1</u>	<u>group residential housing</u>	<u>housing support</u>
104.3	<u>256P.05, subdivision 1</u>	<u>group residential housing</u>	<u>housing support</u>
104.4	<u>256P.07, subdivision 1</u>	<u>group residential housing</u>	<u>housing support</u>
104.5	<u>256P.08, subdivision 1</u>	<u>group residential housing</u>	<u>housing support</u>
104.6	<u>290A.03, subdivision 8</u>	<u>accepts group residential</u>	<u>accepts housing support</u>
104.7		<u>housing</u>	
104.8	<u>290A.03, subdivision 8</u>	<u>the group residential housing</u>	<u>the housing support program</u>
104.9		<u>program</u>	

ARTICLE 3

CONTINUING CARE

104.12 Section 1. Minnesota Statutes 2016, section 144.0724, subdivision 4, is amended to read:

104.13 Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically
104.14 submit to the commissioner of health MDS assessments that conform with the assessment
104.15 schedule defined by Code of Federal Regulations, title 42, section 483.20, and published
104.16 by the United States Department of Health and Human Services, Centers for Medicare and
104.17 Medicaid Services, in the Long Term Care Assessment Instrument User's Manual, version
104.18 3.0, and subsequent updates when issued by the Centers for Medicare and Medicaid Services.
104.19 The commissioner of health may substitute successor manuals or question and answer
104.20 documents published by the United States Department of Health and Human Services,
104.21 Centers for Medicare and Medicaid Services, to replace or supplement the current version
104.22 of the manual or document.

104.23 (b) The assessments used to determine a case mix classification for reimbursement
104.24 include the following:

104.25 (1) a new admission assessment;

104.26 (2) an annual assessment which must have an assessment reference date (ARD) within
104.27 92 days of the previous assessment and the previous comprehensive assessment;

104.28 (3) a significant change in status assessment must be completed within 14 days of the
104.29 identification of a significant change, whether improvement or decline, and regardless of
104.30 the amount of time since the last significant change in status assessment;

104.31 (4) all quarterly assessments must have an assessment reference date (ARD) within 92
104.32 days of the ARD of the previous assessment;

105.1 (5) any significant correction to a prior comprehensive assessment, if the assessment
105.2 being corrected is the current one being used for RUG classification; and

105.3 (6) any significant correction to a prior quarterly assessment, if the assessment being
105.4 corrected is the current one being used for RUG classification.

105.5 (c) In addition to the assessments listed in paragraph (b), the assessments used to
105.6 determine nursing facility level of care include the following:

105.7 (1) preadmission screening completed under section 256.975, subdivisions 7a to 7c, by
105.8 the Senior LinkAge Line or other organization under contract with the Minnesota Board on
105.9 Aging; and

105.10 (2) a nursing facility level of care determination as provided for under section 256B.0911,
105.11 subdivision 4e, as part of a face-to-face long-term care consultation assessment completed
105.12 under section 256B.0911, by a county, tribe, or managed care organization under contract
105.13 with the Department of Human Services.

105.14 Sec. 2. Minnesota Statutes 2016, section 144.0724, subdivision 6, is amended to read:

105.15 Subd. 6. **Penalties for late or nonsubmission.** (a) A facility that fails to complete or
105.16 submit an assessment according to subdivisions 4 and 5 for a RUG-IV classification within
105.17 seven days of the time requirements listed in the Long-Term Care Facility Resident
105.18 Assessment Instrument User's Manual is subject to a reduced rate for that resident. The
105.19 reduced rate shall be the lowest rate for that facility. The reduced rate is effective on the
105.20 day of admission for new admission assessments, on the ARD for significant change in
105.21 status assessments, or on the day that the assessment was due for all other assessments and
105.22 continues in effect until the first day of the month following the date of submission and
105.23 acceptance of the resident's assessment.

105.24 (b) If loss of revenue due to penalties incurred by a facility for any period of 92 days
105.25 are equal to or greater than ~~1.0~~ 0.1 percent of the total operating costs on the facility's most
105.26 recent annual statistical and cost report, a facility may apply to the commissioner of human
105.27 services for a reduction in the total penalty amount. The commissioner of human services,
105.28 in consultation with the commissioner of health, may, at the sole discretion of the
105.29 commissioner of human services, limit the penalty for residents covered by medical assistance
105.30 to ~~15~~ ten days.

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

106.1 Sec. 3. Minnesota Statutes 2016, section 144.562, subdivision 2, is amended to read:

106.2 Subd. 2. **Eligibility for license condition.** (a) A hospital is not eligible to receive a
106.3 license condition for swing beds unless (1) it either has a licensed bed capacity of less than
106.4 50 beds defined in the federal Medicare regulations, Code of Federal Regulations, title 42,
106.5 section 482.66, or it has a licensed bed capacity of 50 beds or more and has swing beds that
106.6 were approved for Medicare reimbursement before May 1, 1985, or it has a licensed bed
106.7 capacity of less than 65 beds and the available nursing homes within 50 miles have had, in
106.8 the aggregate, an average occupancy rate of 96 percent or higher in the most recent two
106.9 years as documented on the statistical reports to the Department of Health; and (2) it is
106.10 located in a rural area as defined in the federal Medicare regulations, Code of Federal
106.11 Regulations, title 42, section 482.66.

106.12 (b) Except for those critical access hospitals established under section 144.1483, clause
106.13 (9), and section 1820 of the federal Social Security Act, United States Code, title 42, section
106.14 1395i-4, that have an attached nursing home or that owned a nursing home located in the
106.15 same municipality as of May 1, 2005, eligible hospitals are allowed a total of 2,000 days
106.16 of swing bed use per year. Critical access hospitals that have an attached nursing home or
106.17 that owned a nursing home located in the same municipality as of May 1, 2005, are allowed
106.18 swing bed use as provided in federal law.

106.19 (c) Except for critical access hospitals that have an attached nursing home or that owned
106.20 a nursing home located in the same municipality as of May 1, 2005, the commissioner of
106.21 health may approve swing bed use beyond 2,000 days as long as there are no Medicare
106.22 certified skilled nursing facility beds available within 25 miles of that hospital that are
106.23 willing to admit the patient and the patient agrees to the referral being sent to the skilled
106.24 nursing facility. Critical access hospitals exceeding 2,000 swing bed days must maintain
106.25 documentation that they have contacted skilled nursing facilities within 25 miles to determine
106.26 if any skilled nursing facility beds are available that are willing to admit the patient and the
106.27 patient agrees to the referral being sent to the skilled nursing facility.

106.28 (d) After reaching 2,000 days of swing bed use in a year, an eligible hospital to which
106.29 this limit applies may admit six additional patients to swing beds each year without seeking
106.30 approval from the commissioner or being in violation of this subdivision. These six swing
106.31 bed admissions are exempt from the limit of 2,000 annual swing bed days for hospitals
106.32 subject to this limit.

107.1 (e) A health care system that is in full compliance with this subdivision may allocate its
107.2 total limit of swing bed days among the hospitals within the system, provided that no hospital
107.3 in the system without an attached nursing home may exceed 2,000 swing bed days per year.

107.4 Sec. 4. Minnesota Statutes 2016, section 144A.071, subdivision 4d, as amended by Laws
107.5 2017, chapter 40, article 1, section 25, is amended to read:

107.6 Subd. 4d. **Consolidation of nursing facilities.** (a) The commissioner of health, in
107.7 consultation with the commissioner of human services, may approve a request for
107.8 consolidation of nursing facilities which includes the closure of one or more facilities and
107.9 the upgrading of the physical plant of the remaining nursing facility or facilities, the costs
107.10 of which exceed the threshold project limit under subdivision 2, clause (a). The
107.11 commissioners shall consider the criteria in this section, section 144A.073, and section
107.12 256R.40, in approving or rejecting a consolidation proposal. In the event the commissioners
107.13 approve the request, the commissioner of human services shall calculate an external fixed
107.14 costs rate adjustment according to clauses (1) to (3):

107.15 (1) the closure of beds shall not be eligible for a planned closure rate adjustment under
107.16 section 256R.40, subdivision 5;

107.17 (2) the construction project permitted in this clause shall not be eligible for a threshold
107.18 project rate adjustment under section 256B.434, subdivision 4f, or a moratorium exception
107.19 adjustment under section 144A.073; and

107.20 (3) the payment rate for external fixed costs for a remaining facility or facilities shall
107.21 be increased by an amount equal to 65 percent of the projected net cost savings to the state
107.22 calculated in paragraph (b), divided by the state's medical assistance percentage of medical
107.23 assistance dollars, and then divided by estimated medical assistance resident days, as
107.24 determined in paragraph (c), of the remaining nursing facility or facilities in the request in
107.25 this paragraph. The rate adjustment is effective on the ~~later of the first day of the month~~
107.26 following first day of the month of January or July, whichever date occurs first following
107.27 both the completion of the construction upgrades in the consolidation plan or the first day
107.28 of the month following and the complete closure of a facility closure of the facility or
107.29 facilities designated for closure in the consolidation plan. If more than one facility is receiving
107.30 upgrades in the consolidation plan, each facility's date of construction completion must be
107.31 evaluated separately.

107.32 (b) For purposes of calculating the net cost savings to the state, the commissioner shall
107.33 consider clauses (1) to (7):

108.1 (1) the annual savings from estimated medical assistance payments from the net number
108.2 of beds closed taking into consideration only beds that are in active service on the date of
108.3 the request and that have been in active service for at least three years;

108.4 (2) the estimated annual cost of increased case load of individuals receiving services
108.5 under the elderly waiver;

108.6 (3) the estimated annual cost of elderly waiver recipients receiving support under group
108.7 residential housing;

108.8 (4) the estimated annual cost of increased case load of individuals receiving services
108.9 under the alternative care program;

108.10 (5) the annual loss of license surcharge payments on closed beds;

108.11 (6) the savings from not paying planned closure rate adjustments that the facilities would
108.12 otherwise be eligible for under section 256R.40; and

108.13 (7) the savings from not paying external fixed costs payment rate adjustments from
108.14 submission of renovation costs that would otherwise be eligible as threshold projects under
108.15 section 256B.434, subdivision 4f.

108.16 (c) For purposes of the calculation in paragraph (a), clause (3), the estimated medical
108.17 assistance resident days of the remaining facility or facilities shall be computed assuming
108.18 95 percent occupancy multiplied by the historical percentage of medical assistance resident
108.19 days of the remaining facility or facilities, as reported on the facility's or facilities' most
108.20 recent nursing facility statistical and cost report filed before the plan of closure is submitted,
108.21 multiplied by 365.

108.22 (d) For purposes of net cost of savings to the state in paragraph (b), the average occupancy
108.23 percentages will be those reported on the facility's or facilities' most recent nursing facility
108.24 statistical and cost report filed before the plan of closure is submitted, and the average
108.25 payment rates shall be calculated based on the approved payment rates in effect at the time
108.26 the consolidation request is submitted.

108.27 (e) To qualify for the external fixed costs payment rate adjustment under this subdivision,
108.28 the closing facilities shall:

108.29 (1) submit an application for closure according to section 256R.40, subdivision 2; and

108.30 (2) follow the resident relocation provisions of section 144A.161.

108.31 (f) The county or counties in which a facility or facilities are closed under this subdivision
108.32 shall not be eligible for designation as a hardship area under subdivision 3 for five years

109.1 from the date of the approval of the proposed consolidation. The applicant shall notify the
109.2 county of this limitation and the county shall acknowledge this in a letter of support.

109.3 **EFFECTIVE DATE.** This section is effective for consolidations occurring after July
109.4 1, 2017.

109.5 Sec. 5. Minnesota Statutes 2016, section 144A.74, is amended to read:

109.6 **144A.74 MAXIMUM CHARGES.**

109.7 A supplemental nursing services agency must not bill or receive payments from a nursing
109.8 home licensed under this chapter at a rate higher than 150 percent of the sum of the weighted
109.9 average wage rate, plus a factor determined by the commissioner to incorporate payroll
109.10 taxes as defined in ~~Minnesota Rules, part 9549.0020, subpart 33~~ section 256R.02, subdivision
109.11 37, for the applicable employee classification for the geographic group ~~to which the nursing~~
109.12 ~~home is assigned under Minnesota Rules, part 9549.0052~~ specified in section 256R.23,
109.13 subdivision 4. The weighted average wage rates must be determined by the commissioner
109.14 of human services and reported to the commissioner of health on an annual basis. Wages
109.15 are defined as hourly rate of pay and shift differential, including weekend shift differential
109.16 and overtime. Facilities shall provide information necessary to determine weighted average
109.17 wage rates to the commissioner of human services in a format requested by the commissioner.
109.18 The maximum rate must include all charges for administrative fees, contract fees, or other
109.19 special charges in addition to the hourly rates for the temporary nursing pool personnel
109.20 supplied to a nursing home. A nursing home that pays for the actual travel and housing costs
109.21 for supplemental nursing services agency staff working at the facility and that pays these
109.22 costs to the employee, the agency, or another vendor, is not violating the limitation on
109.23 charges described in this section.

109.24 **EFFECTIVE DATE.** This section is effective January 1, 2018.

109.25 Sec. 6. Minnesota Statutes 2016, section 256.975, subdivision 7, is amended to read:

109.26 **Subd. 7. Consumer information and assistance and long-term care options**
109.27 **counseling; Senior LinkAge Line.** (a) The Minnesota Board on Aging shall operate a
109.28 statewide service to aid older Minnesotans and their families in making informed choices
109.29 about long-term care options and health care benefits. Language services to persons with
109.30 limited English language skills may be made available. The service, known as Senior
109.31 LinkAge Line, shall serve older adults as the designated Aging and Disability Resource
109.32 Center under United States Code, title 42, section 3001, the Older Americans Act
109.33 Amendments of 2006 in partnership with the Disability Linkage Line under section 256.01,

110.1 subdivision 24, and must be available during business hours through a statewide toll-free
110.2 number and the Internet. The Minnesota Board on Aging shall consult with, and when
110.3 appropriate work through, the area agencies on aging counties, and other entities that serve
110.4 aging and disabled populations of all ages, to provide and maintain the telephone
110.5 infrastructure and related support for the Aging and Disability Resource Center partners
110.6 which agree by memorandum to access the infrastructure, including the designated providers
110.7 of the Senior LinkAge Line and the Disability Linkage Line.

110.8 (b) The service must provide long-term care options counseling by assisting older adults,
110.9 caregivers, and providers in accessing information and options counseling about choices in
110.10 long-term care services that are purchased through private providers or available through
110.11 public options. The service must:

110.12 (1) develop and provide for regular updating of a comprehensive database that includes
110.13 detailed listings in both consumer- and provider-oriented formats that can provide search
110.14 results down to the neighborhood level;

110.15 (2) make the database accessible on the Internet and through other telecommunication
110.16 and media-related tools;

110.17 (3) link callers to interactive long-term care screening tools and make these tools available
110.18 through the Internet by integrating the tools with the database;

110.19 (4) develop community education materials with a focus on planning for long-term care
110.20 and evaluating independent living, housing, and service options;

110.21 (5) conduct an outreach campaign to assist older adults and their caregivers in finding
110.22 information on the Internet and through other means of communication;

110.23 (6) implement a messaging system for overflow callers and respond to these callers by
110.24 the next business day;

110.25 (7) link callers with county human services and other providers to receive more in-depth
110.26 assistance and consultation related to long-term care options;

110.27 (8) link callers with quality profiles for nursing facilities and other home and
110.28 community-based services providers developed by the commissioners of health and human
110.29 services;

110.30 (9) develop an outreach plan to seniors and their caregivers with a particular focus on
110.31 establishing a clear presence in places that seniors recognize and:

111.1 (i) place a significant emphasis on improved outreach and service to seniors and their
111.2 caregivers by establishing annual plans by neighborhood, city, and county, as necessary, to
111.3 address the unique needs of geographic areas in the state where there are dense populations
111.4 of seniors;

111.5 (ii) establish an efficient workforce management approach and assign community living
111.6 specialist staff and volunteers to geographic areas as well as aging and disability resource
111.7 center sites so that seniors and their caregivers and professionals recognize the Senior
111.8 LinkAge Line as the place to call for aging services and information;

111.9 (iii) recognize the size and complexity of the metropolitan area service system by working
111.10 with metropolitan counties to establish a clear partnership with them, including seeking
111.11 county advice on the establishment of local aging and disabilities resource center sites; and

111.12 (iv) maintain dashboards with metrics that demonstrate how the service is expanding
111.13 and extending or enhancing its outreach efforts in dispersed or hard to reach locations in
111.14 varied population centers;

111.15 (10) incorporate information about the availability of housing options, as well as
111.16 registered housing with services and consumer rights within the MinnesotaHelp.info network
111.17 long-term care database to facilitate consumer comparison of services and costs among
111.18 housing with services establishments and with other in-home services and to support financial
111.19 self-sufficiency as long as possible. Housing with services establishments and their arranged
111.20 home care providers shall provide information that will facilitate price comparisons, including
111.21 delineation of charges for rent and for services available. The commissioners of health and
111.22 human services shall align the data elements required by section 144G.06, the Uniform
111.23 Consumer Information Guide, and this section to provide consumers standardized information
111.24 and ease of comparison of long-term care options. The commissioner of human services
111.25 shall provide the data to the Minnesota Board on Aging for inclusion in the
111.26 MinnesotaHelp.info network long-term care database;

111.27 (11) provide long-term care options counseling. Long-term care options counselors shall:

111.28 (i) for individuals not eligible for case management under a public program or public
111.29 funding source, provide interactive decision support under which consumers, family
111.30 members, or other helpers are supported in their deliberations to determine appropriate
111.31 long-term care choices in the context of the consumer's needs, preferences, values, and
111.32 individual circumstances, including implementing a community support plan;

- 112.1 (ii) provide Web-based educational information and collateral written materials to
112.2 familiarize consumers, family members, or other helpers with the long-term care basics,
112.3 issues to be considered, and the range of options available in the community;
- 112.4 (iii) provide long-term care futures planning, which means providing assistance to
112.5 individuals who anticipate having long-term care needs to develop a plan for the more
112.6 distant future; and
- 112.7 (iv) provide expertise in benefits and financing options for long-term care, including
112.8 Medicare, long-term care insurance, tax or employer-based incentives, reverse mortgages,
112.9 private pay options, and ways to access low or no-cost services or benefits through
112.10 volunteer-based or charitable programs;
- 112.11 (12) using risk management and support planning protocols, provide long-term care
112.12 options counseling under clause (13) to current residents of nursing homes deemed
112.13 appropriate for discharge by the commissioner, ~~former residents of nursing homes who~~
112.14 ~~were discharged to community settings, and older adults who request service after~~
112.15 ~~consultation with the Senior LinkAge Line under clause (13). The Senior LinkAge Line~~
112.16 ~~shall also receive referrals from the residents or staff of nursing homes who meet a profile~~
112.17 that demonstrates that the consumer is either at risk of readmission to a nursing home or
112.18 hospital, or would benefit from long-term care options counseling to age in place. The Senior
112.19 LinkAge Line shall identify and contact residents or patients deemed appropriate ~~for~~
112.20 ~~discharge by developing targeting criteria and creating a profile in consultation with the~~
112.21 ~~commissioner who.~~ The commissioner shall provide designated Senior LinkAge Line contact
112.22 centers with a list of current or former nursing home residents or people discharged from a
112.23 hospital or for whom Medicare home care has ended, that meet the criteria as being
112.24 appropriate for discharge planning long-term care options counseling through a referral via
112.25 a secure Web portal. Senior LinkAge Line shall provide these residents, if they indicate a
112.26 preference to receive long-term care options counseling, with initial assessment and, if
112.27 appropriate, a referral to:
- 112.28 (i) long-term care consultation services under section 256B.0911;
- 112.29 (ii) designated care coordinators of contracted entities under section 256B.035 for persons
112.30 who are enrolled in a managed care plan; or
- 112.31 (iii) the long-term care consultation team for those who are eligible for relocation service
112.32 coordination due to high-risk factors or psychological or physical disability; and
- 112.33 (13) develop referral protocols and processes that will assist certified health care homes,
112.34 Medicare home care, and hospitals to identify at-risk older adults and determine when to

113.1 refer these individuals to the Senior LinkAge Line for long-term care options counseling
113.2 under this section. The commissioner is directed to work with the commissioner of health
113.3 to develop protocols that would comply with the health care home designation criteria and
113.4 protocols available at the time of hospital discharge or the end of Medicare home care. The
113.5 commissioner shall keep a record of the number of people who choose long-term care
113.6 options counseling as a result of this section.

113.7 (c) Nursing homes shall provide contact information to the Senior LinkAge Line for
113.8 residents identified in paragraph (b), clause (12), to provide long-term care options counseling
113.9 pursuant to paragraph (b), clause (11). The contact information for residents shall include
113.10 all information reasonably necessary to contact residents, including first and last names,
113.11 permanent and temporary addresses, telephone numbers, and e-mail addresses.

113.12 (d) The Senior LinkAge Line shall determine when it is appropriate to refer a consumer
113.13 who receives long-term care options counseling under paragraph (b), clause (12) or (13),
113.14 and who uses an unpaid caregiver to the self-directed caregiver service under subdivision
113.15 12.

113.16 **EFFECTIVE DATE.** This section is effective July 1, 2017.

113.17 Sec. 7. Minnesota Statutes 2016, section 256.975, is amended by adding a subdivision to
113.18 read:

113.19 Subd. 12. **Self-directed caregiver grants.** Beginning on July 1, 2019, the Minnesota
113.20 Board on Aging shall administer self-directed caregiver grants to support at risk family
113.21 caregivers of older adults or others eligible under the Older Americans Act of 1965, United
113.22 States Code, title 42, chapter 35, sections 3001 to 3058ff, to sustain family caregivers in
113.23 the caregivers' roles so older adults can remain at home longer. The board shall give priority
113.24 to consumers referred under section 256.975, subdivision 7, paragraph (d).

113.25 **EFFECTIVE DATE.** This section is effective July 1, 2017.

113.26 Sec. 8. Minnesota Statutes 2016, section 256B.0911, subdivision 3a, is amended to read:

113.27 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment, services
113.28 planning, or other assistance intended to support community-based living, including persons
113.29 who need assessment in order to determine waiver or alternative care program eligibility,
113.30 must be visited by a long-term care consultation team within 20 calendar days after the date
113.31 on which an assessment was requested or recommended. Upon statewide implementation
113.32 of subdivisions 2b, 2c, and 5, this requirement also applies to an assessment of a person

114.1 requesting personal care assistance services and home care nursing. The commissioner shall
114.2 provide at least a 90-day notice to lead agencies prior to the effective date of this requirement.
114.3 Face-to-face assessments must be conducted according to paragraphs (b) to (i).

114.4 (b) Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified
114.5 assessors to conduct the assessment. For a person with complex health care needs, a public
114.6 health or registered nurse from the team must be consulted.

114.7 (c) The MnCHOICES assessment provided by the commissioner to lead agencies must
114.8 be used to complete a comprehensive, person-centered assessment. The assessment must
114.9 include the health, psychological, functional, environmental, and social needs of the
114.10 individual necessary to develop a community support plan that meets the individual's needs
114.11 and preferences.

114.12 (d) The assessment must be conducted in a face-to-face interview with the person being
114.13 assessed and the person's legal representative. At the request of the person, other individuals
114.14 may participate in the assessment to provide information on the needs, strengths, and
114.15 preferences of the person necessary to develop a community support plan that ensures the
114.16 person's health and safety. Except for legal representatives or family members invited by
114.17 the person, persons participating in the assessment may not be a provider of service or have
114.18 any financial interest in the provision of services. For persons who are to be assessed for
114.19 elderly waiver customized living or adult day services under section 256B.0915, with the
114.20 permission of the person being assessed or the person's designated or legal representative,
114.21 the client's current or proposed provider of services may submit a copy of the provider's
114.22 nursing assessment or written report outlining its recommendations regarding the client's
114.23 care needs. The person conducting the assessment must notify the provider of the date by
114.24 which this information is to be submitted. This information shall be provided to the person
114.25 conducting the assessment prior to the assessment. For a person who is to be assessed for
114.26 waiver services under section 256B.092 or 256B.49, with the permission of the person being
114.27 assessed or the person's designated legal representative, the person's current provider of
114.28 services may submit a written report outlining recommendations regarding the person's care
114.29 needs prepared by a direct service employee with at least 20 hours of service to that client.
114.30 The person conducting the assessment or reassessment must notify the provider of the date
114.31 by which this information is to be submitted. This information shall be provided to the
114.32 person conducting the assessment and the person or the person's legal representative, and
114.33 must be considered prior to the finalization of the assessment or reassessment.

115.1 (e) The person or the person's legal representative must be provided with a written
115.2 community support plan within 40 calendar days of the assessment visit, regardless of
115.3 whether the individual is eligible for Minnesota health care programs.

115.4 (f) For a person being assessed for elderly waiver services under section 256B.0915, a
115.5 provider who submitted information under paragraph (d) shall receive the final written
115.6 community support plan when available and the Residential Services Workbook.

115.7 (g) The written community support plan must include:

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

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

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

115.13 (4) referral information; and

115.14 (5) informal caregiver supports, if applicable.

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

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

115.23 ~~(g)~~ (i) The person has the right to make the final decision between institutional placement
115.24 and community placement after the recommendations have been provided, except as provided
115.25 in section 256.975, subdivision 7a, paragraph (d).

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

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

115.31 (2) documentation that the most cost-effective alternatives available were offered to the
115.32 individual. For purposes of this clause, "cost-effective" means community services and

116.1 living arrangements that cost the same as or less than institutional care. For an individual
116.2 found to meet eligibility criteria for home and community-based service programs under
116.3 section 256B.0915 or 256B.49, "cost-effectiveness" has the meaning found in the federally
116.4 approved waiver plan for each program;

116.5 (3) the need for and purpose of preadmission screening conducted by long-term care
116.6 options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects
116.7 nursing facility placement. If the individual selects nursing facility placement, the lead
116.8 agency shall forward information needed to complete the level of care determinations and
116.9 screening for developmental disability and mental illness collected during the assessment
116.10 to the long-term care options counselor using forms provided by the commissioner;

116.11 (4) the role of long-term care consultation assessment and support planning in eligibility
116.12 determination for waiver and alternative care programs, and state plan home care, case
116.13 management, and other services as defined in subdivision 1a, paragraphs (a), clause (6),
116.14 and (b);

116.15 (5) information about Minnesota health care programs;

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

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

116.19 (8) the certified assessor's decision regarding the person's need for institutional level of
116.20 care as determined under criteria established in subdivision 4e and the certified assessor's
116.21 decision regarding eligibility for all services and programs as defined in subdivision 1a,
116.22 paragraphs (a), clause (6), and (b); and

116.23 (9) the person's right to appeal the certified assessor's decision regarding eligibility for
116.24 all services and programs as defined in subdivision 1a, paragraphs (a), clauses (6), (7), and
116.25 (8), and (b), and incorporating the decision regarding the need for institutional level of care
116.26 or the lead agency's final decisions regarding public programs eligibility according to section
116.27 256.045, subdivision 3.

116.28 (i) (k) Face-to-face assessment completed as part of eligibility determination for the
116.29 alternative care, elderly waiver, community access for disability inclusion, community
116.30 alternative care, and brain injury waiver programs under sections 256B.0913, 256B.0915,
116.31 and 256B.49 is valid to establish service eligibility for no more than 60 calendar days after
116.32 the date of assessment.

117.1 (i) (l) The effective eligibility start date for programs in paragraph (i)(k) can never be
117.2 prior to the date of assessment. If an assessment was completed more than 60 days before
117.3 the effective waiver or alternative care program eligibility start date, assessment and support
117.4 plan information must be updated and documented in the department's Medicaid Management
117.5 Information System (MMIS). Notwithstanding retroactive medical assistance coverage of
117.6 state plan services, the effective date of eligibility for programs included in paragraph (i)
117.7 (k) cannot be prior to the date the most recent updated assessment is completed.

117.8 (m) If an eligibility update is completed within 90 days of the previous face-to-face
117.9 assessment and documented in the department's Medicaid Management Information System
117.10 (MMIS), the effective date of eligibility for programs included in paragraph (k) is the date
117.11 of the previous face-to-face assessment when all other eligibility requirements are met.

117.12 Sec. 9. Minnesota Statutes 2016, section 256B.0915, subdivision 3a, is amended to read:

117.13 Subd. 3a. **Elderly waiver cost limits.** (a) Effective on the first day of the state fiscal
117.14 year in which the resident assessment system as described in section ~~256B.438~~ 256R.17 for
117.15 nursing home rate determination is implemented and the first day of each subsequent state
117.16 fiscal year, the monthly limit for the cost of waived services to an individual elderly waiver
117.17 client shall be the monthly limit of the case mix resident class to which the waiver client
117.18 would be assigned under Minnesota Rules, parts 9549.0051 to 9549.0059, in effect on the
117.19 last day of the previous state fiscal year, adjusted by any legislatively adopted home and
117.20 community-based services percentage rate adjustment. If a legislatively authorized increase
117.21 is service-specific, the monthly cost limit shall be adjusted based on the overall average
117.22 increase to the elderly waiver program.

117.23 (b) The monthly limit for the cost of waived services under paragraph (a) to an
117.24 individual elderly waiver client assigned to a case mix classification A with:

117.25 (1) no dependencies in activities of daily living; or

117.26 (2) up to two dependencies in bathing, dressing, grooming, walking, and eating when
117.27 the dependency score in eating is three or greater as determined by an assessment performed
117.28 under section 256B.0911 shall be \$1,750 per month effective on July 1, 2011, for all new
117.29 participants enrolled in the program on or after July 1, 2011. This monthly limit shall be
117.30 applied to all other participants who meet this criteria at reassessment. This monthly limit
117.31 shall be increased annually as described in paragraphs (a) and (e).

117.32 (c) If extended medical supplies and equipment or environmental modifications are or
117.33 will be purchased for an elderly waiver client, the costs may be prorated for up to 12

consecutive months beginning with the month of purchase. If the monthly cost of a recipient's waived services exceeds the monthly limit established in paragraph (a), (b), (d), or (e), the annual cost of all waived services shall be determined. In this event, the annual cost of all waived services shall not exceed 12 times the monthly limit of waived services as described in paragraph (a), (b), (d), or (e).

(d) Effective July 1, 2013, the monthly cost limit of waiver services, including any necessary home care services described in section 256B.0651, subdivision 2, for individuals who meet the criteria as ventilator-dependent given in section 256B.0651, subdivision 1, paragraph (g), shall be the average of the monthly medical assistance amount established for home care services as described in section 256B.0652, subdivision 7, and the annual average contracted amount established by the commissioner for nursing facility services for ventilator-dependent individuals. This monthly limit shall be increased annually as described in paragraphs (a) and (e).

(e) Effective ~~July 1, 2016~~ January 1, 2018, and each ~~July~~ January 1 thereafter, the monthly cost limits for elderly waiver services in effect on the previous ~~June 30~~ December 31 shall be increased by the difference between any legislatively adopted home and community-based provider rate increases effective on ~~July~~ January 1 or since the previous ~~July~~ January 1 and the average statewide percentage increase in nursing facility operating payment rates under ~~sections 256B.431, 256B.434, and 256B.441~~ chapter 256R, effective the previous January 1. This paragraph shall only apply if the average statewide percentage increase in nursing facility operating payment rates is greater than any legislatively adopted home and community-based provider rate increases effective on ~~July~~ January 1, or occurring since the previous ~~July~~ January 1.

Sec. 10. Minnesota Statutes 2016, section 256B.0915, subdivision 3e, is amended to read:

Subd. 3e. **Customized living service rate.** (a) Payment for customized living services shall be a monthly rate authorized by the lead agency within the parameters established by the commissioner. The payment agreement must delineate the amount of each component service included in the recipient's customized living service plan. The lead agency, with input from the provider of customized living services, shall ensure that there is a documented need within the parameters established by the commissioner for all component customized living services authorized.

(b) The payment rate must be based on the amount of component services to be provided utilizing component rates established by the commissioner. Counties and tribes shall use

119.1 tools issued by the commissioner to develop and document customized living service plans
119.2 and rates.

119.3 (c) Component service rates must not exceed payment rates for comparable elderly
119.4 waiver or medical assistance services and must reflect economies of scale. Customized
119.5 living services must not include rent or raw food costs.

119.6 (d) With the exception of individuals described in subdivision 3a, paragraph (b), the
119.7 individualized monthly authorized payment for the customized living service plan shall not
119.8 exceed 50 percent of the ~~greater of either the statewide or any of the geographic groups'~~
119.9 weighted average monthly nursing facility rate of the case mix resident class to which the
119.10 elderly waiver eligible client would be assigned under Minnesota Rules, parts 9549.0051
119.11 to 9549.0059, less the maintenance needs allowance as described in subdivision 1d, paragraph
119.12 (a). ~~Effective On July 1 of the state fiscal each year in which the resident assessment system~~
119.13 ~~as described in section 256B.438 for nursing home rate determination is implemented and~~
119.14 ~~July 1 of each subsequent state fiscal year,~~ the individualized monthly authorized payment
119.15 for the services described in this clause shall not exceed the limit which was in effect on
119.16 June 30 of the previous state fiscal year updated annually based on legislatively adopted
119.17 changes to all service rate maximums for home and community-based service providers.

119.18 (e) ~~Effective July 1, 2011,~~ The individualized monthly payment for the customized living
119.19 service plan for individuals described in subdivision 3a, paragraph (b), must be the monthly
119.20 authorized payment limit for customized living for individuals classified as case mix A,
119.21 reduced by 25 percent. This rate limit must be applied to all new participants enrolled in
119.22 the program on or after July 1, 2011, who meet the criteria described in subdivision 3a,
119.23 paragraph (b). This monthly limit also applies to all other participants who meet the criteria
119.24 described in subdivision 3a, paragraph (b), at reassessment.

119.25 (f) Customized living services are delivered by a provider licensed by the Department
119.26 of Health as a class A or class F home care provider and provided in a building that is
119.27 registered as a housing with services establishment under chapter 144D. Licensed home
119.28 care providers are subject to section 256B.0651, subdivision 14.

119.29 (g) A provider may not bill or otherwise charge an elderly waiver participant or their
119.30 family for additional units of any allowable component service beyond those available under
119.31 the service rate limits described in paragraph ~~(d)~~ (e), nor for additional units of any allowable
119.32 component service beyond those approved in the service plan by the lead agency.

119.33 (h) ~~Effective July 1, 2016~~ January 1, 2018, and each ~~July~~ January 1 thereafter,
119.34 individualized service rate limits for customized living services under this subdivision shall

120.1 be increased by the difference between any legislatively adopted home and community-based
120.2 provider rate increases effective on ~~July~~ January 1 or since the previous ~~July~~ January 1 and
120.3 the average statewide percentage increase in nursing facility operating payment rates under
120.4 sections ~~256B.431, 256B.434, and 256B.441~~ chapter 256R, effective the previous January
120.5 1. This paragraph shall only apply if the average statewide percentage increase in nursing
120.6 facility operating payment rates is greater than any legislatively adopted home and
120.7 community-based provider rate increases effective on ~~July~~ January 1, or occurring since
120.8 the previous ~~July~~ January 1.

120.9 **EFFECTIVE DATE.** This section prevails over any conflicting amendment regardless
120.10 of the order of enactment.

120.11 Sec. 11. Minnesota Statutes 2016, section 256B.0915, subdivision 3h, is amended to read:

120.12 Subd. 3h. **Service rate limits; 24-hour customized living services.** (a) The payment
120.13 rate for 24-hour customized living services is a monthly rate authorized by the lead agency
120.14 within the parameters established by the commissioner of human services. The payment
120.15 agreement must delineate the amount of each component service included in each recipient's
120.16 customized living service plan. The lead agency, with input from the provider of customized
120.17 living services, shall ensure that there is a documented need within the parameters established
120.18 by the commissioner for all component customized living services authorized. The lead
120.19 agency shall not authorize 24-hour customized living services unless there is a documented
120.20 need for 24-hour supervision.

120.21 (b) For purposes of this section, "24-hour supervision" means that the recipient requires
120.22 assistance due to needs related to one or more of the following:

120.23 (1) intermittent assistance with toileting, positioning, or transferring;

120.24 (2) cognitive or behavioral issues;

120.25 (3) a medical condition that requires clinical monitoring; or

120.26 (4) for all new participants enrolled in the program on or after July 1, 2011, and all other
120.27 participants at their first reassessment after July 1, 2011, dependency in at least three of the
120.28 following activities of daily living as determined by assessment under section 256B.0911:
120.29 bathing; dressing; grooming; walking; or eating when the dependency score in eating is
120.30 three or greater; and needs medication management and at least 50 hours of service per
120.31 month. The lead agency shall ensure that the frequency and mode of supervision of the
120.32 recipient and the qualifications of staff providing supervision are described and meet the
120.33 needs of the recipient.

121.1 (c) The payment rate for 24-hour customized living services must be based on the amount
121.2 of component services to be provided utilizing component rates established by the
121.3 commissioner. Counties and tribes will use tools issued by the commissioner to develop
121.4 and document customized living plans and authorize rates.

121.5 (d) Component service rates must not exceed payment rates for comparable elderly
121.6 waiver or medical assistance services and must reflect economies of scale.

121.7 (e) The individually authorized 24-hour customized living payments, in combination
121.8 with the payment for other elderly waiver services, including case management, must not
121.9 exceed the recipient's community budget cap specified in subdivision 3a. Customized living
121.10 services must not include rent or raw food costs.

121.11 (f) The individually authorized 24-hour customized living payment rates shall not exceed
121.12 the 95 percentile of statewide monthly authorizations for 24-hour customized living services
121.13 in effect and in the Medicaid management information systems on March 31, 2009, for each
121.14 case mix resident class under Minnesota Rules, parts 9549.0051 to 9549.0059, to which
121.15 elderly waiver service clients are assigned. When there are fewer than 50 authorizations in
121.16 effect in the case mix resident class, the commissioner shall multiply the calculated service
121.17 payment rate maximum for the A classification by the standard weight for that classification
121.18 under Minnesota Rules, parts 9549.0051 to 9549.0059, to determine the applicable payment
121.19 rate maximum. Service payment rate maximums shall be updated annually based on
121.20 legislatively adopted changes to all service rates for home and community-based service
121.21 providers.

121.22 (g) Notwithstanding the requirements of paragraphs (d) and (f), the commissioner may
121.23 establish alternative payment rate systems for 24-hour customized living services in housing
121.24 with services establishments which are freestanding buildings with a capacity of 16 or fewer,
121.25 by applying a single hourly rate for covered component services provided in either:

121.26 (1) licensed corporate adult foster homes; or

121.27 (2) specialized dementia care units which meet the requirements of section 144D.065
121.28 and in which:

121.29 (i) each resident is offered the option of having their own apartment; or

121.30 (ii) the units are licensed as board and lodge establishments with maximum capacity of
121.31 eight residents, and which meet the requirements of Minnesota Rules, part 9555.6205,
121.32 subparts 1, 2, 3, and 4, item A.

122.1 (h) Twenty-four-hour customized living services are delivered by a provider licensed
122.2 by the Department of Health as a class A or class F home care provider and provided in a
122.3 building that is registered as a housing with services establishment under chapter 144D.
122.4 Licensed home care providers are subject to section 256B.0651, subdivision 14.

122.5 (i) A provider may not bill or otherwise charge an elderly waiver participant or their
122.6 family for additional units of any allowable component service beyond those available under
122.7 the service rate limits described in paragraph (e), nor for additional units of any allowable
122.8 component service beyond those approved in the service plan by the lead agency.

122.9 (j) Effective ~~July 1, 2016~~ January 1, 2018, and each ~~July~~ January 1 thereafter,
122.10 individualized service rate limits for 24-hour customized living services under this
122.11 subdivision shall be increased by the difference between any legislatively adopted home
122.12 and community-based provider rate increases effective on ~~July~~ January 1 or since the previous
122.13 ~~July~~ January 1 and the average statewide percentage increase in nursing facility operating
122.14 payment rates under ~~sections 256B.431, 256B.434, and 256B.441~~ chapter 256R, effective
122.15 the previous January 1. This paragraph shall only apply if the average statewide percentage
122.16 increase in nursing facility operating payment rates is greater than any legislatively adopted
122.17 home and community-based provider rate increases effective on ~~July~~ January 1, or occurring
122.18 since the previous ~~July~~ January 1.

122.19 Sec. 12. Minnesota Statutes 2016, section 256B.0915, subdivision 5, is amended to read:

122.20 Subd. 5. **Assessments and reassessments for waiver clients.** (a) Each client shall
122.21 receive an initial assessment of strengths, informal supports, and need for services in
122.22 accordance with section 256B.0911, subdivisions 3, 3a, and 3b. A reassessment of a client
122.23 served under the elderly waiver must be conducted at least every 12 months ~~and at other~~
122.24 ~~times when the case manager determines that there has been significant change in the client's~~
122.25 ~~functioning. This may include instances where the client is discharged from the hospital.~~
122.26 There must be a determination that the client requires nursing facility level of care as defined
122.27 in section 256B.0911, subdivision 4e, at initial and subsequent assessments to initiate and
122.28 maintain participation in the waiver program.

122.29 (b) Regardless of other assessments identified in section 144.0724, subdivision 4, as
122.30 appropriate to determine nursing facility level of care for purposes of medical assistance
122.31 payment for nursing facility services, only face-to-face assessments conducted according
122.32 to section 256B.0911, subdivisions 3a and 3b, that result in a nursing facility level of care
122.33 determination will be accepted for purposes of initial and ongoing access to waiver service
122.34 payment.

123.1 (c) The lead agency shall conduct a change-in-condition reassessment before the annual
123.2 reassessment in cases where a client's condition changed due to a major health event, an
123.3 emerging need or risk, worsening health condition, or cases where the current services do
123.4 not meet the client's needs. A change-in-condition reassessment may be initiated by the lead
123.5 agency, or it may be requested by the client or requested on the client's behalf by another
123.6 party, such as a provider of services. The lead agency shall complete a change-in-condition
123.7 reassessment no later than 20 calendar days from the request. The lead agency shall conduct
123.8 these assessments in a timely manner and expedite urgent requests. The lead agency shall
123.9 evaluate urgent requests based on the client's needs and risk to the client if a reassessment
123.10 is not completed.

123.11 Sec. 13. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision
123.12 to read:

123.13 Subd. 11. **Payment rates; application.** The payment methodologies in subdivisions 12
123.14 to 16 apply to elderly waiver and elderly waiver customized living under this section,
123.15 alternative care under section 256B.0913, essential community supports under section
123.16 256B.0922, and community access for disability inclusion customized living, brain injury
123.17 customized living, and elderly waiver foster care and residential care.

123.18 Sec. 14. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision
123.19 to read:

123.20 Subd. 12. **Payment rates; phase-in.** Effective January 1, 2019, all rates and rate
123.21 components for services under subdivision 11 shall be the sum of ten percent of the rates
123.22 calculated under subdivisions 13 to 16 and 90 percent of the rates calculated using the rate
123.23 methodology in effect as of June 30, 2017.

123.24 Sec. 15. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision
123.25 to read:

123.26 Subd. 13. **Payment rates; establishment.** (a) When establishing the base wages
123.27 according to subdivision 14, the commissioner shall use standard occupational classification
123.28 (SOC) codes from the Bureau of Labor Statistics as defined in the edition of the Occupational
123.29 Handbook published immediately prior to January 1, 2019, using Minnesota-specific wages
123.30 taken from job descriptions.

124.1 (b) Beginning January 1, 2019, and every January 1 thereafter, the commissioner shall
124.2 establish factors, component rates, and rates according to subdivisions 15 and 16, using
124.3 base wages established according to paragraph (a) and subdivision 14.

124.4 Sec. 16. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision
124.5 to read:

124.6 Subd. 14. **Payment rates; base wage index.** (a) Base wages are calculated for customized
124.7 living, foster care, and residential care component services as follows:

124.8 (1) the home management and support services base wage equals 33.33 percent of the
124.9 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home
124.10 care aide (SOC code 39-9021); 33.33 percent of the Minneapolis-St. Paul-Bloomington,
124.11 MN-WI MetroSA average wage for food preparation workers (SOC code 35-2021); and
124.12 33.34 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage
124.13 for maids and housekeeping cleaners (SOC code 37-2012);

124.14 (2) the home care aide base wage equals 50 percent of the Minneapolis-St.
124.15 Paul-Bloomington, MN-WI MetroSA average wage for home health aides (SOC code
124.16 31-1011); and 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA
124.17 average wage for nursing assistants (SOC code 31-1014);

124.18 (3) the home health aide base wage equals 20 percent of the Minneapolis-St.
124.19 Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed
124.20 vocational nurses (SOC code 29-2061); and 80 percent of the Minneapolis-St.
124.21 Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code
124.22 31-1014); and

124.23 (4) the medication setups by licensed practical nurse base wage equals ten percent of
124.24 the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical
124.25 and licensed vocational nurses (SOC code 29-2061); and 90 percent of the Minneapolis-St.
124.26 Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code
124.27 29-1141).

124.28 (b) Base wages are calculated for the following services as follows:

124.29 (1) the chore services base wage equals 100 percent of the Minneapolis-St.
124.30 Paul-Bloomington, MN-WI MetroSA average wage for landscaping and groundskeeping
124.31 workers (SOC code 37-3011);

124.32 (2) the companion services base wage equals 50 percent of the Minneapolis-St.
124.33 Paul-Bloomington, MN-WI MetroSA average wage for personal and home care aides (SOC

- 125.1 code 39-9021); and 50 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA
125.2 average wage for maids and housekeeping cleaners (SOC code 37-2012);
- 125.3 (3) the homemaker services and assistance with personal care base wage equals 60
125.4 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for
125.5 personal and home care aide (SOC code 39-9021); 20 percent of the Minneapolis-St.
125.6 Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code
125.7 31-1014); and 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA
125.8 average wage for maids and housekeeping cleaners (SOC code 37-2012);
- 125.9 (4) the homemaker services and cleaning base wage equals 60 percent of the
125.10 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home
125.11 care aide (SOC code 39-9021); 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI
125.12 MetroSA average wage for nursing assistants (SOC code 31-1014); and 20 percent of the
125.13 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and
125.14 housekeeping cleaners (SOC code 37-2012);
- 125.15 (5) the homemaker services and home management base wage equals 60 percent of the
125.16 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for personal and home
125.17 care aide (SOC code 39-9021); 20 percent of the Minneapolis-St. Paul-Bloomington, MN-WI
125.18 MetroSA average wage for nursing assistants (SOC code 31-1014); and 20 percent of the
125.19 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for maids and
125.20 housekeeping cleaners (SOC code 37-2012);
- 125.21 (6) the in-home respite care services base wage equals five percent of the Minneapolis-St.
125.22 Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code
125.23 29-1141); 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average
125.24 wage for nursing assistants (SOC code 31-1014); and 20 percent of the Minneapolis-St.
125.25 Paul-Bloomington, MN-WI MetroSA average wage for licensed practical and licensed
125.26 vocational nurses (SOC code 29-2061);
- 125.27 (7) the out-of-home respite care services base wage equals five percent of the
125.28 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for registered nurses
125.29 (SOC code 29-1141); 75 percent of the Minneapolis-St. Paul-Bloomington, MN-WI MetroSA
125.30 average wage for nursing assistants (SOC code 31-1014); and 20 percent of the
125.31 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical
125.32 and licensed vocational nurses (SOC code 29-2061); and
- 125.33 (8) the individual community living support base wage equals 20 percent of the
125.34 Minneapolis-St. Paul-Bloomington, MN-WI MetroSA average wage for licensed practical

126.1 and licensed vocational nurses (SOC code 29-2061); and 80 percent of the Minneapolis-St.
126.2 Paul-Bloomington, MN-WI MetroSA average wage for nursing assistants (SOC code
126.3 31-1014).

126.4 (c) Base wages are calculated for the following values as follows:

126.5 (1) the registered nurse base wage equals 100 percent of the Minneapolis-St.
126.6 Paul-Bloomington, MN-WI MetroSA average wage for registered nurses (SOC code
126.7 29-1141); and

126.8 (2) the social worker base wage equals 100 percent of the Minneapolis-St.
126.9 Paul-Bloomington, MN-WI MetroSA average wage for medical and public health social
126.10 workers (SOC code 21-1022).

126.11 (d) If any of the SOC codes and positions are no longer available, the commissioner
126.12 shall, in consultation with stakeholders, select a new SOC code and position that is the
126.13 closest match to the previously used SOC position.

126.14 Sec. 17. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision
126.15 to read:

126.16 Subd. 15. **Payment rates; factors.** The commissioner shall use the following factors:

126.17 (1) the payroll taxes and benefits factor is the sum of net payroll taxes and benefits
126.18 divided by the sum of all salaries for all nursing facilities on the most recent and available
126.19 cost report;

126.20 (2) the general and administrative factor is the sum of net general and administrative
126.21 expenses minus administrative salaries divided by total operating expenses for all nursing
126.22 facilities on the most recent and available cost report;

126.23 (3) the program plan support factor is 12.8 percent to cover the cost of direct service
126.24 staff needed to provide support for the home and community-based service when not engaged
126.25 in direct contact with clients.

126.26 (4) the registered nurse management and supervision factor equals 15 percent of the
126.27 product of the position's base wage and the sum of the factors in clauses (1) to (3); and

126.28 (5) the social worker supervision factor equals 15 percent of the product of the position's
126.29 base wage and the sum of the factors in clauses (1) to (3).

127.1 Sec. 18. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision
127.2 to read:

127.3 Subd. 16. **Payment rates; component rates.** (a) For the purposes of this subdivision,
127.4 the "adjusted base wage" for a position equals the position's base wage plus:

127.5 (1) the position's base wage multiplied by the payroll taxes and benefits factor;

127.6 (2) the position's base wage multiplied by the general and administrative factor; and

127.7 (3) the position's base wage multiplied by the program plan support factor.

127.8 (b) For medication setups by licensed nurse, registered nurse, and social worker services,
127.9 the component rate for each service equals the respective position's adjusted base wage.

127.10 (c) For home management and support services, home care aide, and home health aide
127.11 services, the component rate for each service equals the respective position's adjusted base
127.12 wage plus the registered nurse management and supervision factor.

127.13 (d) The home management and support services component rate shall be used for payment
127.14 for socialization and transportation component rates under elderly waiver customized living.

127.15 (e) The 15-minute unit rates for chore services and companion services are calculated
127.16 as follows:

127.17 (1) sum the adjusted base wage for the respective position and the social worker factor;
127.18 and

127.19 (2) divide the result of clause (1) by four.

127.20 (f) The 15-minute unit rates for homemaker services and assistance with personal care,
127.21 homemaker services and cleaning, and homemaker services and home management are
127.22 calculated as follows:

127.23 (1) sum the adjusted base wage for the respective position and the registered nurse
127.24 management and supervision factor; and

127.25 (2) divide the result of clause (1) by four.

127.26 (g) The 15-minute unit rate for in-home respite care services is calculated as follows:

127.27 (1) sum the adjusted base wage for in-home respite care services and the registered nurse
127.28 management and supervision factor; and

127.29 (2) divide the result of clause (1) by four.

- 128.1 (h) The in-home respite care services daily rate equals the in-home respite care services
128.2 15-minute unit rate multiplied by 18.
- 128.3 (i) The 15-minute unit rate for out-of-home respite care is calculated as follows:
128.4 (1) sum the out-of-home respite care services adjusted base wage and the registered
128.5 nurse management and supervision factor; and
128.6 (2) divide the result of clause (1) by four.
- 128.7 (j) The out-of-home respite care services daily rate equals the out-of-home respite care
128.8 services 15-minute unit rate multiplied by 18.
- 128.9 (k) The individual community living support rate is calculated as follows:
128.10 (1) sum the adjusted base wage for the home care aide rate in subdivision 14, paragraph
128.11 (a), clause (2), and the social worker factor; and
128.12 (2) divide the result of clause (1) by four.
- 128.13 (l) The home delivered meals rate equals \$9.30. Beginning July 1, 2018, the commissioner
128.14 shall increase the home delivered meals rate every July 1 by the percent increase in the
128.15 nursing facility dietary per diem using the two most recent and available nursing facility
128.16 cost reports.
- 128.17 (m) The adult day services rate is based on the home care aide rate in subdivision 14,
128.18 paragraph (a), clause (2), plus the additional factors from subdivision 15, except that the
128.19 general and administrative factor used shall be 20 percent. The nonregistered nurse portion
128.20 of the rate shall be multiplied by 0.25, to reflect an assumed-ratio staffing of one caregiver
128.21 to four clients, and divided by four to determine the 15-minute unit rate. The registered
128.22 nurse portion is divided by four to determine the 15-minute unit rate and \$0.63 per 15-minute
128.23 unit is added to cover the cost of meals.
- 128.24 (n) The adult day services bath 15-minute unit rate is the same as the calculation of the
128.25 adult day services 15-minute unit rate without the adjustment for staffing ratio.
- 128.26 (o) If a bath is authorized for an adult day services client, at least two 15-minute units
128.27 must be authorized to allow for adequate time to meet client needs. Adult day services may
128.28 be authorized for up to 48 units, or 12 hours, per day based on client and family caregiver
128.29 needs.

129.1 Sec. 19. Minnesota Statutes 2016, section 256B.0915, is amended by adding a subdivision
129.2 to read:

129.3 Subd. 17. **Evaluation of rate methodology.** The commissioner, in consultation with
129.4 stakeholders, shall conduct a study to evaluate the following:

129.5 (1) base wages in subdivision 14, to determine if the standard occupational classification
129.6 codes for each rate and component rate are an appropriate representation of staff who deliver
129.7 the services; and

129.8 (2) factors in subdivision 15, and adjusted base wage calculation in subdivision 16, to
129.9 determine if the factors and calculations appropriately address nonwage provider costs.

129.10 By January 1, 2019, the commissioner shall submit a report to the legislature on the
129.11 changes to the rate methodology in this statute, based on the results of the evaluation. Where
129.12 feasible, the report shall address the impact of the new rates on the workforce situation and
129.13 client access to services. The report should include any changes to the rate calculations
129.14 methods that the commissioner recommends.

129.15 Sec. 20. Minnesota Statutes 2016, section 256B.431, subdivision 10, is amended to read:

129.16 **Subd. 10. Property rate adjustments and construction projects.** A nursing facility
129.17 completing a construction project that is eligible for a rate adjustment under section
129.18 256B.434, subdivision 4f, and that was not approved through the moratorium exception
129.19 process in section 144A.073 must request from the commissioner a property-related payment
129.20 rate adjustment. ~~If the request is made within 60 days after the construction project's~~
129.21 ~~completion date,~~ The effective date of the rate adjustment is the first of the month of January
129.22 or July, whichever occurs first following both the construction project's completion date
129.23 and submission of the provider's rate adjustment request. ~~If the request is made more than~~
129.24 ~~60 days after the completion date, the rate adjustment is effective on the first of the month~~
129.25 ~~following the request.~~ The commissioner shall provide a rate notice reflecting the allowable
129.26 costs within 60 days after receiving all the necessary information to compute the rate
129.27 adjustment. No sooner than the effective date of the rate adjustment for the construction
129.28 project, a nursing facility may adjust its rates by the amount anticipated to be allowed. Any
129.29 amounts collected from private pay residents in excess of the allowable rate must be repaid
129.30 to private pay residents with interest at the rate used by the commissioner of revenue for
129.31 the late payment of taxes and in effect on the date the rate increase is effective. Construction
129.32 projects with completion dates within one year of the completion date associated with the
129.33 property rate adjustment request and phased projects with project completion dates within
129.34 three years of the last phase of the phased project must be aggregated for purposes of the

130.1 minimum thresholds in subdivisions 16 and 17, and the maximum threshold in section
130.2 144A.071, subdivision 2. "Construction project" and "project construction costs" have the
130.3 meanings given them in Minnesota Statutes, section 144A.071, subdivision 1a.

130.4 **EFFECTIVE DATE.** This section is effective for projects completed after January 1,
130.5 2018.

130.6 Sec. 21. Minnesota Statutes 2016, section 256B.431, subdivision 16, is amended to read:

130.7 Subd. 16. **Major additions and replacements; equity incentive.** For rate years beginning
130.8 after June 30, 1993, if a nursing facility acquires capital assets in connection with a project
130.9 approved under the moratorium exception process in section 144A.073 or in connection
130.10 with an addition to or replacement of buildings, attached fixtures, or land improvements
130.11 for which the total historical cost of those capital asset additions exceeds the lesser of
130.12 \$150,000 or ten percent of the most recent appraised value, the nursing facility shall be
130.13 eligible for an equity incentive payment rate as in paragraphs (a) to (d). This computation
130.14 is separate from the determination of the nursing facility's rental rate. An equity incentive
130.15 payment rate as computed under this subdivision is limited to one in a 12-month period.

130.16 (a) An eligible nursing facility shall receive an equity incentive payment rate equal to
130.17 the allowable historical cost of the capital asset acquired, minus the allowable debt directly
130.18 identified to that capital asset, multiplied by the equity incentive factor as described in
130.19 paragraphs (b) and (c), and divided by the nursing facility's occupancy factor under
130.20 subdivision 3f, paragraph (c). This amount shall be added to the nursing facility's total
130.21 payment rate and shall be effective the same day as the incremental increase in paragraph
130.22 (d) or subdivision 17. The allowable historical cost of the capital assets and the allowable
130.23 debt shall be determined as provided in Minnesota Rules, parts 9549.0010 to 9549.0080,
130.24 and this section.

130.25 (b) The equity incentive factor shall be determined under clauses (1) to (4):

130.26 (1) divide the initial allowable debt in paragraph (a) by the initial historical cost of the
130.27 capital asset additions referred to in paragraph (a), then cube the quotient,

130.28 (2) subtract the amount calculated in clause (1) from the number one,

130.29 (3) determine the difference between the rental factor and the lesser of two percentage
130.30 points above the posted yield for standard conventional fixed rate mortgages of the Federal
130.31 Home Loan Mortgage Corporation as published in the Wall Street Journal and in effect on
130.32 the first day of the month the debt or cost is incurred, or 16 percent,

130.33 (4) multiply the amount calculated in clause (2) by the amount calculated in clause (3).

131.1 (c) The equity incentive payment rate shall be limited to the term of the allowable debt
131.2 in paragraph (a), not greater than 20 years nor less than ten years. If no debt is incurred in
131.3 acquiring the capital asset, the equity incentive payment rate shall be paid for ten years. The
131.4 sale of a nursing facility under subdivision 14 shall terminate application of the equity
131.5 incentive payment rate effective on the date provided in subdivision 14, paragraph (f), for
131.6 the sale.

131.7 (d) A nursing facility with an addition to or a renovation of its buildings, attached fixtures,
131.8 or land improvements meeting the criteria in this subdivision and not receiving the
131.9 property-related payment rate adjustment in subdivision 17, shall receive the incremental
131.10 increase in the nursing facility's rental rate as determined under Minnesota Rules, parts
131.11 9549.0010 to 9549.0080, and this section. The incremental increase shall be added to the
131.12 nursing facility's property-related payment rate. The effective date of this incremental
131.13 increase shall be the first day of the month of January or July, whichever occurs first
131.14 following the ~~month in~~ date on which the addition or replacement is completed.

131.15 **EFFECTIVE DATE.** This section is effective for additions or replacements completed
131.16 after January 1, 2018.

131.17 Sec. 22. Minnesota Statutes 2016, section 256B.431, subdivision 30, is amended to read:

131.18 Subd. 30. **Bed layaway and delicensure.** (a) For rate years beginning on or after July
131.19 1, 2000, a nursing facility reimbursed under this section which has placed beds on layaway
131.20 shall, for purposes of application of the downsizing incentive in subdivision 3a, paragraph
131.21 (c), and calculation of the rental per diem, have those beds given the same effect as if the
131.22 beds had been delicensed so long as the beds remain on layaway. At the time of a layaway,
131.23 a facility may change its single bed election for use in calculating capacity days under
131.24 Minnesota Rules, part 9549.0060, subpart 11. The property payment rate increase shall be
131.25 effective the first day of the month of January or July, whichever occurs first following the
131.26 ~~month in~~ date on which the layaway of the beds becomes effective under section 144A.071,
131.27 subdivision 4b.

131.28 (b) For rate years beginning on or after July 1, 2000, notwithstanding any provision to
131.29 the contrary under section 256B.434, a nursing facility reimbursed under that section ~~which~~
131.30 that has placed beds on layaway shall, for so long as the beds remain on layaway, be allowed
131.31 to:

131.32 (1) aggregate the applicable investment per bed limits based on the number of beds
131.33 licensed immediately prior to entering the alternative payment system;

132.1 (2) retain or change the facility's single bed election for use in calculating capacity days
132.2 under Minnesota Rules, part 9549.0060, subpart 11; and

132.3 (3) establish capacity days based on the number of beds immediately prior to the layaway
132.4 and the number of beds after the layaway.

132.5 The commissioner shall increase the facility's property payment rate by the incremental
132.6 increase in the rental per diem resulting from the recalculation of the facility's rental per
132.7 diem applying only the changes resulting from the layaway of beds and clauses (1), (2), and
132.8 (3). If a facility reimbursed under section 256B.434 completes a moratorium exception
132.9 project after its base year, the base year property rate shall be the moratorium project property
132.10 rate. The base year rate shall be inflated by the factors in section 256B.434, subdivision 4,
132.11 paragraph (c). The property payment rate increase shall be effective the first day of the
132.12 month of January or July, whichever occurs first following the ~~month in~~ date on which the
132.13 layaway of the beds becomes effective.

132.14 (c) If a nursing facility removes a bed from layaway status in accordance with section
132.15 144A.071, subdivision 4b, the commissioner shall establish capacity days based on the
132.16 number of licensed and certified beds in the facility not on layaway and shall reduce the
132.17 nursing facility's property payment rate in accordance with paragraph (b).

132.18 (d) For the rate years beginning on or after July 1, 2000, notwithstanding any provision
132.19 to the contrary under section 256B.434, a nursing facility reimbursed under that section;
132.20 ~~which~~ that has delicensed beds after July 1, 2000, by giving notice of the delicensure to the
132.21 commissioner of health according to the notice requirements in section 144A.071, subdivision
132.22 4b, shall be allowed to:

132.23 (1) aggregate the applicable investment per bed limits based on the number of beds
132.24 licensed immediately prior to entering the alternative payment system;

132.25 (2) retain or change the facility's single bed election for use in calculating capacity days
132.26 under Minnesota Rules, part 9549.0060, subpart 11; and

132.27 (3) establish capacity days based on the number of beds immediately prior to the
132.28 delicensure and the number of beds after the delicensure.

132.29 The commissioner shall increase the facility's property payment rate by the incremental
132.30 increase in the rental per diem resulting from the recalculation of the facility's rental per
132.31 diem applying only the changes resulting from the delicensure of beds and clauses (1), (2),
132.32 and (3). If a facility reimbursed under section 256B.434 completes a moratorium exception
132.33 project after its base year, the base year property rate shall be the moratorium project property

133.1 rate. The base year rate shall be inflated by the factors in section 256B.434, subdivision 4,
133.2 paragraph (c). The property payment rate increase shall be effective the first day of the
133.3 month of January or July, whichever occurs first following the ~~month in~~ date on which the
133.4 delicensure of the beds becomes effective.

133.5 (e) For nursing facilities reimbursed under this section or section 256B.434, any beds
133.6 placed on layaway shall not be included in calculating facility occupancy as it pertains to
133.7 leave days defined in Minnesota Rules, part 9505.0415.

133.8 (f) For nursing facilities reimbursed under this section or section 256B.434, the rental
133.9 rate calculated after placing beds on layaway may not be less than the rental rate prior to
133.10 placing beds on layaway.

133.11 (g) A nursing facility receiving a rate adjustment as a result of this section shall comply
133.12 with section ~~256B.47, subdivision 2~~ 256R.06, subdivision 5.

133.13 (h) A facility that does not utilize the space made available as a result of bed layaway
133.14 or delicensure under this subdivision to reduce the number of beds per room or provide
133.15 more common space for nursing facility uses or perform other activities related to the
133.16 operation of the nursing facility shall have its property rate increase calculated under this
133.17 subdivision reduced by the ratio of the square footage made available that is not used for
133.18 these purposes to the total square footage made available as a result of bed layaway or
133.19 delicensure.

133.20 **EFFECTIVE DATE.** This section is effective for layaways occurring after July 1, 2017.

133.21 Sec. 23. Minnesota Statutes 2016, section 256B.434, subdivision 4, is amended to read:

133.22 Subd. 4. **Alternate rates for nursing facilities.** Effective for the rate years beginning
133.23 on and after January 1, 2019, a nursing facility's ~~ease mix~~ property payment rates ~~rate~~ for
133.24 the second and subsequent years of a facility's contract under this section are the previous
133.25 rate year's contract property payment rates ~~rate~~ plus an inflation adjustment and, for facilities
133.26 ~~reimbursed under this section or section 256B.431, an adjustment to include the cost of any~~
133.27 ~~increase in Health Department licensing fees for the facility taking effect on or after July~~
133.28 ~~1, 2001.~~ The index for the inflation adjustment must be based on the change in the Consumer
133.29 Price Index-All Items (United States City average) (CPI-U) forecasted by the ~~commissioner~~
133.30 ~~of management and budget's national economic consultant~~ Reports and Forecasts Division
133.31 of the Department of Human Services, as forecasted in the fourth quarter of the calendar
133.32 year preceding the rate year. The inflation adjustment must be based on the 12-month period
133.33 from the midpoint of the previous rate year to the midpoint of the rate year for which the

134.1 rate is being determined. For the rate years beginning on July 1, 1999, July 1, 2000, July 1,
134.2 2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006, July 1, 2007, July
134.3 1, 2008, October 1, 2009, and October 1, 2010, this paragraph shall apply only to the
134.4 property-related payment rate. For the rate years beginning on October 1, 2011, October 1,
134.5 2012, October 1, 2013, October 1, 2014, October 1, 2015, January 1, 2016, and January 1,
134.6 2017, the rate adjustment under this paragraph shall be suspended. Beginning in 2005,
134.7 adjustment to the property payment rate under this section and section 256B.431 shall be
134.8 effective on October 1. In determining the amount of the property-related payment rate
134.9 adjustment under this paragraph, the commissioner shall determine the proportion of the
134.10 facility's rates that are property-related based on the facility's most recent cost report.

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

134.12 Sec. 24. Minnesota Statutes 2016, section 256B.434, subdivision 4f, is amended to read:

134.13 Subd. 4f. **Construction project rate adjustments effective October 1, 2006.** (a)
134.14 Effective October 1, 2006, facilities reimbursed under this section may receive a property
134.15 rate adjustment for construction projects exceeding the threshold in section 256B.431,
134.16 subdivision 16, and below the threshold in section 144A.071, subdivision 2, clause (a). For
134.17 these projects, capital assets purchased shall be counted as construction project costs for a
134.18 rate adjustment request made by a facility if they are: (1) purchased within 24 months of
134.19 the completion of the construction project; (2) purchased after the completion date of any
134.20 prior construction project; and (3) are not purchased prior to July 14, 2005. Except as
134.21 otherwise provided in this subdivision, the definitions, rate calculation methods, and
134.22 principles in sections 144A.071 and 256B.431 and Minnesota Rules, parts 9549.0010 to
134.23 9549.0080, shall be used to calculate rate adjustments for allowable construction projects
134.24 under this subdivision and section 144A.073. Facilities completing construction projects
134.25 between October 1, 2005, and October 1, 2006, are eligible to have a property rate adjustment
134.26 effective October 1, 2006. Facilities completing projects after October 1, 2006, are eligible
134.27 for a property rate adjustment effective on the first day of the month following the completion
134.28 date. Facilities completing projects after January 1, 2018, are eligible for a property rate
134.29 adjustment effective on the first day of the month of January or July, whichever occurs
134.30 immediately following the completion date.

134.31 (b) Notwithstanding subdivision 18, as of July 14, 2005, facilities with rates set under
134.32 section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, that commenced a
134.33 construction project on or after October 1, 2004, and do not have a contract under subdivision
134.34 3 by September 30, 2006, are eligible to request a rate adjustment under section 256B.431,

135.1 subdivision 10, through September 30, 2006. If the request results in the commissioner
135.2 determining a rate adjustment is allowable, the rate adjustment is effective on the first of
135.3 the month following project completion. These facilities shall be allowed to accumulate
135.4 construction project costs for the period October 1, 2004, to September 30, 2006.

135.5 (c) Facilities shall be allowed construction project rate adjustments no sooner than 12
135.6 months after completing a previous construction project. Facilities must request the rate
135.7 adjustment according to section 256B.431, subdivision 10.

135.8 (d) Capacity days shall be computed according to Minnesota Rules, part 9549.0060,
135.9 subpart 11. For rate calculations under this section, the number of licensed beds in the
135.10 nursing facility shall be the number existing after the construction project is completed and
135.11 the number of days in the nursing facility's reporting period shall be 365.

135.12 (e) The value of assets to be recognized for a total replacement project as defined in
135.13 section 256B.431, subdivision 17d, shall be computed as described in clause (1). The value
135.14 of assets to be recognized for all other projects shall be computed as described in clause
135.15 (2).

135.16 (1) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the
135.17 number of beds allowed under subdivision 3a, paragraph (c), shall be used to compute the
135.18 maximum amount of assets allowable in a facility's property rate calculation. If a facility's
135.19 current request for a rate adjustment results from the completion of a construction project
135.20 that was previously approved under section 144A.073, the assets to be used in the rate
135.21 calculation cannot exceed the lesser of the amount determined under sections 144A.071,
135.22 subdivision 2, and 144A.073, subdivision 3b, or the actual allowable costs of the construction
135.23 project. A current request that is not the result of a project under section 144A.073 cannot
135.24 exceed the limit under section 144A.071, subdivision 2, paragraph (a). Applicable credits
135.25 must be deducted from the cost of the construction project.

135.26 (2)(i) Replacement-cost-new limits under section 256B.431, subdivision 17e, and the
135.27 number of beds allowed under section 256B.431, subdivision 3a, paragraph (c), shall be
135.28 used to compute the maximum amount of assets allowable in a facility's property rate
135.29 calculation.

135.30 (ii) The value of a facility's assets to be compared to the amount in item (i) begins with
135.31 the total appraised value from the last rate notice a facility received when its rates were set
135.32 under section 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080. This value
135.33 shall be indexed by the factor in section 256B.431, subdivision 3f, paragraph (a), for each
135.34 rate year the facility received an inflation factor on its property-related rate when its rates

136.1 were set under this section. The value of assets listed as previous capital additions, capital
136.2 additions, and special projects on the facility's base year rate notice and the value of assets
136.3 related to a construction project for which the facility received a rate adjustment when its
136.4 rates were determined under this section shall be added to the indexed appraised value.

136.5 (iii) The maximum amount of assets to be recognized in computing a facility's rate
136.6 adjustment after a project is completed is the lesser of the aggregate replacement-cost-new
136.7 limit computed in (i) minus the assets recognized in (ii) or the actual allowable costs of the
136.8 construction project.

136.9 (iv) If a facility's current request for a rate adjustment results from the completion of a
136.10 construction project that was previously approved under section 144A.073, the assets to be
136.11 added to the rate calculation cannot exceed the lesser of the amount determined under
136.12 sections 144A.071, subdivision 2, and 144A.073, subdivision 3b, or the actual allowable
136.13 costs of the construction project. A current request that is not the result of a project under
136.14 section 144A.073 cannot exceed the limit stated in section 144A.071, subdivision 2,
136.15 paragraph (a). Assets disposed of as a result of a construction project and applicable credits
136.16 must be deducted from the cost of the construction project.

136.17 (f) For construction projects approved under section 144A.073, allowable debt may
136.18 never exceed the lesser of the cost of the assets purchased, the threshold limit in section
136.19 144A.071, subdivision 2, or the replacement-cost-new limit less previously existing capital
136.20 debt.

136.21 (g) For construction projects that were not approved under section 144A.073, allowable
136.22 debt is limited to the lesser of the threshold in section 144A.071, subdivision 2, for such
136.23 construction projects or the applicable limit in paragraph (e), clause (1) or (2), less previously
136.24 existing capital debt. Amounts of debt taken out that exceed the costs of a construction
136.25 project shall not be allowed regardless of the use of the funds.

136.26 For all construction projects being recognized, interest expense and average debt shall
136.27 be computed based on the first 12 months following project completion. "Previously existing
136.28 capital debt" means capital debt recognized on the last rate determined under section
136.29 256B.431 and Minnesota Rules, parts 9549.0010 to 9549.0080, and the amount of debt
136.30 recognized for a construction project for which the facility received a rate adjustment when
136.31 its rates were determined under this section.

136.32 For a total replacement project as defined in section 256B.431, subdivision 17d, the
136.33 value of previously existing capital debt shall be zero.

137.1 (h) In addition to the interest expense allowed from the application of paragraph (f), the
137.2 amounts allowed under section 256B.431, subdivision 17a, paragraph (a), clauses (2) and
137.3 (3), will be added to interest expense.

137.4 (i) The equity portion of the construction project shall be computed as the allowable
137.5 assets in paragraph (e), less the average debt in paragraph (f). The equity portion must be
137.6 multiplied by 5.66 percent and the allowable interest expense in paragraph (f) must be added.
137.7 This sum must be divided by 95 percent of capacity days to compute the construction project
137.8 rate adjustment.

137.9 (j) For projects that are not a total replacement of a nursing facility, the amount in
137.10 paragraph (i) is adjusted for nonreimbursable areas and then added to the current property
137.11 payment rate of the facility.

137.12 (k) For projects that are a total replacement of a nursing facility, the amount in paragraph
137.13 (i) becomes the new property payment rate after being adjusted for nonreimbursable areas.
137.14 Any amounts existing in a facility's rate before the effective date of the construction project
137.15 for equity incentives under section 256B.431, subdivision 16; capital repairs and replacements
137.16 under section 256B.431, subdivision 15; or refinancing incentives under section 256B.431,
137.17 subdivision 19, shall be removed from the facility's rates.

137.18 (l) No additional equipment allowance is allowed under Minnesota Rules, part 9549.0060,
137.19 subpart 10, as the result of construction projects under this section. Allowable equipment
137.20 shall be included in the construction project costs.

137.21 (m) Capital assets purchased after the completion date of a construction project shall be
137.22 counted as construction project costs for any future rate adjustment request made by a facility
137.23 under section 144A.071, subdivision 2, clause (a), if they are purchased within 24 months
137.24 of the completion of the future construction project.

137.25 (n) In subsequent rate years, the property payment rate for a facility that results from
137.26 the application of this subdivision shall be the amount inflated in subdivision 4.

137.27 (o) Construction projects are eligible for an equity incentive under section 256B.431,
137.28 subdivision 16. When computing the equity incentive for a construction project under this
137.29 subdivision, only the allowable costs and allowable debt related to the construction project
137.30 shall be used. The equity incentive shall not be a part of the property payment rate and not
137.31 inflated under subdivision 4. Effective October 1, 2006, all equity incentives for nursing
137.32 facilities reimbursed under this section shall be allowed for a duration determined under
137.33 section 256B.431, subdivision 16, paragraph (c).

138.1 **EFFECTIVE DATE.** This section is effective January 1, 2018.

138.2 Sec. 25. Minnesota Statutes 2016, section 256B.50, subdivision 1b, is amended to read:

138.3 Subd. 1b. **Filing an appeal.** To appeal, the provider shall file with the commissioner a
138.4 written notice of appeal; the appeal must be postmarked or received by the commissioner
138.5 within 60 days of the publication date ~~the determination of the payment rate was mailed or~~
138.6 ~~personally received by a provider, whichever is earlier~~ printed on the rate notice. The notice
138.7 of appeal must specify each disputed item; the reason for the dispute; the total dollar amount
138.8 in dispute for each separate disallowance, allocation, or adjustment of each cost item or part
138.9 of a cost item; the computation that the provider believes is correct; the authority in statute
138.10 or rule upon which the provider relies for each disputed item; the name and address of the
138.11 person or firm with whom contacts may be made regarding the appeal; and other information
138.12 required by the commissioner.

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

138.14 Sec. 26. Minnesota Statutes 2016, section 256B.5012, is amended by adding a subdivision
138.15 to read:

138.16 Subd. 3a. **Therapeutic leave days.** Notwithstanding Minnesota Rules, part 9505.0415,
138.17 subpart 7, a vacant bed in an intermediate care facility for persons with developmental
138.18 disabilities shall be counted as a reserved bed when determining occupancy rates and
138.19 eligibility for payment of a therapeutic leave day.

138.20 Sec. 27. Minnesota Statutes 2016, section 256B.5012, is amended by adding a subdivision
138.21 to read:

138.22 Subd. 17. **ICF/DD rate increase effective July 1, 2017; Murray County.** Effective
138.23 July 1, 2017, the daily rate for an intermediate care facility for persons with developmental
138.24 disabilities located in Murray County that is classified as a class B facility and licensed for
138.25 14 beds is \$400. This increase is in addition to any other increase that is effective on July
138.26 1, 2017.

138.27 Sec. 28. Minnesota Statutes 2016, section 256R.02, subdivision 4, is amended to read:

138.28 Subd. 4. **Administrative costs.** "Administrative costs" means the identifiable costs for
138.29 administering the overall activities of the nursing home. These costs include salaries and
138.30 wages of the administrator, assistant administrator, business office employees, security
138.31 guards, and associated fringe benefits and payroll taxes, fees, contracts, or purchases related

139.1 to business office functions, licenses, ~~and~~ permits except as provided in the external fixed
139.2 costs category, employee recognition, travel including meals and lodging, all training except
139.3 as specified in subdivision 17, voice and data communication or transmission, office supplies,
139.4 property and liability insurance and other forms of insurance ~~not designated to other areas~~
139.5 except insurance that is a fringe benefit under subdivision 22, personnel recruitment, legal
139.6 services, accounting services, management or business consultants, data processing,
139.7 information technology, Web site, central or home office costs, business meetings and
139.8 seminars, postage, fees for professional organizations, subscriptions, security services,
139.9 advertising, board of directors fees, working capital interest expense, ~~and~~ bad debts, ~~and~~
139.10 bad debt collection fees, and costs incurred for travel and housing for persons employed by
139.11 a supplemental nursing services agency as defined in section 144A.70, subdivision 6.

139.12 **EFFECTIVE DATE.** This section is effective October 1, 2017.

139.13 Sec. 29. Minnesota Statutes 2016, section 256R.02, subdivision 17, is amended to read:

139.14 Subd. 17. **Direct care costs.** "Direct care costs" means costs for the wages of nursing
139.15 administration, direct care registered nurses, licensed practical nurses, certified nursing
139.16 assistants, trained medication aides, employees conducting training in resident care topics
139.17 and associated fringe benefits and payroll taxes; services from a supplemental nursing
139.18 services agency; supplies that are stocked at nursing stations or on the floor and distributed
139.19 or used individually, including, but not limited to: alcohol, applicators, cotton balls,
139.20 incontinence pads, disposable ice bags, dressings, bandages, water pitchers, tongue
139.21 depressors, disposable gloves, enemas, enema equipment, soap, medication cups, diapers,
139.22 plastic waste bags, sanitary products, thermometers, hypodermic needles and syringes,
139.23 clinical reagents or similar diagnostic agents, drugs that are not paid on a separate fee
139.24 schedule by the medical assistance program or any other payer, and technology related to
139.25 the provision of nursing care to residents, such as electronic charting systems; costs of
139.26 materials used for resident care training, and training courses outside of the facility attended
139.27 by direct care staff on resident care topics; and costs for nurse consultants, pharmacy
139.28 consultants, and medical directors. Salaries and payroll taxes for nurse consultants who
139.29 work out of a central office must be allocated proportionately by total resident days or by
139.30 direct identification to the nursing facilities served by those consultants.

139.31 **EFFECTIVE DATE.** This section is effective October 1, 2017.

140.1 Sec. 30. Minnesota Statutes 2016, section 256R.02, subdivision 18, is amended to read:

140.2 Subd. 18. **Employer health insurance costs.** "Employer health insurance costs" means
140.3 premium expenses for group coverage and ~~reinsurance~~; actual expenses incurred for
140.4 self-insured plans, including reinsurance; and employer contributions to employee health
140.5 reimbursement and health savings accounts. Premium and expense costs and contributions
140.6 are allowable for (1) all employees and (2) the spouse and dependents of those employees
140.7 ~~who meet the definition of full-time employees under the federal Affordable Care Act,~~
140.8 ~~Public Law 111-148~~ are employed on average at least 30 hours per week.

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

140.10 Sec. 31. Minnesota Statutes 2016, section 256R.02, subdivision 19, is amended to read:

140.11 Subd. 19. **External fixed costs.** "External fixed costs" means costs related to the nursing
140.12 home surcharge under section 256.9657, subdivision 1; licensure fees under section 144.122;
140.13 family advisory council fee under section 144A.33; scholarships under section 256R.37;
140.14 planned closure rate adjustments under section 256R.40; consolidation rate adjustments
140.15 under section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d;
140.16 single-bed room incentives under section 256R.41; property taxes, assessments, and payments
140.17 in lieu of taxes; employer health insurance costs; quality improvement incentive payment
140.18 rate adjustments under section 256R.39; performance-based incentive payments under
140.19 section 256R.38; special dietary needs under section 256R.51; rate adjustments for
140.20 compensation-related costs for minimum wage changes under section 256R.49 provided
140.21 on or after January 1, 2018; and Public Employees Retirement Association employer costs.

140.22 Sec. 32. Minnesota Statutes 2016, section 256R.02, subdivision 22, is amended to read:

140.23 Subd. 22. **Fringe benefit costs.** "Fringe benefit costs" means the costs for group life,
140.24 dental, workers' compensation, ~~and other employee insurances and~~ short- and long-term
140.25 disability, long-term care insurance, accident insurance, supplemental insurance, legal
140.26 assistance insurance, profit sharing, health insurance costs not covered under subdivision
140.27 18, including costs associated with part-time employee family members or retirees, and
140.28 pension and retirement plan contributions, except for the Public Employees Retirement
140.29 Association ~~and employer health insurance costs; profit sharing; and retirement plans for~~
140.30 ~~which the employer pays all or a portion of the costs.~~

141.1 Sec. 33. Minnesota Statutes 2016, section 256R.02, subdivision 42, is amended to read:

141.2 Subd. 42. **Raw food costs.** "Raw food costs" means the cost of food provided to nursing
141.3 facility residents and the allocation of dietary credits. Also included are special dietary
141.4 supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet.

141.5 Sec. 34. Minnesota Statutes 2016, section 256R.02, is amended by adding a subdivision
141.6 to read:

141.7 Subd. 42a. **Real estate taxes.** "Real estate taxes" means the real estate tax liability shown
141.8 on the annual property tax statement of the nursing facility for the reporting period. The
141.9 term does not include personnel costs or fees for late payment.

141.10 Sec. 35. Minnesota Statutes 2016, section 256R.02, is amended by adding a subdivision
141.11 to read:

141.12 Subd. 48a. **Special assessments.** "Special assessments" means the actual special
141.13 assessments and related interest paid during the reporting period. The term does not include
141.14 personnel costs or fees for late payment.

141.15 Sec. 36. Minnesota Statutes 2016, section 256R.02, subdivision 52, is amended to read:

141.16 Subd. 52. **Therapy costs.** "Therapy costs" means any costs related to medical assistance
141.17 therapy services provided to residents that are not billed separately billable from the daily
141.18 operating rate.

141.19 Sec. 37. Minnesota Statutes 2016, section 256R.06, subdivision 5, is amended to read:

141.20 Subd. 5. **Notice to residents.** (a) No increase in nursing facility rates for private paying
141.21 residents shall be effective unless the nursing facility notifies the resident or person
141.22 responsible for payment of the increase in writing 30 days before the increase takes effect.
141.23 The notice must include the amount of the rate increase, the new payment rate, and the date
141.24 the rate increase takes effect.

141.25 A nursing facility may adjust its rates without giving the notice required by this
141.26 subdivision when the purpose of the rate adjustment is to reflect a change in the case mix
141.27 classification of the resident. The nursing facility shall notify private pay residents of any
141.28 rate increase related to a change in case mix classifications in a timely manner after
141.29 confirmation of the case mix classification change is received from the Department of
141.30 Health.

142.1 If the state fails to set rates as required by section 256R.09, subdivision 1, the time
142.2 required for giving notice is decreased by the number of days by which the state was late
142.3 in setting the rates.

142.4 (b) If the state does not set rates by the date required in section 256R.09, subdivision 1,
142.5 or otherwise provides nursing facilities with retroactive notification of the amount of a rate
142.6 increase, nursing facilities shall meet the requirement for advance notice by informing the
142.7 resident or person responsible for payments, on or before the effective date of the increase,
142.8 that a rate increase will be effective on that date. The requirements of paragraph (a) do not
142.9 apply to situations described in this paragraph.

142.10 If the exact amount has not yet been determined, the nursing facility may raise the rates
142.11 by the amount anticipated to be allowed. Any amounts collected from private pay residents
142.12 in excess of the allowable rate must be repaid to private pay residents with interest at the
142.13 rate used by the commissioner of revenue for the late payment of taxes and in effect on the
142.14 date the rate increase is effective.

142.15 Sec. 38. Minnesota Statutes 2016, section 256R.07, is amended by adding a subdivision
142.16 to read:

142.17 Subd. 6. **Electronic signature.** For documentation requiring a signature under this
142.18 chapter or section 256B.431 or 256B.434, use of an electronic signature as defined under
142.19 section 325L.02, paragraph (h), is allowed.

142.20 Sec. 39. Minnesota Statutes 2016, section 256R.10, is amended by adding a subdivision
142.21 to read:

142.22 Subd. 7. **Not specified allowed costs.** When the cost category for allowed cost items or
142.23 services is not specified in this chapter or the provider reimbursement manual, the
142.24 commissioner, in consultation with stakeholders, shall determine the cost category for the
142.25 allowed cost item or service.

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

142.27 Sec. 40. **[256R.18] REPORT BY COMMISSIONER OF HUMAN SERVICES.**

142.28 Beginning January 1, 2019, the commissioner shall provide to the house of representatives
142.29 and senate committees with jurisdiction over nursing facility payment rates a biennial report
142.30 on the effectiveness of the reimbursement system in improving quality, restraining costs,
142.31 and any other features of the system as determined by the commissioner.

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

143.2 Sec. 41. Minnesota Statutes 2016, section 256R.37, is amended to read:

143.3 **256R.37 SCHOLARSHIPS.**

143.4 (a) For the 27-month period beginning October 1, 2015, through December 31, 2017,
143.5 the commissioner shall allow a scholarship per diem of up to 25 cents for each nursing
143.6 facility with no scholarship per diem that is requesting a scholarship per diem to be added
143.7 to the external fixed payment rate to be used:

143.8 (1) for employee scholarships that satisfy the following requirements:

143.9 (i) scholarships are available to all employees who work an average of at least ten hours
143.10 per week at the facility except the administrator, and to reimburse student loan expenses
143.11 for newly hired ~~and recently graduated~~ registered nurses and licensed practical nurses, and
143.12 training expenses for nursing assistants as specified in section 144A.611, subdivisions 2
143.13 and 4, who are newly hired ~~and have graduated within the last 12 months~~; and

143.14 (ii) the course of study is expected to lead to career advancement with the facility or in
143.15 long-term care, including medical care interpreter services and social work; and

143.16 (2) to provide job-related training in English as a second language.

143.17 (b) All facilities may annually request a rate adjustment under this section by submitting
143.18 information to the commissioner on a schedule and in a form supplied by the commissioner.
143.19 The commissioner shall allow a scholarship payment rate equal to the reported and allowable
143.20 costs divided by resident days.

143.21 (c) In calculating the per diem under paragraph (b), the commissioner shall allow costs
143.22 related to tuition, direct educational expenses, and reasonable costs as defined by the
143.23 commissioner for child care costs and transportation expenses related to direct educational
143.24 expenses.

143.25 (d) The rate increase under this section is an optional rate add-on that the facility must
143.26 request from the commissioner in a manner prescribed by the commissioner. The rate
143.27 increase must be used for scholarships as specified in this section.

143.28 (e) For instances in which a rate adjustment will be 15 cents or greater, nursing facilities
143.29 that close beds during a rate year may request to have their scholarship adjustment under
143.30 paragraph (b) recalculated by the commissioner for the remainder of the rate year to reflect
143.31 the reduction in resident days compared to the cost report year.

143.32 **EFFECTIVE DATE.** This section is effective October 1, 2017.

144.1 Sec. 42. Minnesota Statutes 2016, section 256R.40, subdivision 1, is amended to read:

144.2 Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

144.3 (b) "Closure" means the cessation of operations of a nursing facility and delicensure and
144.4 decertification of all beds within the facility.

144.5 (c) "Closure plan" means a plan to close a nursing facility and reallocate a portion of
144.6 the resulting savings to provide planned closure rate adjustments at other facilities.

144.7 (d) "Commencement of closure" means the date on which residents and designated
144.8 representatives are notified of a planned closure as provided in section 144A.161, subdivision
144.9 5a, as part of an approved closure plan.

144.10 (e) "Completion of closure" means the date on which the final resident of the nursing
144.11 facility designated for closure in an approved closure plan is discharged from the facility
144.12 or the date that beds from a partial closure are delicensed and decertified.

144.13 (f) "Partial closure" means the delicensure and decertification of a portion of the beds
144.14 within the facility.

144.15 (g) "Planned closure rate adjustment" means an increase in a nursing facility's operating
144.16 rates resulting from a planned closure or a planned partial closure of another facility.

144.17 Sec. 43. Minnesota Statutes 2016, section 256R.40, subdivision 5, is amended to read:

144.18 Subd. 5. **Planned closure rate adjustment.** (a) The commissioner shall calculate the
144.19 amount of the planned closure rate adjustment available under subdivision 6 according to
144.20 clauses (1) to (4):

144.21 (1) the amount available is the net reduction of nursing facility beds multiplied by \$2,080;

144.22 (2) the total number of beds in the nursing facility or facilities receiving the planned
144.23 closure rate adjustment must be identified;

144.24 (3) capacity days are determined by multiplying the number determined under clause
144.25 (2) by 365; and

144.26 (4) the planned closure rate adjustment is the amount available in clause (1), divided by
144.27 capacity days determined under clause (3).

144.28 (b) A planned closure rate adjustment under this section is effective on the first day of
144.29 the month of January or July, whichever occurs immediately following completion of closure
144.30 of the facility designated for closure in the application and becomes part of the nursing
144.31 facility's external fixed payment rate.

145.1 (c) Upon the request of a closing facility, the commissioner must allow the facility a
145.2 closure rate adjustment as provided under section 144A.161, subdivision 10.

145.3 (d) A facility that has received a planned closure rate adjustment may reassign it to
145.4 another facility that is under the same ownership at any time within three years of its effective
145.5 date. The amount of the adjustment is computed according to paragraph (a).

145.6 (e) If the per bed dollar amount specified in paragraph (a), clause (1), is increased, the
145.7 commissioner shall recalculate planned closure rate adjustments for facilities that delicense
145.8 beds under this section on or after July 1, 2001, to reflect the increase in the per bed dollar
145.9 amount. The recalculated planned closure rate adjustment is effective from the date the per
145.10 bed dollar amount is increased.

145.11 **EFFECTIVE DATE.** This section is effective for closures occurring after July 1, 2017.

145.12 Sec. 44. Minnesota Statutes 2016, section 256R.41, is amended to read:

145.13 **256R.41 SINGLE-BED ROOM INCENTIVE.**

145.14 (a) Beginning July 1, 2005, the operating payment rate for nursing facilities reimbursed
145.15 under this chapter shall be increased by 20 percent multiplied by the ratio of the number of
145.16 new single-bed rooms created divided by the number of active beds on July 1, 2005, for
145.17 each bed closure that results in the creation of a single-bed room after July 1, 2005. The
145.18 commissioner may implement rate adjustments for up to 3,000 new single-bed rooms each
145.19 year. For eligible bed closures for which the commissioner receives a notice from a facility
145.20 ~~during a calendar quarter~~ that a bed has been delicensed and a new single-bed room has
145.21 been established, the rate adjustment in this paragraph shall be effective on either the first
145.22 day of the ~~second~~ month of January or July, whichever occurs first following ~~that calendar~~
145.23 ~~quarter~~ the date of the bed delicensure.

145.24 (b) A nursing facility is prohibited from discharging residents for purposes of establishing
145.25 single-bed rooms. A nursing facility must submit documentation to the commissioner in a
145.26 form prescribed by the commissioner, certifying the occupancy status of beds closed to
145.27 create single-bed rooms. In the event that the commissioner determines that a facility has
145.28 discharged a resident for purposes of establishing a single-bed room, the commissioner shall
145.29 not provide a rate adjustment under paragraph (a).

145.30 **EFFECTIVE DATE.** This section is effective for closures occurring after July 1, 2017.

146.1 Sec. 45. Minnesota Statutes 2016, section 256R.47, is amended to read:

146.2 **256R.47 RATE ADJUSTMENT FOR CRITICAL ACCESS NURSING**
146.3 **FACILITIES.**

146.4 (a) The commissioner, in consultation with the commissioner of health, may designate
146.5 certain nursing facilities as critical access nursing facilities. The designation shall be granted
146.6 on a competitive basis, within the limits of funds appropriated for this purpose.

146.7 (b) The commissioner shall request proposals from nursing facilities every two years.
146.8 Proposals must be submitted in the form and according to the timelines established by the
146.9 commissioner. In selecting applicants to designate, the commissioner, in consultation with
146.10 the commissioner of health, and with input from stakeholders, shall develop criteria designed
146.11 to preserve access to nursing facility services in isolated areas, rebalance long-term care,
146.12 and improve quality. To the extent practicable, the commissioner shall ensure an even
146.13 distribution of designations across the state.

146.14 (c) The commissioner shall allow the benefits in clauses (1) to (5) for nursing facilities
146.15 designated as critical access nursing facilities:

146.16 (1) partial rebasing, with the commissioner allowing a designated facility operating
146.17 payment rates being the sum of up to 60 percent of the operating payment rate determined
146.18 in accordance with section 256R.21, subdivision 3, and at least 40 percent, with the sum of
146.19 the two portions being equal to 100 percent, of the operating payment rate that would have
146.20 been allowed had the facility not been designated. The commissioner may adjust these
146.21 percentages by up to 20 percent and may approve a request for less than the amount allowed;

146.22 (2) enhanced payments for leave days. Notwithstanding section 256R.43, upon
146.23 designation as a critical access nursing facility, the commissioner shall limit payment for
146.24 leave days to 60 percent of that nursing facility's total payment rate for the involved resident,
146.25 and shall allow this payment only when the occupancy of the nursing facility, inclusive of
146.26 bed hold days, is equal to or greater than 90 percent;

146.27 (3) two designated critical access nursing facilities, with up to 100 beds in active service,
146.28 may jointly apply to the commissioner of health for a waiver of Minnesota Rules, part
146.29 4658.0500, subpart 2, in order to jointly employ a director of nursing. The commissioner
146.30 of health shall consider each waiver request independently based on the criteria under
146.31 Minnesota Rules, part 4658.0040;

146.32 (4) the minimum threshold under section 256B.431, subdivision 15, paragraph (e), shall
146.33 be 40 percent of the amount that would otherwise apply; and

147.1 (5) the quality-based rate limits under section 256R.23, subdivisions 5 to 7, apply to
147.2 designated critical access nursing facilities.

147.3 (d) Designation of a critical access nursing facility is for a period of two years, after
147.4 which the benefits allowed under paragraph (c) shall be removed. Designated facilities may
147.5 apply for continued designation.

147.6 (e) This section is suspended and no state or federal funding shall be appropriated or
147.7 allocated for the purposes of this section from January 1, 2016, to December 31, ~~2017~~ 2019.

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

147.9 Sec. 46. Minnesota Statutes 2016, section 256R.49, subdivision 1, is amended to read:

147.10 Subdivision 1. **Rate adjustments for compensation-related costs.** (a) ~~Operating payment~~
147.11 ~~rates of all nursing facilities that are reimbursed under this chapter shall be increased effective~~
147.12 ~~for rate years beginning on and after October 1, 2014, to address changes in compensation~~
147.13 ~~costs for nursing facility employees paid less than \$14 per hour in accordance with this~~
147.14 ~~section.~~ Rate increases provided under this section before October 1, 2016, expire effective
147.15 January 1, 2018, and rate increases provided on or after October 1, 2016, expire effective
147.16 January 1, 2019.

147.17 (b) Nursing facilities that receive approval of the applications in subdivision 2 must
147.18 receive rate adjustments according to subdivision 4. The rate adjustments must be used to
147.19 pay compensation costs for nursing facility employees paid less than \$14 per hour.

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

147.21 Sec. 47. **DIRECTION TO THE COMMISSIONER; ADULT DAY SERVICES**
147.22 **STAFFING RATIOS; ELDERLY WAIVER.**

147.23 The commissioner of human services shall:

147.24 (1) study existing adult day services models, including resident acuity, staffing and
147.25 support levels, and quality assurance;

147.26 (2) project demand for adult day services into the future; and

147.27 (3) report to the legislature by January 1, 2019.

147.28 **EFFECTIVE DATE.** This section is effective July 1, 2017.

148.1 Sec. 48. ALZHEIMER'S DISEASE WORKING GROUP.

148.2 Subdivision 1. **Members.** (a) The Minnesota Board on Aging must appoint 16 members
148.3 to an Alzheimer's disease working group, as follows:

148.4 (1) a caregiver of a person who has been diagnosed with Alzheimer's disease;

148.5 (2) a person who has been diagnosed with Alzheimer's disease;

148.6 (3) two representatives from the nursing facility or senior housing profession;

148.7 (4) a representative of the home care or adult day services profession;

148.8 (5) two geriatricians, one of whom serves a diverse or underserved community;

148.9 (6) a psychologist who specializes in dementia care;

148.10 (7) an Alzheimer's researcher;

148.11 (8) a representative of the Alzheimer's Association;

148.12 (9) two members from community-based organizations serving one or more diverse or
148.13 underserved communities;

148.14 (10) the commissioner of human services or a designee;

148.15 (11) the commissioner of health or a designee;

148.16 (12) the ombudsman for long-term care or a designee; and

148.17 (13) one member of the Minnesota Board on Aging, selected by the board.

148.18 (b) The executive director of the Minnesota Board on Aging serves on the working group
148.19 as a nonvoting member.

148.20 (c) The appointing authorities under this subdivision must complete their appointments
148.21 no later than December 15, 2017.

148.22 (d) To the extent practicable, the membership of the working group must reflect the
148.23 diversity in Minnesota, and must include representatives from rural and metropolitan areas
148.24 and representatives of different ethnicities, races, genders, ages, cultural groups, and abilities.

148.25 Subd. 2. **Duties; recommendations.** The Alzheimer's disease working group must
148.26 review and revise the 2011 report, Preparing Minnesota for Alzheimer's: the Budgetary,
148.27 Social and Personal Impacts. The working group shall consider and make recommendations
148.28 and findings on the following issues as related to Alzheimer's disease or other dementias:

148.29 (1) analysis and assessment of public health and health care data to accurately determine
148.30 trends and disparities in cognitive decline;

149.1 (2) public awareness, knowledge, and attitudes, including knowledge gaps, stigma,
149.2 availability of information, and supportive community environments;

149.3 (3) risk reduction, including health education and health promotion on risk factors,
149.4 safety, and potentially avoidable hospitalizations;

149.5 (4) diagnosis and treatment, including early detection, access to diagnosis, quality of
149.6 dementia care, and cost of treatment;

149.7 (5) professional education and training, including geriatric education for licensed health
149.8 care professionals and dementia-specific training for direct care workers, first responders,
149.9 and other professionals in communities;

149.10 (6) residential services, including cost to families as well as regulation and licensing
149.11 gaps; and

149.12 (7) cultural competence and responsiveness to reduce health disparities and improve
149.13 access to high-quality dementia care.

149.14 Subd. 3. **Meetings.** The Board on Aging must convene the first meeting of the working
149.15 group no later than January 15, 2018. Before the first meeting, the Board on Aging must
149.16 designate one member to serve as chair. Meetings of the working group must be open to
149.17 the public, and to the extent practicable, technological means, such as Web casts, shall be
149.18 used to reach the greatest number of people throughout the state. The working group may
149.19 not meet more than five times.

149.20 Subd. 4. **Compensation.** Members of the working group serve without compensation,
149.21 but may be reimbursed for allowed actual and necessary expenses incurred in the performance
149.22 of the member's duties for the working group in the same manner and amount as authorized
149.23 by the commissioner's plan adopted under Minnesota Statutes, section 43A.18, subdivision
149.24 2.

149.25 Subd. 5. **Administrative support.** The Minnesota Board on Aging shall provide
149.26 administrative support and arrange meeting space for the working group.

149.27 Subd. 6. **Report.** The Board on Aging must submit a report providing the findings and
149.28 recommendations of the working group, including any draft legislation necessary to
149.29 implement the recommendations, to the governor and chairs and ranking minority members
149.30 of the legislative committees with jurisdiction over health care by January 15, 2019.

149.31 Subd. 7. **Expiration.** The working group expires June 30, 2019, or the day after the
149.32 working group submits the report required in subdivision 6, whichever is earlier.

150.1 **Sec. 49. ELECTRONIC SERVICE DELIVERY DOCUMENTATION SYSTEM.**

150.2 **Subdivision 1. Documentation; establishment.** The commissioner of human services
150.3 shall establish implementation requirements and standards for an electronic service delivery
150.4 documentation system to comply with the 21st Century Cures Act, Public Law 114-255.
150.5 Within available appropriations, the commissioner shall take steps to comply with the
150.6 electronic visit verification requirements in the 21st Century Cures Act, Public Law 114-255.

150.7 **Subd. 2. Definitions.** (a) For purposes of this section, the terms in this subdivision have
150.8 the meanings given them.

150.9 (b) "Electronic service delivery documentation" means the electronic documentation of
150.10 the:

- 150.11 (1) type of service performed;
150.12 (2) individual receiving the service;
150.13 (3) date of the service;
150.14 (4) location of the service delivery;
150.15 (5) individual providing the service; and
150.16 (6) time the service begins and ends.

150.17 (c) "Electronic service delivery documentation system" means a system that provides
150.18 electronic service delivery documentation that complies with the 21st Century Cures Act,
150.19 Public Law 114-255, and the requirements of subdivision 3.

150.20 (d) "Service" means one of the following:

- 150.21 (1) personal care assistance services as defined in Minnesota Statutes, section 256B.0625,
150.22 subdivision 19a, and provided according to Minnesota Statutes, section 256B.0659; or
150.23 (2) community first services and supports under Minnesota Statutes, section 256B.85.

150.24 **Subd. 3. Requirements.** (a) In developing implementation requirements for an electronic
150.25 service delivery documentation system, the commissioner shall consider electronic visit
150.26 verification systems and other electronic service delivery documentation methods. The
150.27 commissioner shall convene stakeholders that will be impacted by an electronic service
150.28 delivery system, including service providers and their representatives, service recipients
150.29 and their representatives, and, as appropriate, those with expertise in the development and
150.30 operation of an electronic service delivery documentation system, to ensure that the
150.31 requirements:

- 151.1 (1) are minimally administratively and financially burdensome to a provider;
151.2 (2) are minimally burdensome to the service recipient and the least disruptive to the
151.3 service recipient in receiving and maintaining allowed services;
151.4 (3) consider existing best practices and use of electronic service delivery documentation;
151.5 (4) are conducted according to all state and federal laws;
151.6 (5) are effective methods for preventing fraud when balanced against the requirements
151.7 of clauses (1) and (2); and
151.8 (6) are consistent with the Department of Human Services' policies related to covered
151.9 services, flexibility of service use, and quality assurance.

151.10 (b) The commissioner shall make training available to providers on the electronic service
151.11 delivery documentation system requirements.

151.12 (c) The commissioner shall establish baseline measurements related to preventing fraud
151.13 and establish measures to determine the effect of electronic service delivery documentation
151.14 requirements on program integrity.

151.15 Subd. 4. **Legislative report.** (a) The commissioner shall submit a report by January 15,
151.16 2018, to the chairs and ranking minority members of the legislative committees with
151.17 jurisdiction over human services with recommendations, based on the requirements of
151.18 subdivision 3, to establish electronic service delivery documentation system requirements
151.19 and standards. The report shall identify:

151.20 (1) the essential elements necessary to operationalize a base-level electronic service
151.21 delivery documentation system to be implemented by January 1, 2019; and

151.22 (2) enhancements to the base-level electronic service delivery documentation system to
151.23 be implemented by January 1, 2019, or after, with projected operational costs and the costs
151.24 and benefits for system enhancements.

151.25 (b) The report must also identify current regulations on service providers that are either
151.26 inefficient, minimally effective, or will be unnecessary with the implementation of an
151.27 electronic service delivery documentation system.

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

151.29 Sec. 50. **REVISOR'S INSTRUCTION.**

151.30 The revisor of statutes, in consultation with the House Research Department, Office of
151.31 Senate Counsel, Research, and Fiscal Analysis, and Department of Human Services shall

152.1 prepare legislation for the 2018 legislative session to recodify laws governing the elderly
152.2 waiver program in Minnesota Statutes, chapter 256B.

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

152.4 **ARTICLE 4**

152.5 **HEALTH CARE**

152.6 Section 1. Minnesota Statutes 2016, section 3.972, is amended by adding a subdivision
152.7 to read:

152.8 **Subd. 2a. Audits of Department of Human Services.** (a) To ensure continuous
152.9 legislative oversight and accountability, the legislative auditor shall give high priority to
152.10 auditing the programs, services, and benefits administered by the Department of Human
152.11 Services. The audits shall determine whether the department offered programs and provided
152.12 services and benefits only to eligible persons and organizations, and complied with applicable
152.13 legal requirements.

152.14 (b) The legislative auditor shall, based on an assessment of risk and using professional
152.15 standards to provide a statistically significant sample, no less than three times each year,
152.16 test a representative sample of persons enrolled in a medical assistance program or
152.17 MinnesotaCare to determine whether they are eligible to receive benefits under those
152.18 programs. The legislative auditor shall report the results to the commissioner of human
152.19 services and recommend corrective actions. The commissioner shall provide a response to
152.20 the legislative auditor within 20 business days, including corrective actions to be taken to
152.21 address any problems identified by the legislative auditor and anticipated completion dates.
152.22 The legislative auditor shall monitor the commissioner's implementation of corrective actions
152.23 and periodically report the results to the Legislative Audit Commission and the chairs and
152.24 ranking minority members of the legislative committees with jurisdiction over health and
152.25 human services policy and finance. The legislative auditor's reports to the commission and
152.26 the chairs and ranking minority members must include recommendations for any legislative
152.27 actions needed to ensure that medical assistance and MinnesotaCare benefits are provided
152.28 only to eligible persons.

152.29 Sec. 2. Minnesota Statutes 2016, section 3.972, is amended by adding a subdivision to
152.30 read:

152.31 **Subd. 2b. Audits of managed care organizations.** (a) The legislative auditor shall audit
152.32 each managed care organization that contracts with the commissioner of human services to
152.33 provide health care services under sections 256B.69, 256B.692, and 256L.12. The legislative

153.1 auditor shall design the audits to determine if a managed care organization used the public
153.2 money in compliance with federal and state laws, rules, and in accordance with provisions
153.3 in the managed care organization's contract with the commissioner of human services. The
153.4 legislative auditor shall determine the schedule and scope of the audit work and may contract
153.5 with vendors to assist with the audits. The managed care organization must cooperate with
153.6 the legislative auditor and must provide the legislative auditor with all data, documents, and
153.7 other information, regardless of classification, that the legislative auditor requests to conduct
153.8 an audit. The legislative auditor shall periodically report audit results and recommendations
153.9 to the Legislative Audit Commission and the chairs and ranking minority members of the
153.10 legislative committees with jurisdiction over health and human services policy and finance.

153.11 (b) For purposes of this subdivision, a "managed care organization" means a
153.12 demonstration provider as defined under section 256B.69, subdivision 2.

153.13 Sec. 3. Minnesota Statutes 2016, section 62U.02, is amended to read:

153.14 **62U.02 PAYMENT RESTRUCTURING; QUALITY INCENTIVE PAYMENTS.**

153.15 Subdivision 1. **Development.** (a) The commissioner of health shall develop a standardized
153.16 set of measures for use by health plan companies as specified in subdivision 5. As part of
153.17 the standardized set of measures, the commissioner shall establish statewide measures by
153.18 which to assess the quality of health care services offered by health care providers, including
153.19 health care providers certified as health care homes under section 256B.0751. Quality
153.20 measures must be based on medical evidence and be developed through a process in which
153.21 providers participate. The statewide measures shall be used for the quality incentive payment
153.22 system developed in subdivision 2 and the quality transparency requirements in subdivision
153.23 3. The statewide measures must:

153.24 (1) for purposes of assessing the quality of care provided at physician clinics, including
153.25 clinics certified as health care homes under section 256B.0751, be selected from the available
153.26 measures as defined in Code of Federal Regulations, title 42, part 414 or 495, as amended,
153.27 unless the stakeholders identified under paragraph (b) determine that a particular diagnosis,
153.28 condition, service, or procedure is not reflected in any of the available measures in a way
153.29 that meets identified needs;

153.30 (2) be based on medical evidence;

153.31 (3) be developed through a process in which providers participate and consumer and
153.32 community input and perspectives are obtained;

154.1 ~~(1)~~ (4) include uniform definitions, measures, and forms for submission of data, to the
154.2 greatest extent possible;

154.3 ~~(2)~~ (5) seek to avoid increasing the administrative burden on health care providers; and

154.4 (3) be initially based on existing quality indicators for physician and hospital services,
154.5 which are measured and reported publicly by quality measurement organizations, including,
154.6 but not limited to, Minnesota Community Measurement and specialty societies;

154.7 ~~(4)~~ (6) place a priority on measures of health care outcomes, rather than process measures,
154.8 wherever possible; and

154.9 (5) incorporate measures for primary care, including preventive services, coronary artery
154.10 and heart disease, diabetes, asthma, depression, and other measures as determined by the
154.11 commissioner.

154.12 The measures may also include measures of care infrastructure and patient satisfaction.

154.13 (b) By June 30, 2018, the commissioner shall develop a measurement framework that
154.14 identifies the most important elements for assessing the quality of care, articulates statewide
154.15 quality improvement goals, ensures clinical relevance, fosters alignment with other
154.16 measurement efforts, and defines the roles of stakeholders. By December 15, 2018, the
154.17 commissioner shall use the framework to update the statewide measures used to assess the
154.18 quality of health care services offered by health care providers, including health care
154.19 providers certified as health care homes under section 256B.0751. No more than six statewide
154.20 measures shall be required for single-specialty physician practices and no more than ten
154.21 statewide measures shall be required for multispecialty physician practices. Measures in
154.22 addition to the six statewide measures for single-specialty practices and the ten statewide
154.23 measures for multispecialty practices may be included for a physician practice if derived
154.24 from administrative claims data. Care infrastructure measures collected according to section
154.25 62J.495 shall not be counted toward the maximum number of measures specified in this
154.26 paragraph. The commissioner shall develop the framework in consultation with stakeholders
154.27 that include consumer, community, and advocacy organizations representing diverse
154.28 communities and patients; health plan companies; health care providers whose quality is
154.29 assessed, including providers who serve primarily socioeconomically complex patient
154.30 populations; health care purchasers; community health boards; and quality improvement
154.31 and measurement organizations. The commissioner, in consultation with stakeholders, shall
154.32 review the framework at least once every three years. The commissioner shall also submit
154.33 a report to the chairs and ranking minority members of the legislative committees with
154.34 jurisdiction over health and human services policy and finance by September 30, 2018,

155.1 summarizing the development of the measurement framework and making recommendations
155.2 on the type and appropriate maximum number of measures in the statewide measures set
155.3 for implementation on January 1, 2020.

155.4 (b) (c) Effective July 1, 2016, the commissioner shall stratify quality measures by race,
155.5 ethnicity, preferred language, and country of origin beginning with five measures, and
155.6 stratifying additional measures to the extent resources are available. On or after January 1,
155.7 2018, the commissioner may require measures to be stratified by other sociodemographic
155.8 factors or composite indices of multiple factors that according to reliable data are correlated
155.9 with health disparities and have an impact on performance on quality or cost indicators.
155.10 New methods of stratifying data under this paragraph must be tested and evaluated through
155.11 pilot projects prior to adding them to the statewide system. In determining whether to add
155.12 additional sociodemographic factors and developing the methodology to be used, the
155.13 commissioner shall consider the reporting burden on providers and determine whether there
155.14 are alternative sources of data that could be used. The commissioner shall ensure that
155.15 categories and data collection methods are developed in consultation with those communities
155.16 impacted by health disparities using culturally appropriate community engagement principles
155.17 and methods. The commissioner shall implement this paragraph in coordination with the
155.18 contracting entity retained under subdivision 4, in order to build upon the data stratification
155.19 methodology that has been developed and tested by the entity. Nothing in this paragraph
155.20 expands or changes the commissioner's authority to collect, analyze, or report health care
155.21 data. Any data collected to implement this paragraph must be data that is available or is
155.22 authorized to be collected under other laws. Nothing in this paragraph grants authority to
155.23 the commissioner to collect or analyze patient-level or patient-specific data of the patient
155.24 characteristics identified under this paragraph.

155.25 (e) (d) The statewide measures shall be reviewed at least annually by the commissioner.

155.26 Subd. 2. **Quality incentive payments.** (a) By July 1, 2009, the commissioner shall
155.27 develop a system of quality incentive payments under which providers are eligible for
155.28 quality-based payments that are in addition to existing payment levels, based upon a
155.29 comparison of provider performance against specified targets, and improvement over time.
155.30 The targets must be based upon and consistent with the quality measures established under
155.31 subdivision 1.

155.32 (b) To the extent possible, the payment system must adjust for variations in patient
155.33 population in order to reduce incentives to health care providers to avoid high-risk patients
155.34 or populations, including those with risk factors related to race, ethnicity, language, country
155.35 of origin, and sociodemographic factors.

156.1 (c) The requirements of section 62Q.101 do not apply under this incentive payment
156.2 system.

156.3 Subd. 3. **Quality transparency.** (a) The commissioner shall establish standards for
156.4 measuring health outcomes, establish a system for risk adjusting quality measures, and issue
156.5 annual periodic public reports on trends in provider quality beginning July 1, 2010 at the
156.6 statewide, regional, or clinic levels.

156.7 (b) Effective July 1, 2017, the risk adjustment system established under this subdivision
156.8 shall adjust for patient characteristics identified under subdivision 1, paragraph (b) (c), that
156.9 are correlated with health disparities and have an impact on performance on cost and quality
156.10 measures. The risk adjustment method may consist of reporting based on an
156.11 actual-to-expected comparison that reflects the characteristics of the patient population
156.12 served by the clinic or hospital. The commissioner shall implement this paragraph in
156.13 coordination with any contracting entity retained under subdivision 4.

156.14 (c) By January 1, 2010, Physician clinics and hospitals shall submit standardized
156.15 electronic information on the outcomes and processes associated with patient care for the
156.16 identified statewide measures to the commissioner or the commissioner's designee in the
156.17 formats specified by the commissioner, which must include alternative formats for clinics
156.18 or hospitals experiencing technological or economic barriers to submission in standardized
156.19 electronic form. In addition to measures of care processes and outcomes, the report may
156.20 include other measures designated by the commissioner, including, but not limited to, care
156.21 infrastructure and patient satisfaction. The commissioner shall ensure that any quality data
156.22 reporting requirements established under this subdivision are not duplicative of publicly
156.23 reported, communitywide quality reporting activities currently under way in Minnesota.
156.24 The commissioner shall ensure that any quality data reporting requirements for physician
156.25 clinics are aligned with the specifications and timelines for the selected measures as defined
156.26 in subdivision 1, paragraph (a), clause (1). The commissioner may develop additional data
156.27 on race, ethnicity, preferred language, country of origin, or other sociodemographic factors
156.28 as identified under subdivision 1, paragraph (c), and as required for stratification or risk
156.29 adjustment. None of the statewide measures selected shall require providers to use an external
156.30 vendor to administer or collect data. Nothing in this subdivision is intended to replace or
156.31 duplicate current privately supported activities related to quality measurement and reporting
156.32 in Minnesota.

156.33 Subd. 4. **Contracting.** The commissioner may contract with a private entity or consortium
156.34 of private entities to complete the tasks in subdivisions 1 to 3. The private entity or
156.35 consortium must be nonprofit and have governance that includes representatives from the

157.1 following stakeholder groups: health care providers, including providers serving high
157.2 concentrations of patients and communities impacted by health disparities; health plan
157.3 companies; consumers, including consumers representing groups who experience health
157.4 disparities; employers or other health care purchasers; and state government. No one
157.5 stakeholder group shall have a majority of the votes on any issue or hold extraordinary
157.6 powers not granted to any other governance stakeholder.

157.7 Subd. 5. **Implementation.** (a) By January 1, 2010, Health plan companies shall use the
157.8 standardized quality set of measures established under this section and shall not require
157.9 providers to use and report health plan company-specific quality and outcome measures.

157.10 ~~(b) By July 1, 2010, the commissioner of management and budget shall implement this~~
157.11 ~~incentive payment system for all participants in the state employee group insurance program.~~

157.12 Sec. 4. Minnesota Statutes 2016, section 256.01, is amended by adding a subdivision to
157.13 read:

157.14 Subd. 18f. **Asset verification system.** The commissioner shall implement the Asset
157.15 Verification System (AVS) according to Public Law 110-252, title VII, section 7001(d), to
157.16 verify assets for an individual applying for or renewing health care benefits under section
157.17 256B.055, subdivision 7.

157.18 **EFFECTIVE DATE.** This section is effective July 1, 2017.

157.19 Sec. 5. Minnesota Statutes 2016, section 256.9685, subdivision 1, is amended to read:

157.20 Subdivision 1. **Authority.** (a) The commissioner shall establish procedures for
157.21 determining medical assistance payment rates under a prospective payment system for
157.22 inpatient hospital services in hospitals that qualify as vendors of medical assistance. The
157.23 commissioner shall establish, by rule, procedures for implementing this section and sections
157.24 256.9686, 256.969, and 256.9695. Services must meet the requirements of section 256B.04,
157.25 subdivision 15, to be eligible for payment.

157.26 ~~(b) The commissioner may reduce the types of inpatient hospital admissions that are~~
157.27 ~~required to be certified as medically necessary after notice in the State Register and a 30-day~~
157.28 ~~comment period.~~

157.29 Sec. 6. Minnesota Statutes 2016, section 256.9685, subdivision 1a, is amended to read:

157.30 Subd. 1a. **Administrative reconsideration.** Notwithstanding section 256B.04,
157.31 subdivision 15, the commissioner shall establish an administrative reconsideration process

158.1 for appeals of inpatient hospital services determined to be medically unnecessary. A physician
158.2 or hospital may request a reconsideration of the decision that inpatient hospital services are
158.3 not medically necessary by submitting a written request for review to the commissioner
158.4 within 30 days after receiving notice of the decision. The reconsideration process shall take
158.5 place prior to the procedures of subdivision 1b and shall be conducted by ~~physicians~~ the
158.6 medical review agent that ~~are~~ is independent of the case under reconsideration. ~~A majority~~
158.7 ~~decision by the physicians is necessary to make a determination that the services were not~~
158.8 ~~medically necessary.~~

158.9 Sec. 7. Minnesota Statutes 2016, section 256.9686, subdivision 8, is amended to read:

158.10 Subd. 8. **Rate year.** "Rate year" means a calendar year from January 1 to December 31.
158.11 Effective with the 2012 base year, rate year means a state fiscal year from July 1 to June
158.12 30.

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

158.14 Sec. 8. Minnesota Statutes 2016, section 256.969, subdivision 1, is amended to read:

158.15 Subdivision 1. **Hospital cost index.** (a) The hospital cost index shall be the change in
158.16 the Centers for Medicare and Medicaid Services Inpatient Hospital Market Basket. The
158.17 commissioner shall use the indices as forecasted for the midpoint of the prior rate year to
158.18 the midpoint of the current rate year.

158.19 (b) Except as authorized under this section, for fiscal years beginning on or after July
158.20 1, 1993, the commissioner of human services shall not provide automatic annual inflation
158.21 adjustments for hospital payment rates under medical assistance.

158.22 **EFFECTIVE DATE.** This section is effective July 1, 2017.

158.23 Sec. 9. Minnesota Statutes 2016, section 256.969, subdivision 2b, is amended to read:

158.24 Subd. 2b. **Hospital payment rates.** (a) For discharges occurring on or after November
158.25 1, 2014, hospital inpatient services for hospitals located in Minnesota shall be paid according
158.26 to the following:

158.27 (1) critical access hospitals as defined by Medicare shall be paid using a cost-based
158.28 methodology;

158.29 (2) long-term hospitals as defined by Medicare shall be paid on a per diem methodology
158.30 under subdivision 25;

159.1 (3) rehabilitation hospitals or units of hospitals that are recognized as rehabilitation
159.2 distinct parts as defined by Medicare shall be paid according to the methodology under
159.3 subdivision 12; and

159.4 (4) all other hospitals shall be paid on a diagnosis-related group (DRG) methodology.

159.5 (b) For the period beginning January 1, 2011, through October 31, 2014, rates shall not
159.6 be rebased, except that a Minnesota long-term hospital shall be rebased effective January
159.7 1, 2011, based on its most recent Medicare cost report ending on or before September 1,
159.8 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on
159.9 December 31, 2010. For rate setting periods after November 1, 2014, in which the base
159.10 years are updated, a Minnesota long-term hospital's base year shall remain within the same
159.11 period as other hospitals.

159.12 (c) Effective for discharges occurring on and after November 1, 2014, payment rates
159.13 for hospital inpatient services provided by hospitals located in Minnesota or the local trade
159.14 area, except for the hospitals paid under the methodologies described in paragraph (a),
159.15 clauses (2) and (3), shall be rebased, incorporating cost and payment methodologies in a
159.16 manner similar to Medicare. The base year for the rates effective November 1, 2014, shall
159.17 be calendar year 2012. The rebasing under this paragraph shall be budget neutral, ensuring
159.18 that the total aggregate payments under the rebased system are equal to the total aggregate
159.19 payments that were made for the same number and types of services in the base year. Separate
159.20 budget neutrality calculations shall be determined for payments made to critical access
159.21 hospitals and payments made to hospitals paid under the DRG system. Only the rate increases
159.22 or decreases under subdivision 3a or 3c that applied to the hospitals being rebased during
159.23 the entire base period shall be incorporated into the budget neutrality calculation.

159.24 (d) For discharges occurring on or after November 1, 2014, through the next rebasing
159.25 that occurs, the rebased rates under paragraph (c) that apply to hospitals under paragraph
159.26 (a), clause (4), shall include adjustments to the projected rates that result in no greater than
159.27 a five percent increase or decrease from the base year payments for any hospital. Any
159.28 adjustments to the rates made by the commissioner under this paragraph and paragraph (e)
159.29 shall maintain budget neutrality as described in paragraph (c).

159.30 (e) For discharges occurring on or after November 1, 2014, through the next two rebasing
159.31 ~~that occurs~~ periods the commissioner may make additional adjustments to the rebased rates,
159.32 and when evaluating whether additional adjustments should be made, the commissioner
159.33 shall consider the impact of the rates on the following:

159.34 (1) pediatric services;

- 160.1 (2) behavioral health services;
- 160.2 (3) trauma services as defined by the National Uniform Billing Committee;
- 160.3 (4) transplant services;
- 160.4 (5) obstetric services, newborn services, and behavioral health services provided by
- 160.5 hospitals outside the seven-county metropolitan area;
- 160.6 (6) outlier admissions;
- 160.7 (7) low-volume providers; and
- 160.8 (8) services provided by small rural hospitals that are not critical access hospitals.
- 160.9 (f) Hospital payment rates established under paragraph (c) must incorporate the following:
- 160.10 (1) for hospitals paid under the DRG methodology, the base year payment rate per
- 160.11 admission is standardized by the applicable Medicare wage index and adjusted by the
- 160.12 hospital's disproportionate population adjustment;
- 160.13 (2) for critical access hospitals, payment rates for discharges between November 1, 2014,
- 160.14 and June 30, 2015, shall be set to the same rate of payment that applied for discharges on
- 160.15 October 31, 2014;
- 160.16 (3) the cost and charge data used to establish hospital payment rates must only reflect
- 160.17 inpatient services covered by medical assistance; and
- 160.18 (4) in determining hospital payment rates for discharges occurring on or after the rate
- 160.19 year beginning January 1, 2011, through December 31, 2012, the hospital payment rate per
- 160.20 discharge shall be based on the cost-finding methods and allowable costs of the Medicare
- 160.21 program in effect during the base year or years. In determining hospital payment rates for
- 160.22 discharges in subsequent base years, the per discharge rates shall be based on the cost-finding
- 160.23 methods and allowable costs of the Medicare program in effect during the base year or
- 160.24 years.
- 160.25 (g) The commissioner shall validate the rates effective November 1, 2014, by applying
- 160.26 the rates established under paragraph (c), and any adjustments made to the rates under
- 160.27 paragraph (d) or (e), to hospital claims paid in calendar year 2013 to determine whether the
- 160.28 total aggregate payments for the same number and types of services under the rebased rates
- 160.29 are equal to the total aggregate payments made during calendar year 2013.
- 160.30 (h) Effective for discharges occurring on or after July 1, 2017, and every two years
- 160.31 thereafter, payment rates under this section shall be rebased to reflect only those changes
- 160.32 in hospital costs between the existing base year and the next base year. Changes in costs

161.1 between base years shall be measured using the lower of the hospital cost index defined in
161.2 subdivision 1, paragraph (a), or the percentage change in the case mix adjusted cost per
161.3 claim. The commissioner shall establish the base year for each rebasing period considering
161.4 the most recent year for which filed Medicare cost reports are available. The estimated
161.5 change in the average payment per hospital discharge resulting from a scheduled rebasing
161.6 must be calculated and made available to the legislature by January 15 of each year in which
161.7 rebasing is scheduled to occur, and must include by hospital the differential in payment
161.8 rates compared to the individual hospital's costs.

161.9 (i) Effective for discharges occurring on or after July 1, 2015, inpatient payment rates
161.10 for critical access hospitals located in Minnesota or the local trade area shall be determined
161.11 using a new cost-based methodology. The commissioner shall establish within the
161.12 methodology tiers of payment designed to promote efficiency and cost-effectiveness.
161.13 Payment rates for hospitals under this paragraph shall be set at a level that does not exceed
161.14 the total cost for critical access hospitals as reflected in base year cost reports. Until the
161.15 next rebasing that occurs, the new methodology shall result in no greater than a five percent
161.16 decrease from the base year payments for any hospital, except a hospital that had payments
161.17 that were greater than 100 percent of the hospital's costs in the base year shall have their
161.18 rate set equal to 100 percent of costs in the base year. The rates paid for discharges on and
161.19 after July 1, 2016, covered under this paragraph shall be increased by the inflation factor
161.20 in subdivision 1, paragraph (a). The new cost-based rate shall be the final rate and shall not
161.21 be settled to actual incurred costs. Hospitals shall be assigned a payment tier based on the
161.22 following criteria:

161.23 (1) hospitals that had payments at or below 80 percent of their costs in the base year
161.24 shall have a rate set that equals 85 percent of their base year costs;

161.25 (2) hospitals that had payments that were above 80 percent, up to and including 90
161.26 percent of their costs in the base year shall have a rate set that equals 95 percent of their
161.27 base year costs; and

161.28 (3) hospitals that had payments that were above 90 percent of their costs in the base year
161.29 shall have a rate set that equals 100 percent of their base year costs.

161.30 (j) The commissioner may refine the payment tiers and criteria for critical access hospitals
161.31 to coincide with the next rebasing under paragraph (h). The factors used to develop the new
161.32 methodology may include, but are not limited to:

161.33 (1) the ratio between the hospital's costs for treating medical assistance patients and the
161.34 hospital's charges to the medical assistance program;

162.1 (2) the ratio between the hospital's costs for treating medical assistance patients and the
162.2 hospital's payments received from the medical assistance program for the care of medical
162.3 assistance patients;

162.4 (3) the ratio between the hospital's charges to the medical assistance program and the
162.5 hospital's payments received from the medical assistance program for the care of medical
162.6 assistance patients;

162.7 (4) the statewide average increases in the ratios identified in clauses (1), (2), and (3);

162.8 (5) the proportion of that hospital's costs that are administrative and trends in
162.9 administrative costs; and

162.10 (6) geographic location.

162.11 **EFFECTIVE DATE.** This section is effective July 1, 2017.

162.12 Sec. 10. Minnesota Statutes 2016, section 256.969, subdivision 3a, is amended to read:

162.13 Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical assistance program
162.14 must not be submitted until the recipient is discharged. However, the commissioner shall
162.15 establish monthly interim payments for inpatient hospitals that have individual patient
162.16 lengths of stay over 30 days regardless of diagnostic category. Except as provided in section
162.17 256.9693, medical assistance reimbursement for treatment of mental illness shall be
162.18 reimbursed based on diagnostic classifications. Individual hospital payments established
162.19 under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third-party
162.20 and recipient liability, for discharges occurring during the rate year shall not exceed, in
162.21 aggregate, the charges for the medical assistance covered inpatient services paid for the
162.22 same period of time to the hospital. Services that have rates established under subdivision
162.23 ~~11~~ or 12, must be limited separately from other services. After consulting with the affected
162.24 hospitals, the commissioner may consider related hospitals one entity and may merge the
162.25 payment rates while maintaining separate provider numbers. The operating and property
162.26 base rates per admission or per day shall be derived from the best Medicare and claims data
162.27 available when rates are established. The commissioner shall determine the best Medicare
162.28 and claims data, taking into consideration variables of recency of the data, audit disposition,
162.29 settlement status, and the ability to set rates in a timely manner. The commissioner shall
162.30 notify hospitals of payment rates 30 days prior to implementation. The rate setting data
162.31 must reflect the admissions data used to establish relative values. The commissioner may
162.32 adjust base year cost, relative value, and case mix index data to exclude the costs of services
162.33 that have been discontinued by the October 1 of the year preceding the rate year or that are

163.1 paid separately from inpatient services. Inpatient stays that encompass portions of two or
163.2 more rate years shall have payments established based on payment rates in effect at the time
163.3 of admission unless the date of admission preceded the rate year in effect by six months or
163.4 more. In this case, operating payment rates for services rendered during the rate year in
163.5 effect and established based on the date of admission shall be adjusted to the rate year in
163.6 effect by the hospital cost index.

163.7 (b) For fee-for-service admissions occurring on or after July 1, 2002, the total payment,
163.8 before third-party liability and spenddown, made to hospitals for inpatient services is reduced
163.9 by .5 percent from the current statutory rates.

163.10 (c) In addition to the reduction in paragraph (b), the total payment for fee-for-service
163.11 admissions occurring on or after July 1, 2003, made to hospitals for inpatient services before
163.12 third-party liability and spenddown, is reduced five percent from the current statutory rates.
163.13 Mental health services within diagnosis related groups 424 to 432 or corresponding
163.14 APR-DRGs, and facilities defined under subdivision 16 are excluded from this paragraph.

163.15 (d) In addition to the reduction in paragraphs (b) and (c), the total payment for
163.16 fee-for-service admissions occurring on or after August 1, 2005, made to hospitals for
163.17 inpatient services before third-party liability and spenddown, is reduced 6.0 percent from
163.18 the current statutory rates. Mental health services within diagnosis related groups 424 to
163.19 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded
163.20 from this paragraph. Payments made to managed care plans shall be reduced for services
163.21 provided on or after January 1, 2006, to reflect this reduction.

163.22 (e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
163.23 fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made
163.24 to hospitals for inpatient services before third-party liability and spenddown, is reduced
163.25 3.46 percent from the current statutory rates. Mental health services with diagnosis related
163.26 groups 424 to 432 or corresponding APR-DRGs, and facilities defined under subdivision
163.27 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced
163.28 for services provided on or after January 1, 2009, through June 30, 2009, to reflect this
163.29 reduction.

163.30 (f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
163.31 fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2011, made
163.32 to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.9
163.33 percent from the current statutory rates. Mental health services with diagnosis related groups
163.34 424 to 432 or corresponding APR-DRGs, and facilities defined under subdivision 16 are

164.1 excluded from this paragraph. Payments made to managed care plans shall be reduced for
164.2 services provided on or after July 1, 2009, through June 30, 2011, to reflect this reduction.

164.3 (g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
164.4 fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for inpatient
164.5 services before third-party liability and spenddown, is reduced 1.79 percent from the current
164.6 statutory rates. Mental health services with diagnosis related groups 424 to 432 or
164.7 corresponding APR-DRGs, and facilities defined under subdivision 16 are excluded from
164.8 this paragraph. Payments made to managed care plans shall be reduced for services provided
164.9 on or after July 1, 2011, to reflect this reduction.

164.10 (h) In addition to the reductions in paragraphs (b), (c), (d), (f), and (g), the total payment
164.11 for fee-for-service admissions occurring on or after July 1, 2009, made to hospitals for
164.12 inpatient services before third-party liability and spenddown, is reduced one percent from
164.13 the current statutory rates. Facilities defined under subdivision 16 are excluded from this
164.14 paragraph. Payments made to managed care plans shall be reduced for services provided
164.15 on or after October 1, 2009, to reflect this reduction.

164.16 (i) In addition to the reductions in paragraphs (b), (c), (d), (g), and (h), the total payment
164.17 for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for
164.18 inpatient services before third-party liability and spenddown, is reduced 1.96 percent from
164.19 the current statutory rates. Facilities defined under subdivision 16 are excluded from this
164.20 paragraph. Payments made to managed care plans shall be reduced for services provided
164.21 on or after January 1, 2011, to reflect this reduction.

164.22 (j) Effective for discharges on and after November 1, 2014, from hospitals paid under
164.23 subdivision 2b, paragraph (a), clauses (1) and (4), the rate adjustments in this subdivision
164.24 must be incorporated into the rebased rates established under subdivision 2b, paragraph (c),
164.25 and must not be applied to each claim.

164.26 (k) Effective for discharges on and after July 1, 2015, from hospitals paid under
164.27 subdivision 2b, paragraph (a), clauses (2) and (3), the rate adjustments in this subdivision
164.28 must be incorporated into the rates and must not be applied to each claim.

164.29 (l) Effective for discharges on and after July 1, 2017, from hospitals paid under
164.30 subdivision 2b, paragraph (a), clause (2), the rate adjustments in this subdivision must be
164.31 incorporated into the rates and must not be applied to each claim.

164.32 **EFFECTIVE DATE.** This section is effective July 1, 2017.

165.1 Sec. 11. Minnesota Statutes 2016, section 256.969, subdivision 8, is amended to read:

165.2 Subd. 8. **Unusual length of stay experience.** (a) The commissioner shall establish day
165.3 outlier thresholds for each diagnostic category established under subdivision 2 at two standard
165.4 deviations beyond the mean length of stay. Payment for the days beyond the outlier threshold
165.5 shall be in addition to the operating and property payment rates per admission established
165.6 under subdivisions 2 and 2b. Payment for outliers shall be at 70 percent of the allowable
165.7 operating cost, after adjustment by the case mix index, hospital cost index, relative values
165.8 and the disproportionate population adjustment. The outlier threshold for neonatal and burn
165.9 diagnostic categories shall be established at one standard deviation beyond the mean length
165.10 of stay, and payment shall be at 90 percent of allowable operating cost calculated in the
165.11 same manner as other outliers. A hospital may choose an alternative to the 70 percent outlier
165.12 payment that is at a minimum of 60 percent and a maximum of 80 percent if the
165.13 commissioner is notified in writing of the request by October 1 of the year preceding the
165.14 rate year. The chosen percentage applies to all diagnostic categories except burns and
165.15 neonates. The percentage of allowable cost that is unrecognized by the outlier payment shall
165.16 be added back to the base year operating payment rate per admission.

165.17 (b) Effective for admissions and transfers occurring on and after November 1, 2014, the
165.18 commissioner shall establish payment rates for outlier payments that are based on Medicare
165.19 methodologies.

165.20 **EFFECTIVE DATE.** This section is effective July 1, 2017.

165.21 Sec. 12. Minnesota Statutes 2016, section 256.969, subdivision 8c, is amended to read:

165.22 Subd. 8c. **Hospital residents.** (a) For discharges occurring on or after November 1,
165.23 2014, payments for hospital residents shall be made as follows:

165.24 (1) payments for the first 180 days of inpatient care shall be the APR-DRG system plus
165.25 any outliers; and

165.26 (2) payment for all medically necessary patient care subsequent to the first 180 days
165.27 shall be reimbursed at a rate computed by multiplying the statewide average cost-to-charge
165.28 ratio by the usual and customary charges.

165.29 (b) For discharges occurring on or after July 1, 2017, payment for hospital residents
165.30 shall be equal to the payments under subdivision 8, paragraph (b).

165.31 **EFFECTIVE DATE.** This section is effective July 1, 2017.

166.1 Sec. 13. Minnesota Statutes 2016, section 256.969, subdivision 9, is amended to read:

166.2 Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For admissions
166.3 occurring on or after July 1, 1993, the medical assistance disproportionate population
166.4 adjustment shall comply with federal law and shall be paid to a hospital, excluding regional
166.5 treatment centers and facilities of the federal Indian Health Service, with a medical assistance
166.6 inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined
166.7 as follows:

166.8 (1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic
166.9 mean for all hospitals excluding regional treatment centers and facilities of the federal Indian
166.10 Health Service but less than or equal to one standard deviation above the mean, the
166.11 adjustment must be determined by multiplying the total of the operating and property
166.12 payment rates by the difference between the hospital's actual medical assistance inpatient
166.13 utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers
166.14 and facilities of the federal Indian Health Service; and

166.15 (2) for a hospital with a medical assistance inpatient utilization rate above one standard
166.16 deviation above the mean, the adjustment must be determined by multiplying the adjustment
166.17 that would be determined under clause (1) for that hospital by 1.1. The commissioner shall
166.18 report annually on the number of hospitals likely to receive the adjustment authorized by
166.19 this paragraph. The commissioner shall specifically report on the adjustments received by
166.20 public hospitals and public hospital corporations located in cities of the first class.

166.21 (b) Certified public expenditures made by Hennepin County Medical Center shall be
166.22 considered Medicaid disproportionate share hospital payments. Hennepin County and
166.23 Hennepin County Medical Center shall report by June 15, 2007, on payments made beginning
166.24 July 1, 2005, or another date specified by the commissioner, that may qualify for
166.25 reimbursement under federal law. Based on these reports, the commissioner shall apply for
166.26 federal matching funds.

166.27 (c) Upon federal approval of the related state plan amendment, paragraph (b) is effective
166.28 retroactively from July 1, 2005, or the earliest effective date approved by the Centers for
166.29 Medicare and Medicaid Services.

166.30 (d) Effective July 1, 2015, disproportionate share hospital (DSH) payments shall be paid
166.31 in accordance with a new methodology using 2012 as the base year. Annual payments made
166.32 under this paragraph shall equal the total amount of payments made for 2012. A licensed
166.33 children's hospital shall receive only a single DSH factor for children's hospitals. Other
166.34 DSH factors may be combined to arrive at a single factor for each hospital that is eligible

167.1 for DSH payments. The new methodology shall make payments only to hospitals located
167.2 in Minnesota and include the following factors:

167.3 (1) a licensed children's hospital with at least 1,000 fee-for-service discharges in the
167.4 base year shall receive a factor of 0.868. A licensed children's hospital with less than 1,000
167.5 fee-for-service discharges in the base year shall receive a factor of 0.7880;

167.6 (2) a hospital that has in effect for the initial rate year a contract with the commissioner
167.7 to provide extended psychiatric inpatient services under section 256.9693 shall receive a
167.8 factor of 0.0160;

167.9 (3) a hospital that has received payment from the fee-for-service program for at least 20
167.10 transplant services in the base year shall receive a factor of 0.0435;

167.11 (4) a hospital that has a medical assistance utilization rate in the base year between 20
167.12 percent up to one standard deviation above the statewide mean utilization rate shall receive
167.13 a factor of 0.0468;

167.14 (5) a hospital that has a medical assistance utilization rate in the base year that is at least
167.15 one standard deviation above the statewide mean utilization rate but is less than three standard
167.16 deviations above the mean shall receive a factor of 0.2300; and

167.17 (6) a hospital that has a medical assistance utilization rate in the base year that is at least
167.18 three standard deviations above the statewide mean utilization rate shall receive a factor of
167.19 0.3711.

167.20 (e) Any payments or portion of payments made to a hospital under this subdivision that
167.21 are subsequently returned to the commissioner because the payments are found to exceed
167.22 the hospital-specific DSH limit for that hospital shall be redistributed, proportionate to the
167.23 number of fee-for-service discharges, to other DSH-eligible ~~nonchildren's~~ non-children's
167.24 hospitals that have a medical assistance utilization rate that is at least one standard deviation
167.25 above the mean.

167.26 **EFFECTIVE DATE.** This section is effective July 1, 2017.

167.27 Sec. 14. Minnesota Statutes 2016, section 256.969, subdivision 12, is amended to read:

167.28 Subd. 12. **Rehabilitation hospitals and distinct parts.** (a) Units of hospitals that are
167.29 recognized as rehabilitation distinct parts by the Medicare program shall have separate
167.30 provider numbers under the medical assistance program for rate establishment and billing
167.31 purposes only. These units shall also have operating payment rates and the disproportionate

168.1 population adjustment, if allowed by federal law, established separately from other inpatient
168.2 hospital services.

168.3 (b) The commissioner shall establish separate relative values under subdivision 2 for
168.4 rehabilitation hospitals and distinct parts as defined by the Medicare program. Effective for
168.5 discharges occurring on and after November 1, 2014, the commissioner, to the extent
168.6 possible, shall replicate the existing payment rate methodology under the new diagnostic
168.7 classification system. The result must be budget neutral, ensuring that the total aggregate
168.8 payments under the new system are equal to the total aggregate payments made for the same
168.9 number and types of services in the base year, calendar year 2012.

168.10 (c) For individual hospitals that did not have separate medical assistance rehabilitation
168.11 provider numbers or rehabilitation distinct parts in the base year, hospitals shall provide the
168.12 information needed to separate rehabilitation distinct part cost and claims data from other
168.13 inpatient service data.

168.14 (d) Effective with discharges on or after July 1, 2017, payment to rehabilitation hospitals
168.15 shall be established under subdivision 2b, paragraph (a), clause (4).

168.16 **EFFECTIVE DATE.** This section is effective July 1, 2017.

168.17 Sec. 15. Minnesota Statutes 2016, section 256.9695, subdivision 1, is amended to read:

168.18 Subdivision 1. **Appeals.** A hospital may appeal a decision arising from the application
168.19 of standards or methods under section 256.9685, 256.9686, or 256.969, if an appeal would
168.20 result in a change to the hospital's payment rate or payments. Both overpayments and
168.21 underpayments that result from the submission of appeals shall be implemented. Regardless
168.22 of any appeal outcome, relative values, Medicare wage indexes, Medicare cost-to-charge
168.23 ratios, and policy adjusters shall not be recalculated changed. The appeal shall be heard by
168.24 an administrative law judge according to sections 14.57 to 14.62, or upon agreement by
168.25 both parties, according to a modified appeals procedure established by the commissioner
168.26 and the Office of Administrative Hearings. In any proceeding under this section, the appealing
168.27 party must demonstrate by a preponderance of the evidence that the commissioner's
168.28 determination is incorrect or not according to law.

168.29 (a) To appeal a payment rate or payment determination or a determination made from
168.30 base year information, the hospital shall file a written appeal request to the commissioner
168.31 within 60 days of the date the preliminary payment rate determination was mailed. The
168.32 appeal request shall specify: (i) the disputed items; (ii) the authority in federal or state statute
168.33 or rule upon which the hospital relies for each disputed item; and (iii) the name and address

169.1 of the person to contact regarding the appeal. Facts to be considered in any appeal of base
169.2 year information are limited to those in existence at the time the payment rates of the first
169.3 rate year were established from the base year information. In the case of Medicare settled
169.4 appeals, the 60-day appeal period shall begin on the mailing date of the notice by the
169.5 Medicare program or the date the medical assistance payment rate determination notice is
169.6 mailed, whichever is later 12 months after the last day of the calendar year that is the base
169.7 year for the payment rates in dispute.

169.8 (b) ~~To appeal a payment rate or payment change that results from a difference in case~~
169.9 ~~mix between the base year and a rate year, the procedures and requirements of paragraph~~
169.10 ~~(a) apply. However, the appeal must be filed with the commissioner within 120 days after~~
169.11 ~~the end of a rate year. A case mix appeal must apply to the cost of services to all medical~~
169.12 ~~assistance patients that received inpatient services from the hospital during the rate year~~
169.13 ~~appealed. For case mix appeals filed after January 1, 1997, the difference in case mix and~~
169.14 ~~the corresponding payment adjustment must exceed a threshold of five percent.~~

169.15 Sec. 16. Minnesota Statutes 2016, section 256B.04, subdivision 12, is amended to read:

169.16 Subd. 12. **Limitation on services.** (a) Place limits on the types of services covered by
169.17 medical assistance, the frequency with which the same or similar services may be covered
169.18 by medical assistance for an individual recipient, and the amount paid for each covered
169.19 service. The state agency shall promulgate rules establishing maximum reimbursement rates
169.20 for emergency and nonemergency transportation.

169.21 The rules shall provide:

169.22 (1) an opportunity for all recognized transportation providers to be reimbursed for
169.23 nonemergency transportation consistent with the maximum rates established by the agency;
169.24 and

169.25 (2) reimbursement of public and private nonprofit providers serving the disabled
169.26 population generally at reasonable maximum rates that reflect the cost of providing the
169.27 service regardless of the fare that might be charged by the provider for similar services to
169.28 individuals other than those receiving medical assistance or medical care under this chapter;
169.29 and.

169.30 (3) ~~reimbursement for each additional passenger carried on a single trip at a substantially~~
169.31 ~~lower rate than the first passenger carried on that trip.~~

169.32 (b) The commissioner shall encourage providers reimbursed under this chapter to
169.33 coordinate their operation with similar services that are operating in the same community.

170.1 To the extent practicable, the commissioner shall encourage eligible individuals to utilize
170.2 less expensive providers capable of serving their needs.

170.3 (c) For the purpose of this subdivision and section 256B.02, subdivision 8, and effective
170.4 on January 1, 1981, "recognized provider of transportation services" means an operator of
170.5 special transportation service as defined in section 174.29 that has been issued a current
170.6 certificate of compliance with operating standards of the commissioner of transportation
170.7 or, if those standards do not apply to the operator, that the agency finds is able to provide
170.8 the required transportation in a safe and reliable manner. Until January 1, 1981, "recognized
170.9 transportation provider" includes an operator of special transportation service that the agency
170.10 finds is able to provide the required transportation in a safe and reliable manner.

170.11 Sec. 17. Minnesota Statutes 2016, section 256B.04, subdivision 24, is amended to read:

170.12 Subd. 24. **Medicaid waiver requests and state plan amendments.** The commissioner
170.13 shall notify the chairs and ranking minority members of the legislative committees with
170.14 jurisdiction over medical assistance at least 30 days before submitting a new Medicaid
170.15 waiver request to the federal government. Prior to submitting any Medicaid waiver request
170.16 or Medicaid state plan amendment to the federal government for approval, the commissioner
170.17 shall publish the text of the waiver request or state plan amendment, and a summary of and
170.18 explanation of the need for the request, on the agency's Web site and provide a 30-day public
170.19 comment period. The commissioner shall notify the public of the availability of this
170.20 information through the agency's electronic subscription service. The commissioner shall
170.21 consider public comments when preparing the final waiver request or state plan amendment
170.22 that is to be submitted to the federal government for approval. The commissioner shall also
170.23 publish on the agency's Web site notice of any federal decision related to the state request
170.24 for approval, within 30 days of the decision. This notice must describe any modifications
170.25 to the state request that have been agreed to by the commissioner as a condition of receiving
170.26 federal approval.

170.27 Sec. 18. Minnesota Statutes 2016, section 256B.056, subdivision 3b, is amended to read:

170.28 Subd. 3b. **Treatment of trusts.** (a) A "medical assistance qualifying trust" is a revocable
170.29 or irrevocable trust, or similar legal device, established on or before August 10, 1993, by a
170.30 person or the person's spouse under the terms of which the person receives or could receive
170.31 payments from the trust principal or income and the trustee has discretion in making payments
170.32 to the person from the trust principal or income. Notwithstanding that definition, a medical
170.33 assistance qualifying trust does not include: (1) a trust set up by will; (2) a trust set up before

171.1 April 7, 1986, solely to benefit a person with a developmental disability living in an
171.2 intermediate care facility for persons with developmental disabilities; or (3) a trust set up
171.3 by a person with payments made by the Social Security Administration pursuant to the
171.4 United States Supreme Court decision in *Sullivan v. Zebley*, 110 S. Ct. 885 (1990). The
171.5 maximum amount of payments that a trustee of a medical assistance qualifying trust may
171.6 make to a person under the terms of the trust is considered to be available assets to the
171.7 person, without regard to whether the trustee actually makes the maximum payments to the
171.8 person and without regard to the purpose for which the medical assistance qualifying trust
171.9 was established.

171.10 (b) ~~Except as provided in paragraphs (c) and (d),~~ Trusts established after August 10,
171.11 1993, are treated according to ~~section 13611(b) of the Omnibus Budget Reconciliation Act~~
171.12 ~~of 1993 (OBRA), Public Law 103-66~~ United States Code, title 42, section 1396p(d).

171.13 (c) For purposes of paragraph (d), a pooled trust means a trust established under United
171.14 States Code, title 42, section 1396p(d)(4)(C).

171.15 (d) A beneficiary's interest in a pooled trust is considered an available asset unless the
171.16 trust provides that upon the death of the beneficiary or termination of the trust during the
171.17 beneficiary's lifetime, whichever is sooner, the department receives any amount, up to the
171.18 amount of medical assistance benefits paid on behalf of the beneficiary, remaining in the
171.19 beneficiary's trust account after a deduction for reasonable administrative fees and expenses,
171.20 and an additional remainder amount. The retained remainder amount of the subaccount
171.21 must not exceed ten percent of the account value at the time of the beneficiary's death or
171.22 termination of the trust, and must only be used for the benefit of disabled individuals who
171.23 have a beneficiary interest in the pooled trust.

171.24 (e) Trusts may be established on or after December 12, 2016, by a person who has been
171.25 determined to be disabled, according to United States Code, title 42, section 1396p(d)(4)(A),
171.26 as amended by section 5007 of the 21st Century Cures Act, Public Law 114-255.

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

171.28 Sec. 19. Minnesota Statutes 2016, section 256B.056, subdivision 3c, is amended to read:

171.29 Subd. 3c. **Asset limitations for families and children.** (a) A household of two or more
171.30 persons must not own more than \$20,000 in total net assets, and a household of one person
171.31 must not own more than \$10,000 in total net assets. In addition to these maximum amounts,
171.32 an eligible individual or family may accrue interest on these amounts, but they must be
171.33 reduced to the maximum at the time of an eligibility redetermination. The value of assets

172.1 that are not considered in determining eligibility for medical assistance for families and
172.2 children is the value of those assets excluded under the AFDC state plan as of July 16, 1996,
172.3 as required by the Personal Responsibility and Work Opportunity Reconciliation Act of
172.4 1996 (PRWORA), Public Law 104-193, with the following exceptions:

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

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

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

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

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

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

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

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

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

172.23 (b) Beginning January 1, 2014, this subdivision applies only to parents and caretaker
172.24 relatives who qualify for medical assistance under subdivision 5.

172.25 **EFFECTIVE DATE.** This section is effective July 1, 2017.

172.26 Sec. 20. Minnesota Statutes 2016, section 256B.056, subdivision 5c, is amended to read:

172.27 Subd. 5c. **Excess income standard.** (a) The excess income standard for parents and
172.28 caretaker relatives, pregnant women, infants, and children ages two through 20 is the standard
172.29 specified in subdivision 4, paragraph (b).

173.1 (b) The excess income standard for a person whose eligibility is based on blindness,
173.2 disability, or age of 65 or more years shall equal ~~80~~ 81 percent of the federal poverty
173.3 guidelines.

173.4 **EFFECTIVE DATE.** This section is effective June 1, 2019.

173.5 Sec. 21. Minnesota Statutes 2016, section 256B.0561, subdivision 2, is amended to read:

173.6 Subd. 2. **Periodic data matching.** (a) Beginning ~~March 1, 2016~~ April 1, 2018, the
173.7 commissioner shall conduct periodic data matching to identify recipients who, based on
173.8 available electronic data, may not meet eligibility criteria for the public health care program
173.9 in which the recipient is enrolled. The commissioner shall conduct data matching for medical
173.10 assistance or MinnesotaCare recipients at least once during a recipient's 12-month period
173.11 of eligibility.

173.12 (b) If data matching indicates a recipient may no longer qualify for medical assistance
173.13 or MinnesotaCare, the commissioner must notify the recipient and allow the recipient no
173.14 more than 30 days to confirm the information obtained through the periodic data matching
173.15 or provide a reasonable explanation for the discrepancy to the state or county agency directly
173.16 responsible for the recipient's case. If a recipient does not respond within the advance notice
173.17 period or does not respond with information that demonstrates eligibility or provides a
173.18 reasonable explanation for the discrepancy within the 30-day time period, the commissioner
173.19 shall terminate the recipient's eligibility in the manner provided for by the laws and
173.20 regulations governing the health care program for which the recipient has been identified
173.21 as being ineligible.

173.22 (c) The commissioner shall not terminate eligibility for a recipient who is cooperating
173.23 with the requirements of paragraph (b) and needs additional time to provide information in
173.24 response to the notification.

173.25 (d) Any termination of eligibility for benefits under this section may be appealed as
173.26 provided for in sections 256.045 to 256.0451, and the laws governing the health care
173.27 programs for which eligibility is terminated.

173.28 Sec. 22. Minnesota Statutes 2016, section 256B.0561, subdivision 4, is amended to read:

173.29 Subd. 4. **Report.** By September 1, ~~2017~~ 2019, and each September 1 thereafter, the
173.30 commissioner shall submit a report to the chairs and ranking minority members of the house
173.31 and senate committees with jurisdiction over human services finance that includes the
173.32 number of cases affected by periodic data matching under this section, the number of

174.1 recipients identified as possibly ineligible as a result of a periodic data match, and the number
174.2 of recipients whose eligibility was terminated as a result of a periodic data match. The report
174.3 must also specify, for recipients whose eligibility was terminated, how many cases were
174.4 closed due to failure to cooperate.

174.5 Sec. 23. Minnesota Statutes 2016, section 256B.057, subdivision 9, as amended by Laws
174.6 2017, chapter 59, section 9, is amended to read:

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

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

174.11 (2) meets the asset limits in paragraph (d); and

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

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

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

174.21 (1) is temporarily unable to work and without receipt of earned income due to a medical
174.22 condition, as verified by a physician, advanced practice registered nurse, or physician
174.23 assistant; or

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

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

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

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

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

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

175.5 (e) All enrollees must pay a premium to be eligible for medical assistance under this
175.6 subdivision, except as provided under clause (5).

175.7 (1) An enrollee must pay the greater of a \$35 premium or the premium calculated based
175.8 on the person's gross earned and unearned income and the applicable family size using a
175.9 sliding fee scale established by the commissioner, which begins at one percent of income
175.10 at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income for
175.11 those with incomes at or above 300 percent of the federal poverty guidelines.

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

175.14 (3) All enrollees who receive unearned income must pay one-half of one percent of
175.15 unearned income in addition to the premium amount, except as provided under clause (5).

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

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

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

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

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

176.3 (i) Nonpayment of the premium shall result in denial or termination of medical assistance
176.4 unless the person demonstrates good cause for nonpayment. ~~Good cause exists if the~~
176.5 ~~requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to D, are~~
176.6 ~~met~~ "Good cause" means an excuse for the enrollee's failure to pay the required premium
176.7 when due because the circumstances were beyond the enrollee's control or not reasonably
176.8 foreseeable. The commissioner shall determine whether good cause exists based on the
176.9 weight of the supporting evidence submitted by the enrollee to demonstrate good cause.

176.10 Except when an installment agreement is accepted by the commissioner, all persons
176.11 disenrolled for nonpayment of a premium must pay any past due premiums as well as current
176.12 premiums due prior to being reenrolled. Nonpayment shall include payment with a returned,
176.13 refused, or dishonored instrument. The commissioner may require a guaranteed form of
176.14 payment as the only means to replace a returned, refused, or dishonored instrument.

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

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

176.20 Sec. 24. Minnesota Statutes 2016, section 256B.059, subdivision 6, as amended by Laws
176.21 2017, chapter 40, article 1, section 66, is amended to read:

176.22 Subd. 6. **Temporary application.** (a) During the period in which rules against spousal
176.23 impoverishment are temporarily applied according to section 2404 of the Patient Protection
176.24 Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education
176.25 Reconciliation Act of 2010, Public Law 111-152, this section applies to an institutionalized
176.26 spouse:

176.27 (1) applying for home and community-based waivers under sections 256B.092, 256B.093,
176.28 and 256B.49 on or after June 1, 2016;

176.29 (2) enrolled in home and community-based waivers under sections 256B.092, 256B.093,
176.30 and 256B.49 before June 1, 2016, based on an application submitted on or after January 1,
176.31 2014; or

176.32 (3) applying for services under section 256B.85 upon the effective date of that section.

177.1 (b) During the applicable period of paragraph (a), the definition of "institutionalized
177.2 spouse" in subdivision 1, paragraph (e), also includes an institutionalized spouse referenced
177.3 in paragraph (a).

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

177.5 Sec. 25. Minnesota Statutes 2016, section 256B.0621, subdivision 10, is amended to read:

177.6 Subd. 10. **Payment rates.** The commissioner shall set payment rates for targeted case
177.7 management under this subdivision. Case managers may bill according to the following
177.8 criteria:

177.9 (1) for relocation targeted case management, case managers may bill for direct case
177.10 management activities, including face-to-face ~~and contact~~, telephone ~~contacts~~ contact, and
177.11 interactive video contact according to section 256B.0924, subdivision 4a, in the lesser of:

177.12 (i) 180 days preceding an eligible recipient's discharge from an institution; or

177.13 (ii) the limits and conditions which apply to federal Medicaid funding for this service;

177.14 (2) for home care targeted case management, case managers may bill for direct case
177.15 management activities, including face-to-face and telephone contacts; and

177.16 (3) billings for targeted case management services under this subdivision shall not
177.17 duplicate payments made under other program authorities for the same purpose.

177.18 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
177.19 of human services shall notify the revisor of statutes when federal approval is obtained.

177.20 Sec. 26. Minnesota Statutes 2016, section 256B.0625, subdivision 1, is amended to read:

177.21 Subdivision 1. **Inpatient hospital services.** (a) Medical assistance covers inpatient
177.22 hospital services. A second medical opinion is required prior to reimbursement for elective
177.23 surgeries requiring a second opinion. The commissioner shall publish in the State Register
177.24 a list of elective surgeries that require a second medical opinion prior to reimbursement,
177.25 and the criteria and standards for deciding whether an elective surgery should require a
177.26 second medical opinion. The list and the criteria and standards are not subject to the
177.27 requirements of sections 14.001 to 14.69. The commissioner's decision whether a second
177.28 medical opinion is required, made in accordance with rules governing that decision, is not
177.29 subject to administrative appeal.

178.1 (b) When determining medical necessity for inpatient hospital services, the medical
178.2 review agent shall follow industry standard medical necessity criteria in determining the
178.3 following:

178.4 (1) whether a recipient's admission is medically necessary;

178.5 (2) whether the inpatient hospital services provided to the recipient were medically
178.6 necessary;

178.7 (3) whether the recipient's continued stay was or will be medically necessary; and

178.8 (4) whether all medically necessary inpatient hospital services were provided to the
178.9 recipient.

178.10 The medical review agent will determine medical necessity of inpatient hospital services,
178.11 including inpatient psychiatric treatment, based on a review of the patient's medical condition
178.12 and records, in conjunction with industry standard evidence-based criteria to ensure consistent
178.13 and optimal application of medical appropriateness criteria.

178.14 Sec. 27. Minnesota Statutes 2016, section 256B.0625, subdivision 3b, is amended to read:

178.15 Subd. 3b. **Telemedicine services.** (a) Medical assistance covers medically necessary
178.16 services and consultations delivered by a licensed health care provider via telemedicine in
178.17 the same manner as if the service or consultation was delivered in person. Coverage is
178.18 limited to three telemedicine services per enrollee per calendar week. Telemedicine services
178.19 shall be paid at the full allowable rate.

178.20 (b) The commissioner shall establish criteria that a health care provider must attest to
178.21 in order to demonstrate the safety or efficacy of delivering a particular service via
178.22 telemedicine. The attestation may include that the health care provider:

178.23 (1) has identified the categories or types of services the health care provider will provide
178.24 via telemedicine;

178.25 (2) has written policies and procedures specific to telemedicine services that are regularly
178.26 reviewed and updated;

178.27 (3) has policies and procedures that adequately address patient safety before, during,
178.28 and after the telemedicine service is rendered;

178.29 (4) has established protocols addressing how and when to discontinue telemedicine
178.30 services; and

178.31 (5) has an established quality assurance process related to telemedicine services.

179.1 (c) As a condition of payment, a licensed health care provider must document each
179.2 occurrence of a health service provided by telemedicine to a medical assistance enrollee.
179.3 Health care service records for services provided by telemedicine must meet the requirements
179.4 set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

179.5 (1) the type of service provided by telemedicine;

179.6 (2) the time the service began and the time the service ended, including an a.m. and p.m.
179.7 designation;

179.8 (3) the licensed health care provider's basis for determining that telemedicine is an
179.9 appropriate and effective means for delivering the service to the enrollee;

179.10 (4) the mode of transmission of the telemedicine service and records evidencing that a
179.11 particular mode of transmission was utilized;

179.12 (5) the location of the originating site and the distant site;

179.13 (6) if the claim for payment is based on a physician's telemedicine consultation with
179.14 another physician, the written opinion from the consulting physician providing the
179.15 telemedicine consultation; and

179.16 (7) compliance with the criteria attested to by the health care provider in accordance
179.17 with paragraph (b).

179.18 (d) For purposes of this subdivision, unless otherwise covered under this chapter,
179.19 "telemedicine" is defined as the delivery of health care services or consultations while the
179.20 patient is at an originating site and the licensed health care provider is at a distant site. A
179.21 communication between licensed health care providers, or a licensed health care provider
179.22 and a patient that consists solely of a telephone conversation, e-mail, or facsimile transmission
179.23 does not constitute telemedicine consultations or services. Telemedicine may be provided
179.24 by means of real-time two-way, interactive audio and visual communications, including the
179.25 application of secure video conferencing or store-and-forward technology to provide or
179.26 support health care delivery, which facilitate the assessment, diagnosis, consultation,
179.27 treatment, education, and care management of a patient's health care.

179.28 (e) For purposes of this section, "licensed health care provider" ~~is defined~~ means a
179.29 licensed health care provider under section 62A.671, subdivision 6, and a mental health
179.30 practitioner defined under section 245.462, subdivision 17, or 245.4871, subdivision 26,
179.31 working under the general supervision of a mental health professional; "health care provider"
179.32 is defined under section 62A.671, subdivision 3; and "originating site" is defined under
179.33 section 62A.671, subdivision 7.

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

180.2 Sec. 28. Minnesota Statutes 2016, section 256B.0625, subdivision 7, is amended to read:

180.3 Subd. 7. **Home care nursing.** Medical assistance covers home care nursing services in
180.4 a recipient's home. Recipients who are authorized to receive home care nursing services in
180.5 their home may use approved hours outside of the home during hours when normal life
180.6 activities take them outside of their home. To use home care nursing services at school, the
180.7 recipient or responsible party must provide written authorization in the care plan identifying
180.8 the chosen provider and the daily amount of services to be used at school. Medical assistance
180.9 does not cover home care nursing services for residents of a hospital, nursing facility,
180.10 intermediate care facility, or a health care facility licensed by the commissioner of health,
180.11 ~~except as authorized in section 256B.64 for ventilator-dependent recipients in hospitals or~~
180.12 unless a resident who is otherwise eligible is on leave from the facility and the facility either
180.13 pays for the home care nursing services or forgoes the facility per diem for the leave days
180.14 that home care nursing services are used. Total hours of service and payment allowed for
180.15 services outside the home cannot exceed that which is otherwise allowed in an in-home
180.16 setting according to sections 256B.0651 and 256B.0654 . All home care nursing services
180.17 must be provided according to the limits established under sections 256B.0651, 256B.0653,
180.18 and 256B.0654. Home care nursing services may not be reimbursed if the nurse is the family
180.19 foster care provider of a recipient who is under age 18, unless allowed under section
180.20 256B.0654, subdivision 4.

180.21 Sec. 29. Minnesota Statutes 2016, section 256B.0625, subdivision 17, is amended to read:

180.22 Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service"
180.23 means motor vehicle transportation provided by a public or private person that serves
180.24 Minnesota health care program beneficiaries who do not require emergency ambulance
180.25 service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

180.26 (b) Medical assistance covers medical transportation costs incurred solely for obtaining
180.27 emergency medical care or transportation costs incurred by eligible persons in obtaining
180.28 emergency or nonemergency medical care when paid directly to an ambulance company,
180.29 ~~common carrier~~ nonemergency medical transportation company, or other recognized
180.30 providers of transportation services. Medical transportation must be provided by:

180.31 (1) nonemergency medical transportation providers who meet the requirements of this
180.32 subdivision;

180.33 (2) ambulances, as defined in section 144E.001, subdivision 2;

181.1 (3) taxicabs that meet the requirements of this subdivision;

181.2 (4) public transit, as defined in section 174.22, subdivision 7; or

181.3 (5) not-for-hire vehicles, including volunteer drivers.

181.4 (c) Medical assistance covers nonemergency medical transportation provided by
181.5 nonemergency medical transportation providers enrolled in the Minnesota health care
181.6 programs. All nonemergency medical transportation providers must comply with the
181.7 operating standards for special transportation service as defined in sections 174.29 to 174.30
181.8 and Minnesota Rules, chapter 8840, and in consultation with the Minnesota Department of
181.9 Transportation. All nonemergency medical transportation providers shall bill for
181.10 nonemergency medical transportation services in accordance with Minnesota health care
181.11 programs criteria. Publicly operated transit systems, volunteers, and not-for-hire vehicles
181.12 are exempt from the requirements outlined in this paragraph.

181.13 (d) An organization may be terminated, denied, or suspended from enrollment if:

181.14 (1) the provider has not initiated background studies on the individuals specified in
181.15 section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

181.16 (2) the provider has initiated background studies on the individuals specified in section
181.17 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

181.18 (i) the commissioner has sent the provider a notice that the individual has been
181.19 disqualified under section 245C.14; and

181.20 (ii) the individual has not received a disqualification set-aside specific to the special
181.21 transportation services provider under sections 245C.22 and 245C.23.

181.22 (e) The administrative agency of nonemergency medical transportation must:

181.23 (1) adhere to the policies defined by the commissioner in consultation with the
181.24 Nonemergency Medical Transportation Advisory Committee;

181.25 (2) pay nonemergency medical transportation providers for services provided to
181.26 Minnesota health care programs beneficiaries to obtain covered medical services;

181.27 (3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled
181.28 trips, and number of trips by mode; and

181.29 (4) by July 1, 2016, in accordance with subdivision 18e, utilize a Web-based single
181.30 administrative structure assessment tool that meets the technical requirements established
181.31 by the commissioner, reconciles trip information with claims being submitted by providers,
181.32 and ensures prompt payment for nonemergency medical transportation services.

182.1 (f) Until the commissioner implements the single administrative structure and delivery
182.2 system under subdivision 18e, clients shall obtain their level-of-service certificate from the
182.3 commissioner or an entity approved by the commissioner that does not dispatch rides for
182.4 clients using modes of transportation under paragraph (i), clauses (4), (5), (6), and (7).

182.5 (g) The commissioner may use an order by the recipient's attending physician or a medical
182.6 or mental health professional to certify that the recipient requires nonemergency medical
182.7 transportation services. Nonemergency medical transportation providers shall perform
182.8 driver-assisted services for eligible individuals, when appropriate. Driver-assisted service
182.9 includes passenger pickup at and return to the individual's residence or place of business,
182.10 assistance with admittance of the individual to the medical facility, and assistance in
182.11 passenger securement or in securing of wheelchairs, child seats, or stretchers in the vehicle.

182.12 Nonemergency medical transportation providers must take clients to the health care
182.13 provider using the most direct route, and must not exceed 30 miles for a trip to a primary
182.14 care provider or 60 miles for a trip to a specialty care provider, unless the client receives
182.15 authorization from the local agency.

182.16 Nonemergency medical transportation providers may not bill for separate base rates for
182.17 the continuation of a trip beyond the original destination. Nonemergency medical
182.18 transportation providers must maintain trip logs, which include pickup and drop-off times,
182.19 signed by the medical provider or client, whichever is deemed most appropriate, attesting
182.20 to mileage traveled to obtain covered medical services. Clients requesting client mileage
182.21 reimbursement must sign the trip log attesting mileage traveled to obtain covered medical
182.22 services.

182.23 (h) The administrative agency shall use the level of service process established by the
182.24 commissioner in consultation with the Nonemergency Medical Transportation Advisory
182.25 Committee to determine the client's most appropriate mode of transportation. If public transit
182.26 or a certified transportation provider is not available to provide the appropriate service mode
182.27 for the client, the client may receive a onetime service upgrade.

182.28 (i) The covered modes of transportation, ~~which may not be implemented without a new~~
182.29 ~~rate structure~~, are:

182.30 (1) client reimbursement, which includes client mileage reimbursement provided to
182.31 clients who have their own transportation, or to family or an acquaintance who provides
182.32 transportation to the client;

182.33 (2) volunteer transport, which includes transportation by volunteers using their own
182.34 vehicle;

183.1 (3) unassisted transport, which includes transportation provided to a client by a taxicab
183.2 or public transit. If a taxicab or public transit is not available, the client can receive
183.3 transportation from another nonemergency medical transportation provider;

183.4 (4) assisted transport, which includes transport provided to clients who require assistance
183.5 by a nonemergency medical transportation provider;

183.6 (5) lift-equipped/ramp transport, which includes transport provided to a client who is
183.7 dependent on a device and requires a nonemergency medical transportation provider with
183.8 a vehicle containing a lift or ramp;

183.9 (6) protected transport, which includes transport provided to a client who has received
183.10 a prescreening that has deemed other forms of transportation inappropriate and who requires
183.11 a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety
183.12 locks, a video recorder, and a transparent thermoplastic partition between the passenger and
183.13 the vehicle driver; and (ii) who is certified as a protected transport provider; and

183.14 (7) stretcher transport, which includes transport for a client in a prone or supine position
183.15 and requires a nonemergency medical transportation provider with a vehicle that can transport
183.16 a client in a prone or supine position.

183.17 (j) The local agency shall be the single administrative agency and shall administer and
183.18 reimburse for modes defined in paragraph (i) according to paragraphs (m) and (n) when the
183.19 commissioner has developed, made available, and funded the Web-based single
183.20 administrative structure, assessment tool, and level of need assessment under subdivision
183.21 18e. The local agency's financial obligation is limited to funds provided by the state or
183.22 federal government.

183.23 (k) The commissioner shall:

183.24 (1) in consultation with the Nonemergency Medical Transportation Advisory Committee,
183.25 verify that the mode and use of nonemergency medical transportation is appropriate;

183.26 (2) verify that the client is going to an approved medical appointment; and

183.27 (3) investigate all complaints and appeals.

183.28 (l) The administrative agency shall pay for the services provided in this subdivision and
183.29 seek reimbursement from the commissioner, if appropriate. As vendors of medical care,
183.30 local agencies are subject to the provisions in section 256B.041, the sanctions and monetary
183.31 recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.

184.1 (m) Payments for nonemergency medical transportation must be paid based on the client's
184.2 assessed mode under paragraph (h), not the type of vehicle used to provide the service. The
184.3 medical assistance reimbursement rates for nonemergency medical transportation services
184.4 that are payable by or on behalf of the commissioner for nonemergency medical
184.5 transportation services are:

184.6 (1) \$0.22 per mile for client reimbursement;

184.7 (2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer
184.8 transport;

184.9 (3) equivalent to the standard fare for unassisted transport when provided by public
184.10 transit, and \$11 for the base rate and \$1.30 per mile when provided by a nonemergency
184.11 medical transportation provider;

184.12 (4) \$13 for the base rate and \$1.30 per mile for assisted transport;

184.13 (5) \$18 for the base rate and \$1.55 per mile for lift-equipped/ramp transport;

184.14 (6) \$75 for the base rate and \$2.40 per mile for protected transport; and

184.15 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for
184.16 an additional attendant if deemed medically necessary.

184.17 (n) The base rate for nonemergency medical transportation services in areas defined
184.18 under RUCA to be super rural is equal to 111.3 percent of the respective base rate in
184.19 paragraph (m), clauses (1) to (7). The mileage rate for nonemergency medical transportation
184.20 services in areas defined under RUCA to be rural or super rural areas is:

184.21 (1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage
184.22 rate in paragraph (m), clauses (1) to (7); and

184.23 (2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage
184.24 rate in paragraph (m), clauses (1) to (7).

184.25 (o) For purposes of reimbursement rates for nonemergency medical transportation
184.26 services under paragraphs (m) and (n), the zip code of the recipient's place of residence
184.27 shall determine whether the urban, rural, or super rural reimbursement rate applies.

184.28 (p) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means
184.29 a census-tract based classification system under which a geographical area is determined
184.30 to be urban, rural, or super rural.

185.1 (q) The commissioner, when determining reimbursement rates for nonemergency medical
185.2 transportation under paragraphs (m) and (n), shall exempt all modes of transportation listed
185.3 under paragraph (i) from Minnesota Rules, part 9505.0445, item R, subitem (2).

185.4 Sec. 30. Minnesota Statutes 2016, section 256B.0625, subdivision 17b, is amended to
185.5 read:

185.6 Subd. 17b. **Documentation required.** (a) As a condition for payment, nonemergency
185.7 medical transportation providers must document each occurrence of a service provided to
185.8 a recipient according to this subdivision. Providers must maintain odometer and other records
185.9 sufficient to distinguish individual trips with specific vehicles and drivers. The documentation
185.10 may be collected and maintained using electronic systems or software or in paper form but
185.11 must be made available and produced upon request. Program funds paid for transportation
185.12 that is not documented according to this subdivision shall be recovered by the department.

185.13 (b) A nonemergency medical transportation provider must compile transportation records
185.14 that meet the following requirements:

185.15 (1) the record must be in English and must be legible according to the standard of a
185.16 reasonable person;

185.17 (2) the recipient's name must be on each page of the record; and

185.18 (3) each entry in the record must document:

185.19 (i) the date on which the entry is made;

185.20 (ii) the date or dates the service is provided;

185.21 (iii) the printed last name, first name, and middle initial of the driver;

185.22 (iv) the signature of the driver attesting to the following: "I certify that I have accurately
185.23 reported in this record the trip miles I actually drove and the dates and times I actually drove
185.24 them. I understand that misreporting the miles driven and hours worked is fraud for which
185.25 I could face criminal prosecution or civil proceedings.";

185.26 (v) the signature of the recipient or authorized party attesting to the following: "I certify
185.27 that I received the reported transportation service.", or the signature of the provider of
185.28 medical services certifying that the recipient was delivered to the provider;

185.29 (vi) the address, or the description if the address is not available, of both the origin and
185.30 destination, and the mileage for the most direct route from the origin to the destination;

185.31 (vii) the mode of transportation in which the service is provided;

- 186.1 (viii) the license plate number of the vehicle used to transport the recipient;
- 186.2 (ix) whether the service was ambulatory or nonambulatory ~~until the modes under~~
- 186.3 ~~subdivision 17 are implemented;~~
- 186.4 (x) the time of the pickup and the time of the drop-off with "a.m." and "p.m."
- 186.5 designations;
- 186.6 (xi) the name of the extra attendant when an extra attendant is used to provide special
- 186.7 transportation service; and
- 186.8 (xii) the electronic source documentation used to calculate driving directions and mileage.

186.9 Sec. 31. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision

186.10 to read:

186.11 Subd. 17c. **Nursing facility transports.** A Minnesota health care program enrollee

186.12 residing in, or being discharged from, a licensed nursing facility is exempt from a level of

186.13 need determination and is eligible for nonemergency medical transportation services until

186.14 the enrollee no longer resides in a licensed nursing facility, as provided in section 256B.04,

186.15 subdivision 14a.

186.16 Sec. 32. Minnesota Statutes 2016, section 256B.0625, subdivision 18h, is amended to

186.17 read:

186.18 Subd. 18h. **Managed care.** (a) The following subdivisions ~~do not~~ apply to managed

186.19 care plans and county-based purchasing plans:

186.20 (1) subdivision 17, paragraphs ~~(d) to (k)~~ (a), (b), (i), and (n);

186.21 (2) subdivision ~~18e~~ 18; and

186.22 (3) subdivision ~~18g~~ 18a.

186.23 (b) A nonemergency medical transportation provider must comply with the operating

186.24 standards for special transportation service specified in sections 174.29 to 174.30 and

186.25 Minnesota Rules, chapter 8840. Publicly operated transit systems, volunteers, and not-for-hire

186.26 vehicles are exempt from the requirements in this paragraph.

186.27 Sec. 33. Minnesota Statutes 2016, section 256B.0625, subdivision 20, is amended to read:

186.28 Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the

186.29 state agency, medical assistance covers case management services to persons with serious

186.30 and persistent mental illness and children with severe emotional disturbance. Services

187.1 provided under this section must meet the relevant standards in sections 245.461 to 245.4887,
187.2 the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts
187.3 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

187.4 (b) Entities meeting program standards set out in rules governing family community
187.5 support services as defined in section 245.4871, subdivision 17, are eligible for medical
187.6 assistance reimbursement for case management services for children with severe emotional
187.7 disturbance when these services meet the program standards in Minnesota Rules, parts
187.8 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

187.9 (c) Medical assistance and MinnesotaCare payment for mental health case management
187.10 shall be made on a monthly basis. In order to receive payment for an eligible child, the
187.11 provider must document at least a face-to-face contact with the child, the child's parents, or
187.12 the child's legal representative. To receive payment for an eligible adult, the provider must
187.13 document:

187.14 (1) at least a face-to-face contact with the adult or the adult's legal representative or a
187.15 contact by interactive video that meets the requirements of subdivision 20b; or

187.16 (2) at least a telephone contact with the adult or the adult's legal representative and
187.17 document a face-to-face contact or a contact by interactive video that meets the requirements
187.18 of subdivision 20b with the adult or the adult's legal representative within the preceding
187.19 two months.

187.20 (d) Payment for mental health case management provided by county or state staff shall
187.21 be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph
187.22 (b), with separate rates calculated for child welfare and mental health, and within mental
187.23 health, separate rates for children and adults.

187.24 (e) Payment for mental health case management provided by Indian health services or
187.25 by agencies operated by Indian tribes may be made according to this section or other relevant
187.26 federally approved rate setting methodology.

187.27 (f) Payment for mental health case management provided by vendors who contract with
187.28 a county or Indian tribe shall be based on a monthly rate negotiated by the host county or
187.29 tribe. The negotiated rate must not exceed the rate charged by the vendor for the same
187.30 service to other payers. If the service is provided by a team of contracted vendors, the county
187.31 or tribe may negotiate a team rate with a vendor who is a member of the team. The team
187.32 shall determine how to distribute the rate among its members. No reimbursement received
187.33 by contracted vendors shall be returned to the county or tribe, except to reimburse the county
187.34 or tribe for advance funding provided by the county or tribe to the vendor.

188.1 (g) If the service is provided by a team which includes contracted vendors, tribal staff,
188.2 and county or state staff, the costs for county or state staff participation in the team shall be
188.3 included in the rate for county-provided services. In this case, the contracted vendor, the
188.4 tribal agency, and the county may each receive separate payment for services provided by
188.5 each entity in the same month. In order to prevent duplication of services, each entity must
188.6 document, in the recipient's file, the need for team case management and a description of
188.7 the roles of the team members.

188.8 (h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for
188.9 mental health case management shall be provided by the recipient's county of responsibility,
188.10 as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds
188.11 used to match other federal funds. If the service is provided by a tribal agency, the nonfederal
188.12 share, if any, shall be provided by the recipient's tribe. When this service is paid by the state
188.13 without a federal share through fee-for-service, 50 percent of the cost shall be provided by
188.14 the recipient's county of responsibility.

188.15 (i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance
188.16 and MinnesotaCare include mental health case management. When the service is provided
188.17 through prepaid capitation, the nonfederal share is paid by the state and the county pays no
188.18 share.

188.19 (j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider
188.20 that does not meet the reporting or other requirements of this section. The county of
188.21 responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency,
188.22 is responsible for any federal disallowances. The county or tribe may share this responsibility
188.23 with its contracted vendors.

188.24 (k) The commissioner shall set aside a portion of the federal funds earned for county
188.25 expenditures under this section to repay the special revenue maximization account under
188.26 section 256.01, subdivision 2, paragraph (o). The repayment is limited to:

188.27 (1) the costs of developing and implementing this section; and

188.28 (2) programming the information systems.

188.29 (l) Payments to counties and tribal agencies for case management expenditures under
188.30 this section shall only be made from federal earnings from services provided under this
188.31 section. When this service is paid by the state without a federal share through fee-for-service,
188.32 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors
188.33 shall include the federal earnings, the state share, and the county share.

189.1 (m) Case management services under this subdivision do not include therapy, treatment,
189.2 legal, or outreach services.

189.3 (n) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital,
189.4 and the recipient's institutional care is paid by medical assistance, payment for case
189.5 management services under this subdivision is limited to the lesser of:

189.6 (1) the last 180 days of the recipient's residency in that facility and may not exceed more
189.7 than six months in a calendar year; or

189.8 (2) the limits and conditions which apply to federal Medicaid funding for this service.

189.9 (o) Payment for case management services under this subdivision shall not duplicate
189.10 payments made under other program authorities for the same purpose.

189.11 (p) If the recipient is receiving care in a hospital, nursing facility, or residential setting
189.12 licensed under chapter 245A or 245D that is staffed 24 hours a day, seven days a week,
189.13 mental health targeted case management services must actively support identification of
189.14 community alternatives for the recipient and discharge planning.

189.15 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
189.16 of human services shall notify the revisor of statutes when federal approval is obtained.

189.17 Sec. 34. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision
189.18 to read:

189.19 Subd. 20b. **Mental health targeted case management through interactive video.** (a)
189.20 Subject to federal approval, contact made for targeted case management by interactive video
189.21 shall be eligible for payment if:

189.22 (1) the person receiving targeted case management services is residing in:

189.23 (i) a hospital;

189.24 (ii) a nursing facility; or

189.25 (iii) a residential setting licensed under chapter 245A or 245D or a boarding and lodging
189.26 establishment or lodging establishment that provides supportive services or health supervision
189.27 services according to section 157.17 that is staffed 24 hours a day, seven days a week;

189.28 (2) interactive video is in the best interests of the person and is deemed appropriate by
189.29 the person receiving targeted case management or the person's legal guardian, the case
189.30 management provider, and the provider operating the setting where the person is residing;

190.1 (3) the use of interactive video is approved as part of the person's written personal service
190.2 or case plan, taking into consideration the person's vulnerability and active personal
190.3 relationships; and

190.4 (4) interactive video is used for up to, but not more than, 50 percent of the minimum
190.5 required face-to-face contact.

190.6 (b) The person receiving targeted case management or the person's legal guardian has
190.7 the right to choose and consent to the use of interactive video under this subdivision and
190.8 has the right to refuse the use of interactive video at any time.

190.9 (c) The commissioner shall establish criteria that a targeted case management provider
190.10 must attest to in order to demonstrate the safety or efficacy of delivering the service via
190.11 interactive video. The attestation may include that the case management provider has:

190.12 (1) written policies and procedures specific to interactive video services that are regularly
190.13 reviewed and updated;

190.14 (2) policies and procedures that adequately address client safety before, during, and after
190.15 the interactive video services are rendered;

190.16 (3) established protocols addressing how and when to discontinue interactive video
190.17 services; and

190.18 (4) established a quality assurance process related to interactive video services.

190.19 (d) As a condition of payment, the targeted case management provider must document
190.20 the following for each occurrence of targeted case management provided by interactive
190.21 video:

190.22 (1) the time the service began and the time the service ended, including an a.m. and p.m.
190.23 designation;

190.24 (2) the basis for determining that interactive video is an appropriate and effective means
190.25 for delivering the service to the person receiving case management services;

190.26 (3) the mode of transmission of the interactive video services and records evidencing
190.27 that a particular mode of transmission was utilized;

190.28 (4) the location of the originating site and the distant site; and

190.29 (5) compliance with the criteria attested to by the targeted case management provider
190.30 as provided in paragraph (c).

191.1 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
191.2 of human services shall notify the revisor of statutes when federal approval is obtained.

191.3 Sec. 35. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision
191.4 to read:

191.5 Subd. 31c. **Preferred incontinence product program.** The commissioner shall
191.6 implement a preferred incontinence product program by July 1, 2018. The program shall
191.7 require the commissioner to volume purchase incontinence products and related supplies
191.8 in accordance with section 256B.04, subdivision 14. Medical assistance coverage for
191.9 incontinence products and related supplies shall conform to the limitations established under
191.10 the program.

191.11 Sec. 36. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision
191.12 to read:

191.13 Subd. 56a. **Post-arrest community-based service coordination.** (a) Medical assistance
191.14 covers post-arrest community-based service coordination for an individual who:

191.15 (1) has been identified as having a mental illness or substance use disorder using a
191.16 screening tool approved by the commissioner;

191.17 (2) does not require the security of a public detention facility and is not considered an
191.18 inmate of a public institution as defined in Code of Federal Regulations, title 42, section
191.19 435.1010;

191.20 (3) meets the eligibility requirements in section 256B.056; and

191.21 (4) has agreed to participate in post-arrest community-based service coordination through
191.22 a diversion contract in lieu of incarceration.

191.23 (b) Post-arrest community-based service coordination means navigating services to
191.24 address a client's mental health, chemical health, social, economic, and housing needs, or
191.25 any other activity targeted at reducing the incidence of jail utilization and connecting
191.26 individuals with existing covered services available to them, including, but not limited to,
191.27 targeted case management, waiver case management, or care coordination.

191.28 (c) Post-arrest community-based service coordination must be provided by an individual
191.29 who is an employee of a county or is under contract with a county to provide post-arrest
191.30 community-based coordination and is qualified under one of the following criteria:

192.1 (1) a licensed mental health professional as defined in section 245.462, subdivision 18,
192.2 clauses (1) to (6);

192.3 (2) a mental health practitioner as defined in section 245.462, subdivision 17, working
192.4 under the clinical supervision of a mental health professional; or

192.5 (3) a certified peer specialist under section 256B.0615, working under the clinical
192.6 supervision of a mental health professional.

192.7 (d) Reimbursement is allowed for up to 60 days following the initial determination of
192.8 eligibility.

192.9 (e) Providers of post-arrest community-based service coordination shall annually report
192.10 to the commissioner on the number of individuals served, and number of the
192.11 community-based services that were accessed by recipients. The commissioner shall ensure
192.12 that services and payments provided under post-arrest community-based service coordination
192.13 do not duplicate services or payments provided under section 256B.0625, subdivision 20,
192.14 256B.0753, 256B.0755, or 256B.0757.

192.15 (f) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of cost for
192.16 post-arrest community-based service coordination services shall be provided by the county
192.17 providing the services, from sources other than federal funds or funds used to match other
192.18 federal funds.

192.19 **EFFECTIVE DATE.** This section is effective upon federal approval for services
192.20 provided on or after July 1, 2017. The commissioner of human services shall notify the
192.21 revisor of statutes when federal approval is obtained.

192.22 Sec. 37. Minnesota Statutes 2016, section 256B.0625, subdivision 64, is amended to read:

192.23 Subd. 64. **Investigational drugs, biological products, and devices.** (a) Medical
192.24 assistance and the early periodic screening, diagnosis, and treatment (EPSDT) program do
192.25 not cover costs incidental to, associated with, or resulting from the use of investigational
192.26 drugs, biological products, or devices as defined in section 151.375.

192.27 (b) Notwithstanding paragraph (a), stiripentol may be covered by the EPSDT program
192.28 if all the following conditions are met:

192.29 (1) the use of stiripentol is determined to be medically necessary;

192.30 (2) the enrollee has a documented diagnosis of Dravet syndrome, regardless of whether
192.31 an SCN1A genetic mutation is found, or the enrollee is a child with malignant migrating
192.32 partial epilepsy in infancy due to an SCN2A genetic mutation;

193.1 (3) all other available covered prescription medications that are medically necessary for
193.2 the enrollee have been tried without successful outcomes; and

193.3 (4) the United States Food and Drug Administration has approved the treating physician's
193.4 individual patient investigational new drug application (IND) for the use of stiripentol for
193.5 treatment.

193.6 This paragraph does not apply to MinnesotaCare coverage under chapter 256L.

193.7 Sec. 38. Minnesota Statutes 2016, section 256B.0644, is amended to read:

193.8 **256B.0644 REIMBURSEMENT UNDER OTHER STATE HEALTH CARE**
193.9 **PROGRAMS.**

193.10 (a) A vendor of medical care, as defined in section 256B.02, subdivision 7, and a health
193.11 maintenance organization, as defined in chapter 62D, must participate as a provider or
193.12 contractor in the medical assistance program and MinnesotaCare as a condition of
193.13 participating as a provider in health insurance plans and programs or contractor for state
193.14 employees established under section 43A.18, the public employees insurance program under
193.15 section 43A.316, for health insurance plans offered to local statutory or home rule charter
193.16 city, county, and school district employees, the workers' compensation system under section
193.17 176.135, and insurance plans provided through the Minnesota Comprehensive Health
193.18 Association under sections 62E.01 to 62E.19. The limitations on insurance plans offered to
193.19 local government employees shall not be applicable in geographic areas where provider
193.20 participation is limited by managed care contracts with the Department of Human Services.
193.21 This section does not apply to dental service providers providing dental services outside
193.22 the seven-county metropolitan area.

193.23 (b) For providers other than health maintenance organizations, participation in the medical
193.24 assistance program means that:

193.25 (1) the provider accepts new medical assistance and MinnesotaCare patients;

193.26 (2) for providers other than dental service providers, at least 20 percent of the provider's
193.27 patients are covered by medical assistance and MinnesotaCare as their primary source of
193.28 coverage; or

193.29 (3) for dental service providers providing dental services in the seven-county metropolitan
193.30 area, at least ten percent of the provider's patients are covered by medical assistance and
193.31 MinnesotaCare as their primary source of coverage, or the provider accepts new medical
193.32 assistance and MinnesotaCare patients who are children with special health care needs. For
193.33 purposes of this section, "children with special health care needs" means children up to age

18 who: (i) require health and related services beyond that required by children generally; and (ii) have or are at risk for a chronic physical, developmental, behavioral, or emotional condition, including: bleeding and coagulation disorders; immunodeficiency disorders; cancer; endocrinopathy; developmental disabilities; epilepsy, cerebral palsy, and other neurological diseases; visual impairment or deafness; Down syndrome and other genetic disorders; autism; fetal alcohol syndrome; and other conditions designated by the commissioner after consultation with representatives of pediatric dental providers and consumers.

(c) Patients seen on a volunteer basis by the provider at a location other than the provider's usual place of practice may be considered in meeting the participation requirement in this section. The commissioner shall establish participation requirements for health maintenance organizations. The commissioner shall provide lists of participating medical assistance providers on a quarterly basis to the commissioner of management and budget, the commissioner of labor and industry, and the commissioner of commerce. Each of the commissioners shall develop and implement procedures to exclude as participating providers in the program or programs under their jurisdiction those providers who do not participate in the medical assistance program. The commissioner of management and budget shall implement this section through contracts with participating health and dental carriers.

(d) A volunteer dentist who has signed a volunteer agreement under section 256B.0625, subdivision 9a, shall not be considered to be participating in medical assistance or MinnesotaCare for the purpose of this section.

EFFECTIVE DATE. This section is effective upon receipt of any necessary federal waiver or approval. The commissioner of human services shall notify the revisor of statutes if a federal waiver or approval is sought and, if sought, when a federal waiver or approval is obtained.

Sec. 39. Minnesota Statutes 2016, section 256B.072, is amended to read:

256B.072 PERFORMANCE REPORTING AND QUALITY IMPROVEMENT SYSTEM.

Subdivision 1. Performance measures. (a) The commissioner of human services shall establish a performance reporting system for health care providers who provide health care services to public program recipients covered under chapters 256B, 256D, and 256L, reporting separately for managed care and fee-for-service recipients.

195.1 (b) The measures used for the performance reporting system for medical groups shall
195.2 include measures of care for asthma, diabetes, hypertension, and coronary artery disease
195.3 and measures of preventive care services. The measures used for the performance reporting
195.4 system for inpatient hospitals shall include measures of care for acute myocardial infarction,
195.5 heart failure, and pneumonia, and measures of care and prevention of surgical infections.
195.6 In the case of a medical group, the measures used shall be consistent with measures published
195.7 ~~by nonprofit Minnesota or national organizations that produce and disseminate health care~~
195.8 ~~quality measures or evidence-based health care guidelines~~ section 62U.02, subdivision 1,
195.9 paragraph (a), clause (1). In the case of inpatient hospital measures, the commissioner shall
195.10 appoint the Minnesota Hospital Association and Stratis Health to advise on the development
195.11 of the performance measures to be used for hospital reporting. To enable a consistent
195.12 measurement process across the community, the commissioner may use measures of care
195.13 provided for patients in addition to those identified in paragraph (a). The commissioner
195.14 shall ensure collaboration with other health care reporting organizations so that the measures
195.15 described in this section are consistent with those reported by those organizations and used
195.16 by other purchasers in Minnesota.

195.17 (c) The commissioner may require providers to submit information in a required format
195.18 to a health care reporting organization or to cooperate with the information collection
195.19 procedures of that organization. The commissioner may collaborate with a reporting
195.20 organization to collect information reported and to prevent duplication of reporting.

195.21 (d) By October 1, 2007, and annually thereafter, the commissioner shall report through
195.22 a public Web site the results by medical groups and hospitals, where possible, of the measures
195.23 under this section, and shall compare the results by medical groups and hospitals for patients
195.24 enrolled in public programs to patients enrolled in private health plans. To achieve this
195.25 reporting, the commissioner may collaborate with a health care reporting organization that
195.26 operates a Web site suitable for this purpose.

195.27 (e) Performance measures must be stratified as provided under section 62U.02,
195.28 subdivision 1, paragraph ~~(b)~~ (c), and risk-adjusted as specified in section 62U.02, subdivision
195.29 3, paragraph (b).

195.30 (f) Notwithstanding paragraph (b), by January 1, 2019, the commissioner shall consider
195.31 and appropriately adjust quality metrics and benchmarks for providers who primarily serve
195.32 socioeconomically complex patient populations and request to be scored on additional
195.33 measures in this subdivision. This applies to all Minnesota health care programs, including
195.34 for patient populations enrolled in health plans, county-based purchasing plans, or managed
195.35 care organizations and for value-based purchasing arrangements, including, but not limited

196.1 to, initiatives operating under sections 256B.0751, 256B.0753, 256B.0755, 256B.0756, and
196.2 256B.0757.

196.3 (g) Assessment of patient satisfaction with chronic pain management for the purpose of
196.4 determining compensation or quality incentive payments is prohibited. The commissioner
196.5 shall require managed care plans, county-based purchasing plans, and integrated health
196.6 partnerships to comply with this requirement as a condition of contract. This prohibition
196.7 does not apply to:

196.8 (1) assessing patient satisfaction with chronic pain management for the purpose of quality
196.9 improvement; and

196.10 (2) pain management as a part of a palliative care treatment plan to treat patients with
196.11 cancer or patients receiving hospice care.

196.12 Subd. 2. Adjustment of quality metrics for special populations. Notwithstanding
196.13 subdivision 1, paragraph (b), by January 1, 2019, the commissioner shall consider and
196.14 appropriately adjust quality metrics and benchmarks for providers who primarily serve
196.15 socio-economically complex patient populations and request to be scored on additional
196.16 measures in this subdivision. This requirement applies to all medical assistance and
196.17 MinnesotaCare programs and enrollees, including persons enrolled in managed care and
196.18 county-based purchasing plans or other managed care organizations, persons receiving care
196.19 under fee-for-service, and persons receiving care under value-based purchasing arrangements,
196.20 including but not limited to initiatives operating under sections 256B.0751, 256B.0753,
196.21 256B.0755, 256B.0756, and 256B.0757.

196.22 Sec. 40. Minnesota Statutes 2016, section 256B.0755, subdivision 1, is amended to read:

196.23 Subdivision 1. **Implementation.** (a) The commissioner shall ~~develop and authorize~~
196.24 continue a demonstration project established under this section to test alternative and
196.25 innovative integrated health care delivery systems partnerships, including accountable care
196.26 organizations that provide services to a specified patient population for an agreed-upon total
196.27 cost of care or risk/gain sharing payment arrangement. The commissioner shall develop a
196.28 request for proposals for participation in the demonstration project in consultation with
196.29 hospitals, primary care providers, health plans, and other key stakeholders.

196.30 (b) In developing the request for proposals, the commissioner shall:

196.31 (1) establish uniform statewide methods of forecasting utilization and cost of care for
196.32 the appropriate Minnesota public program populations, to be used by the commissioner for
196.33 the ~~health care delivery system~~ integrated health partnership projects;

- 197.1 (2) identify key indicators of quality, access, patient satisfaction, and other performance
197.2 indicators that will be measured, in addition to indicators for measuring cost savings;
- 197.3 (3) allow maximum flexibility to encourage innovation and variation so that a variety
197.4 of provider collaborations are able to become ~~health care delivery systems~~ integrated health
197.5 partnerships, and may be customized for the special needs and barriers of patient populations
197.6 experiencing health disparities due to social, economic, racial, or ethnic factors;
- 197.7 (4) encourage and authorize different levels and types of financial risk;
- 197.8 (5) encourage and authorize projects representing a wide variety of geographic locations,
197.9 patient populations, provider relationships, and care coordination models;
- 197.10 (6) encourage projects that involve close partnerships between the ~~health care delivery~~
197.11 ~~system~~ integrated health partnership and counties and nonprofit agencies that provide services
197.12 to patients enrolled with the ~~health care delivery system~~ integrated health partnership,
197.13 including social services, public health, mental health, community-based services, and
197.14 continuing care;
- 197.15 (7) encourage projects established by community hospitals, clinics, and other providers
197.16 in rural communities;
- 197.17 (8) identify required covered services for a total cost of care model or services considered
197.18 in whole or partially in an analysis of utilization for a risk/gain sharing model;
- 197.19 (9) establish a mechanism to monitor enrollment;
- 197.20 (10) establish quality standards for the ~~delivery system~~ integrated health partnership
197.21 demonstrations that are appropriate for the particular patient population to be served; and
- 197.22 (11) encourage participation of privately insured population so as to create sufficient
197.23 alignment in demonstration systems.
- 197.24 (c) To be eligible to participate in the ~~demonstration project~~ an integrated health
197.25 partnership, a health care delivery system must:
- 197.26 (1) provide required covered services and care coordination to recipients enrolled in the
197.27 ~~health care delivery system~~ integrated health partnership;
- 197.28 (2) establish a process to monitor enrollment and ensure the quality of care provided;
- 197.29 (3) in cooperation with counties and community social service agencies, coordinate the
197.30 delivery of health care services with existing social services programs;
- 197.31 (4) provide a system for advocacy and consumer protection; and

198.1 (5) adopt innovative and cost-effective methods of care delivery and coordination, which
198.2 may include the use of allied health professionals, telemedicine, patient educators, care
198.3 coordinators, and community health workers.

198.4 (d) ~~A health care delivery system~~ An integrated health partnership demonstration may
198.5 be formed by the following groups of providers of services and suppliers if they have
198.6 established a mechanism for shared governance:

198.7 (1) professionals in group practice arrangements;

198.8 (2) networks of individual practices of professionals;

198.9 (3) partnerships or joint venture arrangements between hospitals and health care
198.10 professionals;

198.11 (4) hospitals employing professionals; and

198.12 (5) other groups of providers of services and suppliers as the commissioner determines
198.13 appropriate.

198.14 A managed care plan or county-based purchasing plan may participate in this
198.15 demonstration in collaboration with one or more of the entities listed in clauses (1) to (5).

198.16 ~~A health care delivery system~~ An integrated health partnership may contract with a
198.17 managed care plan or a county-based purchasing plan to provide administrative services,
198.18 including the administration of a payment system using the payment methods established
198.19 by the commissioner for ~~health care delivery systems~~ integrated health partnerships.

198.20 (e) The commissioner may require ~~a health care delivery system~~ an integrated health
198.21 partnership to enter into additional third-party contractual relationships for the assessment
198.22 of risk and purchase of stop loss insurance or another form of insurance risk management
198.23 related to the delivery of care described in paragraph (c).

198.24 **EFFECTIVE DATE.** This section is effective January 1, 2018.

198.25 Sec. 41. Minnesota Statutes 2016, section 256B.0755, subdivision 3, is amended to read:

198.26 Subd. 3. **Accountability.** (a) ~~Health care delivery systems~~ Integrated health partnerships
198.27 must accept responsibility for the quality of care based on standards established under
198.28 subdivision 1, paragraph (b), clause (10), and the cost of care or utilization of services
198.29 provided to its enrollees under subdivision 1, paragraph (b), clause (1). Accountability
198.30 standards must be appropriate to the particular population served.

199.1 (b) ~~A health care delivery system~~ An integrated health partnership may contract and
199.2 coordinate with providers and clinics for the delivery of services and shall contract with
199.3 community health clinics, federally qualified health centers, community mental health
199.4 centers or programs, county agencies, and rural clinics to the extent practicable.

199.5 (c) ~~A health care delivery system~~ An integrated health partnership must indicate how it
199.6 will coordinate with other services affecting its patients' health, quality of care, and cost of
199.7 care that are provided by other providers, county agencies, and other organizations in the
199.8 local service area. ~~The health care delivery system~~ integrated health partnership must indicate
199.9 how it will engage other providers, counties, and organizations, including county-based
199.10 purchasing plans, that provide services to patients of the ~~health care delivery system~~
199.11 integrated health partnership on issues related to local population health, including applicable
199.12 local needs, priorities, and public health goals. ~~The health care delivery system~~ integrated
199.13 health partnership must describe how local providers, counties, organizations, including
199.14 county-based purchasing plans, and other relevant purchasers were consulted in developing
199.15 the application to participate in the demonstration project.

199.16 **EFFECTIVE DATE.** This section is effective January 1, 2018.

199.17 Sec. 42. Minnesota Statutes 2016, section 256B.0755, subdivision 4, is amended to read:

199.18 Subd. 4. **Payment system.** (a) In developing a payment system for ~~health care delivery~~
199.19 ~~systems~~ integrated health partnerships, the commissioner shall establish a total cost of care
199.20 benchmark or a risk/gain sharing payment model to be paid for services provided to the
199.21 recipients enrolled in a ~~health care delivery system~~ an integrated health partnership.

199.22 (b) The payment system may include incentive payments to ~~health care delivery systems~~
199.23 integrated health partnerships that meet or exceed annual quality and performance targets
199.24 realized through the coordination of care.

199.25 (c) An amount equal to the savings realized to the general fund as a result of the
199.26 demonstration project shall be transferred each fiscal year to the health care access fund.

199.27 (d) The payment system shall include a population-based payment that supports care
199.28 coordination services for all enrollees served by the integrated health partnerships, and is
199.29 risk-adjusted to reflect varying levels of care coordination intensiveness for enrollees with
199.30 chronic conditions, limited English skills, cultural differences, are homeless, or experience
199.31 health disparities or other barriers to health care. The population-based payment shall be a
199.32 per member, per month payment paid at least on a quarterly basis. Integrated health
199.33 partnerships receiving this payment must continue to meet cost and quality metrics under

200.1 the program to maintain eligibility for the population-based payment. An integrated health
200.2 partnership is eligible to receive a payment under this paragraph even if the partnership is
200.3 not participating in a risk-based or gain-sharing payment model and regardless of the size
200.4 of the patient population served by the integrated health partnership. Any integrated health
200.5 partnership participant certified as a health care home under section 256B.0751 that agrees
200.6 to a payment method that includes population-based payments for care coordination is not
200.7 eligible to receive health care home payment or care coordination fee authorized under
200.8 section 62U.03 or 256B.0753, subdivision 1, or in-reach care coordination under section
200.9 256B.0625, subdivision 56, for any medical assistance or MinnesotaCare recipients enrolled
200.10 or attributed to the integrated health partnership under this demonstration.

200.11 **EFFECTIVE DATE.** This section is effective January 1, 2018.

200.12 Sec. 43. Minnesota Statutes 2016, section 256B.0755, is amended by adding a subdivision
200.13 to read:

200.14 Subd. 9. **Patient incentives.** The commissioner may authorize an integrated health
200.15 partnership to provide incentives for patients to:

200.16 (1) see a primary care provider for an initial health assessment;

200.17 (2) maintain a continuous relationship with the primary care provider; and

200.18 (3) participate in ongoing health improvement and coordination of care activities.

200.19 **EFFECTIVE DATE.** This section is effective January 1, 2018, or upon federal approval,
200.20 whichever is later.

200.21 Sec. 44. Minnesota Statutes 2016, section 256B.0924, is amended by adding a subdivision
200.22 to read:

200.23 Subd. 4a. **Targeted case management through interactive video.** (a) Subject to federal
200.24 approval, contact made for targeted case management by interactive video shall be eligible
200.25 for payment under subdivision 6 if:

200.26 (1) the person receiving targeted case management services is residing in:

200.27 (i) a hospital;

200.28 (ii) a nursing facility; or

200.29 (iii) a residential setting licensed under chapter 245A or 245D or a boarding and lodging
200.30 establishment or lodging establishment that provides supportive services or health supervision
200.31 services according to section 157.17 that is staffed 24 hours a day, seven days a week;

201.1 (2) interactive video is in the best interests of the person and is deemed appropriate by
201.2 the person receiving targeted case management or the person's legal guardian, the case
201.3 management provider, and the provider operating the setting where the person is residing;

201.4 (3) the use of interactive video is approved as part of the person's written personal service
201.5 or case plan; and

201.6 (4) interactive video is used for up to, but not more than, 50 percent of the minimum
201.7 required face-to-face contact.

201.8 (b) The person receiving targeted case management or the person's legal guardian has
201.9 the right to choose and consent to the use of interactive video under this subdivision and
201.10 has the right to refuse the use of interactive video at any time.

201.11 (c) The commissioner shall establish criteria that a targeted case management provider
201.12 must attest to in order to demonstrate the safety or efficacy of delivering the service via
201.13 interactive video. The attestation may include that the case management provider has:

201.14 (1) written policies and procedures specific to interactive video services that are regularly
201.15 reviewed and updated;

201.16 (2) policies and procedures that adequately address client safety before, during, and after
201.17 the interactive video services are rendered;

201.18 (3) established protocols addressing how and when to discontinue interactive video
201.19 services; and

201.20 (4) established a quality assurance process related to interactive video services.

201.21 (d) As a condition of payment, the targeted case management provider must document
201.22 the following for each occurrence of targeted case management provided by interactive
201.23 video:

201.24 (1) the time the service began and the time the service ended, including an a.m. and p.m.
201.25 designation;

201.26 (2) the basis for determining that interactive video is an appropriate and effective means
201.27 for delivering the service to the person receiving case management services;

201.28 (3) the mode of transmission of the interactive video services and records evidencing
201.29 that a particular mode of transmission was utilized;

201.30 (4) the location of the originating site and the distant site; and

202.1 (5) compliance with the criteria attested to by the targeted case management provider
202.2 as provided in paragraph (c).

202.3 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner
202.4 of human services shall notify the revisor of statutes when federal approval is obtained.

202.5 Sec. 45. Minnesota Statutes 2016, section 256B.196, subdivision 2, is amended to read:

202.6 Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and subdivision
202.7 3, the commissioner shall determine the fee-for-service outpatient hospital services upper
202.8 payment limit for nonstate government hospitals. The commissioner shall then determine
202.9 the amount of a supplemental payment to Hennepin County Medical Center and Regions
202.10 Hospital for these services that would increase medical assistance spending in this category
202.11 to the aggregate upper payment limit for all nonstate government hospitals in Minnesota.
202.12 In making this determination, the commissioner shall allot the available increases between
202.13 Hennepin County Medical Center and Regions Hospital based on the ratio of medical
202.14 assistance fee-for-service outpatient hospital payments to the two facilities. The commissioner
202.15 shall adjust this allotment as necessary based on federal approvals, the amount of
202.16 intergovernmental transfers received from Hennepin and Ramsey Counties, and other factors,
202.17 in order to maximize the additional total payments. The commissioner shall inform Hennepin
202.18 County and Ramsey County of the periodic intergovernmental transfers necessary to match
202.19 federal Medicaid payments available under this subdivision in order to make supplementary
202.20 medical assistance payments to Hennepin County Medical Center and Regions Hospital
202.21 equal to an amount that when combined with existing medical assistance payments to
202.22 nonstate governmental hospitals would increase total payments to hospitals in this category
202.23 for outpatient services to the aggregate upper payment limit for all hospitals in this category
202.24 in Minnesota. Upon receipt of these periodic transfers, the commissioner shall make
202.25 supplementary payments to Hennepin County Medical Center and Regions Hospital.

202.26 (b) For the purposes of this subdivision and subdivision 3, the commissioner shall
202.27 determine an upper payment limit for physicians and other billing professionals affiliated
202.28 with Hennepin County Medical Center and with Regions Hospital. The upper payment limit
202.29 shall be based on the average commercial rate or be determined using another method
202.30 acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall
202.31 inform Hennepin County and Ramsey County of the periodic intergovernmental transfers
202.32 necessary to match the federal Medicaid payments available under this subdivision in order
202.33 to make supplementary payments to physicians and other billing professionals affiliated
202.34 with Hennepin County Medical Center and to make supplementary payments to physicians

203.1 and other billing professionals affiliated with Regions Hospital through HealthPartners
203.2 Medical Group equal to the difference between the established medical assistance payment
203.3 for physician and other billing professional services and the upper payment limit. Upon
203.4 receipt of these periodic transfers, the commissioner shall make supplementary payments
203.5 to physicians and other billing professionals affiliated with Hennepin County Medical Center
203.6 and shall make supplementary payments to physicians and other billing professionals
203.7 affiliated with Regions Hospital through HealthPartners Medical Group.

203.8 (c) Beginning January 1, 2010, Hennepin County and Ramsey County may make monthly
203.9 voluntary intergovernmental transfers to the commissioner in amounts not to exceed
203.10 \$12,000,000 per year from Hennepin County and \$6,000,000 per year from Ramsey County.
203.11 The commissioner shall increase the medical assistance capitation payments to any licensed
203.12 health plan under contract with the medical assistance program that agrees to make enhanced
203.13 payments to Hennepin County Medical Center or Regions Hospital. The increase shall be
203.14 in an amount equal to the annual value of the monthly transfers plus federal financial
203.15 participation, with each health plan receiving its pro rata share of the increase based on the
203.16 pro rata share of medical assistance admissions to Hennepin County Medical Center and
203.17 Regions Hospital by those plans. For the purposes of this paragraph, "the base amount"
203.18 means the total annual value of increased medical assistance capitation payments, including
203.19 the voluntary intergovernmental transfers, under this paragraph in calendar year 2017. For
203.20 managed care contracts beginning on or after January 1, 2018, the commissioner shall reduce
203.21 the total annual value of increased medical assistance capitation payments under this
203.22 paragraph by an amount equal to ten percent of the base amount, and by an additional ten
203.23 percent of the base amount for each subsequent contract year until December 31, 2025.
203.24 Upon the request of the commissioner, health plans shall submit individual-level cost data
203.25 for verification purposes. The commissioner may ratably reduce these payments on a pro
203.26 rata basis in order to satisfy federal requirements for actuarial soundness. If payments are
203.27 reduced, transfers shall be reduced accordingly. Any licensed health plan that receives
203.28 increased medical assistance capitation payments under the intergovernmental transfer
203.29 described in this paragraph shall increase its medical assistance payments to Hennepin
203.30 County Medical Center and Regions Hospital by the same amount as the increased payments
203.31 received in the capitation payment described in this paragraph. This paragraph expires
203.32 January 1, 2026.

203.33 (d) For the purposes of this subdivision and subdivision 3, the commissioner shall
203.34 determine an upper payment limit for ambulance services affiliated with Hennepin County
203.35 Medical Center and the city of St. Paul, and ambulance services owned and operated by

204.1 another governmental entity that chooses to participate by requesting the commissioner to
204.2 determine an upper payment limit. The upper payment limit shall be based on the average
204.3 commercial rate or be determined using another method acceptable to the Centers for
204.4 Medicare and Medicaid Services. The commissioner shall inform Hennepin County and,
204.5 the city of St. Paul, and other participating governmental entities of the periodic
204.6 intergovernmental transfers necessary to match the federal Medicaid payments available
204.7 under this subdivision in order to make supplementary payments to Hennepin County
204.8 Medical Center and, the city of St. Paul, and other participating governmental entities equal
204.9 to the difference between the established medical assistance payment for ambulance services
204.10 and the upper payment limit. Upon receipt of these periodic transfers, the commissioner
204.11 shall make supplementary payments to Hennepin County Medical Center and, the city of
204.12 St. Paul, and other participating governmental entities. A tribal government that owns and
204.13 operates an ambulance service is not eligible to participate under this subdivision.

204.14 (e) For the purposes of this subdivision and subdivision 3, the commissioner shall
204.15 determine an upper payment limit for physicians, dentists, and other billing professionals
204.16 affiliated with the University of Minnesota and University of Minnesota Physicians. The
204.17 upper payment limit shall be based on the average commercial rate or be determined using
204.18 another method acceptable to the Centers for Medicare and Medicaid Services. The
204.19 commissioner shall inform the University of Minnesota Medical School and University of
204.20 Minnesota School of Dentistry of the periodic intergovernmental transfers necessary to
204.21 match the federal Medicaid payments available under this subdivision in order to make
204.22 supplementary payments to physicians, dentists, and other billing professionals affiliated
204.23 with the University of Minnesota and the University of Minnesota Physicians equal to the
204.24 difference between the established medical assistance payment for physician, dentist, and
204.25 other billing professional services and the upper payment limit. Upon receipt of these periodic
204.26 transfers, the commissioner shall make supplementary payments to physicians, dentists,
204.27 and other billing professionals affiliated with the University of Minnesota and the University
204.28 of Minnesota Physicians.

204.29 (f) The commissioner shall inform the transferring governmental entities on an ongoing
204.30 basis of the need for any changes needed in the intergovernmental transfers in order to
204.31 continue the payments under paragraphs (a) to (d) (e), at their maximum level, including
204.32 increases in upper payment limits, changes in the federal Medicaid match, and other factors.

204.33 (g) The payments in paragraphs (a) to (d) (e) shall be implemented independently of
204.34 each other, subject to federal approval and to the receipt of transfers under subdivision 3.

205.1 (h) All of the data and funding transactions related to the payments in paragraphs (a) to
205.2 (e) shall be between the commissioner and the governmental entities.

205.3 (i) For purposes of this subdivision, billing professionals are limited to physicians, nurse
205.4 practitioners, nurse midwives, clinical nurse specialists, physician assistants,
205.5 anesthesiologists, certified registered nurse anesthetists, dentists, dental hygienists, and
205.6 dental therapists.

205.7 **EFFECTIVE DATE.** Paragraph (d) is effective July 1, 2017, or upon federal approval,
205.8 whichever is later. The commissioner of human services shall notify the revisor of statutes
205.9 when federal approval is received.

205.10 Sec. 46. Minnesota Statutes 2016, section 256B.196, subdivision 3, is amended to read:

205.11 Subd. 3. **Intergovernmental transfers.** Based on the determination by the commissioner
205.12 under subdivision 2, Hennepin County and Ramsey County shall make periodic
205.13 intergovernmental transfers to the commissioner for the purposes of subdivision 2, paragraphs
205.14 (a) and (b). All of the intergovernmental transfers made by Hennepin County shall be used
205.15 to match federal payments to Hennepin County Medical Center under subdivision 2,
205.16 paragraph (a), and to physicians and other billing professionals affiliated with Hennepin
205.17 County Medical Center under subdivision 2, paragraph (b). All of the intergovernmental
205.18 transfers made by Ramsey County shall be used to match federal payments to Regions
205.19 Hospital under subdivision 2, paragraph (a), and to physicians and other billing professionals
205.20 affiliated with Regions Hospital through HealthPartners Medical Group under subdivision
205.21 2, paragraph (b). All of the intergovernmental transfer payments made by the University of
205.22 Minnesota Medical School and the University of Minnesota School of Dentistry shall be
205.23 used to match federal payments to the University of Minnesota and the University of
205.24 Minnesota Physicians under subdivision 2, paragraph (e).

205.25 Sec. 47. Minnesota Statutes 2016, section 256B.196, subdivision 4, is amended to read:

205.26 Subd. 4. **Adjustments permitted.** (a) The commissioner may adjust the
205.27 intergovernmental transfers under subdivision 3 and the payments under subdivision 2,
205.28 based on the commissioner's determination of Medicare upper payment limits,
205.29 hospital-specific charge limits, hospital-specific limitations on disproportionate share
205.30 payments, medical inflation, actuarial certification, average commercial rates for physician
205.31 and other professional services as defined in this section, and cost-effectiveness for purposes
205.32 of federal waivers. Any adjustments must be made on a proportional basis. The commissioner
205.33 may make adjustments under this subdivision only after consultation with the affected

206.1 counties, university schools, and hospitals. All payments under subdivision 2 and all
206.2 intergovernmental transfers under subdivision 3 are limited to amounts available after all
206.3 other base rates, adjustments, and supplemental payments in chapter 256B are calculated.

206.4 (b) The ratio of medical assistance payments specified in subdivision 2 to the voluntary
206.5 intergovernmental transfers specified in subdivision 3 shall not be reduced except as provided
206.6 under paragraph (a).

206.7 Sec. 48. Minnesota Statutes 2016, section 256B.69, subdivision 9e, is amended to read:

206.8 Subd. 9e. **Financial audits.** (a) The legislative auditor shall ~~conduct or contract with~~
206.9 ~~vendors to conduct independent third-party financial audits of the information required to~~
206.10 ~~be provided by~~ audit managed care plans and county-based purchasing plans under
206.11 ~~subdivision 9e, paragraph (b). The audits by the vendors shall be conducted as vendor~~
206.12 ~~resources permit and in accordance with generally accepted government auditing standards~~
206.13 ~~issued by the United States Government Accountability Office. The contract with the vendors~~
206.14 ~~shall be designed and administered so as to render the independent third-party audits eligible~~
206.15 ~~for a federal subsidy, if available. The contract shall require the audits to include a~~
206.16 ~~determination of compliance with the federal Medicaid rate certification process to determine~~
206.17 if a managed care plan or county-based purchasing plan used public money in compliance
206.18 with federal and state laws, rules, and in accordance with provisions in the plan's contract
206.19 with the commissioner. The legislative auditor shall conduct the audits in accordance with
206.20 section 3.972, subdivision 2b.

206.21 (b) ~~For purposes of this subdivision, "independent third-party" means a vendor that is~~
206.22 ~~independent in accordance with government auditing standards issued by the United States~~
206.23 ~~Government Accountability Office.~~

206.24 Sec. 49. Minnesota Statutes 2016, section 256B.75, is amended to read:

206.25 **256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.**

206.26 (a) For outpatient hospital facility fee payments for services rendered on or after October
206.27 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge,
206.28 or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for
206.29 which there is a federal maximum allowable payment. Effective for services rendered on
206.30 or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and
206.31 emergency room facility fees shall be increased by eight percent over the rates in effect on
206.32 December 31, 1999, except for those services for which there is a federal maximum allowable
206.33 payment. Services for which there is a federal maximum allowable payment shall be paid

207.1 at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total
207.2 aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare
207.3 upper limit. If it is determined that a provision of this section conflicts with existing or
207.4 future requirements of the United States government with respect to federal financial
207.5 participation in medical assistance, the federal requirements prevail. The commissioner
207.6 may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial
207.7 participation resulting from rates that are in excess of the Medicare upper limitations.

207.8 (b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory
207.9 surgery hospital facility fee services for critical access hospitals designated under section
207.10 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the
207.11 cost-finding methods and allowable costs of the Medicare program. Effective for services
207.12 provided on or after July 1, 2015, rates established for critical access hospitals under this
207.13 paragraph for the applicable payment year shall be the final payment and shall not be settled
207.14 to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal
207.15 year ending in 2016, the rate for outpatient hospital services shall be computed using
207.16 information from each hospital's Medicare cost report as filed with Medicare for the year
207.17 that is two years before the year that the rate is being computed. Rates shall be computed
207.18 using information from Worksheet C series until the department finalizes the medical
207.19 assistance cost reporting process for critical access hospitals. After the cost reporting process
207.20 is finalized, rates shall be computed using information from Title XIX Worksheet D series.
207.21 The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs
207.22 related to rural health clinics and federally qualified health clinics, divided by ancillary
207.23 charges plus outpatient charges, excluding charges related to rural health clinics and federally
207.24 qualified health clinics.

207.25 (c) Effective for services provided on or after July 1, 2003, rates that are based on the
207.26 Medicare outpatient prospective payment system shall be replaced by a budget neutral
207.27 prospective payment system that is derived using medical assistance data. The commissioner
207.28 shall provide a proposal to the 2003 legislature to define and implement this provision.

207.29 (d) For fee-for-service services provided on or after July 1, 2002, the total payment,
207.30 before third-party liability and spenddown, made to hospitals for outpatient hospital facility
207.31 services is reduced by .5 percent from the current statutory rate.

207.32 (e) In addition to the reduction in paragraph (d), the total payment for fee-for-service
207.33 services provided on or after July 1, 2003, made to hospitals for outpatient hospital facility
207.34 services before third-party liability and spenddown, is reduced five percent from the current

208.1 statutory rates. Facilities defined under section 256.969, subdivision 16, are excluded from
208.2 this paragraph.

208.3 (f) In addition to the reductions in paragraphs (d) and (e), the total payment for
208.4 fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient
208.5 hospital facility services before third-party liability and spenddown, is reduced three percent
208.6 from the current statutory rates. Mental health services and facilities defined under section
208.7 256.969, subdivision 16, are excluded from this paragraph.

208.8 **EFFECTIVE DATE.** This section is effective July 1, 2017.

208.9 Sec. 50. Minnesota Statutes 2016, section 256B.76, subdivision 1, as amended by Laws
208.10 2017, chapter 40, article 1, section 79, is amended to read:

208.11 Subdivision 1. **Physician reimbursement.** (a) Effective for services rendered on or after
208.12 October 1, 1992, the commissioner shall make payments for physician services as follows:

208.13 (1) payment for level one Centers for Medicare and Medicaid Services' common
208.14 procedural coding system codes titled "office and other outpatient services," "preventive
208.15 medicine new and established patient," "delivery, antepartum, and postpartum care," "critical
208.16 care," cesarean delivery and pharmacologic management provided to psychiatric patients,
208.17 and level three codes for enhanced services for prenatal high risk, shall be paid at the lower
208.18 of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;

208.19 (2) payments for all other services shall be paid at the lower of (i) submitted charges,
208.20 or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

208.21 (3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th
208.22 percentile of 1989, less the percent in aggregate necessary to equal the above increases
208.23 except that payment rates for home health agency services shall be the rates in effect on
208.24 September 30, 1992.

208.25 (b) Effective for services rendered on or after January 1, 2000, payment rates for physician
208.26 and professional services shall be increased by three percent over the rates in effect on
208.27 December 31, 1999, except for home health agency and family planning agency services.
208.28 The increases in this paragraph shall be implemented January 1, 2000, for managed care.

208.29 (c) Effective for services rendered on or after July 1, 2009, payment rates for physician
208.30 and professional services shall be reduced by five percent, except that for the period July
208.31 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent for the medical
208.32 assistance and general assistance medical care programs, over the rates in effect on June
208.33 30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other

209.1 outpatient visits, preventive medicine visits and family planning visits billed by physicians,
209.2 advanced practice nurses, or physician assistants in a family planning agency or in one of
209.3 the following primary care practices: general practice, general internal medicine, general
209.4 pediatrics, general geriatrics, and family medicine. This reduction and the reductions in
209.5 paragraph (d) do not apply to federally qualified health centers, rural health centers, and
209.6 Indian health services. Effective October 1, 2009, payments made to managed care plans
209.7 and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall
209.8 reflect the payment reduction described in this paragraph.

209.9 (d) Effective for services rendered on or after July 1, 2010, payment rates for physician
209.10 and professional services shall be reduced an additional seven percent over the five percent
209.11 reduction in rates described in paragraph (c). This additional reduction does not apply to
209.12 physical therapy services, occupational therapy services, and speech pathology and related
209.13 services provided on or after July 1, 2010. This additional reduction does not apply to
209.14 physician services billed by a psychiatrist or an advanced practice nurse with a specialty in
209.15 mental health. Effective October 1, 2010, payments made to managed care plans and
209.16 county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect
209.17 the payment reduction described in this paragraph.

209.18 (e) Effective for services rendered on or after September 1, 2011, through June 30, 2013,
209.19 payment rates for physician and professional services shall be reduced three percent from
209.20 the rates in effect on August 31, 2011. This reduction does not apply to physical therapy
209.21 services, occupational therapy services, and speech pathology and related services.

209.22 (f) Effective for services rendered on or after September 1, 2014, payment rates for
209.23 physician and professional services, including physical therapy, occupational therapy, speech
209.24 pathology, and mental health services shall be increased by five percent from the rates in
209.25 effect on August 31, 2014. In calculating this rate increase, the commissioner shall not
209.26 include in the base rate for August 31, 2014, the rate increase provided under section
209.27 256B.76, subdivision 7. This increase does not apply to federally qualified health centers,
209.28 rural health centers, and Indian health services. Payments made to managed care plans and
209.29 county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

209.30 (g) Effective for services rendered on or after July 1, 2015, payment rates for physical
209.31 therapy, occupational therapy, and speech pathology and related services provided by a
209.32 hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause
209.33 (4), shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments
209.34 made to managed care plans and county-based purchasing plans shall not be adjusted to
209.35 reflect payments under this paragraph.

210.1 (h) Any ratables effective before July 1, 2015, do not apply to autism early intensive
210.2 intervention benefits described in section 256B.0949.

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

210.4 Sec. 51. Minnesota Statutes 2016, section 256B.76, subdivision 2, is amended to read:

210.5 Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after October
210.6 1, 1992, the commissioner shall make payments for dental services as follows:

210.7 (1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent
210.8 above the rate in effect on June 30, 1992; and

210.9 (2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile
210.10 of 1989, less the percent in aggregate necessary to equal the above increases.

210.11 (b) Beginning October 1, 1999, the payment for tooth sealants and fluoride treatments
210.12 shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

210.13 (c) Effective for services rendered on or after January 1, 2000, payment rates for dental
210.14 services shall be increased by three percent over the rates in effect on December 31, 1999.

210.15 (d) Effective for services provided on or after January 1, 2002, payment for diagnostic
210.16 examinations and dental x-rays provided to children under age 21 shall be the lower of (1)
210.17 the submitted charge, or (2) 85 percent of median 1999 charges.

210.18 (e) The increases listed in paragraphs (b) and (c) shall be implemented January 1, 2000,
210.19 for managed care.

210.20 (f) Effective for dental services rendered on or after October 1, 2010, by a state-operated
210.21 dental clinic, payment shall be paid on a reasonable cost basis that is based on the Medicare
210.22 principles of reimbursement. This payment shall be effective for services rendered on or
210.23 after January 1, 2011, to recipients enrolled in managed care plans or county-based
210.24 purchasing plans.

210.25 (g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics in
210.26 paragraph (f), including state and federal shares, are less than \$1,850,000 per fiscal year, a
210.27 supplemental state payment equal to the difference between the total payments in paragraph
210.28 (f) and \$1,850,000 shall be paid from the general fund to state-operated services for the
210.29 operation of the dental clinics.

210.30 (h) If the cost-based payment system for state-operated dental clinics described in
210.31 paragraph (f) does not receive federal approval, then state-operated dental clinics shall be
210.32 designated as critical access dental providers under subdivision 4, paragraph (b), and shall

211.1 receive the critical access dental reimbursement rate as described under subdivision 4,
211.2 paragraph (a).

211.3 (i) Effective for services rendered on or after September 1, 2011, through June 30, 2013,
211.4 payment rates for dental services shall be reduced by three percent. This reduction does not
211.5 apply to state-operated dental clinics in paragraph (f).

211.6 (j) Effective for services rendered on or after January 1, 2014, payment rates for dental
211.7 services shall be increased by five percent from the rates in effect on December 31, 2013.
211.8 This increase does not apply to state-operated dental clinics in paragraph (f), federally
211.9 qualified health centers, rural health centers, and Indian health services. Effective January
211.10 1, 2014, payments made to managed care plans and county-based purchasing plans under
211.11 sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase described in
211.12 this paragraph.

211.13 (k) Effective for services rendered on or after July 1, 2015, through December 31, 2016,
211.14 the commissioner shall increase payment rates for services furnished by dental providers
211.15 located outside of the seven-county metropolitan area by the maximum percentage possible
211.16 above the rates in effect on June 30, 2015, while remaining within the limits of funding
211.17 appropriated for this purpose. This increase does not apply to state-operated dental clinics
211.18 in paragraph (f), federally qualified health centers, rural health centers, and Indian health
211.19 services. Effective January 1, 2016, through December 31, 2016, payments to managed care
211.20 plans and county-based purchasing plans under sections 256B.69 and 256B.692 shall reflect
211.21 the payment increase described in this paragraph. The commissioner shall require managed
211.22 care and county-based purchasing plans to pass on the full amount of the increase, in the
211.23 form of higher payment rates to dental providers located outside of the seven-county
211.24 metropolitan area.

211.25 (l) Effective for services provided on or after January 1, 2017, the commissioner shall
211.26 increase payment rates by 9.65 percent for dental services provided outside of the
211.27 seven-county metropolitan area. This increase does not apply to state-operated dental clinics
211.28 in paragraph (f), federally qualified health centers, rural health centers, or Indian health
211.29 services. Effective January 1, 2017, payments to managed care plans and county-based
211.30 purchasing plans under sections 256B.69 and 256B.692 shall reflect the payment increase
211.31 described in this paragraph.

211.32 (m) Effective for services provided on or after July 1, 2017, the commissioner shall
211.33 increase payment rates by 23.8 percent for dental services provided to enrollees under the
211.34 age of 21. This rate increase does not apply to state-operated dental clinics in paragraph (f),

212.1 federally qualified health centers, rural health centers, or Indian health centers. This rate
212.2 increase does not apply to managed care plans and county-based purchasing plans.

212.3 Sec. 52. Minnesota Statutes 2016, section 256B.761, is amended to read:

212.4 **256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.**

212.5 (a) Effective for services rendered on or after July 1, 2001, payment for medication
212.6 management provided to psychiatric patients, outpatient mental health services, day treatment
212.7 services, home-based mental health services, and family community support services shall
212.8 be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of
212.9 1999 charges.

212.10 (b) Effective July 1, 2001, the medical assistance rates for outpatient mental health
212.11 services provided by an entity that operates: (1) a Medicare-certified comprehensive
212.12 outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1, 1993,
212.13 with at least 33 percent of the clients receiving rehabilitation services in the most recent
212.14 calendar year who are medical assistance recipients, will be increased by 38 percent, when
212.15 those services are provided within the comprehensive outpatient rehabilitation facility and
212.16 provided to residents of nursing facilities owned by the entity.

212.17 (c) The commissioner shall establish three levels of payment for mental health diagnostic
212.18 assessment, based on three levels of complexity. The aggregate payment under the tiered
212.19 rates must not exceed the projected aggregate payments for mental health diagnostic
212.20 assessment under the previous single rate. The new rate structure is effective January 1,
212.21 2011, or upon federal approval, whichever is later.

212.22 (d) In addition to rate increases otherwise provided, the commissioner may restructure
212.23 coverage policy and rates to improve access to adult rehabilitative mental health services
212.24 under section 256B.0623 and related mental health support services under section 256B.021,
212.25 subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and 2016, the projected
212.26 state share of increased costs due to this paragraph is transferred from adult mental health
212.27 grants under sections 245.4661 and 256E.12. The transfer for fiscal year 2016 is a permanent
212.28 base adjustment for subsequent fiscal years. Payments made to managed care plans and
212.29 county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect
212.30 the rate changes described in this paragraph.

212.31 (e) Any ratables effective before July 1, 2015, do not apply to autism early intensive
212.32 intervention benefits described in section 256B.0949.

212.33 **EFFECTIVE DATE.** This section is effective July 1, 2017.

213.1 Sec. 53. [256B.7635] REIMBURSEMENT FOR EVIDENCE-BASED PUBLIC
213.2 HEALTH NURSE HOME VISITS.

213.3 Effective for services provided on or after January 1, 2018, prenatal and postpartum
213.4 follow-up home visits provided by public health nurses or registered nurses supervised by
213.5 a public health nurse using evidence-based models shall be paid \$140 per visit.
213.6 Evidence-based postpartum follow-up home visits must be administered by home visiting
213.7 programs that meet the United States Department of Health and Human Services criteria
213.8 for evidence-based models and are identified by the commissioner of health as eligible to
213.9 be implemented under the Maternal, Infant, and Early Childhood Home Visiting program.
213.10 Home visits must target mothers and their children beginning with prenatal visits through
213.11 age three for the child.

213.12 Sec. 54. Minnesota Statutes 2016, section 256B.766, is amended to read:

213.13 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

213.14 (a) Effective for services provided on or after July 1, 2009, total payments for basic care
213.15 services, shall be reduced by three percent, except that for the period July 1, 2009, through
213.16 June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance
213.17 and general assistance medical care programs, prior to third-party liability and spenddown
213.18 calculation. Effective July 1, 2010, the commissioner shall classify physical therapy services,
213.19 occupational therapy services, and speech-language pathology and related services as basic
213.20 care services. The reduction in this paragraph shall apply to physical therapy services,
213.21 occupational therapy services, and speech-language pathology and related services provided
213.22 on or after July 1, 2010.

213.23 (b) Payments made to managed care plans and county-based purchasing plans shall be
213.24 reduced for services provided on or after October 1, 2009, to reflect the reduction effective
213.25 July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010,
213.26 to reflect the reduction effective July 1, 2010.

213.27 (c) Effective for services provided on or after September 1, 2011, through June 30, 2013,
213.28 total payments for outpatient hospital facility fees shall be reduced by five percent from the
213.29 rates in effect on August 31, 2011.

213.30 (d) Effective for services provided on or after September 1, 2011, through June 30, 2013,
213.31 total payments for ambulatory surgery centers facility fees, medical supplies and durable
213.32 medical equipment not subject to a volume purchase contract, prosthetics and orthotics,
213.33 renal dialysis services, laboratory services, public health nursing services, physical therapy

214.1 services, occupational therapy services, speech therapy services, eyeglasses not subject to
214.2 a volume purchase contract, hearing aids not subject to a volume purchase contract, and
214.3 anesthesia services shall be reduced by three percent from the rates in effect on August 31,
214.4 2011.

214.5 (e) Effective for services provided on or after September 1, 2014, payments for
214.6 ambulatory surgery centers facility fees, hospice services, renal dialysis services, laboratory
214.7 services, public health nursing services, eyeglasses not subject to a volume purchase contract,
214.8 and hearing aids not subject to a volume purchase contract shall be increased by three percent
214.9 and payments for outpatient hospital facility fees shall be increased by three percent.
214.10 Payments made to managed care plans and county-based purchasing plans shall not be
214.11 adjusted to reflect payments under this paragraph.

214.12 (f) Payments for medical supplies and durable medical equipment not subject to a volume
214.13 purchase contract, and prosthetics and orthotics, provided on or after July 1, 2014, through
214.14 June 30, 2015, shall be decreased by .33 percent. Payments for medical supplies and durable
214.15 medical equipment not subject to a volume purchase contract, and prosthetics and orthotics,
214.16 provided on or after July 1, 2015, shall be increased by three percent from the rates as
214.17 determined under paragraphs (i) and (j).

214.18 (g) Effective for services provided on or after July 1, 2015, payments for outpatient
214.19 hospital facility fees, medical supplies and durable medical equipment not subject to a
214.20 volume purchase contract, prosthetics, and orthotics, ~~and laboratory services~~ to a hospital
214.21 meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4),
214.22 shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments made
214.23 to managed care plans and county-based purchasing plans shall not be adjusted to reflect
214.24 payments under this paragraph.

214.25 (h) This section does not apply to physician and professional services, inpatient hospital
214.26 services, family planning services, mental health services, dental services, prescription
214.27 drugs, medical transportation, federally qualified health centers, rural health centers, Indian
214.28 health services, and Medicare cost-sharing.

214.29 (i) Effective for services provided on or after July 1, 2015, the following categories of
214.30 medical supplies and durable medical equipment shall be individually priced items: enteral
214.31 nutrition and supplies, customized and other specialized tracheostomy tubes and supplies,
214.32 electric patient lifts, and durable medical equipment repair and service. This paragraph does
214.33 not apply to medical supplies and durable medical equipment subject to a volume purchase
214.34 contract, products subject to the preferred diabetic testing supply program, and items provided

215.1 to dually eligible recipients when Medicare is the primary payer for the item. The
215.2 commissioner shall not apply any medical assistance rate reductions to durable medical
215.3 equipment as a result of Medicare competitive bidding.

215.4 (j) Effective for services provided on or after July 1, 2015, medical assistance payment
215.5 rates for durable medical equipment, prosthetics, orthotics, or supplies shall be increased
215.6 as follows:

215.7 (1) payment rates for durable medical equipment, prosthetics, orthotics, or supplies that
215.8 were subject to the Medicare competitive bid that took effect in January of 2009 shall be
215.9 increased by 9.5 percent; and

215.10 (2) payment rates for durable medical equipment, prosthetics, orthotics, or supplies on
215.11 the medical assistance fee schedule, whether or not subject to the Medicare competitive bid
215.12 that took effect in January of 2009, shall be increased by 2.94 percent, with this increase
215.13 being applied after calculation of any increased payment rate under clause (1).

215.14 This paragraph does not apply to medical supplies and durable medical equipment subject
215.15 to a volume purchase contract, products subject to the preferred diabetic testing supply
215.16 program, items provided to dually eligible recipients when Medicare is the primary payer
215.17 for the item, and individually priced items identified in paragraph (i). Payments made to
215.18 managed care plans and county-based purchasing plans shall not be adjusted to reflect the
215.19 rate increases in this paragraph.

215.20 (k) Effective for nonpressure support ventilators provided on or after January 1, 2016,
215.21 the rate shall be the lower of the submitted charge or the Medicare fee schedule rate. Effective
215.22 for pressure support ventilators provided on or after January 1, 2016, the rate shall be the
215.23 lower of the submitted charge or 47 percent above the Medicare fee schedule rate. For
215.24 payments made in accordance with this paragraph, if, and to the extent that, the commissioner
215.25 identifies that the state has received federal financial participation for ventilators in excess
215.26 of the amount allowed effective January 1, 2018, under United States Code, title 42, section
215.27 1396b(i)(27), the state shall repay the excess amount to the Centers for Medicare and
215.28 Medicaid Services with state funds and maintain the full payment rate under this paragraph.

215.29 **EFFECTIVE DATE.** This section is effective retroactively from January 1, 2016.

215.30 Sec. 55. Minnesota Statutes 2016, section 256L.03, subdivision 1, is amended to read:

215.31 Subdivision 1. **Covered health services.** (a) "Covered health services" means the health
215.32 services reimbursed under chapter 256B, with the exception of special education services,
215.33 home care nursing services, adult dental care services other than services covered under

216.1 section 256B.0625, subdivision 9, orthodontic services, nonemergency medical transportation
216.2 services, personal care assistance and case management services, and nursing home or
216.3 intermediate care facilities services.

216.4 (b) No public funds shall be used for coverage of abortion under MinnesotaCare except
216.5 where the life of the female would be endangered or substantial and irreversible impairment
216.6 of a major bodily function would result if the fetus were carried to term; or where the
216.7 pregnancy is the result of rape or incest.

216.8 (c) Covered health services shall be expanded as provided in this section.

216.9 (d) For the purposes of covered health services under this section, "child" means an
216.10 individual younger than 19 years of age.

216.11 Sec. 56. Minnesota Statutes 2016, section 256L.03, subdivision 1a, is amended to read:

216.12 Subd. 1a. **Children; MinnesotaCare health care reform waiver.** Children are eligible
216.13 for coverage of all services that are eligible for reimbursement under the medical assistance
216.14 program according to chapter 256B, except special education services and that abortion
216.15 services under MinnesotaCare shall be limited as provided under subdivision 1. Children
216.16 are exempt from the provisions of subdivision 5, regarding co-payments. Children who are
216.17 lawfully residing in the United States but who are not "qualified noncitizens" under title IV
216.18 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public
216.19 Law 104-193, Statutes at Large, volume 110, page 2105, are eligible for coverage of all
216.20 services provided under the medical assistance program according to chapter 256B.

216.21 Sec. 57. Minnesota Statutes 2016, section 256L.03, subdivision 5, is amended to read:

216.22 Subd. 5. **Cost-sharing.** ~~(a) Except as otherwise provided in this subdivision, the~~
216.23 ~~MinnesotaCare benefit plan shall include the following cost-sharing requirements for all~~
216.24 ~~enrollees:~~

216.25 ~~(1) \$3 per prescription for adult enrollees;~~

216.26 ~~(2) \$25 for eyeglasses for adult enrollees;~~

216.27 ~~(3) \$3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an~~
216.28 ~~episode of service which is required because of a recipient's symptoms, diagnosis, or~~
216.29 ~~established illness, and which is delivered in an ambulatory setting by a physician or~~
216.30 ~~physician assistant, chiropractor, podiatrist, nurse midwife, advanced practice nurse,~~
216.31 ~~audiologist, optician, or optometrist;~~

217.1 ~~(4) \$6 for nonemergency visits to a hospital-based emergency room for services provided~~
217.2 ~~through December 31, 2010, and \$3.50 effective January 1, 2011; and~~

217.3 ~~(5) a family deductible equal to \$2.75 per month per family and adjusted annually by~~
217.4 ~~the percentage increase in the medical care component of the CPI-U for the period of~~
217.5 ~~September to September of the preceding calendar year, rounded to the next higher five~~
217.6 ~~cent increment.~~

217.7 ~~(b) Paragraph (a) does~~ (a) Co-payments, coinsurance, and deductibles do not apply to
217.8 children under the age of 21 and to American Indians as defined in Code of Federal
217.9 Regulations, title 42, section 447.51 600.5.

217.10 ~~(c) Paragraph (a), clause (3), does not apply to mental health services.~~

217.11 ~~(d) MinnesotaCare reimbursements to fee-for-service providers and payments to managed~~
217.12 ~~care plans or county-based purchasing plans shall not be increased as a result of the reduction~~
217.13 ~~of the co-payments in paragraph (a), clause (4), effective January 1, 2011.~~

217.14 ~~(e) The commissioner, through the contracting process under section 256L.12, may~~
217.15 ~~allow managed care plans and county-based purchasing plans to waive the family deductible~~
217.16 ~~under paragraph (a), clause (5). The value of the family deductible shall not be included in~~
217.17 ~~the capitation payment to managed care plans and county-based purchasing plans. Managed~~
217.18 ~~care plans and county-based purchasing plans shall certify annually to the commissioner~~
217.19 ~~the dollar value of the family deductible.~~

217.20 ~~(f)~~ (b) The commissioner shall increase adjust co-payments, coinsurance, and deductibles
217.21 for covered services in a manner sufficient to reducee maintain the actuarial value of the
217.22 benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to
217.23 eligible recipients or services exempt from cost-sharing under state law. The cost-sharing
217.24 changes described in this paragraph shall not be implemented prior to January 1, 2016.

217.25 ~~(g)~~ (c) The cost-sharing changes authorized under paragraph (f) (b) must satisfy the
217.26 requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal
217.27 Regulations, title 42, sections 600.510 and 600.520.

217.28 **EFFECTIVE DATE.** This section is effective January 1, 2018.

217.29 Sec. 58. Minnesota Statutes 2016, section 256L.11, is amended by adding a subdivision
217.30 to read:

217.31 **Subd. 6a. Dental providers.** Effective for dental services provided to MinnesotaCare
217.32 enrollees on or after January 1, 2018, the commissioner shall increase payment rates to

218.1 dental providers by 54 percent. Payments made to prepaid health plans under section 256L.12
218.2 shall reflect the payment increase described in this subdivision. The prepaid health plans
218.3 under contract with the commissioner shall provide payments to dental providers that are
218.4 at least equal to a rate that includes the payment rate specified in this subdivision, and if
218.5 applicable to the provider, the rates described under subdivision 7.

218.6 Sec. 59. Minnesota Statutes 2016, section 256L.11, subdivision 7, is amended to read:

218.7 Subd. 7. **Critical access dental providers.** Effective for dental services provided to
218.8 MinnesotaCare enrollees on or after July 1, ~~2016~~ 2017, the commissioner shall increase
218.9 payment rates to dentists and dental clinics deemed by the commissioner to be critical access
218.10 providers under section 256B.76, subdivision 4, by ~~32.5~~ 20 percent above the payment rate
218.11 that would otherwise be paid to the provider, ~~except for a dental clinic or dental group~~
218.12 ~~described in section 256B.76, subdivision 4, paragraph (b), in which the commissioner shall~~
218.13 ~~increase the payment rate by 30 percent above the payment rate that would otherwise be~~
218.14 ~~paid to the provider.~~ The commissioner shall pay the prepaid health plans under contract
218.15 with the commissioner amounts sufficient to reflect this rate increase. The prepaid health
218.16 plan must pass this rate increase to providers who have been identified by the commissioner
218.17 as critical access dental providers under section 256B.76, subdivision 4.

218.18 Sec. 60. Minnesota Statutes 2016, section 256L.15, subdivision 2, is amended to read:

218.19 Subd. 2. **Sliding fee scale; monthly individual or family income.** (a) The commissioner
218.20 shall establish a sliding fee scale to determine the percentage of monthly individual or family
218.21 income that households at different income levels must pay to obtain coverage through the
218.22 MinnesotaCare program. The sliding fee scale must be based on the enrollee's monthly
218.23 individual or family income.

218.24 (b) Beginning January 1, 2014, MinnesotaCare enrollees shall pay premiums according
218.25 to the premium scale specified in paragraph (d).

218.26 (c) Paragraph (b) does not apply to:

218.27 (1) children 20 years of age or younger; and

218.28 (2) individuals with household incomes below 35 percent of the federal poverty
218.29 guidelines.

218.30 (d) The following premium scale is established for each individual in the household who
218.31 is 21 years of age or older and enrolled in MinnesotaCare:

219.1	Federal Poverty Guideline	Less than	Individual Premium
219.2	Greater than or Equal to		Amount
219.3	35%	55%	\$4
219.4	55%	80%	\$6
219.5	80%	90%	\$8
219.6	90%	100%	\$10
219.7	100%	110%	\$12
219.8	110%	120%	\$14
219.9	120%	130%	\$15
219.10	130%	140%	\$16
219.11	140%	150%	\$25
219.12	150%	160%	\$29 <u>\$37</u>
219.13	160%	170%	\$33 <u>\$44</u>
219.14	170%	180%	\$38 <u>\$52</u>
219.15	180%	190%	\$43 <u>\$61</u>
219.16	190%	<u>200%</u>	\$50 <u>\$71</u>
219.17	<u>200%</u>		<u>\$80</u>

219.18 **EFFECTIVE DATE.** This section is effective August 1, 2015.

219.19 Sec. 61. **CAPITATION PAYMENT DELAY.**

219.20 (a) The commissioner of human services shall delay the medical assistance capitation
 219.21 payment to managed care plans and county-based purchasing plans due in May 2019 until
 219.22 July 1, 2019. The payment shall be made no earlier than July 1, 2019, and no later than July
 219.23 31, 2019.

219.24 (b) The commissioner of human services shall delay the medical assistance capitation
 219.25 payment to managed care plans and county-based purchasing plans due in May 2021 until
 219.26 July 1, 2021. The payment shall be made no earlier than July 1, 2021, and no later than July
 219.27 31, 2021.

219.28 Sec. 62. **FEDERAL WAIVER OR APPROVAL; STATE PROGRAM**
 219.29 **PARTICIPATION REQUIREMENT.**

219.30 The commissioner of human services shall seek any federal waiver or approval necessary
 219.31 to implement section 38.

220.1 **Sec. 63. OPIOID USE AND ACUPUNCTURE STUDY.**

220.2 (a) The commissioner of human services, within the limits of available appropriations,
220.3 shall study the use of opiates for the treatment of chronic pain conditions when acupuncture
220.4 services are also part of the treatment for chronic pain as compared to opiate use among
220.5 medical assistance recipients who are not receiving acupuncture. In comparing the sample
220.6 groups, the commissioner shall look at each group's opiate use and other services as identified
220.7 by the commissioner.

220.8 (b) The aggregate findings of the study shall be submitted by the commissioner to the
220.9 chairs and ranking minority members of the legislative committees with jurisdiction over
220.10 health and human services policy and finance by February 15, 2018. The report shall not
220.11 contain or disclose any patient identifying data.

220.12 **Sec. 64. STUDY OF PAYMENT RATES FOR DURABLE MEDICAL EQUIPMENT**
220.13 **AND SUPPLIES.**

220.14 The commissioner of human services shall study the impact of basing medical assistance
220.15 payment for durable medical equipment and medical supplies on Medicare payment rates,
220.16 as limited by the payment provisions in the 21st Century Cures Act, Public Law 114-255,
220.17 on access by medical assistance enrollees to these items. The study must include
220.18 recommendations for ensuring and improving access by medical assistance enrollees to
220.19 durable medical equipment and medical supplies. The commissioner shall report study
220.20 results and recommendations to the chairs and ranking minority members of the legislative
220.21 committees with jurisdiction over health and human services policy and finance by January
220.22 1, 2019.

220.23 **Sec. 65. ELIGIBILITY VERIFICATION FEDERAL COMPLIANCE.**

220.24 The commissioner of human services shall implement a process to terminate coverage
220.25 for medical assistance enrollees who fail to submit requested verifications within 95 days
220.26 of coverage approval. The commissioner shall implement a manual process by July 1, 2017,
220.27 with the counties and tribal agencies, and provide them with instructions and necessary
220.28 reports. The commissioner shall ensure that the Minnesota eligibility technology system
220.29 (METS) has the required functionality to implement an automated process by April 1, 2018.

221.1 Sec. 66. **REVISOR'S INSTRUCTION.**

221.2 The revisor of statutes, in the next edition of Minnesota Statutes, shall change the term
221.3 "health care delivery system" and similar terms to "integrated health partnership" and similar
221.4 terms, wherever it appears in Minnesota Statutes, section 256B.0755.

221.5 Sec. 67. **REPEALER.**

221.6 (a) Minnesota Statutes 2016, sections 256B.19, subdivision 1c; and 256B.64, are repealed.

221.7 (b) Minnesota Rules, part 9500.1140, subparts 3, 4, 5, and 6, are repealed.

221.8 **ARTICLE 5**

221.9 **HEALTH INSURANCE**

221.10 Section 1. Minnesota Statutes 2016, section 62A.04, subdivision 1, is amended to read:

221.11 Subdivision 1. **Reference.** (a) Any reference to "standard provisions" which may appear
221.12 in other sections and which refer to accident and sickness or accident and health insurance
221.13 shall hereinafter be construed as referring to accident and sickness policy provisions.

221.14 (b) Notwithstanding paragraph (a), the following do not apply to health plans:

221.15 (1) subdivision 2, clauses (5) to (10) and (12);

221.16 (2) subdivision 3, clauses (1) and (3) to (7); and

221.17 (3) subdivisions 6 and 10.

221.18 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
221.19 renewed on or after January 1, 2018.

221.20 Sec. 2. Minnesota Statutes 2016, section 62A.21, subdivision 2a, is amended to read:

221.21 Subd. 2a. **Continuation privilege.** Every policy described in subdivision 1 shall contain
221.22 a provision which permits continuation of coverage under the policy for the insured's former
221.23 ~~spouse and dependent children upon~~, which is defined as required by section 62A.302, and
221.24 former spouse, who was covered on the day before the entry of a valid decree of dissolution
221.25 of marriage. The coverage shall be continued until the earlier of the following dates:

221.26 (a) the date the insured's former spouse becomes covered under any other group health
221.27 plan; or

221.28 (b) the date coverage would otherwise terminate under the policy.

222.1 If the coverage is provided under a group policy, any required premium contributions
222.2 for the coverage shall be paid by the insured on a monthly basis to the group policyholder
222.3 for remittance to the insurer. The policy must require the group policyholder to, upon request,
222.4 provide the insured with written verification from the insurer of the cost of this coverage
222.5 promptly at the time of eligibility for this coverage and at any time during the continuation
222.6 period. In no event shall the amount of premium charged exceed 102 percent of the cost to
222.7 the plan for such period of coverage for other similarly situated spouses and dependent
222.8 children with respect to whom the marital relationship has not dissolved, without regard to
222.9 whether such cost is paid by the employer or employee.

222.10 Upon request by the insured's former spouse, who was covered on the day before the
222.11 entry of a valid decree of dissolution, or dependent child, a health carrier must provide the
222.12 instructions necessary to enable the child or former spouse to elect continuation of coverage.

222.13 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
222.14 renewed on or after January 1, 2018.

222.15 Sec. 3. Minnesota Statutes 2016, section 62A.3075, is amended to read:

222.16 **62A.3075 CANCER CHEMOTHERAPY TREATMENT COVERAGE.**

222.17 (a) A health plan company that provides coverage under a health plan for cancer
222.18 chemotherapy treatment shall not require a higher co-payment, deductible, or coinsurance
222.19 amount for a prescribed, orally administered anticancer medication that is used to kill or
222.20 slow the growth of cancerous cells than what the health plan requires for an intravenously
222.21 administered or injected cancer medication that is provided, regardless of formulation or
222.22 benefit category determination by the health plan company.

222.23 (b) A health plan company must not achieve compliance with this section by imposing
222.24 an increase in co-payment, deductible, or coinsurance amount for an intravenously
222.25 administered or injected cancer chemotherapy agent covered under the health plan.

222.26 (c) Nothing in this section shall be interpreted to prohibit a health plan company from
222.27 requiring prior authorization or imposing other appropriate utilization controls in approving
222.28 coverage for any chemotherapy.

222.29 (d) A plan offered by the commissioner of management and budget under section 43A.23
222.30 is deemed to be at parity and in compliance with this section.

222.31 (e) A health plan company is in compliance with this section if it does not include orally
222.32 administered anticancer medication in the fourth tier of its pharmacy benefit.

223.1 (f) A health plan company that provides coverage under a health plan for cancer
223.2 chemotherapy treatment must indicate the level of coverage for orally administered anticancer
223.3 medication within its pharmacy benefit filing with the commissioner.

223.4 **EFFECTIVE DATE.** This section is effective January 1, 2018, and applies to health
223.5 plans offered, sold, issued, or renewed on or after that date.

223.6 Sec. 4. Minnesota Statutes 2016, section 62D.105, is amended to read:

223.7 **62D.105 COVERAGE OF CURRENT SPOUSE, FORMER SPOUSE, AND**
223.8 **CHILDREN.**

223.9 Subdivision 1. **Requirement.** Every health maintenance contract, which in addition to
223.10 covering the enrollee also provides coverage to the spouse and, dependent children, which
223.11 is defined as required by section 62A.302, and former spouse who was covered on the day
223.12 before the entry of a valid decree of dissolution of marriage, of the enrollee shall: (1) permit
223.13 the spouse, former spouse, and dependent children to elect to continue coverage when the
223.14 enrollee becomes enrolled for benefits under title XVIII of the Social Security Act
223.15 (Medicare); and (2) permit the dependent children to continue coverage when they cease
223.16 to be dependent children under the generally applicable requirement of the plan.

223.17 Subd. 2. **Continuation privilege.** The coverage described in subdivision 1 may be
223.18 continued until the earlier of the following dates:

223.19 (1) the date coverage would otherwise terminate under the contract;

223.20 (2) 36 months after continuation by the spouse, former spouse, or dependent was elected;
223.21 or

223.22 (3) the date the spouse, former spouse, or dependent children become covered under
223.23 another group health plan or Medicare.

223.24 If coverage is provided under a group policy, any required fees for the coverage shall
223.25 be paid by the enrollee on a monthly basis to the group contract holder for remittance to the
223.26 health maintenance organization. In no event shall the fee charged exceed 102 percent of
223.27 the cost to the plan for such coverage for other similarly situated spouse and dependent
223.28 children to whom subdivision 1 is not applicable, without regard to whether such cost is
223.29 paid by the employer or employee.

223.30 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
223.31 renewed on or after January 1, 2018.

224.1 Sec. 5. Minnesota Statutes 2016, section 62E.04, subdivision 11, is amended to read:

224.2 Subd. 11. **Essential health benefits package Affordable Care Act compliant plans.**

224.3 For ~~individual or small group health plans that include the essential health benefits package~~
224.4 ~~and are~~ any policy of accident and health insurance subject to the requirements of the
224.5 Affordable Care Act, as defined under section 62A.011, subdivision 1a, that is offered, sold,
224.6 issued, or renewed on or after January 1, 2014 2018, the requirements of this section do not
224.7 apply.

224.8 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
224.9 renewed on or after January 1, 2018.

224.10 Sec. 6. Minnesota Statutes 2016, section 62E.05, subdivision 1, is amended to read:

224.11 Subdivision 1. **Certification.** Upon application by an insurer, fraternal, or employer for
224.12 certification of a plan of health coverage as a qualified plan or a qualified Medicare
224.13 supplement plan for the purposes of sections 62E.01 to 62E.19, the commissioner shall
224.14 make a determination within 90 days as to whether the plan is qualified. All plans of health
224.15 coverage, except Medicare supplement policies, shall be labeled as "qualified" or
224.16 "nonqualified" on the front of the policy or contract, or on the schedule page. All qualified
224.17 plans shall indicate whether they are number one, two, or three coverage plans. For any
224.18 policy of accident and health insurance subject to the requirements of the Affordable Care
224.19 Act, as defined under section 62A.011, subdivision 1a, that is offered, sold, issued, or
224.20 renewed on or after January 1, 2018, the requirements of this section do not apply.

224.21 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
224.22 renewed on or after January 1, 2018.

224.23 Sec. 7. Minnesota Statutes 2016, section 62E.06, is amended by adding a subdivision to
224.24 read:

224.25 Subd. 5. **Affordable Care Act compliant plans.** For any policy of accident and health
224.26 insurance subject to the requirements of the Affordable Care Act, as defined under section
224.27 62A.011, subdivision 1a, that is offered, sold, issued, or renewed on or after January 1,
224.28 2018, the requirements of this section do not apply.

224.29 **EFFECTIVE DATE.** This section is effective for policies offered, sold, issued, or
224.30 renewed on or after January 1, 2018.

225.1 Sec. 8. Laws 2017, chapter 2, article 1, section 5, is amended to read:

225.2 Sec. 5. **SUNSET.**

225.3 This article ~~sunsets June 30,~~ other than section 2, subdivision 5; section 3; and section
225.4 7, sunsets August 31, 2018.

225.5 Sec. 9. Laws 2017, chapter 2, article 1, section 7, is amended to read:

225.6 Sec. 7. **APPROPRIATIONS.**

225.7 (a) \$311,788,000 in fiscal year 2017 is appropriated from the general fund to the
225.8 commissioner of management and budget for premium assistance under section 2. This
225.9 appropriation is onetime and is available through ~~June 30~~ August 31, 2018.

225.10 (b) \$157,000 in fiscal year 2017 is appropriated from the general fund to the legislative
225.11 auditor for purposes of section 3. This appropriation is onetime.

225.12 (c) Any unexpended amount from the appropriation in paragraph (a) after June 30, 2018,
225.13 shall be transferred ~~on July 1~~ no later than August 31, 2018, from the general fund to the
225.14 budget reserve account under Minnesota Statutes, section 16A.152, subdivision 1a.

225.15 Sec. 10. Laws 2017, chapter 13, article 1, section 15, is amended to read:

225.16 Sec. 15. **MINNESOTA PREMIUM SECURITY PLAN FUNDING.**

225.17 (a) The Minnesota Comprehensive Health Association shall fund the operational and
225.18 administrative costs and reinsurance payments of the Minnesota security plan and association
225.19 using the following amounts deposited in the premium security plan account in Minnesota
225.20 Statutes, section 62E.25, subdivision 1, in the following order:

225.21 (1) any federal funding available;

225.22 (2) funds deposited under article 1, sections 12 and 13;

225.23 (3) any state funds from the health care access fund; and

225.24 (4) any state funds from the general fund.

225.25 (b) The association shall transfer from the premium security plan account any ~~general~~
225.26 ~~fund amount~~ state funds not used for the Minnesota premium security plan by June 30,
225.27 2021, to the commissioner of commerce. Any amount transferred to the commissioner of
225.28 commerce shall be deposited in the ~~general fund.~~

225.29 ~~(c) The association shall transfer from the premium security plan account any health~~
225.30 ~~care access fund amount not used for the Minnesota premium security plan by June 30,~~