State of Minnesota

# HOUSE OF REPRESENTATIVES

**EIGHTY-EIGHTH SESSION**

**H. F. No. 2950**

03/10/2014 Authored by Liebling
The bill was read for the first time and referred to the Committee on Health and Human Services Policy

A bill for an act

relating to human services; removing obsolete provisions from statute relating to children and family services, health care, chemical and mental health services, continuing care, and operations; modifying provisions governing the elderly waiver, the alternative care program, and mental health services for children; amending Minnesota Statutes 2012, sections 13.46, subdivision 4; 245.4871, subdivisions 3, 6, 27; 245.4873, subdivision 2; 245.4874, subdivision 1; 245.4881, subdivisions 3, 4; 245.4882, subdivision 1; 245A.40, subdivision 8; 245C.04, subdivision 1; 245C.05, subdivision 5; 246.01; 254B.05, subdivision 2; 256.01, subdivision 14b; 256.963, subdivision 2; 256.969, subdivision 9; 256B.0913, subdivisions 5a, 14; 256B.0915, subdivisions 3c, 3d, 3f, 3g; 256B.0943, subdivisions 8, 10, 12; 256B.69, subdivisions 2, 4b, 5, 5a, 5b, 6b, 6d, 17, 26, 29, 30; 256B.692, subdivisions 2, 5; 256D.02, subdivision 11; 256D.04; 256D.045; 256D.07; 256I.04, subdivision 3; 256I.05, subdivision 1c; 256J.425, subdivision 4; 518A.65; 626.556, subdivision 3c; Minnesota Statutes 2013 Supplement, sections 245A.03, subdivision 7; 245A.40, subdivision 5; 245A.50, subdivision 3; 256B.0943, subdivisions 2, 7; 256B.69, subdivisions 5c, 28; 256B.76, subdivision 4; 256D.02, subdivision 12a; Laws 2013, chapter 108, article 3, section 48; repealing Minnesota Statutes 2012, sections 4.47; 119A.04, subdivision 1; 119B.035; 119B.09, subdivision 2; 119B.23; 119B.231; 119B.232; 245.0311; 245.0312; 245.072; 245.4861; 245.487, subdivisions 4, 5; 245.4871, subdivisions 7, 11, 18, 25; 245.4872; 245.4873, subdivisions 3, 6; 245.4875, subdivisions 3, 6, 7; 245.4883, subdivision 1; 245.490; 245.492, subdivisions 6, 8, 13, 19; 245.4932, subdivisions 2, 3, 4; 245.4933; 245.494; 245.63; 245.69, subdivision 1; 245.714; 245.715; 245.717; 245.718; 245.721; 245.77; 245.827; 245.981; 245A.02, subdivision 7b; 245A.09, subdivision 12; 245A.11, subdivision 5; 245A.655; 246.0135; 246.016; 246.023, subdivision 1; 246.16; 246.28; 246.325; 246.70; 246.71; 246.711; 246.712; 246.713; 246.714; 246.715; 246.716; 246.717; 246.718; 246.719; 246.72; 246.721; 246.722; 253B.22; 254.01; 254.03; 254.04; 254.06; 254.07; 254.09; 254.10; 254.11; 254A.05, subdivision 1; 254A.07, subdivisions 1, 2; 254A.16, subdivision 1; 254B.01, subdivision 1; 254B.04, subdivision 3; 256.01, subdivisions 3, 14, 14a; 256.959; 256.964; 256.9691; 256.971; 256.975, subdivision 3; 256.9753, subdivision 4; 256.9792; 256B.04, subdivision 16; 256B.043; 256B.0636; 256B.0656; 256B.0657; 256B.075, subdivision 4; 256B.0757, subdivision 7; 256B.0913, subdivision 9; 256B.0916, subdivisions 6, 6a; 256B.0928; 256B.19, subdivision 3; 256B.431, subdivisions 28, 31, 33, 34, 37, 38, 39, 40, 41, 43; 256B.434, subdivision 19; 256B.440; 256B.441, subdivisions 46, 46a; 256B.491; 256B.501, subdivisions 3a, 3b, 3h, 3j, 3k, 3l, 5e; 256B.5016; 256B.503; 256B.53; 256B.69,

subdivisions 5e, 6c, 24a; 256B.692, subdivision 10; 256D.02, subdivision 19; 256D.05, subdivision 4; 256D.46; 256I.05, subdivisions 1b, 5; 256I.07; 256J.24, subdivision 10; 256K.35; 259.85, subdivisions 2, 3, 4, 5; 518A.53, subdivision 7; 518A.74; 626.557, subdivision 16; 626.5593; Minnesota Statutes 2013 Supplement, sections 246.0141; 246.0251; 254.05; 254B.13, subdivision 3; 256B.501, subdivision 5b; 256C.29; 259.85, subdivision 1; Minnesota Rules, parts 9549.0020, subparts 2, 12, 13, 20, 23, 24, 25, 26, 27, 30, 31, 32, 33, 34, 35, 36, 38, 41, 42, 43, 44, 46, 47; 9549.0030; 9549.0035, subparts 4, 5, 6; 9549.0036; 9549.0040; 9549.0041, subparts 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15; 9549.0050; 9549.0051, subparts 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14; 9549.0053; 9549.0054; 9549.0055, subpart 4; 9549.0056; 9549.0058; 9549.0059; 9549.0060, subparts 1, 2, 3, 8, 9, 12, 13; 9549.0061; 9549.0070, subparts 1, 4.

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

## ARTICLE 1

## CHILDREN AND FAMILY SERVICES

Section 1. Minnesota Statutes 2012, section 256D.02, subdivision 11, is amended to read:

Subd. 11. **State aid.** "State aid" means state aid to county agencies for general assistance ~~and general assistance medical care~~ expenditures as provided for in section 256D.03, ~~subdivisions~~ subdivision 2 ~~and 3~~.

Sec. 2. Minnesota Statutes 2013 Supplement, section 256D.02, subdivision 12a, is amended to read:

Subd. 12a. **Resident.** (a) For purposes of eligibility for general assistance ~~and general assistance medical care~~, a person must be a resident of this state.

(b) A "resident" is a person living in the state for at least 30 days with the intention of making the person's home here and not for any temporary purpose. Time spent in a shelter for battered women shall count toward satisfying the 30-day residency requirement. All applicants for these programs are required to demonstrate the requisite intent and can do so in any of the following ways:

(1) by showing that the applicant maintains a residence at a verified address, other than a place of public accommodation. An applicant may verify a residence address by presenting a valid state driver's license, a state identification card, a voter registration card, a rent receipt, a statement by the landlord, apartment manager, or homeowner verifying that the individual is residing at the address, or other form of verification approved by the commissioner; or

(2) by verifying residence according to Minnesota Rules, part 9500.1219, subpart 3, item C.

(c) For general assistance, a county shall waive the 30-day residency requirement where unusual hardship would result from denial of general assistance. For purposes of this subdivision, "unusual hardship" means the applicant is without shelter or is without available resources for food.

The county agency must report to the commissioner within 30 days on any waiver granted under this section. The county shall not deny an application solely because the applicant does not meet at least one of the criteria in this subdivision, but shall continue to process the application and leave the application pending until the residency requirement is met or until eligibility or ineligibility is established.

(d) For purposes of paragraph (c), the following definitions apply (1) "metropolitan statistical area" is as defined by the United States Census Bureau; (2) "shelter" includes any shelter that is located within the metropolitan statistical area containing the county and for which the applicant is eligible, provided the applicant does not have to travel more than 20 miles to reach the shelter and has access to transportation to the shelter. Clause (2) does not apply to counties in the Minneapolis-St. Paul metropolitan statistical area.

(e) Migrant workers as defined in section 256J.08 ~~and, until March 31, 1998, their immediate families~~ are exempt from the residency requirements of this section, provided the migrant worker provides verification that the migrant family worked in this state within the last 12 months and earned at least $1,000 in gross wages during the time the migrant worker worked in this state.

(f) For purposes of eligibility for emergency general assistance, the 30-day residency requirement under this section shall not be waived.

(g) If any provision of this subdivision is enjoined from implementation or found unconstitutional by any court of competent jurisdiction, the remaining provisions shall remain valid and shall be given full effect.

Sec. 3. Minnesota Statutes 2012, section 256D.04, is amended to read:

**256D.04 DUTIES OF THE COMMISSIONER.**

In addition to any other duties imposed by law, the commissioner shall:

(1) supervise according to section 256.01 the administration of general assistance ~~and general assistance medical care~~ by county agencies as provided in sections 256D.01 to 256D.21;

(2) promulgate uniform rules consistent with law for carrying out and enforcing the provisions of sections 256D.01 to 256D.21, including ~~section 256D.05, subdivision 3, and~~ section 256.01, subdivision 2, paragraph (16), to the end that general assistance may be administered as uniformly as possible throughout the state; rules shall be furnished

immediately to all county agencies and other interested persons; in promulgating rules, the provisions of sections 14.001 to 14.69, shall apply;

(3) allocate money appropriated for general assistance ~~and general assistance medical care~~ to county agencies as provided in section 256D.03, ~~subdivisions~~ subdivision 2 ~~and 3~~;

(4) accept and supervise the disbursement of any funds that may be provided by the federal government or from other sources for use in this state for general assistance ~~and general assistance medical care~~;

(5) cooperate with other agencies including any agency of the United States or of another state in all matters concerning the powers and duties of the commissioner under sections 256D.01 to 256D.21;

(6) cooperate to the fullest extent with other public agencies empowered by law to provide vocational training, rehabilitation, or similar services;

(7) gather and study current information and report at least annually to the governor on the nature and need for general assistance ~~and general assistance medical care~~, the amounts expended under the supervision of each county agency, and the activities of each county agency and publish such reports for the information of the public;

(8) specify requirements for general assistance ~~and general assistance medical care~~ reports, including fiscal reports, according to section 256.01, subdivision 2, paragraph (17); and

(9) ensure that every notice of eligibility for general assistance includes a notice that women who are pregnant may be eligible for medical assistance benefits.

Sec. 4. Minnesota Statutes 2012, section 256D.045, is amended to read:

**256D.045 SOCIAL SECURITY NUMBER REQUIRED.**

To be eligible for general assistance under sections 256D.01 to 256D.21, an individual must provide the individual's Social Security number to the county agency or submit proof that an application has been made. ~~An individual who refuses to provide a Social Security number because of a well-established religious objection as described in Code of Federal Regulations, title 42, section 435.910, may be eligible for general assistance medical care under section 256D.03.~~ The provisions of this section do not apply to the determination of eligibility for emergency general assistance under section 256D.06, subdivision 2. This provision applies to eligible children under the age of 18 effective July 1, 1997.

Sec. 5. Minnesota Statutes 2012, section 256D.07, is amended to read:

**256D.07 TIME OF PAYMENT OF ASSISTANCE.**

An applicant for general assistance ~~or general assistance medical care authorized by section 256D.03, subdivision 3,~~ shall be deemed eligible if the application and the verification of the statement on that application demonstrate that the applicant is within the eligibility criteria established by sections 256D.01 to 256D.21 and any applicable rules of the commissioner. Any person requesting general assistance ~~or general assistance medical care~~ shall be permitted by the county agency to make an application for assistance as soon as administratively possible and in no event later than the fourth day following the date on which assistance is first requested, and no county agency shall require that a person requesting assistance appear at the offices of the county agency more than once prior to the date on which the person is permitted to make the application. The application shall be in writing in the manner and upon the form prescribed by the commissioner and attested to by the oath of the applicant or in lieu thereof shall contain the following declaration which shall be signed by the applicant: "I declare that this application has been examined by me and to the best of my knowledge and belief is a true and correct statement of every material point." On the date that general assistance is first requested, the county agency shall inquire and determine whether the person requesting assistance is in immediate need of food, shelter, clothing, assistance for necessary transportation, or other emergency assistance pursuant to section 256D.06, subdivision 2. A person in need of emergency assistance shall be granted emergency assistance immediately, and necessary emergency assistance shall continue for up to 30 days following the date of application. A determination of an applicant's eligibility for general assistance shall be made by the county agency as soon as the required verifications are received by the county agency and in no event later than 30 days following the date that the application is made. Any verifications required of the applicant shall be reasonable, and the commissioner shall by rule establish reasonable verifications. General assistance shall be granted to an eligible applicant without the necessity of first securing action by the board of the county agency. The first month's grant must be computed to cover the time period starting with the date a signed application form is received by the county agency or from the date that the applicant meets all eligibility factors, whichever occurs later.

If upon verification and due investigation it appears that the applicant provided false information and the false information materially affected the applicant's eligibility for general assistance ~~or general assistance medical care provided pursuant to section 256D.03, subdivision 3,~~ or the amount of the applicant's general assistance grant, the county agency may refer the matter to the county attorney. The county attorney may commence a criminal prosecution or a civil action for the recovery of any general assistance wrongfully received, or both.

Sec. 6. Minnesota Statutes 2012, section 256I.04, subdivision 3, is amended to read:

Subd. 3. **Moratorium on development of group residential housing beds.** (a) County agencies shall not enter into agreements for new group residential housing beds with total rates in excess of the MSA equivalent rate except:

(1) for group residential housing establishments licensed under Minnesota Rules, parts 9525.0215 to 9525.0355, provided the facility is needed to meet the census reduction targets for persons with developmental disabilities at regional treatment centers;

~~(2) to ensure compliance with the federal Omnibus Budget Reconciliation Act alternative disposition plan requirements for inappropriately placed persons with developmental disabilities or mental illness;~~

~~(3)~~ (2) up to 80 beds in a single, specialized facility located in Hennepin County that will provide housing for chronic inebriates who are repetitive users of detoxification centers and are refused placement in emergency shelters because of their state of intoxication, and planning for the specialized facility must have been initiated before July 1, 1991, in anticipation of receiving a grant from the Housing Finance Agency under section 462A.05, subdivision 20a, paragraph (b);

~~(4)~~ (3) notwithstanding the provisions of subdivision 2a, for up to 190 supportive housing units in Anoka, Dakota, Hennepin, or Ramsey County for homeless adults with a mental illness, a history of substance abuse, or human immunodeficiency virus or acquired immunodeficiency syndrome. For purposes of this section, "homeless adult" means a person who is living on the street or in a shelter or discharged from a regional treatment center, community hospital, or residential treatment program and has no appropriate housing available and lacks the resources and support necessary to access appropriate housing. At least 70 percent of the supportive housing units must serve homeless adults with mental illness, substance abuse problems, or human immunodeficiency virus or acquired immunodeficiency syndrome who are about to be or, within the previous six months, has been discharged from a regional treatment center, or a state-contracted psychiatric bed in a community hospital, or a residential mental health or chemical dependency treatment program. If a person meets the requirements of subdivision 1, paragraph (a), and receives a federal or state housing subsidy, the group residential housing rate for that person is limited to the supplementary rate under section 256I.05, subdivision 1a, and is determined by subtracting the amount of the person's countable income that exceeds the MSA equivalent rate from the group residential housing supplementary rate. A resident in a demonstration project site who no longer participates in the demonstration program shall retain eligibility for a group residential housing payment in an amount determined under section 256I.06, subdivision 8, using the MSA equivalent rate. Service

funding under section 256I.05, subdivision 1a, will end June 30, 1997, if federal matching funds are available and the services can be provided through a managed care entity. If federal matching funds are not available, then service funding will continue under section 256I.05, subdivision 1a;

~~(5) for group residential housing beds in settings meeting the requirements of subdivision 2a, clauses (1) and (3), which are used exclusively for recipients receiving home and community-based waiver services under sections 256B.0915, 256B.092, subdivision 5, 256B.093, and 256B.49, and who resided in a nursing facility for the six months immediately prior to the month of entry into the group residential housing setting. The group residential housing rate for these beds must be set so that the monthly group residential housing payment for an individual occupying the bed when combined with the nonfederal share of services delivered under the waiver for that person does not exceed the nonfederal share of the monthly medical assistance payment made for the person to the nursing facility in which the person resided prior to entry into the group residential housing establishment. The rate may not exceed the MSA equivalent rate plus $426.37 for any case;~~

~~(6)~~ (4) for an additional two beds, resulting in a total of 32 beds, for a facility located in Hennepin County providing services for recovering and chemically dependent men that has had a group residential housing contract with the county and has been licensed as a board and lodge facility with special services since 1980;

~~(7)~~ (5) for a group residential housing provider located in the city of St. Cloud, or a county contiguous to the city of St. Cloud, that operates a 40-bed facility, that received financing through the Minnesota Housing Finance Agency Ending Long-Term Homelessness Initiative and serves chemically dependent clientele, providing 24-hour-a-day supervision;

~~(8)~~ (6) for a new 65-bed facility in Crow Wing County that will serve chemically dependent persons, operated by a group residential housing provider that currently operates a 304-bed facility in Minneapolis, and a 44-bed facility in Duluth;

~~(9)~~ (7) for a group residential housing provider that operates two ten-bed facilities, one located in Hennepin County and one located in Ramsey County, that provide community support and 24-hour-a-day supervision to serve the mental health needs of individuals who have chronically lived unsheltered; and

~~(10)~~ (8) for a group residential facility in Hennepin County with a capacity of up to 48 beds that has been licensed since 1978 as a board and lodging facility and that until August 1, 2007, operated as a licensed chemical dependency treatment program.

(b) A county agency may enter into a group residential housing agreement for beds with rates in excess of the MSA equivalent rate in addition to those currently covered

under a group residential housing agreement if the additional beds are only a replacement of beds with rates in excess of the MSA equivalent rate which have been made available due to closure of a setting, a change of licensure or certification which removes the beds from group residential housing payment, or as a result of the downsizing of a group residential housing setting. The transfer of available beds from one county to another can only occur by the agreement of both counties.

Sec. 7. Minnesota Statutes 2012, section 256I.05, subdivision 1c, is amended to read:

Subd. 1c. **Rate increases.** A county agency may not increase the rates negotiated for group residential housing above those in effect on June 30, 1993, except as provided in paragraphs (a) to ~~(g)~~ (f).

(a) A county may increase the rates for group residential housing settings to the MSA equivalent rate for those settings whose current rate is below the MSA equivalent rate.

(b) A county agency may increase the rates for residents in adult foster care whose difficulty of care has increased. The total group residential housing rate for these residents must not exceed the maximum rate specified in subdivisions 1 and 1a. County agencies must not include nor increase group residential housing difficulty of care rates for adults in foster care whose difficulty of care is eligible for funding by home and community-based waiver programs under title XIX of the Social Security Act.

(c) The room and board rates will be increased each year when the MSA equivalent rate is adjusted for SSI cost-of-living increases by the amount of the annual SSI increase, less the amount of the increase in the medical assistance personal needs allowance under section 256B.35.

(d) When a group residential housing rate is used to pay for an individual's room and board, or other costs necessary to provide room and board, the rate payable to the residence must continue for up to 18 calendar days per incident that the person is temporarily absent from the residence, not to exceed 60 days in a calendar year, if the absence or absences have received the prior approval of the county agency's social service staff. Prior approval is not required for emergency absences due to crisis, illness, or injury.

(e) For facilities meeting substantial change criteria within the prior year. Substantial change criteria exists if the group residential housing establishment experiences a 25 percent increase or decrease in the total number of its beds, if the net cost of capital additions or improvements is in excess of 15 percent of the current market value of the residence, or if the residence physically moves, or changes its licensure, and incurs a resulting increase in operation and property costs.

(f) Until June 30, 1994, a county agency may increase by up to five percent the total rate paid for recipients of assistance under sections 256D.01 to 256D.21 or 256D.33 to 256D.54 who reside in residences that are licensed by the commissioner of health as a boarding care home, but are not certified for the purposes of the medical assistance program. However, an increase under this clause must not exceed an amount equivalent to 65 percent of the 1991 medical assistance reimbursement rate for nursing home resident class A, in the geographic grouping in which the facility is located, as established under Minnesota Rules, parts 9549.0050 to 9549.0058.

~~(g) For the rate year beginning July 1, 1996, a county agency may increase the total rate paid for recipients of assistance under sections 256D.01 to 256D.21 or 256D.33 to 256D.54 who reside in a residence that meets the following criteria:~~

~~(1) it is licensed by the commissioner of health as a boarding care home;~~

~~(2) it is not certified for the purposes of the medical assistance program;~~

~~(3) at least 50 percent of its residents have a primary diagnosis of mental illness;~~

~~(4) it has at least 17 beds; and~~

~~(5) it provides medication administration to residents.~~

~~The rate following an increase under this paragraph must not exceed an amount equivalent to the average 1995 medical assistance payment for nursing home resident class A under the age of 65, in the geographic grouping in which the facility is located, as established under Minnesota Rules, parts 9549.0010 to 9549.0080.~~

Sec. 8. Minnesota Statutes 2012, section 256J.425, subdivision 4, is amended to read:

Subd. 4. **Employed participants.** (a) An assistance unit subject to the time limit under section 256J.42, subdivision 1, is eligible to receive assistance under a hardship extension if the participant who reached the time limit belongs to:

(1) a one-parent assistance unit in which the participant is participating in work activities for at least 30 hours per week, of which an average of at least 25 hours per week every month are spent participating in employment;

(2) a two-parent assistance unit in which the participants are participating in work activities for at least 55 hours per week, of which an average of at least 45 hours per week every month are spent participating in employment; or

(3) an assistance unit in which a participant is participating in employment for fewer hours than those specified in clause (1), and the participant submits verification from a qualified professional, in a form acceptable to the commissioner, stating that the number of hours the participant may work is limited due to illness or disability, as long as the participant is participating in employment for at least the number of hours specified by the

qualified professional. The participant must be following the treatment recommendations of the qualified professional providing the verification. The commissioner shall develop a form to be completed and signed by the qualified professional, documenting the diagnosis and any additional information necessary to document the functional limitations of the participant that limit work hours. If the participant is part of a two-parent assistance unit, the other parent must be treated as a one-parent assistance unit for purposes of meeting the work requirements under this subdivision.

(b) For purposes of this section, employment means:

(1) unsubsidized employment under section 256J.49, subdivision 13, clause (1);

(2) subsidized employment under section 256J.49, subdivision 13, clause (2);

(3) on-the-job training under section 256J.49, subdivision 13, clause (2);

(4) an apprenticeship under section 256J.49, subdivision 13, clause (1);

(5) supported work under section 256J.49, subdivision 13, clause (2);

(6) a combination of clauses (1) to (5); or

(7) child care under section 256J.49, subdivision 13, clause (7), if it is in combination with paid employment.

(c) If a participant is complying with a child protection plan under chapter 260C, the number of hours required under the child protection plan count toward the number of hours required under this subdivision.

(d) The county shall provide the opportunity for subsidized employment to participants needing that type of employment within available appropriations.

(e) To be eligible for a hardship extension for employed participants under this subdivision, a participant must be in compliance for at least ten out of the 12 months the participant received MFIP immediately preceding the participant's 61st month on assistance. If ten or fewer months of eligibility for TANF assistance remain at the time the participant from another state applies for assistance, the participant must be in compliance every month.

(f) The employment plan developed under section 256J.521, subdivision 2, for participants under this subdivision must contain at least the minimum number of hours specified in paragraph (a) for the purpose of meeting the requirements for an extension under this subdivision. The job counselor and the participant must sign the employment plan to indicate agreement between the job counselor and the participant on the contents of the plan.

(g) Participants who fail to meet the requirements in paragraph (a), without good cause under section 256J.57, shall be sanctioned or permanently disqualified under subdivision 6. Good cause may only be granted for that portion of the month for which

the good cause reason applies. Participants must meet all remaining requirements in the approved employment plan or be subject to sanction or permanent disqualification.

(h) If the noncompliance with an employment plan is due to the involuntary loss of employment, the participant is exempt from the hourly employment requirement under this subdivision for one month. Participants must meet all remaining requirements in the approved employment plan or be subject to sanction or permanent disqualification. ~~This exemption is available to each participant two times in a 12-month period.~~

Sec. 9. Minnesota Statutes 2012, section 518A.65, is amended to read:

**518A.65 DRIVER'S LICENSE SUSPENSION.**

(a) Upon motion of an obligee, which has been properly served on the obligor and upon which there has been an opportunity for hearing, if a court finds that the obligor has been or may be issued a driver's license by the commissioner of public safety and the obligor is in arrears in court-ordered child support or maintenance payments, or both, in an amount equal to or greater than three times the obligor's total monthly support and maintenance payments and is not in compliance with a written payment agreement pursuant to section 518A.69 that is approved by the court, a child support magistrate, or the public authority, the court shall order the commissioner of public safety to suspend the obligor's driver's license. The court's order must be stayed for 90 days in order to allow the obligor to execute a written payment agreement pursuant to section 518A.69. The payment agreement must be approved by either the court or the public authority responsible for child support enforcement. If the obligor has not executed or is not in compliance with a written payment agreement pursuant to section 518A.69 after the 90 days expires, the court's order becomes effective and the commissioner of public safety shall suspend the obligor's driver's license. The remedy under this section is in addition to any other enforcement remedy available to the court. An obligee may not bring a motion under this paragraph within 12 months of a denial of a previous motion under this paragraph.

(b) If a public authority responsible for child support enforcement determines that the obligor has been or may be issued a driver's license by the commissioner of public safety and the obligor is in arrears in court-ordered child support or maintenance payments or both in an amount equal to or greater than three times the obligor's total monthly support and maintenance payments and not in compliance with a written payment agreement pursuant to section 518A.69 that is approved by the court, a child support magistrate, or the public authority, the public authority shall direct the commissioner of public safety to suspend the obligor's driver's license. The remedy under this section is in addition to any other enforcement remedy available to the public authority.

(c) At least 90 days prior to notifying the commissioner of public safety according to paragraph (b), the public authority must mail a written notice to the obligor at the obligor's last known address, that it intends to seek suspension of the obligor's driver's license and that the obligor must request a hearing within 30 days in order to contest the suspension. If the obligor makes a written request for a hearing within 30 days of the date of the notice, a court hearing must be held. Notwithstanding any law to the contrary, the obligor must be served with 14 days' notice in writing specifying the time and place of the hearing and the allegations against the obligor. The notice must include information that apprises the obligor of the requirement to develop a written payment agreement that is approved by a court, a child support magistrate, or the public authority responsible for child support enforcement regarding child support, maintenance, and any arrearages in order to avoid license suspension. The notice may be served personally or by mail. If the public authority does not receive a request for a hearing within 30 days of the date of the notice, and the obligor does not execute a written payment agreement pursuant to section 518A.69 that is approved by the public authority within 90 days of the date of the notice, the public authority shall direct the commissioner of public safety to suspend the obligor's driver's license under paragraph (b).

(d) At a hearing requested by the obligor under paragraph (c), and on finding that the obligor is in arrears in court-ordered child support or maintenance payments or both in an amount equal to or greater than three times the obligor's total monthly support and maintenance payments, the district court or child support magistrate shall order the commissioner of public safety to suspend the obligor's driver's license or operating privileges unless the court or child support magistrate determines that the obligor has executed and is in compliance with a written payment agreement pursuant to section 518A.69 that is approved by the court, a child support magistrate, or the public authority.

(e) An obligor whose driver's license or operating privileges are suspended may:

(1) provide proof to the public authority responsible for child support enforcement that the obligor is in compliance with all written payment agreements pursuant to section 518A.69;

(2) bring a motion for reinstatement of the driver's license. At the hearing, if the court or child support magistrate orders reinstatement of the driver's license, the court or child support magistrate must establish a written payment agreement pursuant to section 518A.69; or

(3) seek a limited license under section 171.30. A limited license issued to an obligor under section 171.30 expires 90 days after the date it is issued.

Within 15 days of the receipt of that proof or a court order, the public authority shall inform the commissioner of public safety that the obligor's driver's license or operating privileges should no longer be suspended.

~~(f) On January 15, 1997, and every two years after that, the commissioner of human services shall submit a report to the legislature that identifies the following information relevant to the implementation of this section:~~

~~(1) the number of child support obligors notified of an intent to suspend a driver's license;~~

~~(2) the amount collected in payments from the child support obligors notified of an intent to suspend a driver's license;~~

~~(3) the number of cases paid in full and payment agreements executed in response to notification of an intent to suspend a driver's license;~~

~~(4) the number of cases in which there has been notification and no payments or payment agreements;~~

~~(5) the number of driver's licenses suspended;~~

~~(6) the cost of implementation and operation of the requirements of this section; and~~

~~(7) the number of limited licenses issued and number of cases in which payment agreements are executed and cases are paid in full following issuance of a limited license.~~

~~(g)~~ (f) In addition to the criteria established under this section for the suspension of an obligor's driver's license, a court, a child support magistrate, or the public authority may direct the commissioner of public safety to suspend the license of a party who has failed, after receiving notice, to comply with a subpoena relating to a paternity or child support proceeding. Notice to an obligor of intent to suspend must be served by first class mail at the obligor's last known address. The notice must inform the obligor of the right to request a hearing. If the obligor makes a written request within ten days of the date of the hearing, a hearing must be held. At the hearing, the only issues to be considered are mistake of fact and whether the obligor received the subpoena.

~~(h)~~ (g) The license of an obligor who fails to remain in compliance with an approved written payment agreement may be suspended. Prior to suspending a license for noncompliance with an approved written payment agreement, the public authority must mail to the obligor's last known address a written notice that (1) the public authority intends to seek suspension of the obligor's driver's license under this paragraph, and (2) the obligor must request a hearing, within 30 days of the date of the notice, to contest the suspension. If, within 30 days of the date of the notice, the public authority does not receive a written request for a hearing and the obligor does not comply with an approved written payment agreement, the public authority must direct the Department of Public

Safety to suspend the obligor's license under paragraph (b). If the obligor makes a written request for a hearing within 30 days of the date of the notice, a court hearing must be held. Notwithstanding any law to the contrary, the obligor must be served with 14 days' notice in writing specifying the time and place of the hearing and the allegations against the obligor. The notice may be served personally or by mail at the obligor's last known address. If the obligor appears at the hearing and the court determines that the obligor has failed to comply with an approved written payment agreement, the court or public authority shall notify the Department of Public Safety to suspend the obligor's license under paragraph (b). If the obligor fails to appear at the hearing, the court or public authority must notify the Department of Public Safety to suspend the obligor's license under paragraph (b).

Sec. 10. Laws 2013, chapter 108, article 3, section 48, is amended to read:

Sec. 48. **REPEALER.**

(a) Minnesota Statutes 2012, section 256J.24, subdivision 6, is repealed January 1, 2015.

(b) Minnesota Statutes 2012, section 609.093, is repealed effective the day following final enactment.

Sec. 11. **TRANSITION; PROVISIONS GOVERNING PERFORMANCE BASE FUNDS.**

(a) Laws 2013, chapter 107, article 4, section 19, is repealed effective January 1, 2016.

(b) Laws 2013, chapter 108, article 3, section 31, is effective January 1, 2016.

Sec. 12. **REPEALER.**

(a) Minnesota Statutes 2012, sections 119A.04, subdivision 1; 119B.035; 119B.09, subdivision 2; 119B.23; 119B.231; 119B.232; 256.01, subdivisions 3, 14, and 14a; 256.9792; 256D.02, subdivision 19; 256D.05, subdivision 4; 256D.46; 256I.05, subdivisions 1b and 5; 256I.07; 256K.35; 259.85, subdivisions 2, 3, 4, and 5; 518A.53, subdivision 7; 518A.74; and 626.5593, are repealed.

(b) Minnesota Statutes 2012, section 256J.24, subdivision 10, is repealed effective October 1, 2014.

(c) Minnesota Statutes 2013 Supplement, section 259.85, subdivision 1, is repealed.

## ARTICLE 2

## HEALTH CARE

Section 1. Minnesota Statutes 2012, section 256.963, subdivision 2, is amended to read:

Subd. 2. **Evaluation.** ~~(a)~~ The grantee must report to the commissioner on a quarterly basis the following information:

(1) the total number of appointments available for scheduling by specialty;

(2) the average length of time between scheduling and actual appointment;

(3) the total number of patients referred and whether the patient was insured or uninsured; and

(4) the total number of appointments resulting in visits completed and number of patients continuing services with the referring clinic.

~~(b) The commissioner, in consultation with the Minnesota Hospital Association, shall conduct an evaluation of the emergency room diversion pilot project and submit the results to the legislature by January 15, 2009. The evaluation shall compare the number of nonemergency visits and repeat visits to hospital emergency rooms for the period before the commencement of the project and one year after the commencement, and an estimate of the costs saved from any documented reductions.~~

Sec. 2. Minnesota Statutes 2012, section 256.969, subdivision 9, is amended to read:

Subd. 9. **Disproportionate numbers of low-income patients served.** ~~(a) For admissions occurring on or after October 1, 1992, through December 31, 1992, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:~~

~~(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service but less than or equal to one standard deviation above the mean, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and~~

~~(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1. If federal matching funds are not available for all adjustments under this subdivision, the commissioner shall reduce payments on a pro rata basis so that all adjustments qualify for federal match. The commissioner may establish a separate disproportionate population operating payment rate adjustment under the general assistance medical care program.~~

~~For purposes of this subdivision medical assistance does not include general assistance medical care. The commissioner shall report annually on the number of hospitals likely to receive the adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class.~~

~~(b)~~ (a) For admissions occurring on or after July 1, 1993, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service but less than or equal to one standard deviation above the mean, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service;

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1. The commissioner may establish a separate disproportionate population operating payment rate adjustment under the general assistance medical care program. For purposes of this subdivision, medical assistance does not include general assistance medical care. The commissioner shall report annually on the number of hospitals likely to receive the adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class;

(3) for a hospital that had medical assistance fee-for-service payment volume during calendar year 1991 in excess of 13 percent of total medical assistance fee-for-service payment volume, a medical assistance disproportionate population adjustment shall be paid in addition to any other disproportionate payment due under this subdivision as follows: $1,515,000 due on the 15th of each month after noon, beginning July 15, 1995. For a hospital that had medical assistance fee-for-service payment volume during calendar year 1991 in excess of eight percent of total medical assistance fee-for-service payment volume and was the primary hospital affiliated with the University of Minnesota, a medical assistance disproportionate population adjustment shall be paid in addition to any

other disproportionate payment due under this subdivision as follows: $505,000 due on the 15th of each month after noon, beginning July 15, 1995; and

(4) effective August 1, 2005, the payments in ~~paragraph (b),~~ clause (3)~~,~~ shall be reduced to zero.

~~(c)~~ (b) The commissioner shall adjust rates paid to a health maintenance organization under contract with the commissioner to reflect rate increases provided in paragraph ~~(b)~~ (a), clauses (1) and (2), on a nondiscounted hospital-specific basis but shall not adjust those rates to reflect payments provided in paragraph (a), clause (3).

~~(d)~~ (c) If federal matching funds are not available for all adjustments under paragraph ~~(b)~~ (a), the commissioner shall reduce payments under paragraph ~~(b)~~ (a), clauses (1) and (2), on a pro rata basis so that all adjustments under paragraph ~~(b)~~ (a) qualify for federal match.

~~(e)~~ (d) For purposes of this subdivision, medical assistance does not include general assistance medical care.

~~(f)~~ (e) For hospital services occurring on or after July 1, 2005, to June 30, 2007:

(1) general assistance medical care expenditures for fee-for-service inpatient and outpatient hospital payments made by the department shall be considered Medicaid disproportionate share hospital payments, except as limited below:

(i) only the portion of Minnesota's disproportionate share hospital allotment under section 1923(f) of the Social Security Act that is not spent on the disproportionate population adjustments in paragraph ~~(b)~~ (a), clauses (1) and (2), may be used for general assistance medical care expenditures;

(ii) only those general assistance medical care expenditures made to hospitals that qualify for disproportionate share payments under section 1923 of the Social Security Act and the Medicaid state plan may be considered disproportionate share hospital payments;

(iii) only those general assistance medical care expenditures made to an individual hospital that would not cause the hospital to exceed its individual hospital limits under section 1923 of the Social Security Act may be considered; and

(iv) general assistance medical care expenditures may be considered only to the extent of Minnesota's aggregate allotment under section 1923 of the Social Security Act.

All hospitals and prepaid health plans participating in general assistance medical care must provide any necessary expenditure, cost, and revenue information required by the commissioner as necessary for purposes of obtaining federal Medicaid matching funds for general assistance medical care expenditures; and

(2) certified public expenditures made by Hennepin County Medical Center shall be considered Medicaid disproportionate share hospital payments. Hennepin County and Hennepin County Medical Center shall report by June 15, 2007, on payments made

beginning July 1, 2005, or another date specified by the commissioner, that may qualify for reimbursement under federal law. Based on these reports, the commissioner shall apply for federal matching funds.

~~(g)~~ (f) Upon federal approval of the related state plan amendment, paragraph ~~(f)~~ (e) is effective retroactively from July 1, 2005, or the earliest effective date approved by the Centers for Medicare and Medicaid Services.

Sec. 3. Minnesota Statutes 2012, section 256B.69, subdivision 2, is amended to read:

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

(a) "Commissioner" means the commissioner of human services. For the remainder of this section, the commissioner's responsibilities for methods and policies for implementing the project will be proposed by the project advisory committees and approved by the commissioner.

(b) "Demonstration provider" means a health maintenance organization, community integrated service network, or accountable provider network authorized and operating under chapter 62D, 62N, or 62T that participates in the demonstration project according to criteria, standards, methods, and other requirements established for the project and approved by the commissioner. For purposes of this section, a county board, or group of county boards operating under a joint powers agreement, is considered a demonstration provider if the county or group of county boards meets the requirements of section 256B.692. ~~Notwithstanding the above, Itasca County may continue to participate as a demonstration provider until July 1, 2004.~~

(c) "Eligible individuals" means those persons eligible for medical assistance benefits as defined in sections 256B.055, 256B.056, and 256B.06.

(d) "Limitation of choice" means suspending freedom of choice while allowing eligible individuals to choose among the demonstration providers.

Sec. 4. Minnesota Statutes 2012, section 256B.69, subdivision 4b, is amended to read:

Subd. 4b. **Individualized education program and individualized family service plan services.** The commissioner shall amend the federal waiver allowing the state to separate out individualized education program and individualized family service plan services for children enrolled in the prepaid medical assistance program and the MinnesotaCare program. ~~Effective July 1, 1999, or upon federal approval,~~ Medical assistance coverage of eligible individualized education program and individualized family service plan services shall not be included in the capitated services for children enrolled

in health plans through the prepaid medical assistance program and the MinnesotaCare program. ~~Upon federal approval,~~ Local school districts shall bill the commissioner for these services, and claims shall be paid on a fee-for-service basis.

Sec. 5. Minnesota Statutes 2012, section 256B.69, subdivision 5, is amended to read:

Subd. 5. **Prospective per capita payment.** The commissioner shall establish the method and amount of payments for services. The commissioner shall annually contract with demonstration providers to provide services consistent with these established methods and amounts for payment.

If allowed by the commissioner, a demonstration provider may contract with an insurer, health care provider, nonprofit health service plan corporation, or the commissioner, to provide insurance or similar protection against the cost of care provided by the demonstration provider or to provide coverage against the risks incurred by demonstration providers under this section. The recipients enrolled with a demonstration provider are a permissible group under group insurance laws and chapter 62C, the Nonprofit Health Service Plan Corporations Act. Under this type of contract, the insurer or corporation may make benefit payments to a demonstration provider for services rendered or to be rendered to a recipient. Any insurer or nonprofit health service plan corporation licensed to do business in this state is authorized to provide this insurance or similar protection.

Payments to providers participating in the project are exempt from the requirements of sections 256.966 and 256B.03, subdivision 2. The commissioner shall complete development of capitation rates for payments before delivery of services under this section is begun. ~~For payments made during calendar year 1990 and later years,~~ The commissioner shall contract with an independent actuary to establish prepayment rates.

~~By January 15, 1996, the commissioner shall report to the legislature on the methodology used to allocate to participating counties available administrative reimbursement for advocacy and enrollment costs. The report shall reflect the commissioner's judgment as to the adequacy of the funds made available and of the methodology for equitable distribution of the funds. The commissioner must involve participating counties in the development of the report.~~

Beginning July 1, 2004, the commissioner may include payments for elderly waiver services and 180 days of nursing home care in capitation payments for the prepaid medical assistance program for recipients age 65 and older.

Sec. 6. Minnesota Statutes 2012, section 256B.69, subdivision 5a, is amended to read:

Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and section 256L.12 shall be entered into or renewed on a calendar year basis ~~beginning January 1, 1996. Managed care contracts which were in effect on June 30, 1995, and set to renew on July 1, 1995, shall be renewed for the period July 1, 1995 through December 31, 1995 at the same terms that were in effect on June 30, 1995~~. The commissioner may issue separate contracts with requirements specific to services to medical assistance recipients age 65 and older.

(b) A prepaid health plan providing covered health services for eligible persons pursuant to chapters 256B and 256L is responsible for complying with the terms of its contract with the commissioner. Requirements applicable to managed care programs under chapters 256B and 256L established after the effective date of a contract with the commissioner take effect when the contract is next issued or renewed.

(c) ~~Effective for services rendered on or after January 1, 2003,~~ The commissioner shall withhold five percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. The managed care or county-based purchasing plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

~~(d) Effective for services rendered on or after January 1, 2009, through December 31, 2009, the commissioner shall withhold three percent of managed care plan payments~~

~~under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.~~

~~(e) Effective for services provided on or after January 1, 2010,~~ (d) The commissioner shall require that managed care plans use the assessment and authorization processes, forms, timelines, standards, documentation, and data reporting requirements, protocols, billing processes, and policies consistent with medical assistance fee-for-service or the Department of Human Services contract requirements consistent with medical assistance fee-for-service or the Department of Human Services contract requirements for all personal care assistance services under section 256B.0659.

~~(f) Effective for services rendered on or after January 1, 2010, through December 31, 2010, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.~~

~~(g) Effective for services rendered on or after January 1, 2011, through December 31, 2011, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency room utilization rate for state health care program enrollees by a measurable rate of five percent from the plan's utilization rate for state health care program enrollees for the previous calendar year.~~ (e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reduction shall be based on the health plan's utilization in 2009. To earn the return of the withhold each subsequent year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous measurement year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

~~(h)~~ (f) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than five percent of the plan's hospital admission rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous calendar year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue until there is a 25 percent reduction in the hospital admission rate compared to the hospital admission rates in calendar year 2011, as determined by the commissioner. The hospital admissions in this performance target do not include the admissions applicable to the subsequent hospital admission performance target under paragraph ~~(i)~~ (g). Hospitals shall cooperate with the

plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

~~(i)~~ (g) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rates for subsequent hospitalizations within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, of no less than five percent compared to the previous calendar year until the final performance target is reached.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a qualifying reduction in the subsequent hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph must continue for each consecutive contract period until the plan's subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved.

~~(j) Effective for services rendered on or after January 1, 2011, through December 31, 2011, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.~~

~~(k) Effective for services rendered on or after January 1, 2012, through December 31, 2012, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no~~

~~sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.~~

~~(l)~~ (h) Effective for services rendered on or after January 1, 2013, through December 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

~~(m)~~ (i) Effective for services rendered on or after January 1, 2014, the commissioner shall withhold three percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

~~(n)~~ (j) A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this section that is reasonably expected to be returned.

~~(o)~~ (k) Contracts between the commissioner and a prepaid health plan are exempt from the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and 7.

~~(p)~~ (l) The return of the withhold under paragraphs ~~(d), (f), and (j) to (m)~~ (h) and (i) is not subject to the requirements of paragraph (c).

Sec. 7. Minnesota Statutes 2012, section 256B.69, subdivision 5b, is amended to read:

Subd. 5b. **Prospective reimbursement rates.** (a) For prepaid medical assistance program contract rates set by the commissioner under subdivision 5 ~~and effective on or after January 1, 2003~~, capitation rates for nonmetropolitan counties shall on a weighted average be no less than 87 percent of the capitation rates for metropolitan counties, excluding Hennepin County. The commissioner shall make a pro rata adjustment in capitation rates paid to counties other than nonmetropolitan counties in order to make this provision budget neutral. The commissioner, in consultation with a health care actuary, shall evaluate the regional rate relationships based on actual health plan costs for Minnesota health care programs. The commissioner may establish, based on the actuary's recommendation, new rate regions that recognize metropolitan areas outside of the seven-county metropolitan area.

(b) This subdivision shall not affect the nongeographically based risk adjusted rates established under section 62Q.03, subdivision 5a.

Sec. 8. Minnesota Statutes 2013 Supplement, section 256B.69, subdivision 5c, is amended to read:

Subd. 5c. **Medical education and research fund.** (a) The commissioner of human services shall transfer each year to the medical education and research fund established under section 62J.692, an amount specified in this subdivision. The commissioner shall calculate the following:

(1) an amount equal to the reduction in the prepaid medical assistance payments as specified in this clause. ~~Until January 1, 2002, the county medical assistance capitation base rate prior to plan specific adjustments and after the regional rate adjustments under subdivision 5b is reduced 6.3 percent for Hennepin County, two percent for the remaining metropolitan counties, and no reduction for nonmetropolitan Minnesota counties; and~~ After January 1, 2002, the county medical assistance capitation base rate prior to plan specific adjustments is reduced 6.3 percent for Hennepin County, two percent for the remaining metropolitan counties, and 1.6 percent for nonmetropolitan Minnesota counties. Nursing facility and elderly waiver payments and demonstration project payments operating under subdivision 23 are excluded from this reduction. The amount calculated under this clause shall not be adjusted for periods already paid due to subsequent changes to the capitation payments;

(2) beginning July 1, 2003, $4,314,000 from the capitation rates paid under this section;

(3) beginning July 1, 2002, an additional $12,700,000 from the capitation rates paid under this section; and

(4) beginning July 1, 2003, an additional $4,700,000 from the capitation rates paid under this section.

(b) This subdivision shall be effective upon approval of a federal waiver which allows federal financial participation in the medical education and research fund. The amount specified under paragraph (a), clauses (1) to (4), shall not exceed the total amount transferred for fiscal year 2009. Any excess shall first reduce the amounts specified under paragraph (a), clauses (2) to (4). Any excess following this reduction shall proportionally reduce the amount specified under paragraph (a), clause (1).

(c) Beginning September 1, 2011, of the amount in paragraph (a), the commissioner shall transfer $21,714,000 each fiscal year to the medical education and research fund.

(d) Beginning September 1, 2011, of the amount in paragraph (a), following the transfer under paragraph (c), the commissioner shall transfer to the medical education research fund $23,936,000 in fiscal years 2012 and 2013 and $49,552,000 in fiscal year 2014 and thereafter.

Sec. 9. Minnesota Statutes 2012, section 256B.69, subdivision 6b, is amended to read:

Subd. 6b. **Home and community-based waiver services.** (a) For individuals enrolled in the Minnesota senior health options project authorized under subdivision 23, elderly waiver services shall be covered according to the terms and conditions of the federal agreement governing that demonstration project.

(b) For individuals under age 65 enrolled in demonstrations authorized under subdivision 23, home and community-based waiver services shall be covered according to the terms and conditions of the federal agreement governing that demonstration project.

(c) The commissioner of human services shall issue requests for proposals for collaborative service models between counties and managed care organizations to integrate the home and community-based elderly waiver services and additional nursing home services into the prepaid medical assistance program.

(d) Notwithstanding Minnesota Rules, part 9500.1457, subpart 1, item C, elderly waiver services shall be covered statewide ~~no sooner than July 1, 2006,~~ under the prepaid medical assistance program for all individuals who are eligible according to section 256B.0915. The commissioner may develop a schedule to phase in implementation of these waiver services, including collaborative service models under paragraph (c). The commissioner shall phase in implementation beginning with those counties participating under section 256B.692, and those counties where a viable collaborative service model has been developed. In consultation with counties and all managed care organizations that have expressed an interest in participating in collaborative service models, the commissioner shall evaluate the models. The commissioner shall consider the evaluation in selecting the most appropriate models for statewide implementation.

Sec. 10. Minnesota Statutes 2012, section 256B.69, subdivision 6d, is amended to read:

Subd. 6d. **Prescription drugs.** ~~Effective January 1, 2004,~~ The commissioner may exclude or modify coverage for prescription drugs from the prepaid managed care contracts entered into under this section in order to increase savings to the state by collecting additional prescription drug rebates. The contracts must maintain incentives for the managed care plan to manage drug costs and utilization and may require that the managed care plans maintain an open drug formulary. In order to manage drug costs and

utilization, the contracts may authorize the managed care plans to use preferred drug lists and prior authorization. This subdivision is contingent on federal approval of the managed care contract changes and the collection of additional prescription drug rebates.

Sec. 11. Minnesota Statutes 2012, section 256B.69, subdivision 17, is amended to read:

Subd. 17. **Continuation of prepaid medical assistance.** The commissioner may continue the provisions of this section ~~after June 30, 1990,~~ in any or all of the participating counties if necessary federal authority is granted. The commissioner may adopt permanent rules to continue prepaid medical assistance in these areas.

Sec. 12. Minnesota Statutes 2012, section 256B.69, subdivision 26, is amended to read:

Subd. 26. **American Indian recipients.** (a) ~~Beginning on or after January 1, 1999,~~ For American Indian recipients of medical assistance who are required to enroll with a demonstration provider under subdivision 4 or in a county-based purchasing entity, if applicable, under section 256B.692, medical assistance shall cover health care services provided at Indian health services facilities and facilities operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title III of the Indian Self-Determination and Education Assistance Act, Public Law 93-638, if those services would otherwise be covered under section 256B.0625. Payments for services provided under this subdivision shall be made on a fee-for-service basis, and may, at the option of the tribe or tribal organization, be made according to rates authorized under sections 256.969, subdivision 16, and 256B.0625, subdivision 34. Implementation of this purchasing model is contingent on federal approval.

(b) The commissioner of human services, in consultation with the tribal governments, shall develop a plan for tribes to assist in the enrollment process for American Indian recipients enrolled in the prepaid medical assistance program under this section. This plan also shall address how tribes will be included in ensuring the coordination of care for American Indian recipients between Indian health service or tribal providers and other providers.

(c) For purposes of this subdivision, "American Indian" has the meaning given to persons to whom services will be provided for in Code of Federal Regulations, title 42, section 36.12.

Sec. 13. Minnesota Statutes 2013 Supplement, section 256B.69, subdivision 28, is amended to read:

Subd. 28. **Medicare special needs plans; medical assistance basic health care.** (a) The commissioner may contract with demonstration providers and current or former sponsors of qualified Medicare-approved special needs plans, to provide medical assistance basic health care services to persons with disabilities, including those with developmental disabilities. Basic health care services include:

(1) those services covered by the medical assistance state plan except for ICF/DD services, home and community-based waiver services, case management for persons with developmental disabilities under section 256B.0625, subdivision 20a, and personal care and certain home care services defined by the commissioner in consultation with the stakeholder group established under paragraph (d); and

(2) basic health care services may also include risk for up to 100 days of nursing facility services for persons who reside in a noninstitutional setting and home health services related to rehabilitation as defined by the commissioner after consultation with the stakeholder group.

The commissioner may exclude other medical assistance services from the basic health care benefit set. Enrollees in these plans can access any excluded services on the same basis as other medical assistance recipients who have not enrolled.

(b) ~~Beginning January 1, 2007,~~ The commissioner may contract with demonstration providers and current and former sponsors of qualified Medicare special needs plans, to provide basic health care services under medical assistance to persons who are dually eligible for both Medicare and Medicaid and those Social Security beneficiaries eligible for Medicaid but in the waiting period for Medicare. The commissioner shall consult with the stakeholder group under paragraph (d) in developing program specifications for these services. ~~The commissioner shall report to the chairs of the house of representatives and senate committees with jurisdiction over health and human services policy and finance by February 1, 2007, on implementation of these programs and the need for increased funding for the ombudsman for managed care and other consumer assistance and protections needed due to enrollment in managed care of persons with disabilities.~~ Payment for Medicaid services provided under this subdivision for the months of May and June will be made no earlier than July 1 of the same calendar year.

(c) Notwithstanding subdivision 4, beginning January 1, 2012, the commissioner shall enroll persons with disabilities in managed care under this section, unless the individual chooses to opt out of enrollment. The commissioner shall establish enrollment and opt out procedures consistent with applicable enrollment procedures under this section.

(d) The commissioner shall establish a state-level stakeholder group to provide advice on managed care programs for persons with disabilities, including both MnDHO

and contracts with special needs plans that provide basic health care services as described in paragraphs (a) and (b). The stakeholder group shall provide advice on program expansions under this subdivision and subdivision 23, including:

(1) implementation efforts;

(2) consumer protections; and

(3) program specifications such as quality assurance measures, data collection and reporting, and evaluation of costs, quality, and results.

(e) Each plan under contract to provide medical assistance basic health care services shall establish a local or regional stakeholder group, including representatives of the counties covered by the plan, members, consumer advocates, and providers, for advice on issues that arise in the local or regional area.

(f) The commissioner is prohibited from providing the names of potential enrollees to health plans for marketing purposes. The commissioner shall mail no more than two sets of marketing materials per contract year to potential enrollees on behalf of health plans, at the health plan's request. The marketing materials shall be mailed by the commissioner within 30 days of receipt of these materials from the health plan. The health plans shall cover any costs incurred by the commissioner for mailing marketing materials.

Sec. 14. Minnesota Statutes 2012, section 256B.69, subdivision 29, is amended to read:

Subd. 29. **Prepaid health plan rates.** In negotiating ~~the~~ prepaid health plan contract rates ~~for services rendered on or after January 1, 2011~~, the commissioner of human services shall take into consideration, and the rates shall reflect, the anticipated savings in the medical assistance program due to extending medical assistance coverage to services provided in licensed birth centers, the anticipated use of these services within the medical assistance population, and the reduced medical assistance costs associated with the use of birth centers for normal, low-risk deliveries.

Sec. 15. Minnesota Statutes 2012, section 256B.69, subdivision 30, is amended to read:

Subd. 30. **Provision of required materials in alternative formats.** (a) For the purposes of this subdivision, "alternative format" means a medium other than paper and "prepaid health plan" means managed care plans and county-based purchasing plans.

(b) A prepaid health plan may provide in an alternative format a provider directory and certificate of coverage, or materials otherwise required to be available in writing under Code of Federal Regulations, title 42, section 438.10, or under the commissioner's contract with the prepaid health plan, if the following conditions are met:

(1) the prepaid health plan, local agency, or commissioner, as applicable, informs the enrollee that:

(i) an alternative format is available and the enrollee affirmatively requests of the prepaid health plan that the provider directory, certificate of coverage, or materials otherwise required under Code of Federal Regulations, title 42, section 438.10, or under the commissioner's contract with the prepaid health plan be provided in an alternative format; and

(ii) a record of the enrollee request is retained by the prepaid health plan in the form of written direction from the enrollee or a documented telephone call followed by a confirmation letter to the enrollee from the prepaid health plan that explains that the enrollee may change the request at any time;

(2) the materials are sent to a secure electronic mailbox and are made available at a password-protected secure electronic Web site or on a data storage device if the materials contain enrollee data that is individually identifiable;

(3) the enrollee is provided a customer service number on the enrollee's membership card that may be called to request a paper version of the materials provided in an alternative format; and

(4) the materials provided in an alternative format meets all other requirements of the commissioner regarding content, size of the typeface, and any required time frames for distribution. "Required time frames for distribution" must permit sufficient time for prepaid health plans to distribute materials in alternative formats upon receipt of enrollees' requests for the materials.

(c) A prepaid health plan may provide in an alternative format its primary care network list to the commissioner and to local agencies within its service area. The commissioner or local agency, as applicable, shall inform a potential enrollee of the availability of a prepaid health plan's primary care network list in an alternative format. If the potential enrollee requests an alternative format of the prepaid health plan's primary care network list, a record of that request shall be retained by the commissioner or local agency. The potential enrollee is permitted to withdraw the request at any time.

The prepaid health plan shall submit sufficient paper versions of the primary care network list to the commissioner and to local agencies within its service area to accommodate potential enrollee requests for paper versions of the primary care network list.

(d) A prepaid health plan may provide in an alternative format materials otherwise required to be available in writing under Code of Federal Regulations, title 42, section 438.10, or under the commissioner's contract with the prepaid health plan, if the conditions

of paragraphs (b)~~;~~ and (c)~~, and (e),~~ are met for persons who are eligible for enrollment in managed care.

~~(e) The commissioner shall seek any federal Medicaid waivers within 90 days after the effective date of this subdivision that are necessary to provide alternative formats of required material to enrollees of prepaid health plans as authorized under this subdivision.~~

~~(f)~~ (e) The commissioner shall consult with managed care plans, county-based purchasing plans, counties, and other interested parties to determine how materials required to be made available to enrollees under Code of Federal Regulations, title 42, section 438.10, or under the commissioner's contract with a prepaid health plan may be provided in an alternative format on the basis that the enrollee has not opted in to receive the alternative format. The commissioner shall consult with managed care plans, county-based purchasing plans, counties, and other interested parties to develop recommendations relating to the conditions that must be met for an opt-out process to be granted.

Sec. 16. Minnesota Statutes 2012, section 256B.692, subdivision 2, is amended to read:

Subd. 2. **Duties of commissioner of health.** (a) Notwithstanding chapters 62D and 62N, a county that elects to purchase medical assistance in return for a fixed sum without regard to the frequency or extent of services furnished to any particular enrollee is not required to obtain a certificate of authority under chapter 62D or 62N. The county board of commissioners is the governing body of a county-based purchasing program. In a multicounty arrangement, the governing body is a joint powers board established under section 471.59.

(b) A county that elects to purchase medical assistance services under this section must satisfy the commissioner of health that the requirements for assurance of consumer protection, provider protection, and~~, effective January 1, 2010,~~ fiscal solvency of chapter 62D, applicable to health maintenance organizations will be met according to the following schedule:

(1) for a county-based purchasing plan approved on or before June 30, 2008, the plan must have in reserve:

(i) at least 50 percent of the minimum amount required under chapter 62D as of January 1, 2010;

(ii) at least 75 percent of the minimum amount required under chapter 62D as of January 1, 2011;

(iii) at least 87.5 percent of the minimum amount required under chapter 62D as of January 1, 2012; and

(iv) at least 100 percent of the minimum amount required under chapter 62D as of January 1, 2013; and

(2) for a county-based purchasing plan first approved after June 30, 2008, the plan must have in reserve:

(i) at least 50 percent of the minimum amount required under chapter 62D at the time the plan begins enrolling enrollees;

(ii) at least 75 percent of the minimum amount required under chapter 62D after the first full calendar year;

(iii) at least 87.5 percent of the minimum amount required under chapter 62D after the second full calendar year; and

(iv) at least 100 percent of the minimum amount required under chapter 62D after the third full calendar year.

(c) Until a plan is required to have reserves equaling at least 100 percent of the minimum amount required under chapter 62D, the plan may demonstrate its ability to cover any losses by satisfying the requirements of chapter 62N. A county-based purchasing plan must also assure the commissioner of health that the requirements of sections 62J.041; 62J.48; 62J.71 to 62J.73; 62M.01 to 62M.16; all applicable provisions of chapter 62Q, including sections 62Q.075; 62Q.1055; 62Q.106; 62Q.12; 62Q.135; 62Q.14; 62Q.145; 62Q.19; 62Q.23, paragraph (c); 62Q.43; 62Q.47; 62Q.50; 62Q.52 to 62Q.56; 62Q.58; 62Q.68 to 62Q.72; and 72A.201 will be met.

(d) All enforcement and rulemaking powers available under chapters 62D, 62J, 62M, 62N, and 62Q are hereby granted to the commissioner of health with respect to counties that purchase medical assistance services under this section.

(e) The commissioner, in consultation with county government, shall develop administrative and financial reporting requirements for county-based purchasing programs relating to sections 62D.041, 62D.042, 62D.045, 62D.08, 62N.28, 62N.29, and 62N.31, and other sections as necessary, that are specific to county administrative, accounting, and reporting systems and consistent with other statutory requirements of counties.

(f) The commissioner shall collect from a county-based purchasing plan under this section the following fees:

(1) fees attributable to the costs of audits and other examinations of plan financial operations. These fees are subject to the provisions of Minnesota Rules, part 4685.2800, subpart 1, item F; and

(2) an annual fee of $21,500, to be paid by June 15 of each calendar year~~, beginning in calendar year 2009; and~~

~~(3) for fiscal year 2009 only, a per-enrollee fee of 14.6 cents, based on the number of enrollees as of December 31, 2008~~.

All fees collected under this paragraph shall be deposited in the state government special revenue fund.

Sec. 17. Minnesota Statutes 2012, section 256B.692, subdivision 5, is amended to read:

Subd. 5. **County proposals.** (a) ~~On or before September 1, 1997,~~ A county board that wishes to purchase or provide health care under this section must submit a preliminary proposal that substantially demonstrates the county's ability to meet all the requirements of this section in response to criteria for proposals issued by the department ~~on or before July 1, 1997~~. Counties submitting preliminary proposals must establish a local planning process that involves input from medical assistance recipients, recipient advocates, providers and representatives of local school districts, labor, and tribal government to advise on the development of a final proposal and its implementation.

(b) The county board must submit a final proposal ~~on or before July 1, 1998,~~ that demonstrates the ability to meet all the requirements of this section~~, including beginning enrollment on January 1, 1999, unless a delay has been granted under section 256B.69, subdivision 3a, paragraph (g)~~.

(c) ~~After January 1, 1999,~~ For a county in which the prepaid medical assistance program is in existence, the county board must submit a preliminary proposal at least 15 months prior to termination of health plan contracts in that county and a final proposal six months prior to the health plan contract termination date in order to begin enrollment after the termination. Nothing in this section shall impede or delay implementation or continuation of the prepaid medical assistance program in counties for which the board does not submit a proposal, or submits a proposal that is not in compliance with this section.

~~(d) The commissioner is not required to terminate contracts for the prepaid medical assistance program that begin on or after September 1, 1997, in a county for which a county board has submitted a proposal under this paragraph, until two years have elapsed from the date of initial enrollment in the prepaid medical assistance program.~~

Sec. 18. Minnesota Statutes 2013 Supplement, section 256B.76, subdivision 4, is amended to read:

Subd. 4. **Critical access dental providers.** (a) Effective for dental services rendered on or after January 1, 2002, the commissioner shall increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. For dental services rendered on or after July 1, 2007, the commissioner shall

increase reimbursement by 35 percent above the reimbursement rate that would otherwise be paid to the critical access dental provider. The commissioner shall pay the managed care plans and county-based purchasing plans in amounts sufficient to reflect increased reimbursements to critical access dental providers as approved by the commissioner.

(b) The commissioner shall designate the following dentists and dental clinics as critical access dental providers:

(1) nonprofit community clinics that:

(i) have nonprofit status in accordance with chapter 317A;

(ii) have tax exempt status in accordance with the Internal Revenue Code, section 501(c)(3);

(iii) are established to provide oral health services to patients who are low income, uninsured, have special needs, and are underserved;

(iv) have professional staff familiar with the cultural background of the clinic's patients;

(v) charge for services on a sliding fee scale designed to provide assistance to low-income patients based on current poverty income guidelines and family size;

(vi) do not restrict access or services because of a patient's financial limitations or public assistance status; and

(vii) have free care available as needed;

(2) federally qualified health centers, rural health clinics, and public health clinics;

(3) city or county owned and operated hospital-based dental clinics;

(4) a dental clinic or dental group owned and operated by a nonprofit corporation in accordance with chapter 317A with more than 10,000 patient encounters per year with patients who are uninsured or covered by medical assistance or MinnesotaCare;

(5) a dental clinic owned and operated by the University of Minnesota or the Minnesota State Colleges and Universities system; and

(6) private practicing dentists if:

(i) the dentist's office is located within a health professional shortage area as defined under Code of Federal Regulations, title 42, part 5, and United States Code, title 42, section 254E;

(ii) more than 50 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare;

(iii) the dentist does not restrict access or services because of a patient's financial limitations or public assistance status; and

(iv) the level of service provided by the dentist is critical to maintaining adequate levels of patient access within the service area in which the dentist operates.

~~(c) A designated critical access clinic shall receive the reimbursement rate specified in paragraph (a) for dental services provided off site at a private dental office if the following requirements are met:~~

~~(1) the designated critical access dental clinic is located within a health professional shortage area as defined under Code of Federal Regulations, title 42, part 5, and United States Code, title 42, section 254E, and is located outside the seven-county metropolitan area;~~

~~(2) the designated critical access dental clinic is not able to provide the service and refers the patient to the off-site dentist;~~

~~(3) the service, if provided at the critical access dental clinic, would be reimbursed at the critical access reimbursement rate;~~

~~(4) the dentist and allied dental professionals providing the services off site are licensed and in good standing under chapter 150A;~~

~~(5) the dentist providing the services is enrolled as a medical assistance provider;~~

~~(6) the critical access dental clinic submits the claim for services provided off site and receives the payment for the services; and~~

~~(7) the critical access dental clinic maintains dental records for each claim submitted under this paragraph, including the name of the dentist, the off-site location, and the license number of the dentist and allied dental professionals providing the services.~~

Sec. 19. **REPEALER.**

Minnesota Statutes 2012, sections 256.959; 256.964; 256.9691; 256B.043; 256B.0636; 256B.075, subdivision 4; 256B.0757, subdivision 7; 256B.19, subdivision 3; 256B.53; 256B.69, subdivisions 5e, 6c, and 24a; and 256B.692, subdivision 10, are repealed.

## ARTICLE 3

## CHEMICAL AND MENTAL HEALTH SERVICES

Section 1. Minnesota Statutes 2012, section 245.4871, subdivision 3, is amended to read:

Subd. 3. **Case management services.** "Case management services" means activities that are coordinated with the family community support services and are designed to help the child with severe emotional disturbance and the child's family obtain needed mental health services, social services, educational services, health services, vocational services, recreational services, and related services in the areas of volunteer services, advocacy, transportation, and legal services. Case management services include assisting in obtaining a comprehensive diagnostic assessment, ~~if needed, developing a functional~~

~~assessment,~~ developing an individual family community support plan, and assisting the child and the child's family in obtaining needed services by coordination with other agencies and assuring continuity of care. Case managers must assess and reassess the delivery, appropriateness, and effectiveness of services over time.

Sec. 2. Minnesota Statutes 2012, section 245.4871, subdivision 6, is amended to read:

Subd. 6. **Child with severe emotional disturbance.** For purposes of eligibility for case management and family community support services, "child with severe emotional disturbance" means a child who has an emotional disturbance and who meets one of the following criteria:

(1) the child has been admitted within the last three years or is at risk of being admitted to inpatient treatment or residential treatment for an emotional disturbance; or

(2) the child is a Minnesota resident and is receiving inpatient treatment or residential treatment for an emotional disturbance through the interstate compact; or

(3) the child has one of the following as determined by a mental health professional:

(i) psychosis or a clinical depression; or

(ii) risk of harming self or others as a result of an emotional disturbance; or

(iii) psychopathological symptoms as a result of being a victim of physical or sexual abuse or of psychic trauma within the past year; or

(4) the child, as a result of an emotional disturbance, has significantly impaired home, school, or community functioning that has lasted at least one year or that, in the written opinion of a mental health professional, presents substantial risk of lasting at least one year.

~~The term "child with severe emotional disturbance" shall be used only for purposes of county eligibility determinations. In all other written and oral communications, case managers, mental health professionals, mental health practitioners, and all other providers of mental health services shall use the term "child eligible for mental health case management" in place of "child with severe emotional disturbance."~~

Sec. 3. Minnesota Statutes 2012, section 245.4871, subdivision 27, is amended to read:

Subd. 27. **Mental health professional.** "Mental health professional" means a person providing clinical services in the diagnosis and treatment of children's ~~emotional disorders~~ mental illnesses or emotional disturbances. A mental health professional must have training and experience in working with children consistent with the age group to which the mental health professional is assigned. A mental health professional must be qualified in at least one of the following ways:

(1) in psychiatric nursing, the mental health professional must be a registered nurse who is licensed under sections 148.171 to 148.285 and who is certified as a clinical specialist in child and adolescent psychiatric or mental health nursing by a national nurse certification organization or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(2) in clinical social work, the mental health professional must be a person licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders;

(3) in psychology, the mental health professional must be an individual licensed by the board of psychology under sections 148.88 to 148.98 who has stated to the board of psychology competencies in the diagnosis and treatment of mental disorders;

(4) in psychiatry, the mental health professional must be a physician licensed under chapter 147 and certified by the American board of psychiatry and neurology or eligible for board certification in psychiatry;

(5) in marriage and family therapy, the mental health professional must be a marriage and family therapist licensed under sections 148B.29 to 148B.39 with at least two years of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders or emotional disturbances; or

(6) in licensed professional clinical counseling, the mental health professional shall be a licensed professional clinical counselor under section 148B.5301 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental disorders or emotional disturbances~~; or~~.

~~(7) in allied fields, the mental health professional must be a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of emotional disturbances.~~

Sec. 4. Minnesota Statutes 2012, section 245.4873, subdivision 2, is amended to read:

Subd. 2. **State level; coordination.** The Children's Cabinet, under section 4.045, in consultation with a representative of the Minnesota District Judges Association Juvenile Committee, shall:

(1) educate each agency about the policies, procedures, funding, and services for children with emotional disturbances of all agencies represented;

(2) develop mechanisms for interagency coordination on behalf of children with emotional disturbances;

(3) identify barriers including policies and procedures within all agencies represented that interfere with delivery of mental health services for children;

(4) recommend policy and procedural changes needed to improve development and delivery of mental health services for children in the agency or agencies they represent; and

(5) identify mechanisms for better use of federal and state funding in the delivery of mental health services for children~~; and~~.

~~(6) perform the duties required under sections 245.494 to 245.495.~~

Sec. 5. Minnesota Statutes 2012, section 245.4874, subdivision 1, is amended to read:

Subdivision 1. **Duties of county board.** (a) The county board must:

(1) develop a system of affordable and locally available children's mental health services according to sections 245.487 to 245.4889;

(2) establish a mechanism providing for interagency coordination as specified in section 245.4875, subdivision 6;

(3) consider the assessment of unmet needs in the county as reported by the local children's mental health advisory council under section 245.4875, subdivision 5, paragraph (b), clause (3). The county shall provide, upon request of the local children's mental health advisory council, readily available data to assist in the determination of unmet needs;

(4) assure that parents and providers in the county receive information about how to gain access to services provided according to sections 245.487 to 245.4889;

(5) coordinate the delivery of children's mental health services with services provided by social services, education, corrections, health, and vocational agencies to improve the availability of mental health services to children and the cost-effectiveness of their delivery;

(6) assure that mental health services delivered according to sections 245.487 to 245.4889 are delivered expeditiously and are appropriate to the child's diagnostic assessment and individual treatment plan;

~~(7) provide the community with information about predictors and symptoms of emotional disturbances and how to access children's mental health services according to sections 245.4877 and 245.4878;~~

~~(8)~~ (7) provide for case management services to each child with severe emotional disturbance according to sections 245.486; 245.4871, subdivisions 3 and 4; and 245.4881, subdivisions 1, 3, and 5;

~~(9)~~ (8) provide for screening of each child under section 245.4885 upon admission to a residential treatment facility, acute care hospital inpatient treatment, or informal admission to a regional treatment center;

~~(10)~~ (9) prudently administer grants and purchase-of-service contracts that the county board determines are necessary to fulfill its responsibilities under sections 245.487 to 245.4889;

~~(11)~~ (10) assure that mental health professionals, mental health practitioners, and case managers employed by or under contract to the county to provide mental health services are qualified under section 245.4871;

~~(12)~~ (11) assure that children's mental health services are coordinated with adult mental health services specified in sections 245.461 to 245.486 so that a continuum of mental health services is available to serve persons with mental illness, regardless of the person's age;

~~(13)~~ (12) assure that culturally competent mental health consultants are used as necessary to assist the county board in assessing and providing appropriate treatment for children of cultural or racial minority heritage; and

~~(14)~~ (13) consistent with section 245.486, arrange for or provide a children's mental health screening for:

(i) a child receiving child protective services;

(ii) a child in out-of-home placement;

(iii) a child for whom parental rights have been terminated;

(iv) a child found to be delinquent; or

(v) a child found to have committed a juvenile petty offense for the third or subsequent time.

A children's mental health screening is not required when a screening or diagnostic assessment has been performed within the previous 180 days, or the child is currently under the care of a mental health professional.

(b) When a child is receiving protective services or is in out-of-home placement, the court or county agency must notify a parent or guardian whose parental rights have not been terminated of the potential mental health screening and the option to prevent the screening by notifying the court or county agency in writing.

(c) When a child is found to be delinquent or a child is found to have committed a juvenile petty offense for the third or subsequent time, the court or county agency must obtain written informed consent from the parent or legal guardian before a screening is conducted unless the court, notwithstanding the parent's failure to consent, determines that the screening is in the child's best interest.

(d) The screening shall be conducted with a screening instrument approved by the commissioner of human services according to criteria that are updated and issued annually to ensure that approved screening instruments are valid and useful for child welfare and juvenile justice populations. Screenings shall be conducted by a mental health practitioner as defined in section 245.4871, subdivision 26, or a probation officer or local social services agency staff person who is trained in the use of the screening instrument. Training in the use of the instrument shall include:

(1) training in the administration of the instrument;

(2) the interpretation of its validity given the child's current circumstances;

(3) the state and federal data practices laws and confidentiality standards;

(4) the parental consent requirement; and

(5) providing respect for families and cultural values.

If the screen indicates a need for assessment, the child's family, or if the family lacks mental health insurance, the local social services agency, in consultation with the child's family, shall have conducted a diagnostic assessment, including a functional assessment~~,~~ ~~as defined in section 245.4871~~. The administration of the screening shall safeguard the privacy of children receiving the screening and their families and shall comply with the Minnesota Government Data Practices Act, chapter 13, and the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Screening results shall be considered private data ~~and the commissioner shall not collect individual screening results~~.

(e) When the county board refers clients to providers of children's therapeutic services and supports under section 256B.0943, the county board must clearly identify the desired services components not covered under section 256B.0943 and identify the reimbursement source for those requested services, the method of payment, and the payment rate to the provider.

Sec. 6. Minnesota Statutes 2012, section 245.4881, subdivision 3, is amended to read:

Subd. 3. **Duties of case manager.** (a) Upon a determination of eligibility for case management services, the case manager shall ~~complete a written functional assessment according to section 245.4871, subdivision 18. The case manager shall~~ develop an individual family community support plan for a child as specified in subdivision 4, review the child's progress, and monitor the provision of services. If services are to be provided in a host county that is not the county of financial responsibility, the case manager shall consult with the host county and obtain a letter demonstrating the concurrence of the host county regarding the provision of services.

(b) The case manager shall note in the child's record the services needed by the child and the child's family, the services requested by the family, services that are not available, and the unmet needs of the child and child's family. The case manager shall note this provision in the child's record.

Sec. 7. Minnesota Statutes 2012, section 245.4881, subdivision 4, is amended to read:

Subd. 4. **Individual family community support plan.** (a) For each child, the case manager must develop an individual family community support plan that incorporates the child's individual treatment plan. The individual treatment plan may not be a substitute for the development of an individual family community support plan. The case manager is responsible for developing the individual family community support plan within 30 days of intake based on a diagnostic assessment ~~and a functional assessment~~ and for implementing and monitoring the delivery of services according to the individual family community support plan. The case manager must review the plan at least every 180 calendar days after it is developed, unless the case manager has received a written request from the child's family or an advocate for the child for a review of the plan every 90 days after it is developed. To the extent appropriate, the child with severe emotional disturbance, the child's family, advocates, service providers, and significant others must be involved in all phases of development and implementation of the individual family community support plan. Notwithstanding the lack of an individual family community support plan, the case manager shall assist the child and child's family in accessing the needed services listed in section 245.4884, subdivision 1.

(b) The child's individual family community support plan must state:

(1) the goals and expected outcomes of each service and criteria for evaluating the effectiveness and appropriateness of the service;

(2) the activities for accomplishing each goal;

(3) a schedule for each activity; and

(4) the frequency of face-to-face contacts by the case manager, as appropriate to client need and the implementation of the individual family community support plan.

Sec. 8. Minnesota Statutes 2012, section 245.4882, subdivision 1, is amended to read:

Subdivision 1. **Availability of residential treatment services.** County boards must provide or contract for enough residential treatment services to meet the needs of each child with severe emotional disturbance residing in the county and needing this level of care. Length of stay is based on the child's residential treatment need and shall be subject to the six-month review process established in section 260C.203, and for children in

voluntary placement for treatment, the court review process in section 260D.06. Services must be appropriate to the child's age and treatment needs and must be made available as close to the county as possible. Residential treatment must be designed to:

~~(1) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet the child's needs;~~

~~(2)~~ (1) help the child improve family living and social interaction skills;

~~(3)~~ (2) help the child gain the necessary skills to return to the community;

~~(4)~~ (3) stabilize crisis admissions; and

~~(5)~~ (4) work with families throughout the placement to improve the ability of the families to care for children with severe emotional disturbance in the home.

Sec. 9. Minnesota Statutes 2012, section 246.01, is amended to read:

**246.01 POWERS AND DUTIES.**

The commissioner of human services is hereby specifically constituted the guardian of all persons with developmental disabilities, the guardianship of whom has heretofore been vested in the State Board of Control or in the director of social welfare whether by operation of law or by an order of court without any further act or proceeding, and all the powers and duties vested in or imposed upon the State Board of Control or the director of social welfare, with reference to mental testing of persons with developmental disabilities, and with reference to the institutions of the state of Minnesota except correctional facilities administered and managed by the commissioner of corrections, are hereby transferred to, vested in, and imposed upon the commissioner of human services, and in relation thereto is hereby charged with and shall have the exclusive power of administration and management of all of the following state institutions: state hospitals for persons with developmental disabilities, mental illness, or chemical dependency. The commissioner shall have power and authority to determine all matters relating to the unified and continuous development of all of the foregoing institutions and of such other institutions, the supervision of which may, from time to time, be vested in the commissioner. It is intended that there be vested in the commissioner all of the powers, functions, and authority heretofore vested in the State Board of Control relative to such state institutions. ~~The commissioner shall have the power and authority to accept, in behalf of the state, contributions and gifts of money and personal property for the use and benefit of the residents of the public institutions under the commissioner's control, and all money and securities so received shall be deposited in the state treasury subject to the order of the commissioner of human services. If the gift or contribution is designated by the donor for a certain institution or purpose, the commissioner of human services shall expend or use the same as nearly as may be in~~

~~accordance with the conditions of the gift or contribution, compatible with the best interests of the inmates and the state.~~ The commissioner of human services is hereby constituted the "state agency" as defined by the Social Security Act of the United States and the laws of this state for all purposes relating to mental health and mental hygiene.

~~For the purpose of carrying out these duties, the commissioner of human services shall accept from wards with developmental disabilities for whom the commissioner is specifically appointed guardian a signed application for consent to the marriage of said ward. Upon receipt of such application the commissioner shall promptly conduct such investigation as the commissioner deems proper and determine if the contemplated marriage is for the best interest of the ward and the public. A signed copy of the commissioner's determination shall be mailed to the ward and to the court administrator of the district court of the county where the application for such marriage license was made.~~

There is hereby appropriated to such persons or institutions as are entitled to such sums as are provided for in this section, from the fund or account in the state treasury to which the money was credited, an amount sufficient to make such payment.

Sec. 10. Minnesota Statutes 2012, section 254B.05, subdivision 2, is amended to read:

Subd. 2. **Regulatory methods.** (a) Where appropriate and feasible, the commissioner shall identify and implement alternative methods of regulation and enforcement to the extent authorized in this subdivision. These methods shall include:

(1) expansion of the types and categories of licenses that may be granted;

(2) when the standards of an independent accreditation body have been shown to predict compliance with the rules, the commissioner shall consider compliance with the accreditation standards to be equivalent to partial compliance with the rules; and

(3) use of an abbreviated inspection that employs key standards that have been shown to predict full compliance with the rules.

~~If the commissioner determines that the methods in clause (2) or (3) can be used in licensing a program, the commissioner may reduce any fee set under section 254B.03, subdivision 3, by up to 50 percent.~~

(b) The commissioner shall work with the commissioners of health, public safety, administration, and education in consolidating duplicative licensing and certification rules and standards if the commissioner determines that consolidation is administratively feasible, would significantly reduce the cost of licensing, and would not reduce the protection given to persons receiving services in licensed programs. Where administratively feasible and appropriate, the commissioner shall work with the

commissioners of health, public safety, administration, and education in conducting joint agency inspections of programs.

(c) The commissioner shall work with the commissioners of health, public safety, administration, and education in establishing a single point of application for applicants who are required to obtain concurrent licensure from more than one of the commissioners listed in this clause.

Sec. 11. Minnesota Statutes 2012, section 256.01, subdivision 14b, is amended to read:

Subd. 14b. **American Indian child welfare projects.** (a) The commissioner of human services may authorize projects to test tribal delivery of child welfare services to American Indian children and their parents and custodians living on the reservation. The commissioner has authority to solicit and determine which tribes may participate in a project. Grants may be issued to Minnesota Indian tribes to support the projects. The commissioner may waive existing state rules as needed to accomplish the projects. Notwithstanding section 626.556, the commissioner may authorize projects to use alternative methods of investigating and assessing reports of child maltreatment, provided that the projects comply with the provisions of section 626.556 dealing with the rights of individuals who are subjects of reports or investigations, including notice and appeal rights and data practices requirements. The commissioner may seek any federal approvals necessary to carry out the projects as well as seek and use any funds available to the commissioner, including use of federal funds, foundation funds, existing grant funds, and other funds. The commissioner is authorized to advance state funds as necessary to operate the projects. Federal reimbursement applicable to the projects is appropriated to the commissioner for the purposes of the projects. The projects must be required to address responsibility for safety, permanency, and well-being of children.

(b) For the purposes of this section, "American Indian child" means a person under 21 years old and who is a tribal member or eligible for membership in one of the tribes chosen for a project under this subdivision and who is residing on the reservation of that tribe.

(c) In order to qualify for an American Indian child welfare project, a tribe must:

(1) be one of the existing tribes with reservation land in Minnesota;

(2) have a tribal court with jurisdiction over child custody proceedings;

(3) have a substantial number of children for whom determinations of maltreatment have occurred;

(4) have capacity to respond to reports of abuse and neglect under section 626.556;

(5) provide a wide range of services to families in need of child welfare services; and

(6) have a tribal-state title IV-E agreement in effect.

(d) Grants awarded under this section may be used for the nonfederal costs of providing child welfare services to American Indian children on the tribe's reservation, including costs associated with:

(1) assessment and prevention of child abuse and neglect;

(2) family preservation;

(3) facilitative, supportive, and reunification services;

(4) out-of-home placement for children removed from the home for child protective purposes; and

(5) other activities and services approved by the commissioner that further the goals of providing safety, permanency, and well-being of American Indian children.

(e) When a tribe has initiated a project and has been approved by the commissioner to assume child welfare responsibilities for American Indian children of that tribe under this section, the affected county social service agency is relieved of responsibility for responding to reports of abuse and neglect under section 626.556 for those children during the time within which the tribal project is in effect and funded. The commissioner shall work with tribes and affected counties to develop procedures for data collection, evaluation, and clarification of ongoing role and financial responsibilities of the county and tribe for child welfare services prior to initiation of the project. Children who have not been identified by the tribe as participating in the project shall remain the responsibility of the county. Nothing in this section shall alter responsibilities of the county for law enforcement or court services.

(f) Participating tribes may conduct children's mental health screenings under section 245.4874, subdivision 1, paragraph (a), clause ~~(14)~~ (13), for children who are eligible for the initiative and living on the reservation and who meet one of the following criteria:

(1) the child must be receiving child protective services;

(2) the child must be in foster care; or

(3) the child's parents must have had parental rights suspended or terminated.

Tribes may access reimbursement from available state funds for conducting the screenings. Nothing in this section shall alter responsibilities of the county for providing services under section 245.487.

(g) Participating tribes may establish a local child mortality review panel. In establishing a local child mortality review panel, the tribe agrees to conduct local child mortality reviews for child deaths or near-fatalities occurring on the reservation under subdivision 12. Tribes with established child mortality review panels shall have access to nonpublic data and shall protect nonpublic data under subdivision 12, paragraphs (c) to (e). The tribe shall provide written notice to the commissioner and affected counties

when a local child mortality review panel has been established and shall provide data upon request of the commissioner for purposes of sharing nonpublic data with members of the state child mortality review panel in connection to an individual case.

(h) The commissioner shall collect information on outcomes relating to child safety, permanency, and well-being of American Indian children who are served in the projects. Participating tribes must provide information to the state in a format and completeness deemed acceptable by the state to meet state and federal reporting requirements.

(i) In consultation with the White Earth Band, the commissioner shall develop and submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services a plan to transfer legal responsibility for providing child protective services to White Earth Band member children residing in Hennepin County to the White Earth Band. The plan shall include a financing proposal, definitions of key terms, statutory amendments required, and other provisions required to implement the plan. The commissioner shall submit the plan by January 15, 2012.

Sec. 12. Minnesota Statutes 2013 Supplement, section 256B.0943, subdivision 2, is amended to read:

Subd. 2. **Covered service components of children's therapeutic services and supports.** (a) Subject to federal approval, medical assistance covers medically necessary children's therapeutic services and supports as defined in this section that an eligible provider entity certified under subdivision 4 provides to a client eligible under subdivision 3.

(b) The service components of children's therapeutic services and supports are:

(1) ~~individual~~ patient or family member, family, psychotherapy for crisis, and group psychotherapy;

(2) individual, family, or group skills training provided by a mental health professional or mental health practitioner;

(3) crisis assistance;

(4) mental health behavioral aide services;

(5) direction of a mental health behavioral aide;

(6) mental health service plan development; and

(7) ~~clinical care consultation under section 256B.0625, subdivision 62;~~ children's day treatment.

~~(8) family psychoeducation under section 256B.0625, subdivision 61; and~~

~~(9) services provided by a family peer specialist under section 256B.0616.~~

~~(c) Service components in paragraph (b) may be combined to constitute therapeutic programs, including day treatment programs and therapeutic preschool programs.~~

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

Sec. 13. Minnesota Statutes 2013 Supplement, section 256B.0943, subdivision 7, is amended to read:

Subd. 7. **Qualifications of individual and team providers.** (a) An individual or team provider working within the scope of the provider's practice or qualifications may provide service components of children's therapeutic services and supports that are identified as medically necessary in a client's individual treatment plan.

(b) An individual provider must be qualified as:

(1) a mental health professional as defined in subdivision 1, paragraph (n); or

(2) a mental health practitioner ~~as defined in section 245.4871, subdivision 26~~ or clinical trainee. The mental health practitioner or clinical trainee must work under the clinical supervision of a mental health professional; or

(3) a mental health behavioral aide working under the clinical supervision of a mental health professional to implement the rehabilitative mental health services previously introduced by a mental health professional or practitioner and identified in the client's individual treatment plan and individual behavior plan.

(A) A level I mental health behavioral aide must:

(i) be at least 18 years old;

(ii) have a high school diploma or general equivalency diploma (GED) or two years of experience as a primary caregiver to a child with severe emotional disturbance within the previous ten years; and

(iii) meet preservice and continuing education requirements under subdivision 8.

(B) A level II mental health behavioral aide must:

(i) be at least 18 years old;

(ii) have an associate or bachelor's degree or 4,000 hours of experience in delivering clinical services in the treatment of mental illness concerning children or adolescents or complete a certificate program established under subdivision 8a; and

(iii) meet preservice and continuing education requirements in subdivision 8.

~~(c) A preschool program multidisciplinary team must include at least one mental health professional and one or more of the following individuals under the clinical supervision of a mental health professional:~~

~~(i) a mental health practitioner; or~~

~~(ii) a program person, including a teacher, assistant teacher, or aide, who meets the qualifications and training standards of a level I mental health behavioral aide.~~

~~(d)~~ (c) A day treatment multidisciplinary team must include at least one mental health professional or clinical trainee and one mental health practitioner.

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

Sec. 14. Minnesota Statutes 2012, section 256B.0943, subdivision 8, is amended to read:

Subd. 8. **Required preservice and continuing education.** (a) A provider entity shall establish a plan to provide preservice and continuing education for staff. The plan must clearly describe the type of training necessary to maintain current skills and obtain new skills and that relates to the provider entity's goals and objectives for services offered.

(b) A provider that employs a mental health behavioral aide under this section must require the mental health behavioral aide to complete 30 hours of preservice training. The preservice training must include ~~topics specified in Minnesota Rules, part 9535.4068, subparts 1 and 2, and~~ parent team training. The preservice training must include 15 hours of in-person training of a mental health behavioral aide in mental health services delivery and eight hours of parent team training. Curricula for parent team training must be approved in advance by the commissioner. Components of parent team training include:

(1) partnering with parents;

(2) fundamentals of family support;

(3) fundamentals of policy and decision making;

(4) defining equal partnership;

(5) complexities of the parent and service provider partnership in multiple service delivery systems due to system strengths and weaknesses;

(6) sibling impacts;

(7) support networks; and

(8) community resources.

(c) A provider entity that employs a mental health practitioner and a mental health behavioral aide to provide children's therapeutic services and supports under this section must require the mental health practitioner and mental health behavioral aide to complete 20 hours of continuing education every two calendar years. The continuing education must be related to serving the needs of a child with emotional disturbance in the child's home environment and the child's family. ~~The topics covered in orientation and training must conform to Minnesota Rules, part 9535.4068.~~

(d) The provider entity must document the mental health practitioner's or mental health behavioral aide's annual completion of the required continuing education. The

documentation must include the date, subject, and number of hours of the continuing education, and attendance records, as verified by the staff member's signature, job title, and the instructor's name. The provider entity must keep documentation for each employee, including records of attendance at professional workshops and conferences, at a central location and in the employee's personnel file.

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

Sec. 15. Minnesota Statutes 2012, section 256B.0943, subdivision 10, is amended to read:

Subd. 10. **Service authorization.** ~~The commissioner shall publish in the State Register a list of health services that require prior authorization, as well as the criteria and standards used to select health services on the list. The list and the criteria and standards used to formulate the list are not subject to the requirements of sections 14.001 to 14.69. The commissioner's decision on whether prior authorization is required for a health service is not subject to administrative appeal.~~ Children's therapeutic services and supports are subject to authorization criteria and standards published by the commissioner according to section 256B.0625, subdivision 25.

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

Sec. 16. Minnesota Statutes 2012, section 256B.0943, subdivision 12, is amended to read:

Subd. 12. **Excluded services.** The following services are not eligible for medical assistance payment as children's therapeutic services and supports:

(1) service components of children's therapeutic services and supports simultaneously provided by more than one provider entity unless prior authorization is obtained;

(2) treatment by multiple providers within the same agency at the same clock time;

(3) children's therapeutic services and supports provided in violation of medical assistance policy in Minnesota Rules, part 9505.0220;

(4) mental health behavioral aide services provided by a personal care assistant who is not qualified as a mental health behavioral aide and employed by a certified children's therapeutic services and supports provider entity;

(5) service components of CTSS that are the responsibility of a residential or program license holder, including foster care providers under the terms of a service agreement or administrative rules governing licensure; and

(6) adjunctive activities that may be offered by a provider entity but are not otherwise covered by medical assistance, including:

(i) a service that is primarily recreation oriented or that is provided in a setting that is not medically supervised. This includes sports activities, exercise groups, activities such as craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours;

(ii) a social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the client's emotional disturbance;

~~(iii) consultation with other providers or service agency staff about the care or progress of a client;~~

~~(iv)~~ (iii) prevention or education programs provided to the community; and

~~(v)~~ (iv) treatment for clients with primary diagnoses of alcohol or other drug abuse~~;~~ ~~and~~.

~~(7) activities that are not direct service time.~~

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

Sec. 17. **REPEALER.**

(a) Minnesota Statutes 2012, sections 4.47; 245.0311; 245.0312; 245.4861; 245.487, subdivisions 4 and 5; 245.4871, subdivisions 7, 11, 18, and 25; 245.4872; 245.4873, subdivisions 3 and 6; 245.4875, subdivisions 3, 6, and 7; 245.4883, subdivision 1; 245.490; 245.492, subdivisions 6, 8, 13, and 19; 245.4932, subdivisions 2, 3, and 4; 245.4933; 245.494; 245.63; 245.69, subdivision 1; 245.714; 245.715; 245.717; 245.718; 245.721; 245.77; 245.827; 245.981; 246.0135; 246.016; 246.023, subdivision 1; 246.16; 246.28; 246.325; 246.70; 246.71; 246.711; 246.712; 246.713; 246.714; 246.715; 246.716; 246.717; 246.718; 246.719; 246.72; 246.721; 246.722; 253B.22; 254.01; 254.03; 254.04; 254.06; 254.07; 254.09; 254.10; 254.11; 254A.05, subdivision 1; 254A.07, subdivisions 1 and 2; 254A.16, subdivision 1; 254B.01, subdivision 1; and 254B.04, subdivision 3, are repealed.

(b) Minnesota Statutes 2013 Supplement, sections 246.0141; 246.0251; 254.05; and 254B.13, subdivision 3, are repealed.

## ARTICLE 4

## CONTINUING CARE

Section 1. Minnesota Statutes 2012, section 256B.0913, subdivision 5a, is amended to read:

Subd. 5a. **Services; service definitions; service standards.** (a) Unless specified in statute, the services, service definitions, and standards for alternative care services shall be the same as the services, service definitions, and standards specified in the federally approved elderly waiver plan, except alternative care does not cover transitional support services, assisted living services, adult foster care services, and residential care and benefits defined under section 256B.0625 that meet primary and acute health care needs.

(b) The lead agency must ensure that the funds are not used to supplant or supplement services available through other public assistance or services programs, including supplementation of client co-pays, deductibles, premiums, or other cost-sharing arrangements for health-related benefits and services or entitlement programs and services that are available to the person, but in which they have elected not to enroll. The lead agency must ensure that the benefit department recovery system in the Medicaid Management Information System (MMIS) has the necessary information on any other health insurance or third-party insurance policy to which the client may have access. ~~For a provider of supplies and equipment when the monthly cost of the supplies and equipment is less than $250, persons or agencies must be employed by or under a contract with the lead agency or the public health nursing agency of the local board of health in order to receive funding under the alternative care program.~~ Supplies and equipment may be purchased from a vendor not certified to participate in the Medicaid program if the cost for the item is less than that of a Medicaid vendor.

(c) Personal care services must meet the service standards defined in the federally approved elderly waiver plan, except that a lead agency may ~~contract with~~ authorize services to be provided by a client's relative who meets the relative hardship waiver requirements or a relative who meets the criteria and is also the responsible party under an individual service plan that ensures the client's health and safety and supervision of the personal care services by a qualified professional as defined in section 256B.0625, subdivision 19c. Relative hardship is established by the lead agency when the client's care causes a relative caregiver to do any of the following: resign from a paying job, reduce work hours resulting in lost wages, obtain a leave of absence resulting in lost wages, incur substantial client-related expenses, provide services to address authorized, unstaffed direct care time, or meet special needs of the client unmet in the formal service plan.

Sec. 2. Minnesota Statutes 2012, section 256B.0913, subdivision 14, is amended to read:

Subd. 14. **Provider requirements, payment, and rate adjustments.** (a) Unless otherwise specified in statute, providers must be enrolled as Minnesota health care

program providers and abide by the requirements for provider participation according to Minnesota Rules, part 9505.0195.

(b) Payment for provided alternative care services as approved by the client's case manager shall occur through the invoice processing procedures of the department's Medicaid Management Information System (MMIS). To receive payment, the lead agency or vendor must submit invoices within 12 months following the date of service. The lead agency and its vendors ~~under contract~~ shall not be reimbursed for services which exceed the county allocation. Service rates are governed by section 256B.0915, subdivision 3g.

~~(c) The lead agency shall negotiate individual rates with vendors and may authorize service payment for actual costs up to the county's current approved rate. Notwithstanding any other rule or statutory provision to the contrary, the commissioner shall not be authorized to increase rates by an annual inflation factor, unless so authorized by the legislature. To improve access to community services and eliminate payment disparities between the alternative care program and the elderly waiver program, the commissioner shall establish statewide maximum service rate limits and eliminate county-specific service rate limits.~~

~~(1) Effective July 1, 2001, for service rate limits, except those in subdivision 5, paragraphs (d) and (i), the rate limit for each service shall be the greater of the alternative care statewide maximum rate or the elderly waiver statewide maximum rate.~~

~~(2) Lead agencies may negotiate individual service rates with vendors for actual costs up to the statewide maximum service rate limit.~~

Sec. 3. Minnesota Statutes 2012, section 256B.0915, subdivision 3c, is amended to read:

Subd. 3c. **Service approval ~~and contracting~~ provisions.** ~~(a)~~ Medical assistance funding for skilled nursing services, private duty nursing, home health aide, and personal care services for waiver recipients must be approved by the case manager and included in the coordinated service and support plan.

~~(b) A lead agency is not required to contract with a provider of supplies and equipment if the monthly cost of the supplies and equipment is less than $250.~~

Sec. 4. Minnesota Statutes 2012, section 256B.0915, subdivision 3d, is amended to read:

Subd. 3d. **Adult foster care rate.** The adult foster care rate ~~shall be considered a difficulty of care payment and~~ shall not include room and board. ~~The adult foster care service rate shall be negotiated between the lead agency and the foster care provider.~~ The elderly waiver payment for the foster care service in combination with the payment for

all other elderly waiver services, including case management, must not exceed the limit specified in subdivision 3a, paragraph (a).

Sec. 5. Minnesota Statutes 2012, section 256B.0915, subdivision 3f, is amended to read:

Subd. 3f. **~~Individual service rates~~ Payments for services; expenditure forecasts.** (a) ~~The lead agency shall negotiate individual service rates with vendors and may authorize payment for actual costs up to the lead agency's current approved rate. Persons or agencies must be employed by or under a contract with the lead agency or the public health nursing agency of the local board of health in order to receive funding under the elderly waiver program, except as a provider of supplies and equipment when the monthly cost of the supplies and equipment is less than $250.~~ Lead agencies shall authorize payments for services in accordance with the payment rates and limits published annually by the commissioner.

(b) Reimbursement for the medical assistance recipients under the approved waiver shall be made from the medical assistance account through the invoice processing procedures of the department's Medicaid Management Information System (MMIS), only with the approval of the client's case manager. The budget for the state share of the Medicaid expenditures shall be forecasted with the medical assistance budget, and shall be consistent with the approved waiver.

Sec. 6. Minnesota Statutes 2012, section 256B.0915, subdivision 3g, is amended to read:

Subd. 3g. **Service rate limits; state assumption of costs.** (a) To improve access to community services and eliminate payment disparities between the alternative care program and the elderly waiver, the commissioner shall establish statewide ~~maximum~~ service rate limits and eliminate lead agency-specific service rate limits.

(b) Effective July 1, 2001, for statewide service rate limits, except those described or defined in subdivisions 3d ~~and~~, 3e, and 3h, the statewide service rate limit for each service shall be the greater of the alternative care statewide ~~maximum~~ rate or the elderly waiver statewide ~~maximum~~ rate.

~~(c) Lead agencies may negotiate individual service rates with vendors for actual costs up to the statewide maximum service rate limit.~~

Sec. 7. **REPEALER.**

(a) Minnesota Statutes 2012, sections 245.072; 256.971; 256.975, subdivision 3; 256.9753, subdivision 4; 256B.04, subdivision 16; 256B.0656; 256B.0657; 256B.0913, subdivision 9; 256B.0916, subdivisions 6 and 6a; 256B.0928; 256B.431, subdivisions 28,

31, 33, 34, 37, 38, 39, 40, 41, and 43; 256B.434, subdivision 19; 256B.440; 256B.441, subdivisions 46 and 46a; 256B.491; 256B.501, subdivisions 3a, 3b, 3h, 3j, 3k, 3l, and 5e; 256B.5016; 256B.503; and 626.557, subdivision 16, are repealed.

(b) Minnesota Statutes 2013 Supplement, sections 256B.501, subdivision 5b; and 256C.29, are repealed.

(c) Minnesota Rules, parts 9549.0020, subparts 2, 12, 13, 20, 23, 24, 25, 26, 27, 30, 31, 32, 33, 34, 35, 36, 38, 41, 42, 43, 44, 46, and 47; 9549.0030; 9549.0035, subparts 4, 5, and 6; 9549.0036; 9549.0040; 9549.0041, subparts 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, and 15; 9549.0050; 9549.0051, subparts 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and 14; 9549.0053; 9549.0054; 9549.0055, subpart 4; 9549.0056; 9549.0058; 9549.0059; 9549.0060, subparts 1, 2, 3, 8, 9, 12, and 13; 9549.0061; and 9549.0070, subparts 1 and 4, are repealed.

## ARTICLE 5

## OPERATIONS

Section 1. Minnesota Statutes 2012, section 13.46, subdivision 4, is amended to read:

Subd. 4. **Licensing data.** (a) As used in this subdivision:

(1) "licensing data" are all data collected, maintained, used, or disseminated by the welfare system pertaining to persons licensed or registered or who apply for licensure or registration or who formerly were licensed or registered under the authority of the commissioner of human services;

(2) "client" means a person who is receiving services from a licensee or from an applicant for licensure; and

(3) "personal and personal financial data" are Social Security numbers, identity of and letters of reference, insurance information, reports from the Bureau of Criminal Apprehension, health examination reports, and social/home studies.

(b)(1)(i) Except as provided in paragraph (c), the following data on applicants, license holders, and former licensees are public: name, address, telephone number of licensees, date of receipt of a completed application, dates of licensure, licensed capacity, type of client preferred, variances granted, record of training and education in child care and child development, type of dwelling, name and relationship of other family members, previous license history, class of license, the existence and status of complaints, and the number of serious injuries to or deaths of individuals in the licensed program as reported to the commissioner of human services, the local social services agency, or any other county welfare agency. For purposes of this clause, a serious injury is one that is treated by a physician.

(ii) When a correction order, an order to forfeit a fine, an order of license suspension, an order of temporary immediate suspension, an order of license revocation, an order of license denial, or an order of conditional license has been issued, or a complaint is resolved, the following data on current and former licensees and applicants are public: the substance and investigative findings of the licensing or maltreatment complaint, licensing violation, or substantiated maltreatment; the record of informal resolution of a licensing violation; orders of hearing; findings of fact; conclusions of law; specifications of the final correction order, fine, suspension, temporary immediate suspension, revocation, denial, or conditional license contained in the record of licensing action; whether a fine has been paid; and the status of any appeal of these actions.

(iii) When a license denial under section 245A.05 or a sanction under section 245A.07 is based on a determination that the license holder or applicant is responsible for maltreatment under section 626.556 or 626.557, the identity of the applicant or license holder as the individual responsible for maltreatment is public data at the time of the issuance of the license denial or sanction.

(iv) When a license denial under section 245A.05 or a sanction under section 245A.07 is based on a determination that the license holder or applicant is disqualified under chapter 245C, the identity of the license holder or applicant as the disqualified individual and the reason for the disqualification are public data at the time of the issuance of the licensing sanction or denial. If the applicant or license holder requests reconsideration of the disqualification and the disqualification is affirmed, the reason for the disqualification and the reason to not set aside the disqualification are public data.

~~(2) Notwithstanding sections 626.556, subdivision 11, and 626.557, subdivision 12b, when any person subject to disqualification under section 245C.14 in connection with a license to provide family day care for children, child care center services, foster care for children in the provider's home, or foster care or day care services for adults in the provider's home is a substantiated perpetrator of maltreatment, and the substantiated maltreatment is a reason for a licensing action, the identity of the substantiated perpetrator of maltreatment is public data. For purposes of this clause, a person is a substantiated perpetrator if the maltreatment determination has been upheld under section 256.045; 626.556, subdivision 10i; 626.557, subdivision 9d; or chapter 14, or if an individual or facility has not timely exercised appeal rights under these sections, except as provided under clause (1).~~

~~(3)~~ (2) For applicants who withdraw their application prior to licensure or denial of a license, the following data are public: the name of the applicant, the city and county in which the applicant was seeking licensure, the dates of the commissioner's receipt of

the initial application and completed application, the type of license sought, and the date of withdrawal of the application.

~~(4)~~ (3) For applicants who are denied a license, the following data are public: the name and address of the applicant, the city and county in which the applicant was seeking licensure, the dates of the commissioner's receipt of the initial application and completed application, the type of license sought, the date of denial of the application, the nature of the basis for the denial, the record of informal resolution of a denial, orders of hearings, findings of fact, conclusions of law, specifications of the final order of denial, and the status of any appeal of the denial.

~~(5) The following data on persons subject to disqualification under section 245C.14 in connection with a license to provide family day care for children, child care center services, foster care for children in the provider's home, or foster care or day care services for adults in the provider's home, are public: the nature of any disqualification set aside under section 245C.22, subdivisions 2 and 4, and the reasons for setting aside the disqualification; the nature of any disqualification for which a variance was granted under sections 245A.04, subdivision 9; and 245C.30, and the reasons for granting any variance under section 245A.04, subdivision 9; and, if applicable, the disclosure that any person subject to a background study under section 245C.03, subdivision 1, has successfully passed a background study. If a licensing sanction under section 245A.07, or a license denial under section 245A.05, is based on a determination that an individual subject to disqualification under chapter 245C is disqualified, the disqualification as a basis for the licensing sanction or denial is public data. As specified in clause (1), item (iv), if the disqualified individual is the license holder or applicant, the identity of the license holder or applicant and the reason for the disqualification are public data; and, if the license holder or applicant requested reconsideration of the disqualification and the disqualification is affirmed, the reason for the disqualification and the reason to not set aside the disqualification are public data. If the disqualified individual is an individual other than the license holder or applicant, the identity of the disqualified individual shall remain private data.~~

~~(6)~~ (4) When maltreatment is substantiated under section 626.556 or 626.557 and the victim and the substantiated perpetrator are affiliated with a program licensed under chapter 245A, the commissioner of human services, local social services agency, or county welfare agency may inform the license holder where the maltreatment occurred of the identity of the substantiated perpetrator and the victim.

~~(7)~~ (5) Notwithstanding clause (1), for child foster care, only the name of the license holder and the status of the license are public if the county attorney has requested that data

otherwise classified as public data under clause (1) be considered private data based on the best interests of a child in placement in a licensed program.

(c) The following are private data on individuals under section 13.02, subdivision 12, or nonpublic data under section 13.02, subdivision 9: personal and personal financial data on family day care program and family foster care program applicants and licensees and their family members who provide services under the license.

(d) The following are private data on individuals: the identity of persons who have made reports concerning licensees or applicants that appear in inactive investigative data, and the records of clients or employees of the licensee or applicant for licensure whose records are received by the licensing agency for purposes of review or in anticipation of a contested matter. The names of reporters of complaints or alleged violations of licensing standards under chapters 245A, 245B, 245C, and applicable rules and alleged maltreatment under sections 626.556 and 626.557, are confidential data and may be disclosed only as provided in section 626.556, subdivision 11, or 626.557, subdivision 12b.

(e) Data classified as private, confidential, nonpublic, or protected nonpublic under this subdivision become public data if submitted to a court or administrative law judge as part of a disciplinary proceeding in which there is a public hearing concerning a license which has been suspended, immediately suspended, revoked, or denied.

(f) Data generated in the course of licensing investigations that relate to an alleged violation of law are investigative data under subdivision 3.

(g) Data that are not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report as defined in section 626.556, subdivision 2, or 626.5572, subdivision 18, are subject to the destruction provisions of sections 626.556, subdivision 11c, and 626.557, subdivision 12b.

(h) Upon request, not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report of substantiated maltreatment as defined in section 626.556 or 626.557 may be exchanged with the Department of Health for purposes of completing background studies pursuant to section 144.057 and with the Department of Corrections for purposes of completing background studies pursuant to section 241.021.

(i) Data on individuals collected according to licensing activities under chapters 245A and 245C, data on individuals collected by the commissioner of human services according to investigations under chapters 245A, 245B, and 245C, and sections 626.556 and 626.557 may be shared with the Department of Human Rights, the Department of Health, the Department of Corrections, the ombudsman for mental health and developmental disabilities, and the individual's professional regulatory board when there

is reason to believe that laws or standards under the jurisdiction of those agencies may have been violated or the information may otherwise be relevant to the board's regulatory jurisdiction. Background study data on an individual who is the subject of a background study under chapter 245C for a licensed service for which the commissioner of human services is the license holder may be shared with the commissioner and the commissioner's delegate by the licensing division. Unless otherwise specified in this chapter, the identity of a reporter of alleged maltreatment or licensing violations may not be disclosed.

(j) In addition to the notice of determinations required under section 626.556, subdivision 10f, if the commissioner or the local social services agency has determined that an individual is a substantiated perpetrator of maltreatment of a child based on sexual abuse, as defined in section 626.556, subdivision 2, and the commissioner or local social services agency knows that the individual is a person responsible for a child's care in another facility, the commissioner or local social services agency shall notify the head of that facility of this determination. The notification must include an explanation of the individual's available appeal rights and the status of any appeal. If a notice is given under this paragraph, the government entity making the notification shall provide a copy of the notice to the individual who is the subject of the notice.

(k) All not public data collected, maintained, used, or disseminated under this subdivision and subdivision 3 may be exchanged between the Department of Human Services, Licensing Division, and the Department of Corrections for purposes of regulating services for which the Department of Human Services and the Department of Corrections have regulatory authority.

Sec. 2. Minnesota Statutes 2013 Supplement, section 245A.03, subdivision 7, is amended to read:

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

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

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

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

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

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

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

(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 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. 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 ~~under the following circumstances:~~

~~(1) until August 1, 2013, the license holder's beds occupied by residents whose primary diagnosis is mental illness and the license holder is:~~

~~(i) a provider of assertive community treatment (ACT) or adult rehabilitative mental health services (ARMHS) as defined in section 256B.0623;~~

~~(ii) a mental health center certified under Minnesota Rules, parts 9520.0750 to 9520.0870;~~

~~(iii) a mental health clinic certified under Minnesota Rules, parts 9520.0750 to 9520.0870; or~~

~~(iv) a provider of intensive residential treatment services (IRTS) licensed under Minnesota Rules, parts 9520.0500 to 9520.0670; or~~

~~(2)~~ 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 under paragraph (c) will be implemented. The commissioner shall consult with the stakeholders described in section 144A.351, and employ a variety of methods to improve the state's capacity to meet long-term care service needs within budgetary limits, including seeking proposals from service providers or lead agencies to change service type, capacity, or location to improve services, increase the independence of residents, and better meet needs identified by the long-term care services reports and statewide data and information. By February 1, 2013, and August 1, 2014, and each following year, the commissioner shall provide information and data on the overall capacity of licensed long-term care services, actions taken under this subdivision to manage statewide long-term care services and supports resources, and any recommendations for change to the legislative committees with jurisdiction over health and human services budget.

(f) At the time of application and reapplication for licensure, the applicant and the license holder that are subject to the moratorium or an exclusion established in paragraph (a) are required to inform the commissioner whether the physical location where the foster

care will be provided is or will be the primary residence of the license holder for the entire period of licensure. If the primary residence of the applicant or license holder changes, the applicant or license holder must notify the commissioner immediately. The commissioner shall print on the foster care license certificate whether or not the physical location is the primary residence of the license holder.

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

Sec. 3. Minnesota Statutes 2013 Supplement, section 245A.40, subdivision 5, is amended to read:

Subd. 5. **Sudden unexpected infant death and abusive head trauma training.** (a) License holders must document that before staff persons and volunteers care for infants, they are instructed on the standards in section 245A.1435 and receive training on reducing the risk of sudden unexpected infant death. In addition, license holders must document that before staff persons care for infants or children under school age, they receive training on the risk of abusive head trauma from shaking infants and young children. The training in this subdivision may be provided as orientation training under subdivision 1 and in-service training under subdivision 7.

(b) Sudden unexpected infant death reduction training required under this subdivision must be at least one-half hour in length and must be completed at least once every year. At a minimum, the training must address the risk factors related to sudden unexpected infant death, means of reducing the risk of sudden unexpected infant death in child care, and license holder communication with parents regarding reducing the risk of sudden unexpected infant death.

(c) Abusive head trauma training under this subdivision must be at least one-half hour in length and must be completed at least once every year. At a minimum, the training must address the risk factors related to shaking infants and young children, means to reduce the risk of abusive head trauma in child care, and license holder communication with parents regarding reducing the risk of abusive head trauma.

~~(d) The commissioner shall make available for viewing a video presentation on the dangers associated with shaking infants and young children. The video presentation must be part of the orientation and annual in-service training of licensed child care center~~

~~staff persons caring for children under school age. The commissioner shall provide to child care providers and interested individuals, at cost, copies of a video approved by the commissioner of health under section 144.574 on the dangers associated with shaking infants and young children.~~

Sec. 4. Minnesota Statutes 2012, section 245A.40, subdivision 8, is amended to read:

Subd. 8. **Cultural dynamics and disabilities training for child care providers.** (a) The training required of licensed child care center staff must include training in the cultural dynamics of early childhood development and child care. The cultural dynamics and disabilities training and skills development of child care providers must be designed to achieve outcomes for providers of child care that include, but are not limited to:

(1) an understanding and support of the importance of culture and differences in ability in children's identity development;

(2) understanding the importance of awareness of cultural differences and similarities in working with children and their families;

(3) understanding and support of the needs of families and children with differences in ability;

(4) developing skills to help children develop unbiased attitudes about cultural differences and differences in ability;

(5) developing skills in culturally appropriate caregiving; and

(6) developing skills in appropriate caregiving for children of different abilities.

~~(b) Curriculum for cultural dynamics and disability training shall be approved by the commissioner.~~

~~(c) The commissioner shall amend current rules relating to the training of the licensed child care center staff to require cultural dynamics training. Timelines established in the rule amendments for complying with the cultural dynamics training requirements must be based on the commissioner's determination that curriculum materials and trainers are available statewide.~~

~~(d)~~ (b) For programs caring for children with special needs, the license holder shall ensure that any additional staff training required by the child's individual child care program plan required under Minnesota Rules, part 9503.0065, subpart 3, is provided.

Sec. 5. Minnesota Statutes 2013 Supplement, section 245A.50, subdivision 3, is amended to read:

Subd. 3. **First aid.** (a) When children are present in a family child care home governed by Minnesota Rules, parts 9502.0315 to 9502.0445, at least one staff person

must be present in the home who has been trained in first aid. The first aid training must have been provided by an individual approved to provide first aid instruction. First aid training may be less than eight hours and persons qualified to provide first aid training include individuals approved as first aid instructors. First aid training must be repeated every two years.

(b) A family child care provider is exempt from the first aid training requirements under this subdivision related to any substitute caregiver who provides less than 30 hours of care during any 12-month period.

~~(c) Video training reviewed and approved by the county licensing agency satisfies the training requirement of this subdivision.~~

Sec. 6. Minnesota Statutes 2012, section 245C.04, subdivision 1, is amended to read:

Subdivision 1. **Licensed programs.** (a) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 1, at least upon application for initial license for all license types.

(b) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 1, at reapplication for a license for family child care.

(c) The commissioner is not required to conduct a study of an individual at the time of reapplication for a license if the individual's background study was completed by the commissioner of human services ~~for an adult foster care license holder that is also:~~ and

~~(1) registered under chapter 144D; or~~

~~(2) licensed to provide home and community-based services to people with disabilities at the foster care location and the license holder does not reside in the foster care residence; and~~

~~(3)~~ the following conditions are met:

~~(i)~~ (1) a study of the individual was conducted either at the time of initial licensure or when the individual became affiliated with the license holder;

~~(ii)~~ (2) the individual has been continuously affiliated with the license holder since the last study was conducted; and

~~(iii)~~ (3) the last study of the individual was conducted on or after October 1, 1995.

~~(d) From July 1, 2007, to June 30, 2009, the commissioner of human services shall conduct a study of an individual required to be studied under section 245C.03, at the time of reapplication for a child foster care license. The county or private agency shall collect and forward to the commissioner the information required under section 245C.05, subdivisions 1, paragraphs (a) and (b), and 5, paragraphs (a) and (b). The background~~

~~study conducted by the commissioner of human services under this paragraph must include a review of the information required under section 245C.08, subdivisions 1, paragraph (a), clauses (1) to (5), 3, and 4.~~

~~(e)~~ (d) The commissioner of human services shall conduct a background study of an individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly affiliated with a child foster care license holder. The county or private agency shall collect and forward to the commissioner the information required under section 245C.05, subdivisions 1 and 5. The background study conducted by the commissioner of human services under this paragraph must include a review of the information required under section 245C.08, subdivisions 1, 3, and 4.

~~(f) From January 1, 2010, to December 31, 2012, unless otherwise specified in paragraph (e), the commissioner shall conduct a study of an individual required to be studied under section 245C.03 at the time of reapplication for an adult foster care or family adult day services license: (1) the county shall collect and forward to the commissioner the information required under section 245C.05, subdivision 1, paragraphs (a) and (b), and subdivision 5, paragraphs (a) and (b), for background studies conducted by the commissioner for all family adult day services and for adult foster care when the adult foster care license holder resides in the adult foster care or family adult day services residence; (2) the license holder shall collect and forward to the commissioner the information required under section 245C.05, subdivisions 1, paragraphs (a) and (b); and 5, paragraphs (a) and (b), for background studies conducted by the commissioner for adult foster care when the license holder does not reside in the adult foster care residence; and (3) the background study conducted by the commissioner under this paragraph must include a review of the information required under section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5), and subdivisions 3 and 4.~~

~~(g)~~ (e) The commissioner shall conduct a background study of an individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly affiliated with an adult foster care or family adult day services license holder: (1) the county shall collect and forward to the commissioner the information required under section 245C.05, subdivision 1, paragraphs (a) and (b), and subdivision 5, paragraphs (a) and (b), for background studies conducted by the commissioner for all family adult day services and for adult foster care when the adult foster care license holder resides in the adult foster care residence; (2) the license holder shall collect and forward to the commissioner the information required under section 245C.05, subdivisions 1, paragraphs (a) and (b); and 5, paragraphs (a) and (b), for background studies conducted by the commissioner for adult foster care when the license holder does not reside in the adult

foster care residence; and (3) the background study conducted by the commissioner under this paragraph must include a review of the information required under section 245C.08, subdivision 1, paragraph (a), and subdivisions 3 and 4.

~~(h)~~ (f) Applicants for licensure, license holders, and other entities as provided in this chapter must submit completed background study forms to the commissioner before individuals specified in section 245C.03, subdivision 1, begin positions allowing direct contact in any licensed program.

~~(i)~~ (g) A license holder must initiate a new background study through the commissioner's online background study system when:

(1) an individual returns to a position requiring a background study following an absence of 90 or more consecutive days; or

(2) a program that discontinued providing licensed direct contact services for 90 or more consecutive days begins to provide direct contact licensed services again.

The license holder shall maintain a copy of the notification provided to the commissioner under this paragraph in the program's files. If the individual's disqualification was previously set aside for the license holder's program and the new background study results in no new information that indicates the individual may pose a risk of harm to persons receiving services from the license holder, the previous set-aside shall remain in effect.

~~(j)~~ (h) For purposes of this section, a physician licensed under chapter 147 is considered to be continuously affiliated upon the license holder's receipt from the commissioner of health or human services of the physician's background study results.

~~(k)~~ (i) For purposes of family child care, a substitute caregiver must receive repeat background studies at the time of each license renewal.

Sec. 7. Minnesota Statutes 2012, section 245C.05, subdivision 5, is amended to read:

Subd. 5. **Fingerprints.** (a) Except as provided in paragraph (c), for any background study completed under this chapter, when the commissioner has reasonable cause to believe that further pertinent information may exist on the subject of the background study, the subject shall provide the commissioner with a set of classifiable fingerprints obtained from an authorized agency.

(b) For purposes of requiring fingerprints, the commissioner has reasonable cause when, but not limited to, the:

(1) information from the Bureau of Criminal Apprehension indicates that the subject is a multistate offender;

(2) information from the Bureau of Criminal Apprehension indicates that multistate offender status is undetermined; or

(3) commissioner has received a report from the subject or a third party indicating that the subject has a criminal history in a jurisdiction other than Minnesota.

(c) ~~Except as specified under section 245C.04, subdivision 1, paragraph (d),~~ For background studies conducted by the commissioner for child foster care or adoptions, the subject of the background study, who is 18 years of age or older, shall provide the commissioner with a set of classifiable fingerprints obtained from an authorized agency.

Sec. 8. Minnesota Statutes 2012, section 626.556, subdivision 3c, is amended to read:

Subd. 3c. **Local welfare agency, Department of Human Services or Department of Health responsible for assessing or investigating reports of maltreatment.** (a) The county local welfare agency is the agency responsible for assessing or investigating allegations of maltreatment in child foster care, family child care, legally unlicensed child care, juvenile correctional facilities licensed under section 241.021 located in the local welfare agency's county, and reports involving children served by an unlicensed personal care provider organization under section 256B.0659. Copies of findings related to personal care provider organizations under section 256B.0659 must be forwarded to the Department of Human Services provider enrollment.

(b) The Department of Human Services is the agency responsible for assessing or investigating allegations of maltreatment in facilities licensed under chapters 245A and 245B, except for child foster care and family child care.

(c) The Department of Health is the agency responsible for assessing or investigating allegations of child maltreatment in facilities licensed under sections 144.50 to 144.58 and 144A.46.

~~(d) The commissioners of human services, public safety, and education must jointly submit a written report by January 15, 2007, to the education policy and finance committees of the legislature recommending the most efficient and effective allocation of agency responsibility for assessing or investigating reports of maltreatment and must specifically address allegations of maltreatment that currently are not the responsibility of a designated agency.~~

Sec. 9. **REVISOR'S INSTRUCTION.**

The revisor of statutes shall make necessary technical cross-reference changes in Minnesota Statutes and Minnesota Rules to conform with the sections and parts repealed in articles 1 to 5.

Sec. 10. **REPEALER.**

Minnesota Statutes 2012, sections 245A.02, subdivision 7b; 245A.09, subdivision 12; 245A.11, subdivision 5; and 245A.655, are repealed.

APPENDIX
Article locations in 14-3603

**4.47 REPORT ON COMPULSIVE GAMBLING.**

The governor shall report to the legislature by February 1 of each odd-numbered year on the state's progress in addressing the problem of compulsive gambling. The report must include:

(1) a summary of available data describing the extent of the problem in Minnesota;

(2) a summary of programs, both governmental and private, that

(i) provide diagnosis and treatment for compulsive gambling;

(ii) enhance public awareness of the problem and the availability of compulsive gambling services;

(iii) are designed to prevent compulsive gambling and other problem gambling by elementary and secondary school students and vulnerable adults; and

(iv) offer professional training in the identification, referral, and treatment of compulsive gamblers;

(3) the likely impact on compulsive gambling of each form of gambling; and

(4) budget recommendations for state-level compulsive gambling programs and activities.

**119A.04 TRANSFERS FROM OTHER AGENCIES.**

Subdivision 1. **Department of Education.** The powers and duties of the Department of Education with respect to the following programs are transferred to the Department of Human Services under section 15.039. The programs needing federal approval to transfer shall be transferred when the federal government grants transfer authority to the commissioner:

(1) children's trust fund under sections 256E.20 to 256E.27;

(2) the family services and community-based collaboratives under section 124D.23;

(3) the child care programs under sections 119B.011 to 119B.16;

(4) the migrant child care program under section 256.01;

(5) the child care resource and referral program under section 119B.19; and

(6) the child care service development program under sections 119B.189 to 119B.24.

**119B.035 AT-HOME INFANT CHILD CARE PROGRAM.**

Subdivision 1. **Establishment.** A family in which a parent provides care for the family's infant child may receive a subsidy in lieu of assistance if the family is eligible for or is receiving assistance under the basic sliding fee program. An eligible family must meet the eligibility factors under section 119B.09, except as provided in subdivision 4, and the requirements of this section. Subject to federal match and maintenance of effort requirements for the child care and development fund, and up to available appropriations, the commissioner shall provide assistance under the at-home infant child care program and for administrative costs associated with the program. At the end of a fiscal year, the commissioner may carry forward any unspent funds under this section to the next fiscal year within the same biennium for assistance under the basic sliding fee program.

Subd. 2. **Eligible families.** A family with an infant under the age of one year is eligible for assistance if:

(1) the family is not receiving MFIP, other cash assistance, or other child care assistance;

(2) the family has not previously received a lifelong total of 12 months of assistance under this section; and

(3) the family is participating in the basic sliding fee program or provides verification of participating in an authorized activity at the time of application and meets the program requirements.

Subd. 3. **Eligible parent.** A family is eligible for assistance under this section if one parent cares for the family's infant child. The eligible parent must:

(1) be over the age of 18;

(2) care for the infant full time in the infant's home; and

(3) care for any other children in the family who are eligible for child care assistance under this chapter.

For purposes of this section, "parent" means birth parent, adoptive parent, or stepparent.

Subd. 4. **Assistance.** (a) A family is limited to a lifetime total of 12 months of assistance under subdivision 2. The maximum rate of assistance is equal to 68 percent of the rate established under section 119B.13 for care of infants in licensed family child care in the applicant's county of residence.

(b) A participating family must report income and other family changes as specified in the county's plan under section 119B.08, subdivision 3.

(c) Persons who are admitted to the at-home infant child care program retain their position in any basic sliding fee program. Persons leaving the at-home infant child care program reenter the basic sliding fee program at the position they would have occupied.

(d) Assistance under this section does not establish an employer-employee relationship between any member of the assisted family and the county or state.

Subd. 5. **Implementation.** The commissioner shall implement the at-home infant child care program under this section through counties that administer the basic sliding fee program under section 119B.03. The commissioner must develop and distribute consumer information on the at-home infant child care program to assist parents of infants or expectant parents in making informed child care decisions.

**119B.09 FINANCIAL ELIGIBILITY.**

Subd. 2. **Sliding fee.** Child care services to families must be made available on a sliding fee basis.

**119B.23 OTHER AUTHORIZATION TO MAKE GRANTS.**

Subdivision 1. **Authority.** The county board is authorized to provide child care services or to make grants from the community social service fund, special tax revenue, or its general fund, or other sources to any municipality, or corporation for the cost of providing technical assistance or child care services. The county board is also authorized to contract for services with any licensed child care facility to carry out the purposes of this section.

The county board may also make grants to or contract with any municipality, licensed child care facility, organization designated under section 119B.19, subdivision 1a, or corporation for the following purposes:

(1) creating new licensed child care facilities and expanding existing facilities including, but not limited to, supplies, equipment, and facility renovation and remodeling;

(2) improving licensed child care facility programs, including, but not limited to, staff specialists, staff training, supplies, equipment, and facility renovation and remodeling, with priority for training grants for child care workers caring for infants, toddlers, sick children, children in low-income families, and children with special needs;

(3) providing supportive child development services, including, but not limited to, in-service training, curriculum development, consulting specialists, resource centers, and program and resource materials;

(4) carrying out programs, including, but not limited to, staff, supplies, equipment, facility renovation, and training;

(5) providing interim financing; or

(6) carrying out the resource and referral program services identified in section 119B.19, subdivision 7.

Subd. 2. **Donated materials and services; matching share of cost.** For the purposes of this section, donated professional and volunteer services, program materials, equipment, supplies, and facilities may be approved as part of a matching share of the cost, provided that total costs shall be reduced by the costs charged to parents if a sliding fee scale has been used.

Subd. 3. **Biennial plan.** The county board shall biennially develop a plan for the distribution of money for child care services as part of the child care fund plan under section 119B.08. All licensed child care programs shall be given written notice concerning the availability of money and the application process.

**119B.231 SCHOOL READINESS SERVICE AGREEMENTS.**

Subdivision 1. **Overview.** (a) Effective July 1, 2007, funds must be made available to allow the commissioner to pay higher rates to up to 50 child care providers who are deemed by the commissioner to meet the requirements of a school readiness service agreement (SRSA) provider and perform services that support school readiness for children and economic stability for parents.

(b) A provider may be paid a rate above that currently allowed under section 119B.13 if:

(1) the provider has entered into an SRSA with the commissioner;

(2) a family using that provider receives child care assistance under any provision in chapter 119B except section 119B.035;

(3) the family using that provider meets the criteria in this section; and

(4) funding is available under this section.

Subd. 2. **Provider eligibility.** (a) To be considered for an SRSA, a provider shall apply to the commissioner or have been chosen as an SRSA provider prior to June 30, 2009, and have

complied with all requirements of the SRSA agreement. Priority for funds is given to providers who had agreements prior to June 30, 2009. If sufficient funds are available, the commissioner shall make applications available to additional providers. To be eligible to apply for an SRSA, a provider shall:

(1) be eligible for child care assistance payments under chapter 119B;

(2) have at least 25 percent of the children enrolled with the provider subsidized through the child care assistance program;

(3) provide full-time, full-year child care services; and

(4) have obtained a level 3 or 4 star rating under the voluntary Parent Aware quality rating system.

(b) The commissioner may waive the 25 percent requirement in paragraph (a), clause (2), if necessary to achieve geographic distribution of SRSA providers and diversity of types of care provided by SRSA providers.

(c) An eligible provider who would like to enter into an SRSA with the commissioner shall submit an SRSA application. To determine whether to enter into an SRSA with a provider, the commissioner shall evaluate the following factors:

(1) the provider's Parent Aware rating score;

(2) the provider's current or planned social service and employment linkages;

(3) the geographic distribution needed for SRSA providers;

(4) the inclusion of a variety of child care delivery models; and

(5) other related factors determined by the commissioner.

Subd. 3. **Family and child eligibility.** (a) A family eligible to choose an SRSA provider for their children shall:

(1) be eligible to receive child care assistance under any provision in chapter 119B except section 119B.035;

(2) be in an authorized activity for an average of at least 35 hours per week when initial eligibility is determined; and

(3) include a child who has not yet entered kindergarten.

(b) A family who is determined to be eligible to choose an SRSA provider remains eligible to be paid at a higher rate through the SRSA provider when the following conditions exist:

(1) the child attends child care with the SRSA provider a minimum of 25 hours per week, on average;

(2) the family has a child who has not yet entered kindergarten; and

(3) the family maintains eligibility under chapter 119B except section 119B.035.

(c) After initial eligibility has been determined, a decrease in the family's authorized activities to an average of less than 35 hours per week does not result in ineligibility for the SRSA rate. A family must continue to maintain eligibility under this chapter and be in an authorized activity.

(d) A family that moves between counties but continues to use the same SRSA provider shall continue to receive SRSA funding for the increased payments.

Subd. 4. **Requirements of providers.** An SRSA must include assessment, evaluation, and reporting requirements that promote the goals of improved school readiness and movement toward appropriate child development milestones. A provider who enters into an SRSA shall comply with all SRSA requirements, including the assessment, evaluation, and reporting requirements in the SRSA. Providers who have been selected previously for SRSAs must begin the process to obtain a rating using Parent Aware according to timelines established by the commissioner. If the initial Parent Aware rating is less than three stars, the provider must submit a plan to improve the rating. If a 3 or 4 star rating is not obtained within established timelines, the commissioner may consider continuation of the agreement, depending upon the progress made and other factors. Providers who apply and are selected for a new SRSA agreement on or after July 1, 2009, must have a level 3 or 4 star rating under the voluntary Parent Aware quality rating system at the time the SRSA agreement is signed.

Subd. 5. **Relationship to current law.** (a) The following provisions in chapter 119B must be waived or modified for families receiving services under this section.

(b) Notwithstanding section 119B.13, subdivisions 1 and 1a, maximum weekly rates under this section are 125 percent of the existing maximum weekly rate for like-care. Providers eligible for a differential rate under section 119B.13, subdivision 3a, remain eligible for the differential above the rate identified in this section. Only care for children who have not yet entered kindergarten may be paid at the maximum rate under this section. The provider's charge for service provided through an SRSA may not exceed the rate that the provider charges a private-pay family for like-care arrangements.

(c) A family or child care provider may not be assessed an overpayment for care provided through an SRSA unless:

(1) there was an error in the amount of care authorized for the family; or

(2) the family or provider did not timely report a change as required under the law.

(d) Care provided through an SRSA is authorized on a weekly basis.

(e) Funds appropriated under this section to serve families eligible under section 119B.03 are not allocated through the basic sliding fee formula under section 119B.03. Funds appropriated under this section are used to offset increased costs when payments are made under SRSA's.

(f) Notwithstanding section 119B.09, subdivision 6, the maximum amount of child care assistance that may be authorized for a child receiving care through an SRSA in a two-week period is 160 hours per child.

(g) Effective May 23, 2008, absent day payment limits under section 119B.13, subdivision 7, do not apply to children for care paid through SRSA's provided the family remains eligible under subdivision 3.

Subd. 6. **Establishment of service agreements.** (a) The commissioner shall approve SRSA's for up to 50 providers that represent diverse parts of the state and a variety of child care delivery models. Entering into a service agreement does not guarantee that a provider will receive payment at a higher rate for families receiving child care assistance. A family eligible under this section shall choose a provider participating in an SRSA in order for a higher rate to be paid. Payments through SRSA's are also limited by the availability of SRSA funds.

(b) Nothing in this section shall be construed to limit parent choice as defined in section 119B.09, subdivision 5.

(c) The commissioner may allow for startup time for some providers if failing to do so would limit geographic diversity of SRSA providers or a variety of child care delivery models.

**119B.232 FAMILY, FRIEND, AND NEIGHBOR GRANT PROGRAM.**

Subdivision 1. **Establishment.** A family, friend, and neighbor (FFN) grant program is established to promote children's early literacy, healthy development, and school readiness, and to foster community partnerships to promote children's school readiness. The commissioner shall attempt to ensure that grants are made in all areas of the state. The commissioner of human services shall make grants available to fund: community-based organizations, nonprofit organizations, and Indian tribes working with FFN caregivers under subdivision 2, paragraph (a); and community-based partnerships to implement early literacy programs under subdivision 2, paragraph (b).

Subd. 2. **Program components.** (a)(1) Grants that the commissioner awards under this section must be used by community-based organizations, nonprofit organizations, and Indian tribes working with FFN caregivers in local communities, cultural communities, and Indian tribes to:

(i) provide training, support, and resources to FFN caregivers in order to improve and promote children's health, safety, nutrition, and school readiness;

(ii) connect FFN caregivers and children's families with appropriate community resources that support the families' health, mental health, economic, and developmental needs;

(iii) connect FFN caregivers and children's families to early childhood screening programs and facilitate referrals where appropriate;

(iv) provide FFN caregivers and children's families with information about early learning guidelines from the Departments of Human Services and Education;

(v) provide FFN caregivers and children's families with information about becoming a licensed family child care provider; and

(vi) provide FFN caregivers and children's families with information about early learning allowances and enrollment opportunities in high quality community-based child-care and preschool programs.

(2) Grants that the commissioner awards under this paragraph also may be used for:

(i) health and safety and early learning kits for FFN caregivers;

(ii) play-and-learn groups with FFN caregivers;

(iii) culturally appropriate early childhood training for FFN caregivers;

(iv) transportation for FFN caregivers and children's families to school readiness and other early childhood training activities;

(v) other activities that promote school readiness;

(vi) data collection and evaluation;

(vii) staff outreach and outreach activities;

(viii) translation needs; or

(ix) administrative costs that equal up to 12 percent of the recipient's grant award.

(b) Grants that the commissioner awards under this section also must be used to fund partnerships among Minnesota public and regional library systems, community-based organizations, nonprofit organizations, and Indian tribes to implement early literacy programs in low-income communities, including tribal communities, to:

(1) purchase and equip early childhood read-mobiles that provide FFN caregivers and children's families with books, training, and early literacy activities;

(2) provide FFN caregivers and children's families with translations of early childhood books, training, and early literacy activities in native languages; or

(3) provide FFN caregivers and children's families with early literacy activities in local libraries.

Subd. 3. **Grant awards.** Interested entities eligible to receive a grant under this section may apply to the commissioner in the form and manner the commissioner determines. The commissioner shall awards grants to eligible entities consistent with the requirements of this section.

Subd. 4. **Evaluation.** The commissioner, in consultation with early childhood care and education experts at the University of Minnesota, must evaluate the impact of the grants under subdivision 2 on children's school readiness and submit a written report to the human services and education finance and policy committees of the legislature by February 15, 2010.

**245.0311 TRANSFER OF PERSONNEL.**

(a) Notwithstanding any other law to the contrary, the commissioner of human services shall transfer authorized positions between institutions under the commissioner's control in order to properly staff the institutions, taking into account the differences between programs in each institution.

(b) Notwithstanding any other law to the contrary, the commissioner of corrections may transfer authorized positions between institutions under the commissioner's control in order to more properly staff the institutions.

**245.0312 DESIGNATING SPECIAL CARE UNITS.**

Notwithstanding any provision of law to the contrary, during the biennium, the commissioner of human services, upon the approval of the governor after consulting with the Legislative Advisory Commission, may designate portions of state-operated services facilities under the commissioner's control as special care units.

**245.072 DIVISION FOR PERSONS WITH DEVELOPMENTAL DISABILITIES.**

A Division for Persons with Developmental Disabilities is created in the Department of Human Services which shall coordinate those laws administered and enforced by the commissioner of human services relating to developmental disabilities, as defined in section 252.27, subdivision 1a, which the commissioner may assign to the division. The Division for Persons with Developmental Disabilities shall be under the supervision of a director whose responsibility it shall be to maximize the availability of federal or private money for programs to assist persons with developmental disabilities. The commissioner shall appoint the director who shall serve in the classified service of the state civil service. The commissioner may employ additional personnel with such qualifications and in such numbers as are reasonable and are necessary to carry out the provisions of this section.

**245.4861 PUBLIC/ACADEMIC LIAISON INITIATIVE.**

Subdivision 1. **Establishment of liaison initiative.** The commissioner of human services, in consultation with the appropriate postsecondary institutions, shall establish a public/academic liaison initiative to coordinate and develop brain research and education and training opportunities for mental health professionals in order to improve the quality of staffing and provide state-of-the-art services to residents in regional treatment centers and other state facilities.

Subd. 2. **Consultation.** The commissioner of human services shall consult with the Minnesota Department of Health, the regional treatment centers, the postsecondary educational system, mental health professionals, and citizen and advisory groups.

Subd. 3. **Liaison initiative programs.** The liaison initiative, within the extent of available funding, shall plan, implement, and administer programs which accomplish the objectives of subdivision 1. These shall include but are not limited to:

(1) encourage and coordinate joint research efforts between academic research institutions throughout the state and regional treatment centers, community mental health centers, and other organizations conducting research on mental illness or working with individuals who are mentally ill;

(2) sponsor and conduct basic research on mental illness and applied research on existing treatment models and community support programs;

(3) seek to obtain grants for research on mental illness from the National Institute of Mental Health and other funding sources;

(4) develop and provide grants for training, internship, scholarship, and fellowship programs for mental health professionals, in an effort to combine academic education with practical experience obtained at regional treatment centers and other state facilities, and to increase the number of mental health professionals working in the state.

Subd. 4. **Private and federal funding.** The liaison initiative shall seek private and federal funds to supplement the appropriation provided by the state. Individuals, businesses, and other organizations may contribute to the liaison initiative. All money received shall be administered by the commissioner of human services to implement and administer the programs listed in subdivision 3.

Subd. 5. **Report.** By February 15 of each year, the commissioner of human services shall submit to the legislature a liaison initiative report. The annual report shall be part of the commissioner's February 15 report to the legislature required by section 245.487, subdivision 4.

**245.487 CITATION; DECLARATION OF POLICY; MISSION.**

Subd. 4. **Implementation.** (a) The commissioner shall begin implementing sections 245.487 to 245.4889 by February 15, 1990, and shall fully implement sections 245.487 to 245.4889 by July 1, 1993.

(b) Annually until February 15, 1994, the commissioner shall report to the legislature on all steps taken and recommendations for full implementation of sections 245.487 to 245.4889 and on additional resources needed to further implement those sections. The report shall include information on county and state progress in identifying the needs of cultural and racial minorities and in using special mental health consultants to meet these needs.

Subd. 5. **Continuation of existing mental health services for children.** Counties shall make available case management, community support services, and day treatment to children eligible to receive these services under sections 245.4881 and 245.4884. No later than August 1, 1989, the county board shall notify providers in the local system of care of their obligations to refer children eligible for case management and community support services as of January 1, 1989. The county board shall forward a copy of this notice to the commissioner. The notice shall indicate which children are eligible, a description of the services, and the name of the county employee designated to coordinate case management activities and shall include a copy of the plain language notification described in section 245.4881, subdivision 2, paragraph (b). Providers shall distribute copies of this notification when making a referral for case management.

**245.4871 DEFINITIONS.**

Subd. 7. **Clinical supervision.** "Clinical supervision" means the oversight responsibility for individual treatment plans and individual mental health service delivery, including that provided by the case manager. Clinical supervision does not include authority to make or terminate court-ordered placements of the child. Clinical supervision must be accomplished by full-time or part-time employment of or contracts with mental health professionals. The mental health professional must document the clinical supervision by cosigning individual treatment plans and by making entries in the client's record on supervisory activities.

Subd. 11. **Diagnostic assessment.** "Diagnostic assessment" means a written evaluation by a mental health professional of:

(1) a child's current life situation and sources of stress, including reasons for referral;

(2) the history of the child's current mental health problem or problems, including important developmental incidents, strengths, and vulnerabilities;

(3) the child's current functioning and symptoms;

(4) the child's diagnosis including a determination of whether the child meets the criteria of severely emotionally disturbed as specified in subdivision 6; and

(5) the mental health services needed by the child.

Subd. 18. **Functional assessment.** "Functional assessment" means an assessment by the case manager of the child's:

(1) mental health symptoms as presented in the child's diagnostic assessment;
(2) mental health needs as presented in the child's diagnostic assessment;
(3) use of drugs and alcohol;
(4) vocational and educational functioning;
(5) social functioning, including the use of leisure time;
(6) interpersonal functioning, including relationships with the child's family;
(7) self-care and independent living capacity;
(8) medical and dental health;
(9) financial assistance needs;
(10) housing and transportation needs; and
(11) other needs and problems.

Subd. 25. **Mental health funds.** "Mental health funds" are funds expended under sections 245.73 and 256E.12, federal mental health block grant funds, and funds expended under section 256D.06 to facilities licensed under Minnesota Rules, parts 9520.0500 to 9520.0690.

**245.4872 PLANNING FOR A CHILDREN'S MENTAL HEALTH SYSTEM.**

Subdivision 1. **Planning effort.** Starting on the effective date of sections 245.487 to 245.4889 and ending January 1, 1992, the commissioner and the county agencies shall plan for the development of a unified, accountable, and comprehensive statewide children's mental health system. The system must be planned and developed by stages until it is operating at full capacity.

Subd. 2. **Technical assistance.** The commissioner shall provide ongoing technical assistance to county boards to improve system capacity and quality. The commissioner and county boards shall exchange information as needed about the numbers of children with emotional disturbances residing in the county and the extent of existing treatment components locally available to serve the needs of those persons. County boards shall cooperate with the commissioner in obtaining necessary planning information upon request.

Subd. 3. **Information to counties.** By January 1, 1990, the commissioner shall provide each county with information about the predictors and symptoms of children's emotional disturbances and information about groups identified as at risk of developing emotional disturbance.

**245.4873 COORDINATION OF CHILDREN'S MENTAL HEALTH SYSTEM.**

Subd. 3. **Local level coordination.** (a) Each agency represented in the local system of care coordinating council, including mental health, social services, education, health, corrections, and vocational services as specified in section 245.4875, subdivision 6, is responsible for local coordination and delivery of mental health services for children. The county board shall establish a coordinating council that provides at least:

(1) written interagency agreements with the providers of the local system of care to coordinate the delivery of services to children; and

(2) an annual report of the council to the local county board and the children's mental health advisory council about the unmet children's needs and service priorities.

(b) Each coordinating council shall collect information about the local system of care and report annually to the commissioner of human services on forms and in the manner provided by the commissioner. The report must include a description of the services provided through each of the service systems represented on the council, the various sources of funding for services and the amounts actually expended, a description of the numbers and characteristics of the children and families served during the previous year, and an estimate of unmet needs. Each service system represented on the council shall provide information to the council as necessary to compile the report.

Subd. 6. **Priorities.** By January 1, 1992, the commissioner shall require that each of the treatment services and management activities described in sections 245.487 to 245.4889 be developed for children with emotional disturbances within available resources based on the following ranked priorities. The commissioner shall reassign agency staff and use consultants as necessary to meet this deadline:

(1) the provision of locally available mental health emergency services;

(2) the provision of locally available mental health services to all children with severe emotional disturbance;

(3) the provision of mental health identification and intervention services to children who are at risk of needing or who need mental health services;

(4) the provision of specialized mental health services regionally available to meet the special needs of all children with severe emotional disturbance, and all children with emotional disturbances;

(5) the provision of locally available services to children with emotional disturbances; and

(6) the provision of education and preventive mental health services.

**245.4875 LOCAL SERVICE DELIVERY SYSTEM.**

Subd. 3. **Local contracts.** The county board shall review all proposed county agreements, grants, or other contracts related to children's mental health services from any local, state, or federal governmental sources. Contracts with service providers must:

(1) name the commissioner as a third-party beneficiary;

(2) identify monitoring and evaluation procedures not in violation of the Minnesota Government Data Practices Act, chapter 13, which are necessary to ensure effective delivery of quality services;

(3) include a provision that makes payments conditional on compliance by the contractor and all subcontractors with sections 245.487 to 245.4889 and all other applicable laws, rules, and standards; and

(4) require financial controls and auditing procedures.

Subd. 6. **Local system of care; coordinating council.** The county board shall establish, by January 1, 1990, a council representing all members of the local system of care including mental health services, social services, correctional services, education services, health services, and vocational services. The council shall include a representative of an Indian reservation authority where a reservation exists within the county. When possible, the council must also include a representative of juvenile court or the court responsible for juvenile issues and law enforcement. The members of the coordinating council shall meet at least quarterly to develop recommendations to improve coordination and funding of services to children with severe emotional disturbances. A county may use an existing child-focused interagency task force to fulfill the requirements of this subdivision if the representatives and duties of the existing task force are expanded to include those specified in this subdivision and section 245.4873, subdivision 3.

Subd. 7. **Other local authority.** The county board may establish procedures and policies that are not contrary to those of the commissioner or sections 245.487 to 245.4889 regarding local children's mental health services and facilities. The county board shall perform other acts necessary to carry out sections 245.487 to 245.4889.

**245.4883 ACUTE CARE HOSPITAL INPATIENT SERVICES.**

Subdivision 1. **Availability of acute care hospital inpatient services.** County boards must make available through contract or direct provision enough acute care hospital inpatient treatment services as close to the county as possible for children with severe emotional disturbances residing in the county needing this level of care. Acute care hospital inpatient treatment services must be designed to:

(1) stabilize the medical and mental health condition for which admission is required;

(2) improve functioning to the point where discharge to residential treatment or community-based mental health services is possible;

(3) facilitate appropriate referrals for follow-up mental health care in the community;

(4) work with families to improve the ability of the families to care for those children with severe emotional disturbances at home; and

(5) assist families and children in the transition from inpatient services to community-based services or home setting, and provide notification to the child's case manager, if any, so that the case manager can monitor the transition and make timely arrangements for the child's appropriate follow-up care in the community.

**245.490 REGIONAL TREATMENT CENTERS: MISSION STATEMENT.**

The legislature recognizes that regional treatment centers are an integral part of the continuum of care for people with mental illness. The commissioner of human services shall ensure that regional treatment centers:

(1) develop a policy that identifies persons who have a mental illness and are medically appropriate for admission to inpatient care;

(2) provide active treatment;

(3) provide mental health services in accordance with sections 245.461 to 245.486 for people with mental illness. The services must:

(i) enable and assist people to return to community care settings that promote and maintain community integration at the highest possible level of independent functioning; and

(ii) meet contemporary professional standards for staffing levels and for quality of program, staffing, and physical environment;

(4) maximize contact with the surrounding community to minimize isolation of patients and further the goal of community reintegration;

(5) protect patients' rights and their access to advocacy services;

(6) encourage appropriate voluntary admission of individuals seeking regional treatment center services; and

(7) are appropriately funded to implement the goals of this section.

The commissioner shall implement the goals and objectives of this section by June 30, 1993. By February 15, 1989, and annually after that until February 15, 1993, the commissioner shall report to the legislature all steps taken toward implementation. The reports shall include recommendations for full implementation of this section and a thorough analysis of any additional resources needed for implementation.

**245.492 DEFINITIONS.**

Subd. 6. **Operational target population.** "Operational target population" means a population of children that the local children's mental health collaborative agrees to serve and who fall within the criteria for the target population. The operational target population may be less than the target population.

Subd. 8. **Integrated fund task force.** The "integrated fund task force" means the statewide task force established in Laws 1991, chapter 292, article 6, section 57.

Subd. 13. **Local coordinating council.** "Local coordinating council" refers to the council established under section 245.4875, subdivision 6.

Subd. 19. **Start-up funds.** "Start-up funds" means the funds available to assist a local children's mental health collaborative in planning and implementing the integrated service system for children in the target population, in setting up a local integrated fund, and in developing procedures for enhancing federal financial participation.

**245.4932 REVENUE ENHANCEMENT; AUTHORITY AND RESPONSIBILITIES.**

Subd. 2. **Commissioner's responsibilities.** (1) Notwithstanding sections 256B.19, subdivision 1, and 256B.0625, the commissioner shall be required to amend the state medical assistance plan to include as covered services eligible for medical assistance reimbursement, those services eligible for reimbursement under federal law or waiver, which a collaborative elects to provide and for which the collaborative elects to pay the nonfederal share of the medical assistance costs.

(2) The commissioner may suspend, reduce, or terminate the federal reimbursement to a collaborative that does not meet the requirements of sections 245.493 to 245.495.

(3) The commissioner shall recover from the collaborative any federal fiscal disallowances or sanctions for audit exceptions directly attributable to the collaborative's actions or the proportional share if federal fiscal disallowances or sanctions are based on a statewide random sample.

Subd. 3. **Payments.** Payments under sections 245.493 to 245.495 to providers for services for which the collaborative elects to pay the nonfederal share of medical assistance shall only be made of federal earnings from services provided under sections 245.493 to 245.495.

Subd. 4. **Centralized disbursement of medical assistance payments.** Notwithstanding section 256B.041, and except for family community support services and therapeutic support of foster care, county payments for the cost of services for which the collaborative elects to pay the nonfederal share, for reimbursement under medical assistance, shall not be made to the commissioner of management and budget. For purposes of individualized rehabilitation services under sections 245.493 to 245.495, the centralized disbursement of payments to providers under section 256B.041 consists only of federal earnings from services provided under sections 245.493 to 245.495.

**245.4933 MEDICAL ASSISTANCE PROVIDER STATUS.**

Subdivision 1. **Requirements to become a prepaid medical provider.** (a) In order for a local children's mental health collaborative to become a prepaid provider of medical assistance services and be eligible to receive medical assistance reimbursement, the collaborative must:

(1) enter into a contract with the commissioner of human services to provide mental health services including inpatient, outpatient, medication management, services under the rehabilitation option, and related physician services;

(2) meet the applicable federal requirements;

(3) either carry stop-loss insurance or enter into a risk-sharing agreement with the commissioner of human services; and

(4) provide medically necessary medical assistance mental health services to children in the target population who enroll in the local children's mental health collaborative.

(b) Upon execution of the provider contract with the commissioner of human services the local children's mental health collaborative may:

(1) provide mental health services which are not medical assistance state plan services in addition to the state plan services described in the contract with the commissioner of human services; and

(2) enter into subcontracts which meet the requirements of Code of Federal Regulations, title 42, section 434.6, with other providers of mental health services including prepaid health plans established under section 256B.69.

Subd. 2. **Children enrolled in a prepaid health plan.** A children's mental health collaborative may serve children in the collaborative's target population who are enrolled in a prepaid health plan under contract with the commissioner of human services by contracting with one or more such health plans to provide medical assistance or MinnesotaCare mental health services to children enrolled in the health plan. The collaborative and the health plan shall work cooperatively to ensure the integration of physical and mental health services.

Subd. 3. **Children who become enrolled in a prepaid health plan.** A children's mental health collaborative may provide prepaid medical assistance or MinnesotaCare mental health services to children who are not enrolled in prepaid health plans until those children are enrolled. Publication of a request for proposals in the State Register shall serve as notice to the collaborative of the commissioner's intent to execute contracts for medical assistance and MinnesotaCare services. In order to become or continue to be a provider of medical assistance or MinnesotaCare services the collaborative may contract with one or more such prepaid health plans after the collaborative's target population is enrolled in a prepaid health plan. The collaborative and the health plan shall work cooperatively to ensure the integration of physical and mental health services.

Subd. 4. **Commissioner's duties.** (a) The commissioner of human services shall provide to each children's mental health collaborative that is considering whether to become a prepaid provider of mental health services the commissioner's best estimate of a capitated payment rate prior to an actuarial study based upon the collaborative's operational target population. The capitated payment rate shall be adjusted annually, if necessary, for changes in the operational target population.

(b) The commissioner shall negotiate risk adjustment and reinsurance mechanisms with children's mental health collaboratives that become medical assistance providers including those that subcontract with prepaid health plans.

Subd. 5. **Noncontracting collaboratives.** A local children's mental health collaborative that does not become a prepaid provider of medical assistance or MinnesotaCare services may provide services through individual members of a noncontracting collaborative who have a medical assistance provider agreement to eligible recipients who are not enrolled in the health plan.

Subd. 6. **Individualized rehabilitation services.** A children's mental health collaborative with an integrated service system approved by the Children's Cabinet may become a medical assistance provider for the purpose of obtaining prior authorization for and providing individualized rehabilitation services.

**245.494 STATE LEVEL COORDINATION.**

Subdivision 1. **Children's Cabinet.** The Children's Cabinet, in consultation with the Integrated Fund Task Force, shall:

(1) assist local children's mental health collaboratives in meeting the requirements of sections 245.491 to 245.495, by seeking consultation and technical assistance from national experts and coordinating presentations and assistance from these experts to local children's mental health collaboratives;

(2) assist local children's mental health collaboratives in identifying an economically viable operational target population;

(3) develop methods to reduce duplication and promote coordinated services including uniform forms for reporting, billing, and planning of services;

(4) by September 1, 1994, develop a model multiagency plan of care that can be used by local children's mental health collaboratives in place of an individualized education program, individual family community support plan, individual family support plan, and an individual treatment plan;

(5) assist in the implementation and operation of local children's mental health collaboratives by facilitating the integration of funds, coordination of services, and measurement of results, and by providing other assistance as needed;

(6) develop procedures and provide technical assistance to allow local children's mental health collaboratives to integrate resources for children's mental health services with other resources available to serve children in the target population in order to maximize federal participation and improve efficiency of funding;

(7) ensure that local children's mental health collaboratives and the services received through these collaboratives meet the requirements set out in sections 245.491 to 245.495;

(8) identify base level funding from state and federal sources across systems;

(9) explore ways to access additional federal funds and enhance revenues available to address the needs of the target population;

(10) develop a mechanism for identifying the state share of funding for services to children in the target population and for making these funds available on a per capita basis for services provided through the local children's mental health collaborative to children in the target population. Each year beginning January 1, 1994, forecast the growth in the state share and increase funding for local children's mental health collaboratives accordingly;

(11) identify barriers to integrated service systems that arise from data practices and make recommendations including legislative changes needed in the Data Practices Act to address these barriers; and

(12) annually review the expenditures of local children's mental health collaboratives to ensure that funding for services provided to the target population continues from sources other than the federal funds earned under sections 245.491 to 245.495 and that federal funds earned are spent consistent with sections 245.491 to 245.495.

Subd. 2. **Children's Cabinet report.** By February 1, 1996, the Children's Cabinet, under section 4.045, in consultation with a representative of the Minnesota District Judges Association Juvenile Committee, must submit a report to the legislature on the status of the local children's mental health collaboratives. The report must include the number of local children's mental health collaboratives, the amount and type of resources committed to local children's mental health collaboratives, the additional federal revenue received as a result of local children's mental health collaboratives, the services provided, the number of children served, outcome indicators, the identification of barriers to additional collaboratives and funding integration, and recommendations for further improving service coordination and funding integration.

Subd. 3. **Duties of the commissioner of human services.** The commissioner of human services, in consultation with the Integrated Fund Task Force, shall:

(1) in the first quarter of 1994, in areas where a local children's mental health collaborative has been established, based on an independent actuarial analysis, identify all medical assistance and MinnesotaCare resources devoted to mental health services for children in the target population including inpatient, outpatient, medication management, services under the rehabilitation option, and related physician services in the total health capitation of prepaid plans under contract with the commissioner to provide medical assistance services under section 256B.69;

(2) assist each children's mental health collaborative to determine an actuarially feasible operational target population;

(3) ensure that a prepaid health plan that contracts with the commissioner to provide medical assistance or MinnesotaCare services shall pass through the identified resources to a collaborative or collaboratives upon the collaboratives meeting the requirements of section 245.4933 to serve the collaborative's operational target population. The commissioner shall, through an independent actuarial analysis, specify differential rates the prepaid health plan must pay the collaborative based upon severity, functioning, and other risk factors, taking into consideration the fee-for-service experience of children excluded from prepaid medical assistance participation;

(4) ensure that a children's mental health collaborative that enters into an agreement with a prepaid health plan under contract with the commissioner shall accept medical assistance recipients in the operational target population on a first-come, first-served basis up to the collaborative's operating capacity or as determined in the agreement between the collaborative and the commissioner;

(5) ensure that a children's mental health collaborative that receives resources passed through a prepaid health plan under contract with the commissioner shall be subject to the quality assurance standards, reporting of utilization information, standards set out in sections 245.487 to 245.4889, and other requirements established in Minnesota Rules, part 9500.1460;

(6) ensure that any prepaid health plan that contracts with the commissioner, including a plan that contracts under section 256B.69, must enter into an agreement with any collaborative operating in the same service delivery area that:

(i) meets the requirements of section 245.4933;

(ii) is willing to accept the rate determined by the commissioner to provide medical assistance services; and

(iii) requests to contract with the prepaid health plan;

(7) ensure that no agreement between a health plan and a collaborative shall terminate the legal responsibility of the health plan to assure that all activities under the contract are carried out. The agreement may require the collaborative to indemnify the health plan for activities that are not carried out;

(8) ensure that where a collaborative enters into an agreement with the commissioner to provide medical assistance and MinnesotaCare services a separate capitation rate will be determined through an independent actuarial analysis which is based upon the factors set forth in clause (3) to be paid to a collaborative for children in the operational target population who are eligible for medical assistance but not included in the prepaid health plan contract with the commissioner;

(9) ensure that in counties where no prepaid health plan contract to provide medical assistance or MinnesotaCare services exists, a children's mental health collaborative that meets the requirements of section 245.4933 shall:

(i) be paid a capitated rate, actuarially determined, that is based upon the collaborative's operational target population;

(ii) accept medical assistance or MinnesotaCare recipients in the operational target population on a first-come, first-served basis up to the collaborative's operating capacity or as determined in the contract between the collaborative and the commissioner; and

(iii) comply with quality assurance standards, reporting of utilization information, standards set out in sections 245.487 to 245.4889, and other requirements established in Minnesota Rules, part 9500.1460;

(10) subject to federal approval, in the development of rates for local children's mental health collaboratives, the commissioner shall consider, and may adjust, trend and utilization factors, to reflect changes in mental health service utilization and access;

(11) consider changes in mental health service utilization, access, and price, and determine the actuarial value of the services in the maintenance of rates for local children's mental health collaborative provided services, subject to federal approval;

(12) provide written notice to any prepaid health plan operating within the service delivery area of a children's mental health collaborative of the collaborative's existence within 30 days of the commissioner's receipt of notice of the collaborative's formation;

(13) ensure that in a geographic area where both a prepaid health plan including those established under either section 256B.69 or 256L.12 and a local children's mental health collaborative exist, medical assistance and MinnesotaCare recipients in the operational target population who are enrolled in prepaid health plans will have the choice to receive mental health services through either the prepaid health plan or the collaborative that has a contract with the prepaid health plan, according to the terms of the contract;

(14) develop a mechanism for integrating medical assistance resources for mental health service with MinnesotaCare and any other state and local resources available for services for children in the operational target population, and develop a procedure for making these resources available for use by a local children's mental health collaborative;

(15) gather data needed to manage mental health care including evaluation data and data necessary to establish a separate capitation rate for children's mental health services if that option is selected;

(16) by January 1, 1994, develop a model contract for providers of mental health managed care that meets the requirements set out in sections 245.491 to 245.495 and 256B.69, and utilize this contract for all subsequent awards, and before January 1, 1995, the commissioner of human services shall not enter into or extend any contract for any prepaid plan that would impede the implementation of sections 245.491 to 245.495;

(17) develop revenue enhancement or rebate mechanisms and procedures to certify expenditures made through local children's mental health collaboratives for services including

administration and outreach that may be eligible for federal financial participation under medical assistance and other federal programs;

(18) ensure that new contracts and extensions or modifications to existing contracts under section 256B.69 do not impede implementation of sections 245.491 to 245.495;

(19) provide technical assistance to help local children's mental health collaboratives certify local expenditures for federal financial participation, using due diligence in order to meet implementation timelines for sections 245.491 to 245.495 and recommend necessary legislation to enhance federal revenue, provide clinical and management flexibility, and otherwise meet the goals of local children's mental health collaboratives and request necessary state plan amendments to maximize the availability of medical assistance for activities undertaken by the local children's mental health collaborative;

(20) take all steps necessary to secure medical assistance reimbursement under the rehabilitation option for family community support services and therapeutic support of foster care and for individualized rehabilitation services;

(21) provide a mechanism to identify separately the reimbursement to a county for child welfare targeted case management provided to children served by the local collaborative for purposes of subsequent transfer by the county to the integrated fund;

(22) ensure that family members who are enrolled in a prepaid health plan and whose children are receiving mental health services through a local children's mental health collaborative file complaints about mental health services needed by the family members, the commissioner shall comply with section 256B.69, subdivision 20. A collaborative may assist a family to make a complaint; and

(23) facilitate a smooth transition for children receiving prepaid medical assistance or MinnesotaCare services through a children's mental health collaborative who become enrolled in a prepaid health plan.

Subd. 4. **Rulemaking.** The commissioners of human services, health, corrections, and education shall adopt or amend rules as necessary to implement sections 245.491 to 245.495.

Subd. 5. **Rule modification.** By January 15, 1994, the commissioner shall report to the legislature the extent to which claims for federal reimbursement for case management as set out in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, as they pertain to mental health case management are consistent with the number of children eligible to receive this service. The report shall also identify how the commissioner intends to increase the numbers of eligible children receiving this service, including recommendations for modifying rules or statutes to improve access to this service and to reduce barriers to its provision.

In developing these recommendations, the commissioner shall:

(1) review experience and consider alternatives to the reporting and claiming requirements, such as the rate of reimbursement, the claiming unit of time, and documenting and reporting procedures set out in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, as they pertain to mental health case management;

(2) consider experience gained from implementation of child welfare targeted case management;

(3) determine how to adjust the reimbursement rate to reflect reductions in caseload size;

(4) determine how to ensure that provision of targeted child welfare case management does not preclude an eligible child's right, or limit access, to case management services for children with severe emotional disturbance as set out in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, as they pertain to mental health case management;

(5) determine how to include cost and time data collection for contracted providers for rate setting, claims, and reimbursement purposes;

(6) evaluate the need for cost control measures where there is no county share; and

(7) determine how multiagency teams may share the reimbursement.

The commissioner shall conduct a study of the cost of county staff providing case management services under Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, as they pertain to mental health case management. If the average cost of providing case management services to children with severe emotional disturbance is determined by the commissioner to be greater than the average cost of providing child welfare targeted case management, the commissioner shall ensure that a higher reimbursement rate is provided for case management services under Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, to children with severe emotional disturbance. The total medical assistance funds expended for this service in

the biennium ending in state fiscal year 1995 shall not exceed the amount projected in the state Medicaid forecast for case management for children with serious emotional disturbances.

**245.63 ASSISTANCE OR GRANT FOR A MENTAL HEALTH SERVICES PROGRAM.**

Any city, town, or public or private corporation may apply to a county board for assistance in establishing and funding a mental health services program. No programs shall be eligible for a grant hereunder unless its plan and budget have been approved by the county board or boards.

**245.69 ADDITIONAL DUTIES OF COMMISSIONER.**

Subdivision 1. **Duties.** In addition to the powers and duties already conferred by law the commissioner of human services shall:

(1) promulgate rules prescribing standards for qualification of personnel and quality of professional service and for in-service training and educational leave programs for personnel, governing eligibility for service so that no person will be denied service on the basis of race, color or creed, or inability to pay, providing for establishment, subject to the approval of the commissioner, of fee schedules which shall be based upon ability to pay, and such other rules as the commissioner deems necessary to carry out the purposes of sections 245.61 to 245.69;

(2) review and evaluate local programs and the performance of administrative and psychiatric personnel and make recommendations thereon to county boards and program administrators;

(3) provide consultative staff service to communities to assist in ascertaining local needs and in planning and establishing community mental health programs; and

(4) employ qualified personnel to implement sections 245.61 to 245.69.

**245.714 MAINTENANCE OF EFFORT.**

Beginning in federal fiscal year 1983, each county shall annually certify to the commissioner that the county has not reduced funds from state, county, and other nonfederal sources which would in the absence of the federal funds made available by United States Code, title 42, sections 300X to 300X-9 have been made available for services to mentally ill persons.

**245.715 QUALIFICATIONS AS A COMMUNITY MENTAL HEALTH CENTER.**

(a) In addition to those agencies that have previously qualified as comprehensive community mental health centers under the provisions of the federal Community Mental Health Centers Act, other public or nonprofit private agencies that are able to demonstrate their capacity to provide the following services as defined by the commissioner may qualify as a community mental health center for the purposes of the federal block grant. The federally required services may be provided by separate agencies. These services include:

(1) outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill and residents of its mental health service area who have been discharged from inpatient treatment at a mental health facility;

(2) 24-hour a day emergency care services;

(3) day treatment or partial hospitalization services;

(4) screening for patients being considered for admission to state mental health facilities to determine the appropriateness of the admission; and

(5) consultation and education services.

(b) Before accepting federal block grant funds for mental health services, counties shall provide the commissioner with all necessary assurances that the qualified community mental health centers which receive these block grant funds meet the minimum service requirements of paragraph (a), clauses (1) to (5). At any time at least 30 days prior to the commissioner's allocation of federal funds, any county may notify the commissioner of its decision not to accept the federal funds for qualified community mental health centers.

**245.717 WITHHOLDING OF FUNDS.**

Beginning in federal fiscal year 1983, the distribution of funds to counties provided in section 245.713 shall be reduced by an amount equal to the federal block grant funds allotted pursuant to section 245.713 in the immediately preceding year which have been spent for some purpose other than qualified community mental health centers. If it is determined that the state

is legally liable for any repayment of federal block funds which were not properly used by the counties, the repayment liability shall be assessed against the counties which did not properly use the funds. The commissioner may withhold future block grant funds to those counties until the obligation is met. The commissioner shall not award additional block grant funds to those counties until the commissioner is assured that no future violations will occur.

**245.718 APPEAL.**

At least 30 days prior to certifying any reduction in funds pursuant to section 245.717, the commissioner shall notify the county of an intention to certify a reduction. The commissioner shall notify the county of the right to a hearing. If the county requests a hearing within 30 days of notification of intention to reduce funds, the commissioner shall not certify any reduction in funds until a hearing is conducted and a decision rendered in accordance with the provisions of chapter 14 for contested cases.

**245.721 MENTAL ILLNESS INFORMATION MANAGEMENT SYSTEM.**

By January 1, 1990, the commissioner of human services shall establish an information management system for collecting data about individuals who suffer from severe and persistent mental illness and who receive publicly funded services for mental illness.

**245.77 LEGAL DECISION ON RESIDENCY; RECEIPT OF FEDERAL FUNDS.**

In the event federal funds become available to the state for purposes of reimbursing the several local agencies of the state for costs incurred in providing financial relief to poor persons under the liability imposed by Minnesota Statutes 1986, section 256D.18, or for reimbursing the state and counties for categorical aid assistance furnished to persons who are eligible for such assistance only because of the United States Supreme Court decision invalidating state residence requirements, the commissioner of human services is hereby designated the state agent for receipt of such funds. Upon receipt of any federal funds, the commissioner shall in a uniform and equitable manner use such funds to reimburse counties for expenditures made in providing financial relief to poor persons. The commissioner is further authorized to promulgate rules, consistent with the rules and regulations promulgated by the secretary of health, education, and welfare, governing the reimbursement provided for by this provision.

**245.827 COMMUNITY INITIATIVES FOR CHILDREN.**

Subdivision 1. **Program established.** The commissioner of human services shall establish a demonstration program of grants for community initiatives for children. The goal of the program is to enlist the resources of a community to promote the healthy physical, educational, and emotional development of children who are living in poverty. Community initiatives for children accomplish the goal by offering support services that enable a family to provide the child with a nurturing home environment. The commissioner shall award grants to nonprofit organizations based on the criteria in subdivision 3.

Subd. 2. **Definition.** "Community initiatives for children" are programs that promote the healthy development of children by increasing the stability of their home environment. They include support services such as child care, parenting education, respite activities for parents, counseling, recreation, and other services families may need to maintain a nurturing environment for their children. Community initiatives for children must be planned by members of the community who are concerned about the future of children.

Subd. 3. **Criteria.** In order to qualify for a community initiatives for children grant, a nonprofit organization must:

(1) involve members of the community and use community resources in planning and executing all aspects of the program;

(2) provide a central location that is accessible to low-income families and is available for informal as well as scheduled activities during the day and on evenings and weekends;

(3) provide a wide range of services to families living at or below the poverty level including, but not limited to, quality affordable child care and training in parental skills;

(4) demonstrate that the organization is using and coordinating existing resources of the community;

(5) demonstrate that the organization has applied to private foundations for funding;

(6) ensure that services are focused on development of the whole child; and

(7) have a governing structure that includes consumer families and members of the community.

Subd. 4. **Covered expenses.** Grants awarded under this section may be used for the capital costs of establishing or improving a program that meets the criteria listed in subdivision 3. Capital costs include land and building acquisition, planning, site preparation, design fees, rehabilitation, construction, and equipment costs.

**245.981 COMPULSIVE GAMBLING ANNUAL REPORT.**

(a) Each year by February 15, 2014, and thereafter, the commissioner of human services shall report to the chairs and ranking minority members of the legislative committees having jurisdiction over compulsive gambling on the percentage of gambling revenues that come from gamblers identified as problem gamblers, or a similarly defined term, as defined by the National Council on Problem Gambling. The report must disaggregate the revenue by the various types of gambling, including, but not limited to: lottery; electronic and paper pull-tabs; bingo; linked bingo; and pari-mutuel betting.

(b) By February 15, 2013, the commissioner shall provide a preliminary update for the report required under paragraph (a) to the chairs and ranking minority members of the legislative committees having jurisdiction over compulsive gambling and the estimated cost of the full report.

**245A.02 DEFINITIONS.**

Subd. 7b. **Interpretive guidelines.** "Interpretive guidelines" means a policy statement that has been published pursuant to section 245A.09, subdivision 12, and which provides interpretation, details, or supplementary information concerning the application of laws or rules. Interpretive guidelines are published for the information and guidance of consumers, providers of service, county agencies, the Department of Human Services, and others concerned.

**245A.09 RULES.**

Subd. 12. **Publication of guidelines.** The commissioner shall publish notice of interpretive guidelines availability in the State Register. The commissioner may publish or make available the interpretive guidelines in any manner determined by the commissioner, provided they are accessible to the general public. The commissioner may charge a reasonable fee for copies of the guidelines requested by interested parties when they are provided by the commissioner.

**245A.11 SPECIAL CONDITIONS FOR RESIDENTIAL PROGRAMS.**

Subd. 5. **Overconcentration and dispersal.** (a) Before January 1, 1985, each county having two or more group residential programs within 1,320 feet of each other shall submit to the Department of Human Services a plan to promote dispersal of group residential programs. In formulating its plan, the county shall solicit the participation of affected persons, programs, municipalities having highly concentrated residential program populations, and advocacy groups. For the purposes of this subdivision, "highly concentrated" means having a population in residential programs serving seven or more persons that exceeds one-half of one percent of the population of a recognized planning district or other administrative subdivision.

(b) Within 45 days after the county submits the plan, the commissioner shall certify whether the plan fulfills the purposes and requirements of this subdivision including the following requirements:

(1) a new program serving seven or more persons must not be located in any recognized planning district or other administrative subdivision where the population in residential programs is highly concentrated;

(2) the county plan must promote dispersal of highly concentrated residential program populations;

(3) the county plan shall promote the development of residential programs in areas that are not highly concentrated;

(4) no person in a residential program shall be displaced as a result of this section until a relocation plan has been implemented that provides for an acceptable alternative placement;

(5) if the plan provides for the relocation of residential programs, the relocation must be completed by January 1, 1990. If the commissioner certifies that the plan does not do so, the commissioner shall state the reasons, and the county has 30 days to submit a plan amended to comply with the requirements of the commissioner.

(c) After July 1, 1985, the commissioner may reduce grants under section 245.73 to a county required to have an approved plan under paragraph (a) if the county does not have a plan approved by the commissioner or if the county acts in disregard of its approved plan. The county board has the right to be provided with advance notice and to appeal the commissioner's decision. If the county requests a hearing within 30 days of the notification of intent to reduce grants, the commissioner shall not certify any reduction in grants until a hearing is conducted and a decision made in accordance with the contested case provisions of chapter 14.

**245A.655 FEDERAL GRANTS TO ESTABLISH AND MAINTAIN A SINGLE COMMON ENTRY POINT FOR REPORTING MALTREATMENT OF A VULNERABLE ADULT.**

(a) The commissioner of human services shall seek federal funding to design, implement, maintain, and evaluate the common entry point for reports of suspected maltreatment made under Minnesota Statutes, section 626.557. The purpose of the federal grant funds is to establish a common entry point with a statewide toll-free telephone number and Web site-based system to report known or suspected abuse, neglect, or exploitation of a vulnerable adult.

(b) A common entry point must be operated in a manner that enables the common entry point staff to:

(1) operate under Minnesota Statutes, section 626.557, subdivision 9, paragraph (b); and subdivision 9a;

(2) when appropriate, refer calls that do not allege the abuse, neglect, or exploitation of a vulnerable adult to other organizations that might better resolve the reporter's concerns; and

(3) immediately identify and locate prior reports of abuse, neglect, or exploitation.

(c) A common entry point must be operated in a manner that enables the commissioner of human services to:

(1) track critical steps in the investigative process to ensure compliance with all requirements for all reports;

(2) maintain data to facilitate the production of aggregate statistical reports for monitoring patterns of abuse, neglect, or exploitation;

(3) serve as a resource for the evaluation, management, and planning of preventative and remedial services for vulnerable adults who have been subject to abuse, neglect, or exploitation;

(4) set standards, priorities, and policies to maximize the efficiency and effectiveness of the common entry point; and

(5) develop a system to manage consumer complaints related to the common entry point.

(d) The commissioner of human services may take the actions necessary to design and implement the common entry point in paragraph (a). Funds awarded by the federal government for the purposes of this section are appropriated to the commissioner of human services.

**246.0135 OPERATION OF REGIONAL TREATMENT CENTERS.**

(a) The commissioner of human services is prohibited from closing any regional treatment center or state-operated nursing home or any program at any of the regional treatment centers or state-operated nursing homes, without specific legislative authorization. For persons with developmental disabilities who move from one regional treatment center to another regional treatment center, the provisions of section 256B.092, subdivision 10, must be followed for both the discharge from one regional treatment center and admission to another regional treatment center, except that the move is not subject to the consensus requirement of section 256B.092, subdivision 10, paragraph (b).

(b) Prior to closing or downsizing a regional treatment center, the commissioner of human services shall be responsible for assuring that community-based alternatives developed in response are adequate to meet the program needs identified by each county within the catchment area and do not require additional local county property tax expenditures.

(c) The nonfederal share of the cost of alternative treatment or care developed as the result of the closure of a regional treatment center, including costs associated with fulfillment of responsibilities under chapter 253B shall be paid from state funds appropriated for purposes specified in section 246.013.

(d) Counties in the catchment area of a regional treatment center which has been closed or downsized may not at any time be required to pay a greater cost of care for alternative care and treatment than the county share set by the commissioner for the cost of care provided by regional treatment centers.

(e) The commissioner may not divert state funds used for providing for care or treatment of persons residing in a regional treatment center for purposes unrelated to the care and treatment of such persons.

**246.0141 TOBACCO USE PROHIBITED.**

No patient, staff, guest, or visitor on the grounds or in a state regional treatment center, the Minnesota Security Hospital, or the Minnesota sex offender program may possess or use tobacco or a tobacco-related device. For the purposes of this section, "tobacco" and "tobacco-related device" have the meanings given in section 609.685, subdivision 1. This section does not prohibit the possession or use of tobacco or a tobacco-related device by an adult as part of a traditional Indian spiritual or cultural ceremony. For purposes of this section, an Indian is a person who is a member of an Indian tribe as defined in section 260.755, subdivision 12.

**246.016 OFFICE ABOLISHED.**

The office of the commissioner of mental health and mental hospitals is hereby abolished.

**246.023 INTERAGENCY COMMITTEE.**

Subdivision 1. **Legislative policy.** It is recognized that closure and consolidation of regional treatment centers have negative economic effects upon public employees and communities. It is the policy of the state that deinstitutionalization policies shall be carried out in a manner that ensures fair and equitable arrangements to protect the interests of employees and communities affected by deinstitutionalization.

**246.0251 HOSPITAL ADMINISTRATOR.**

Notwithstanding any provision of law to the contrary, the commissioner of human services may appoint a hospital administrator at any state hospital. Such hospital administrator shall be a graduate of an accredited college giving a course leading to a degree in hospital administration and the commissioner of human services, by rule, shall designate such colleges which in the opinion of the commissioner give an accredited course in hospital administration. In addition to a hospital administrator, the commissioner of human services may appoint a licensed doctor of medicine as chief of the medical staff who shall be in charge of all medical care, treatment, rehabilitation and research.

**246.16 UNCLAIMED MONEY OR PERSONAL PROPERTY.**

Subdivision 1. **Unclaimed money.** When money has accumulated in the hands of the head of the state-operated services facility or designee under the jurisdiction of the commissioner of human services money belonging to patients or residents of the institution who have died there, or disappeared from there, and for which there is no claimant or person entitled to the money known to the head of the state-operated services facility or designee the money may, at the discretion of the head of the state-operated services facility or designee, be expended under the direction of the head of the state-operated services facility or designee for the benefit of the patients or residents of the institution. No money shall be used until it has remained unclaimed for at least five years. If, at any time after the expiration of the five years, the legal heirs of the patients or residents appear and make proper proof of heirship, they shall be entitled to receive from the state the sum of money expended by the head of the state-operated services facility or designee belonging to the patient or resident.

Subd. 2. **Unclaimed personal property.** When any patient or resident of a state-operated services facility under the jurisdiction of the commissioner of human services dies or disappears from the state-operated services facility, leaving personal property exclusive of money in the custody of the head of the state-operated services facility or designee and the property remains unclaimed for a period of two years, with no person entitled to the property known to the head of the state-operated services or designee, the head of the state-operated services facility or designee may sell the property at public auction. Notice of the sale shall be published for two consecutive weeks in a legal newspaper in the county where the state-operated services facility is located and shall state the time and place of the sale. The proceeds of the sale, after deduction of the costs of publication and auction, may be expended, at the discretion of the head of the state-operated services facility or designee, for the benefit of the patients or residents of the state-operated services facility. Any patient or resident, or heir or representative of the patient or resident,

may file with, and make proof of ownership to, the head of the state-operated services facility or designee of the state-operated services facility disposing of the personal property within four years after the sale, and, upon satisfactory proof to the head of the state-operated services or designee, shall certify for payment to the commissioner of management and budget the amount received by the sale of the property. No suit shall be brought for damages consequent to the disposal of personal property or use of money in accordance with this section against the state or any official, employee, or agent thereof.

**246.28 DIAGNOSTIC TESTS AND X-RAY EXAMINATIONS; REPORT.**

The physical examination shall include a standard intradermal tuberculin test, a chest x-ray when the test is positive and additional special diagnostic tests for the detection of the presence of tuberculosis as shall be set up in rules of the state commissioner of health in cooperation with the commissioner of human services. The examination shall be made by a licensed physician and surgeon, who shall report in writing to the superintendent of the institution in which the employment is contemplated on a form set up by the Department of Human Services in cooperation with the state commissioner of health showing the presence or absence of tuberculosis infection and disease based upon the examination.

**246.325 GARDEN OF REMEMBRANCE.**

The cemetery located on the grounds of the Cambridge State Hospital shall be known as the Garden of Remembrance. The commissioner of human services shall approve the wording and design for a sign at the cemetery indicating its name. The commissioner may approve a temporary sign before the permanent sign is completed and installed. All costs related to the sign must be paid with nonstate funds.

**246.70 SERVICES TO FAMILIES.**

(a) The commissioner shall publicize the planned changes to the facilities operated by the commissioner. A parent, other involved family member, private guardian, or health care agent of a resident of a facility must be notified of the changes planned for each facility. When new services developed for a person require the person to move, the commissioner shall provide each parent, family member, health care agent, and guardian of that person with the following:

(1) names and telephone numbers of the state and county contacts;

(2) information on types of services to be developed;

(3) information on how the individual planning process works, including how alternative placements will be determined, and how family members can be involved;

(4) information on the process to be followed when a parent, other family member, health care agent, or guardian disagrees with the proposed services; and

(5) a list of additional resources such as advocates, local volunteer coordinators, and family groups.

(b) At least one staff person in each facility must be available to provide information about:

(1) community placements;

(2) the opportunity for interested family members, guardians, and health care agents to participate in program planning; and

(3) family support groups.

**246.71 DEFINITIONS.**

Subdivision 1. **Scope.** For purposes of sections 246.71 to 246.722, the following terms have the meanings given them.

Subd. 2. **Blood-borne pathogens.** "Blood-borne pathogens" means pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV).

Subd. 3. **Patient.** "Patient" means any person who is receiving treatment from or committed to a secure treatment facility.

Subd. 4. **Employee of a secure treatment facility or employee.** "Employee of a secure treatment facility" or "employee" means an employee of the Minnesota Security Hospital or a secure treatment facility operated by the Minnesota sex offender program.

Subd. 5. **Secure treatment facility.** "Secure treatment facility" means the Minnesota Security Hospital and the Minnesota sex offender program facility in Moose Lake and any portion

of the Minnesota sex offender program operated by the Minnesota sex offender program at the Minnesota Security Hospital.

Subd. 6. **Significant exposure.** "Significant exposure" means contact likely to transmit a blood-borne pathogen, in a manner supported by the most current guidelines and recommendations of the United States Public Health Service at the time an evaluation takes place, that includes:

(1) percutaneous injury, contact of mucous membrane or nonintact skin, or prolonged contact of intact skin; and

(2) contact, in a manner that may transmit a blood-borne pathogen, with blood, tissue, or potentially infectious body fluids.

**246.711 CONDITIONS FOR APPLICABILITY OF PROCEDURES.**

Subdivision 1. **Request for procedures.** An employee of a secure treatment facility may request that the procedures of sections 246.71 to 246.722 be followed when the employee may have experienced a significant exposure to a patient.

Subd. 2. **Conditions.** The secure treatment facility shall follow the procedures in sections 246.71 to 246.722 when all of the following conditions are met:

(1) a licensed physician determines that a significant exposure has occurred following the protocol under section 246.721;

(2) the licensed physician for the employee needs the patient's blood-borne pathogens test results to begin, continue, modify, or discontinue treatment in accordance with the most current guidelines of the United States Public Health Service, because of possible exposure to a blood-borne pathogen; and

(3) the employee consents to providing a blood sample for testing for a blood-borne pathogen.

**246.712 INFORMATION REQUIRED TO BE GIVEN TO INDIVIDUALS.**

Subdivision 1. **Information to patient.** (a) Before seeking any consent required by the procedures under sections 246.71 to 246.722, a secure treatment facility shall inform the patient that the patient's blood-borne pathogen test results, without the patient's name or other uniquely identifying information, shall be reported to the employee if requested and that test results collected under sections 246.71 to 246.722 are for medical purposes as set forth in section 246.718 and may not be used as evidence in any criminal proceedings or civil proceedings, except for procedures under sections 144.4171 to 144.4186.

(b) The secure treatment facility shall inform the patient of the insurance protections in section 72A.20, subdivision 29.

(c) The secure treatment facility shall inform the patient that the patient may refuse to provide a blood sample and that the patient's refusal may result in a request for a court order to require the patient to provide a blood sample.

(d) The secure treatment facility shall inform the patient that the secure treatment facility will advise the employee of a secure treatment facility of the confidentiality requirements and penalties before the employee's health care provider discloses any test results.

Subd. 2. **Information to secure treatment facility employee.** (a) Before disclosing any information about the patient, the secure treatment facility shall inform the employee of a secure treatment facility of the confidentiality requirements of section 246.719 and that the person may be subject to penalties for unauthorized release of test results about the patient under section 246.72.

(b) The secure treatment facility shall inform the employee of the insurance protections in section 72A.20, subdivision 29.

**246.713 DISCLOSURE OF POSITIVE BLOOD-BORNE PATHOGEN TEST RESULTS.**

If the conditions of sections 246.711 and 246.712 are met, the secure treatment facility shall ask the patient if the patient has ever had a positive test for a blood-borne pathogen. The secure treatment facility must attempt to get existing test results under this section before taking any steps to obtain a blood sample or to test for blood-borne pathogens. The secure treatment facility shall disclose the patient's blood-borne pathogen test results to the employee without the patient's name or other uniquely identifying information.

**246.714 CONSENT PROCEDURES GENERALLY.**

(a) For purposes of sections 246.71 to 246.722, whenever the secure treatment facility is required to seek consent, the secure treatment facility shall obtain consent from a patient or a patient's representative consistent with other law applicable to consent.

(b) Consent is not required if the secure treatment facility has made reasonable efforts to obtain the representative's consent and consent cannot be obtained within 24 hours of a significant exposure.

(c) If testing of available blood occurs without consent because the patient is unconscious or unable to provide consent, and a representative cannot be located, the secure treatment facility shall provide the information required in section 246.712 to the patient or representative whenever it is possible to do so.

(d) If a patient dies before an opportunity to consent to blood collection or testing under sections 246.71 to 246.722, the secure treatment facility does not need consent of the patient's representative for purposes of sections 246.71 to 246.722.

**246.715 TESTING OF AVAILABLE BLOOD.**

Subdivision 1. **Procedures with consent.** If a sample of the patient's blood is available, the secure treatment facility shall ensure that blood is tested for blood-borne pathogens with the consent of the patient, provided the conditions in sections 246.711 and 246.712 are met.

Subd. 2. **Procedures without consent.** If the patient has provided a blood sample, but does not consent to blood-borne pathogens testing, the secure treatment facility shall ensure that the blood is tested for blood-borne pathogens if the employee requests the test, provided all of the following criteria are met:

(1) the employee and secure treatment facility have documented exposure to blood or body fluids during performance of the employee's work duties;

(2) a licensed physician has determined that a significant exposure has occurred under section 246.711 and has documented that blood-borne pathogen test results are needed for beginning, modifying, continuing, or discontinuing medical treatment for the employee as recommended by the most current guidelines of the United States Public Health Service;

(3) the employee provides a blood sample for testing for blood-borne pathogens as soon as feasible;

(4) the secure treatment facility asks the patient to consent to a test for blood-borne pathogens and the patient does not consent;

(5) the secure treatment facility has provided the patient and the employee with all of the information required by section 246.712; and

(6) the secure treatment facility has informed the employee of the confidentiality requirements of section 246.719 and the penalties for unauthorized release of patient information under section 246.72.

Subd. 3. **Follow-up.** The secure treatment facility shall inform the patient whose blood was tested of the results. The secure treatment facility shall inform the employee's health care provider of the patient's test results without the patient's name or other uniquely identifying information.

**246.716 BLOOD SAMPLE COLLECTION FOR TESTING.**

Subdivision 1. **Procedures with consent.** (a) If a blood sample is not otherwise available, the secure treatment facility shall obtain consent from the patient before collecting a blood sample for testing for blood-borne pathogens. The consent process shall include informing the patient that the patient may refuse to provide a blood sample and that the patient's refusal may result in a request for a court order under subdivision 2 to require the patient to provide a blood sample.

(b) If the patient consents to provide a blood sample, the secure treatment facility shall collect a blood sample and ensure that the sample is tested for blood-borne pathogens.

(c) The secure treatment facility shall inform the employee's health care provider about the patient's test results without the patient's name or other uniquely identifying information. The secure treatment facility shall inform the patient of the test results.

(d) If the patient refuses to provide a blood sample for testing, the secure treatment facility shall inform the employee of the patient's refusal.

Subd. 2. **Procedures without consent.** (a) A secure treatment facility or an employee of a secure treatment facility may bring a petition for a court order to require a patient to provide a blood sample for testing for blood-borne pathogens. The petition shall be filed in the district court in the county where the patient is receiving treatment from the secure treatment facility. The secure treatment facility shall serve the petition on the patient three days before a hearing on the petition. The petition shall include one or more affidavits attesting that:

(1) the secure treatment facility followed the procedures in sections 246.71 to 246.722 and attempted to obtain blood-borne pathogen test results according to those sections;

(2) a licensed physician knowledgeable about the most current recommendations of the United States Public Health Service has determined that a significant exposure has occurred to the employee of a secure treatment facility under section 246.721; and

(3) a physician has documented that the employee has provided a blood sample and consented to testing for blood-borne pathogens and blood-borne pathogen test results are needed for beginning, continuing, modifying, or discontinuing medical treatment for the employee under section 246.721.

(b) Facilities shall cooperate with petitioners in providing any necessary affidavits to the extent that facility staff can attest under oath to the facts in the affidavits.

(c) The court may order the patient to provide a blood sample for blood-borne pathogen testing if:

(1) there is probable cause to believe the employee of a secure treatment facility has experienced a significant exposure to the patient;

(2) the court imposes appropriate safeguards against unauthorized disclosure that must specify the persons who have access to the test results and the purposes for which the test results may be used;

(3) a licensed physician for the employee of a secure treatment facility needs the test results for beginning, continuing, modifying, or discontinuing medical treatment for the employee; and

(4) the court finds a compelling need for the test results. In assessing compelling need, the court shall weigh the need for the court-ordered blood collection and test results against the interests of the patient, including, but not limited to, privacy, health, safety, or economic interests. The court shall also consider whether involuntary blood collection and testing would serve the public interests.

(d) The court shall conduct the proceeding in camera unless the petitioner or the patient requests a hearing in open court and the court determines that a public hearing is necessary to the public interest and the proper administration of justice.

(e) The patient may arrange for counsel in any proceeding brought under this subdivision.

**246.717 NO DISCRIMINATION.**

A secure treatment facility shall not withhold care or treatment on the requirement that the patient consent to blood-borne pathogen testing under sections 246.71 to 246.722.

**246.718 USE OF TEST RESULTS.**

Blood-borne pathogen test results of a patient obtained under sections 246.71 to 246.722 are for diagnostic purposes and to determine the need for treatment or medical care specific to a blood-borne pathogen-related illness. The test results may not be used as evidence in any criminal proceedings or civil proceedings, except for procedures under sections 144.4171 to 144.4186.

**246.719 TEST INFORMATION CONFIDENTIALITY.**

Test results obtained under sections 246.71 to 246.722 are private data as defined in sections 13.02, subdivision 12, and 13.85, subdivision 2, but shall be released as provided by sections 246.71 to 246.722.

**246.72 PENALTY FOR UNAUTHORIZED RELEASE OF INFORMATION.**

Unauthorized release of the patient's name or other uniquely identifying information under sections 246.71 to 246.722 is subject to the remedies and penalties under sections 13.08 and 13.09. This section does not preclude private causes of action against an individual, state agency, statewide system, political subdivision, or person responsible for releasing private data, or confidential or private information on the inmate.

**246.721 PROTOCOL FOR EXPOSURE TO BLOOD-BORNE PATHOGENS.**

(a) A secure treatment facility shall follow applicable Occupational Safety and Health Administration guidelines under Code of Federal Regulations, title 29, part 1910.1030, for blood-borne pathogens.

(b) Every secure treatment facility shall adopt and follow a postexposure protocol for employees at a secure treatment facility who have experienced a significant exposure. The

postexposure protocol must adhere to the most current recommendations of the United States Public Health Service and include, at a minimum, the following:

(1) a process for employees to report an exposure in a timely fashion;

(2) a process for an infectious disease specialist, or a licensed physician who is knowledgeable about the most current recommendations of the United States Public Health Service in consultation with an infectious disease specialist, (i) to determine whether a significant exposure to one or more blood-borne pathogens has occurred, and (ii) to provide, under the direction of a licensed physician, a recommendation or recommendations for follow-up treatment appropriate to the particular blood-borne pathogen or pathogens for which a significant exposure has been determined;

(3) if there has been a significant exposure, a process to determine whether the patient has a blood-borne pathogen through disclosure of test results, or through blood collection and testing as required by sections 246.71 to 246.722;

(4) a process for providing appropriate counseling prior to and following testing for a blood-borne pathogen regarding the likelihood of blood-borne pathogen transmission and follow-up recommendations according to the most current recommendations of the United States Public Health Service, recommendations for testing, and treatment;

(5) a process for providing appropriate counseling under clause (4) to the employee of a secure treatment facility and to the patient; and

(6) compliance with applicable state and federal laws relating to data practices, confidentiality, informed consent, and the patient bill of rights.

**246.722 IMMUNITY.**

A secure treatment facility, licensed physician, and designated health care personnel are immune from liability in any civil, administrative, or criminal action relating to the disclosure of test results of a patient to an employee of a secure treatment facility and the testing of a blood sample from the patient for blood-borne pathogens if a good faith effort has been made to comply with sections 246.71 to 246.722.

**253B.22 REVIEW BOARDS.**

Subdivision 1. **Establishment.** The commissioner shall establish a review board of three or more persons for each regional center to review the admission and retention of its patients receiving services under this chapter. One member shall be qualified in the diagnosis of mental illness, developmental disability, or chemical dependency, and one member shall be an attorney. The commissioner may, upon written request from the appropriate federal authority, establish a review panel for any federal treatment facility within the state to review the admission and retention of patients hospitalized under this chapter. For any review board established for a federal treatment facility, one of the persons appointed by the commissioner shall be the commissioner of veterans affairs or the commissioner's designee.

Subd. 2. **Right to appear.** Each treatment facility shall be visited by the review board at least once every six months. Upon request each patient in the treatment facility shall have the right to appear before the review board during the visit.

Subd. 3. **Notice.** The head of the treatment facility shall notify each patient at the time of admission by a simple written statement of the patient's right to appear before the review board and the next date when the board will visit the treatment facility. A request to appear before the board need not be in writing. Any employee of the treatment facility receiving a patient's request to appear before the board shall notify the head of the treatment facility of the request.

Subd. 4. **Review.** The board shall review the admission and retention of patients at its respective treatment facility. The board may examine the records of all patients admitted and may examine personally at its own instigation all patients who from the records or otherwise appear to justify reasonable doubt as to continued need of confinement in a treatment facility. The review board shall report its findings to the commissioner and to the head of the treatment facility. The board may also receive reports from patients, interested persons, and treatment facility employees, and investigate conditions affecting the care of patients.

Subd. 5. **Compensation.** Each member of the review board shall receive compensation and reimbursement as established by the commissioner.

**254.01 WILLMAR REGIONAL TREATMENT CENTER.**

There is hereby located and established at the city of Willmar, county of Kandiyohi, state of Minnesota, a state hospital.

**254.03 SUPERVISION.**

The state hospital at Willmar shall be under the control and management of the commissioner of human services and all laws and rules applicable to other state hospitals apply insofar as may be necessary to the state hospital at Willmar.

**254.04 TREATMENT OF CHEMICALLY DEPENDENT PERSONS.**

The commissioner of human services is hereby authorized to continue the treatment of chemically dependent persons at Ah-Gwah-Ching and Moose Lake area programs as well as at the regional treatment centers located at Anoka, Brainerd, Fergus Falls, St. Peter, and Willmar as specified in section 245.652.

**254.05 DESIGNATION OF STATE HOSPITALS.**

The state hospital located at Anoka shall hereafter be known and designated as the Anoka-Metro Regional Treatment Center.

**254.06 SUPERINTENDENT.**

The commissioner of human services shall appoint a superintendent of the Willmar Regional Treatment Center who shall be a duly licensed physician.

**254.07 COMMISSIONER OF HUMAN SERVICES, POWERS.**

The commissioner of human services shall have the supervision and control of the Willmar Regional Treatment Center and may provide employment for patients committed thereto at such occupation as provided by the rules adopted by the commissioner of human services.

**254.09 COMPULSORY TREATMENT FOR HABITUAL USERS OF NARCOTICS.**

When an affidavit duly verified by a person claiming to have knowledge of the facts and setting forth that, with resulting injury to health, any person named or described therein is a habitual user, otherwise than under the direction of a duly licensed and practicing physician, of opium, or cocoa leaves or any compound, manufacture, salt, derivative, or preparation thereof, shall be filed with the county attorney of any county in which such alleged habitual user is or may be found, such county attorney shall issue a notice requiring the person so named or described to appear before a judge of the district court of the county in chambers at a time and place specified in such notice, and cause a copy thereof to be served by the sheriff upon the person so named or described not less than two days before the dates specified for such appearance. The affidavit and the original notice with proof of service shall be filed with the court administrator at or before the time specified for such appearance, but the same and the other records and files of the proceeding shall be open for inspection only by the person named or described therein or the person's counsel, and by public officers.

**254.10 HEARINGS; ORDERS.**

At the time and place specified in the notice, the person named or described in such notice, or the person's counsel being present, the judge shall hear the evidence presented; and, upon being satisfied that the allegations contained in the affidavit are true, make and file an order requiring such habitual user forthwith to take and continue, until otherwise ordered by the court, treatment for the cure of the habit at a private institution to be selected by the user and approved by the judge, if the user is able to pay therefor, otherwise at some public institution selected by the judge and at the expense of the county. In either case the order shall further require reports to be made to the court at stated intervals therein specified by the person and by the physician or superintendent in charge as to the effect and progress of the treatment. A copy of the order forthwith shall be served upon the user.

**254.11 VIOLATIONS OF ORDERS TO BE CONTEMPT OF COURT.**

Any person named or described in a notice so issued by the county attorney and who has been duly served who shall fail, refuse, or neglect to appear at the time and place therein specified, and any person named or described in the order so made and served who shall fail, refuse, or neglect to comply with the terms and conditions of such order shall be deemed guilty of contempt of the court and proceeded against accordingly.

**254A.05 DUTIES OF ADVISORY COUNCIL.**

Subdivision 1. **General duties.** (a) The council shall assist in the formulation of policies and guidelines for the implementation of the commissioner's responsibilities in the area of alcohol and drug abuse.

(b) The council shall advise the commissioner and director on policies, goals, and the operation of the comprehensive state plan for alcohol and drug abuse program services in the state and other matters as directed by the commissioner and director, and shall encourage public understanding and support of the alcohol and drug abuse programs.

(c) The council shall make recommendations to the commissioner regarding grants and contracts which use federal funds, and state funds as authorized under section 254A.03, subdivision 1, clause (h).

**254A.07 COORDINATION OF LOCAL PROGRAMS.**

Subdivision 1. **Coordination of services and agreements.** The county board shall coordinate all alcohol and other drug abuse services conducted by local agencies, and review all proposed agreements, contracts, plans, and programs in relation to alcohol and other drug abuse prepared by any such local agencies for funding from any local, state or federal governmental sources.

Subd. 2. **Grants.** The county boards may make grants for local agency programs for prevention, care, and treatment of alcohol and other drug abuse as developed and defined by the state authority. Grants made for programs serving the American Indian community shall take into account the guidelines established in section 254A.03, subdivision 1, clause (10). Grants may be made for the cost of these local agency programs and services whether provided directly by county boards or by other public and private agencies and organizations, both profit and nonprofit, and individuals, pursuant to contract. Nothing herein shall prevent the state authority from entering into contracts with and making grants to other state agencies for the purpose of providing specific services and programs. With the approval of the county board, the state authority may make grants or contracts for research or demonstration projects specific to needs within that county.

**254A.16 RESPONSIBILITIES OF THE COMMISSIONER.**

Subdivision 1. **Needs assessment.** The commissioner may evaluate or contract for the evaluation of all comprehensive programs providing services for preventing and treating alcohol and drug abuse or dependency. The evaluation shall be directed at determining whether existent and proposed activities are the most appropriate programmatic response to existing needs and whether they are cost-effective.

**254B.01 DEFINITIONS.**

Subdivision 1. **Applicability.** The definitions in this section apply to Laws 1986, chapter 394, sections 8 to 20.

**254B.04 ELIGIBILITY FOR CHEMICAL DEPENDENCY FUND SERVICES.**

Subd. 3. **Amount of contribution.** The commissioner shall adopt a sliding fee scale to determine the amount of contribution to be required from persons under this section. The commissioner may adopt rules to amend existing fee scales. The commissioner may establish a separate fee scale for recipients of chemical dependency transitional and extended care rehabilitation services that provides for the collection of fees for board and lodging expenses. The fee schedule shall ensure that employed persons are allowed the income disregards and savings accounts that are allowed residents of community mental illness facilities under section 256D.06, subdivisions 1 and 1b. The fee scale must not provide assistance to persons whose income is more than 115 percent of the state median income. Payments of liabilities under this section are medical expenses for purposes of determining spenddown under sections 256B.055, 256B.056, 256B.06, and 256D.01 to 256D.21. The required amount of contribution established

by the fee scale in this subdivision is also the cost of care responsibility subject to collection under section 254B.06, subdivision 1.

**254B.13 PILOT PROJECTS; CHEMICAL HEALTH CARE.**

Subd. 3. **Program evaluation.** The commissioner shall evaluate navigator pilot projects under this section and report the results of the evaluation to the chairs and ranking minority members of the legislative committees with jurisdiction over chemical health issues by January 15, 2014. Evaluation of the navigator pilot projects must be based on outcome evaluation criteria negotiated with the navigator pilot projects prior to implementation.

**256.01 COMMISSIONER OF HUMAN SERVICES; POWERS, DUTIES.**

Subd. 3. **Executive council, powers transferred.** All the powers and duties now vested in or imposed upon the executive council, or any other agency which may have succeeded to its authority, relating to the administration and distribution of direct relief to the indigent or destitute, including war veterans and their families and dependents, are hereby transferred to, vested in, and imposed upon the commissioner of human services.

Subd. 14. **Child welfare reform pilots.** The commissioner of human services shall encourage local reforms in the delivery of child welfare services and is authorized to approve local pilot programs which focus on reforming the child protection and child welfare systems in Minnesota. Authority to approve pilots includes authority to waive existing state rules as needed to accomplish reform efforts. Notwithstanding section 626.556, subdivision 10, 10b, or 10d, the commissioner may authorize programs to use alternative methods of investigating and assessing reports of child maltreatment, provided that the programs comply with the provisions of section 626.556 dealing with the rights of individuals who are subjects of reports or investigations, including notice and appeal rights and data practices requirements. Pilot programs must be required to address responsibility for safety and protection of children, be time limited, and include evaluation of the pilot program.

Subd. 14a. **Single benefit demonstration.** The commissioner may conduct a demonstration program under a federal Title IV-E waiver to demonstrate the impact of a single benefit level on the rate of permanency for children in long-term foster care through transfer of permanent legal custody or adoption. The commissioner of human services is authorized to waive enforcement of related statutory program requirements, rules, and standards in one or more counties for the purpose of this demonstration. The demonstration must comply with the requirements of the secretary of health and human services under federal waiver and be cost neutral to the state.

The commissioner may measure cost neutrality to the state by the same mechanism approved by the secretary of health and human services to measure federal cost neutrality. The commissioner is authorized to accept and administer county funds and to transfer state and federal funds among the affected programs as necessary for the conduct of the demonstration.

**256.959 DENTAL PRACTICE DONATION PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of human services shall establish a dental practice donation program that coordinates the donation of a qualifying dental practice to a qualified charitable organization and assists in locating a dentist licensed under chapter 150A who wishes to maintain the dental practice.

Subd. 2. **Qualifying dental practice.** To qualify for the dental practice donation program, a dental practice must meet the following requirements:

(1) the dental practice must be owned by the donating dentist;

(2) the dental practice must be located in a designated underserved area of the state as defined by the commissioner; and

(3) the practice must be equipped with the basic dental equipment necessary to maintain a dental practice as determined by the commissioner.

Subd. 3. **Coordination.** The commissioner shall establish a procedure for dentists to donate their dental practices to a qualified charitable organization. The commissioner shall authorize a practice for donation only if it meets the requirements of subdivision 2 and there is a licensed dentist who is interested in entering into an agreement as described in subdivision 4. Upon donation of the practice, the commissioner shall provide the donating dentist with a statement verifying that a donation of the practice was made to a qualifying charitable organization for purposes of state and federal income tax returns.

Subd. 4. **Donated dental practice agreement.** (a) A dentist accepting the donated practice must enter into an agreement with the qualified charitable organization to maintain the dental

practice for a minimum of five years at the donated practice site and to provide services to underserved populations up to a preagreed percentage of patients served.

(b) The agreement must include the terms for the recovery of the donated dental practice if the dentist accepting the practice does not fulfill the service commitment required under this subdivision.

(c) Any costs associated with operating the dental practice during the service commitment time period are the financial responsibility of the dentist accepting the practice.

**256.964 DENTAL CARE PILOT PROJECTS.**

The commissioner shall authorize pilot projects to reduce the total cost to the state for dental services provided to enrollees of the state public health care programs by reducing hospital emergency room costs for preventable or nonemergency dental services. As part of the project, a community dental clinic or dental provider, in collaboration with a hospital emergency room, shall provide urgent care dental services as an alternative to the hospital emergency room for nonemergency dental care. The project participants shall establish a process to divert a patient presenting at the emergency room for nonemergency dental care to the dental community clinic or to an appropriate dental provider. The commissioner may establish special payment rates for urgent care services provided and may change or waive existing payment policies in order to adequately reimburse providers for providing cost-effective alternative services in an outpatient or urgent care setting. The commissioner may establish a project in conjunction with the initiative authorized under section 256.963.

**256.9691 TECHNOLOGY ASSISTANCE REVIEW PANEL.**

Subdivision 1. **Establishment.** The commissioner of health shall establish a technology assistance review panel to resolve disputes over the provision of health care benefits for technology-assisted persons who receive benefits under a policy or plan of health, medical, hospitalization, or accident and sickness insurance regulated under chapter 62A, a subscriber contract of a nonprofit health service plan corporation regulated under chapter 62C, or a certificate of coverage of a health maintenance organization regulated under chapter 62D.

Subd. 2. **Definition.** For purposes of this section, "technology-assisted person" means a person who:

(1) has a chronic health condition;

(2) requires the routine use of a medical device to compensate for the loss of a life-sustaining body function; and

(3) requires ongoing care or monitoring by trained personnel on a daily basis.

Subd. 3. **Steering committee.** The commissioner shall appoint a seven-member steering committee to appoint the review panel members, develop policies and procedures for the review process, including the replacement of review panel members, serve as a liaison between the regulatory agencies and the review panel, and provide the review panel with technical assistance. The steering committee shall consist of representatives of the Departments of Health, Human Services, and Commerce; a health maintenance organization regulated under chapter 62D; an insurer regulated under chapter 62A or a health service plan corporation regulated under chapter 62C; an advocacy organization representing persons who are technology assisted; and a tertiary care center that serves technology-assisted persons. The steering committee shall not be reimbursed for any expenses as defined under section 15.0575, subdivision 3. The steering committee shall dissolve no later than June 30, 1992.

Subd. 4. **Composition of review panel.** (a) The review panel shall be appointed by the members of the steering committee that do not represent state agencies and must include:

(1) a medical director from an insurer regulated under chapter 62A, a health service plan corporation regulated under chapter 62C, or a health maintenance organization regulated under chapter 62D;

(2) a contract benefits analyst from an insurer regulated under chapter 62A, a health service plan corporation regulated under chapter 62C, or a health maintenance organization regulated under chapter 62D;

(3) a consumer board member of an insurer regulated under chapter 62A, a health service plan corporation regulated under chapter 62C, or a health maintenance organization regulated under chapter 62D;

(4) a physician with expertise in providing care for technology-assisted persons in a nonhospital setting;

(5) a registered nurse with expertise in providing care for technology-assisted persons in a nonhospital setting; and

(6) a consumer of health care benefits regulated under chapter 62A, 62C, or 62D who is a technology-assisted person or the parent or guardian of a technology-assisted person.

(b) The term of service for review panel members is three years except that, for the initial appointment, the steering committee shall establish procedures to assure that the terms of the members are staggered. Members are eligible to serve two consecutive terms.

Subd. 5. **Authority.** The review panel may review cases involving disputes over the provision of contract benefits regarding discharge planning, home health care benefits eligibility and coverage, or changes in the level of home health care services for technology-assisted persons. The review may be requested by a third-party payor, a health or social service professional, or a parent or guardian of a technology-assisted child or a technology-assisted adult. For the case to be eligible for review by the panel, the parent or guardian of a technology-assisted child or technology-assisted adult must consent to the review. The review panel may not review cases involving discharge to a long-term care facility or cases involving coverage by title 18 or 19 of the Social Security Act or other public funding sources. The review panel may seek advice from experts outside the membership of the panel as necessary. The internal grievance process within an insurer, health service plan corporation, or health maintenance organization, except binding arbitration, must be exhausted before requesting a review by the review panel. The recommendations of the review panel are not binding. If, following a review by the review panel, a complaint is filed with the appropriate state agency regarding the same subject matter, the findings of the review panel must be made available to the agency upon request and with the consent of the parent or guardian of a technology-assisted child or technology-assisted adult. The information must be maintained by the agency as nonpublic information under chapter 13. The steering committee may establish policies for reimbursement of expenses for review panel members consistent with the provisions of section 15.0575, subdivision 3.

Subd. 6. **Confidentiality.** All proceedings of the review organization are nonpublic under chapter 13. All data, information, and findings acquired and developed by the review panel in the exercise of its duties or functions must be held in confidence, may not be disclosed to anyone except to the extent necessary to carry out one or more of the purposes of the review panel or as described in subdivision 5, and are not subject to subpoena or discovery. Members of the review panel may not disclose what transpired at a meeting of the review panel except to the extent necessary to carry out one or more of the purposes of the review panel. The proceedings and record of the review panel are not subject to discovery or introduction into evidence in any civil action against a health care professional or insurer, health service plan corporation, or health maintenance organization, arising out of the matter or matters that are the subject of consideration by the review panel.

Subd. 7. **Limitation on liability for members of steering committee and review panel.** A person who is a member of, or who acts in an advisory capacity to or who gives counsel or services to, the steering committee or review panel is not liable for damages or other relief in any action brought by a person or persons whose case has been reviewed by the panel, by reason of the performance of any duty, function, or activity of the review panel, unless the performance of the duty, function, or activity was motivated by malice toward the person affected. A member is not liable for damages or other relief in any action by reason of the performance of the member of any duty, function, or activity as a member of the steering committee or review panel or by reason of any recommendation or action of the review committee when the member acts in the reasonable belief that the action or recommendation is warranted by the facts known to the member or review panel after reasonable efforts to ascertain the facts.

**256.971 SERVICES FOR DEAF.**

The commissioner of human services shall provide such services for the deaf and hard of hearing in the state as will best promote their personal, economic and social well being. The commissioner shall maintain a register of all such persons, with such information as the commissioner deems necessary to improve services for them. The commissioner shall gather and disseminate information relating to the causes of deafness, collect statistics on the deaf and ascertain what trades or occupations are most suitable for them, and use best efforts to aid them in securing vocational rehabilitation and employment, through cooperation with other agencies, both public and private.

**256.975 MINNESOTA BOARD ON AGING.**

Subd. 3. **Policy.** The board shall recommend to the state legislature no later than January 1, 1977, a proposed state policy for citizens dependent on long-term care and services. The proposed state policy shall address, but need not be limited to, the following:

(1) developing alternatives to institutionalization in long-term care facilities and other programs which will assist each citizen dependent on long-term care and services to maintain the highest level of self-sufficiency and independence which the citizen's mental and physical condition allows;

(2) developing methods for ensuring citizens dependent on long-term care and services an effective voice in determining which programs and services are made available to them;

(3) protecting citizens dependent on long-term care and services from unnecessary governmental interference in private and personal affairs; and

(4) informing citizens dependent on long-term care and services of the programs and services for which they are eligible.

**256.9753 VOLUNTEER PROGRAMS FOR RETIRED SENIOR CITIZENS.**

Subd. 4. **Report.** The board shall report to the governor and the legislature by July 1, 1981, on (1) the number, type and location of human services activities assisted by retired senior volunteer programs supported pursuant to subdivisions 1 to 4; (2) the number of retired seniors participating in these activities; (3) the sources and recipients of direct support for the volunteer programs; and (4) any other information which the board believes will assist the governor and the legislature in evaluating the programs.

**256.9792 ARREARAGE COLLECTION PROJECTS.**

Subdivision 1. **Arrearage collections.** Arrearage collection projects are created to increase the revenue to the state and counties, reduce public assistance expenditures for former public assistance cases, and increase payments of arrearages to persons who are not receiving public assistance by submitting cases for arrearage collection to collection entities, including but not limited to, the Department of Revenue and private collection agencies.

Subd. 2. **Definitions.** (a) The definitions in this subdivision apply to this section:

(b) "Public assistance arrearage case" means a case where current support may be due, no payment, with the exception of tax offset, has been made within the last 90 days, and the arrearages are assigned to the public agency according to section 256.741.

(c) "Public authority" means the public authority responsible for child support enforcement.

(d) "Nonpublic assistance arrearage case" means a support case where arrearages have accrued that have not been assigned according to section 256.741.

Subd. 3. **Agency participation.** (a) The collection remedy under this section is in addition to and not in substitution for any other remedy available by law to the public authority. The public authority remains responsible for the case even after collection efforts are referred to the Department of Revenue, a private agency, or other collection entity.

(b) The Department of Revenue, a private agency, or other collection entity may not claim collections made on a case submitted by the public authority for a state tax offset under chapter 270A as a collection for the purposes of this project.

Subd. 4. **Eligible cases.** (a) For a case to be eligible for a collection project, the criteria in paragraphs (b) and (c) must be met. Any case from a county participating in the collections project meeting the criteria under this subdivision must be subcommitted for collection.

(b) Notice must be sent to the debtor, as defined in section 270A.03, subdivision 4, at the debtor's last known address at least 30 days before the date the collections effort is transferred. The notice must inform the debtor that the Department of Revenue or a private collections agency will use enforcement and collections remedies and may charge a fee of up to 30 percent of the arrearages. The notice must advise the debtor of the right to contest the debt on grounds limited to mistakes of fact. The debtor may contest the debt by submitting a written request for review to the public authority within 21 days of the date of the notice.

(c) The arrearages owed must be based on a court or administrative order. The arrearages to be collected must be at least $100 and must be at least 90 days past due. For nonpublic assistance cases referred to private agencies, the arrearages must be a docketed judgment under sections 548.09 and 548.091.

Subd. 5. **County participation.** (a) The commissioner of human services shall designate the counties to participate in the projects, after requesting counties to volunteer for the projects.

(b) The commissioner of human services shall designate which counties shall submit cases to the Department of Revenue, a private collection agency, or other collection entity.

Subd. 6. **Fees.** A collection fee set by the commissioner of human services shall be charged to the person obligated to pay the arrearages. The collection fee is in addition to the amount owed, and must be deposited by the commissioner of revenue in the state treasury and credited to the general fund to cover the costs of administering the program or retained by the private agency or other collection entity to cover the costs of administering the collection services.

Subd. 7. **Contracts.** (a) The commissioner of human services may contract with the commissioner of revenue, private agencies, or other collection entities to implement the projects, charge fees, and exchange necessary information.

(b) The commissioner of human services may provide an advance payment to the commissioner of revenue for collection services to be repaid to the Department of Human Services out of subsequent collection fees.

(c) Summary reports of collections, fees, and other costs charged shall be submitted monthly to the state office of child support enforcement.

Subd. 8. **Remedies.** (a) The commissioner of revenue is authorized to use the tax collection remedies in sections 270C.32, subdivision 1, 270C.63, 270C.67, 270C.68, 270C.69, 270C.70 to 270C.72, and 270C.728, and tax return information to collect arrearages.

(b) Liens arising under paragraph (a) shall be perfected under the provisions of section 270C.63. The lien may be filed as long as the time period allowed by law for collecting the arrearages has not expired. The lien shall attach to all property of the debtor within the state, both real and personal under the provisions of section 270C.63. The lien shall be enforced under the provisions in section 270C.63 relating to state tax liens.

**256B.04 DUTIES OF STATE AGENCY.**

Subd. 16. **Personal care services.** (a) Notwithstanding any contrary language in this paragraph, the commissioner of human services and the commissioner of health shall jointly promulgate rules to be applied to the licensure of personal care services provided under the medical assistance program. The rules shall consider standards for personal care services that are based on the World Institute on Disability's recommendations regarding personal care services. These rules shall at a minimum consider the standards and requirements adopted by the commissioner of health under section 144A.45, which the commissioner of human services determines are applicable to the provision of personal care services, in addition to other standards or modifications which the commissioner of human services determines are appropriate.

The commissioner of human services shall establish an advisory group including personal care consumers and providers to provide advice regarding which standards or modifications should be adopted. The advisory group membership must include not less than 15 members, of which at least 60 percent must be consumers of personal care services and representatives of recipients with various disabilities and diagnoses and ages. At least 51 percent of the members of the advisory group must be recipients of personal care.

The commissioner of human services may contract with the commissioner of health to enforce the jointly promulgated licensure rules for personal care service providers.

Prior to final promulgation of the joint rule the commissioner of human services shall report preliminary findings along with any comments of the advisory group and a plan for monitoring and enforcement by the Department of Health to the legislature by February 15, 1992.

Limits on the extent of personal care services that may be provided to an individual must be based on the cost-effectiveness of the services in relation to the costs of inpatient hospital care, nursing home care, and other available types of care. The rules must provide, at a minimum:

(1) that agencies be selected to contract with or employ and train staff to provide and supervise the provision of personal care services;

(2) that agencies employ or contract with a qualified applicant that a qualified recipient proposes to the agency as the recipient's choice of assistant;

(3) that agencies bill the medical assistance program for a personal care service by a personal care assistant and supervision by a qualified professional supervising the personal care assistant unless the recipient selects the fiscal agent option under section 256B.0659, subdivision 33;

(4) that agencies establish a grievance mechanism; and

(5) that agencies have a quality assurance program.

(b) The commissioner may waive the requirement for the provision of personal care services through an agency in a particular county, when there are less than two agencies providing services in that county and shall waive the requirement for personal care assistants required to join an agency for the first time during 1993 when personal care services are provided under a relative hardship waiver under Minnesota Statutes 1992, section 256B.0627, subdivision 4,

paragraph (b), clause (7), and at least two agencies providing personal care services have refused to employ or contract with the independent personal care assistant.

**256B.043 COST-CONTAINMENT EFFORTS.**

Subdivision 1. **Alternative and complementary health care.** The commissioner of human services, through the medical director and in consultation with the Health Services Policy Committee established under section 256B.0625, subdivision 3c, as part of the commissioner's ongoing duties, shall consider the potential for improving quality and obtaining cost savings through greater use of alternative and complementary treatment methods and clinical practice; shall incorporate these methods into the medical assistance, MinnesotaCare, and general assistance medical care programs; and shall make related legislative recommendations as appropriate. The commissioner shall post the recommendations required under this subdivision on agency Web sites according to section 144.0506, subdivision 1.

Subd. 2. **Access to care.** (a) The commissioners of human services and health, as part of their ongoing duties, shall consider the adequacy of the current system of community health clinics and centers both statewide and in urban areas with significant disparities in health status and access to services across racial and ethnic groups, including:

(1) methods to provide 24-hour availability of care through the clinics and centers;

(2) methods to expand the availability of care through the clinics and centers;

(3) the use of grants to expand the number of clinics and centers, the services provided, and the availability of care; and

(4) the extent to which increased use of physician assistants, nurse practitioners, medical residents and interns, and other allied health professionals in clinics and centers would increase the availability of services.

(b) The commissioners shall make departmental modifications and legislative recommendations as appropriate on the basis of their considerations under paragraph (a).

**256B.0636 CONTROLLED SUBSTANCE PRESCRIPTIONS; ABUSE PREVENTION.**

The commissioner of human services shall develop and implement a plan to:

(1) review utilization patterns of Minnesota health care program enrollees for controlled substances listed in section 152.02, subdivisions 3 and 4, and those substances defined by the Board of Pharmacy under section 152.02, subdivisions 8 and 12;

(2) develop a mechanism to address abuses both for fee-for-service Minnesota health care program enrollees and those enrolled in managed care plans; and

(3) provide education to Minnesota health care program enrollees on the proper use of controlled substances.

For purposes of this section, "Minnesota health care program" means medical assistance, MinnesotaCare, or general assistance medical care.

**256B.0656 CONSUMER-DIRECTED HOME CARE PROJECT.**

(a) Upon the receipt of federal waiver authority, the commissioner shall implement a consumer-directed home care demonstration project. The consumer-directed home care demonstration project must demonstrate and evaluate the outcomes of a consumer-directed service delivery alternative to improve access, increase consumer control and accountability over available resources, and enable the use of supports that are more individualized and cost-effective for eligible medical assistance recipients receiving certain medical assistance home care services. The consumer-directed home care demonstration project will be administered locally by county agencies, tribal governments, or administrative entities under contract with the state in regions where counties choose not to provide this service.

(b) Grant awards for persons who have been receiving medical assistance covered personal care, home health aide, or private duty nursing services for a period of 12 consecutive months or more prior to enrollment in the consumer-directed home care demonstration project will be established on a case-by-case basis using historical service expenditure data. An average monthly expenditure for each continuing enrollee will be calculated based on historical expenditures made on behalf of the enrollee for personal care, home health aide, or private duty nursing services during the 12 month period directly prior to enrollment in the project. The grant award will equal 90 percent of the average monthly expenditure.

(c) Grant awards for project enrollees who have been receiving medical assistance covered personal care, home health aide, or private duty nursing services for a period of less than 12

consecutive months prior to project enrollment will be calculated on a case-by-case basis using the service authorization in place at the time of enrollment. The total number of units of personal care, home health aide, or private duty nursing services the enrollee has been authorized to receive will be converted to the total cost of the authorized services in a given month using the statewide average service payment rates. To determine an estimated monthly expenditure, the total authorized monthly personal care, home health aide or private duty nursing service costs will be reduced by a percentage rate equivalent to the difference between the statewide average service authorization and the statewide average utilization rate for each of the services by medical assistance eligibles during the most recent fiscal year for which 12 months of data is available. The grant award will equal 90 percent of the estimated monthly expenditure.

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

(e) With federal approval, the commissioner may adjust methodologies in paragraphs (b) and (c) to simplify program administration, improve consistency between state and federal programs, and maximize federal financial participation.

**256B.0657 SELF-DIRECTED SUPPORTS OPTION.**

Subdivision 1. **Definition.** "Self-directed supports option" means personal assistance, supports, items, and related services purchased under an approved budget plan and budget by a recipient.

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

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

(2) is eligible for personal care assistance services under section 256B.0659;

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

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

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

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

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

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

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

Subd. 3. **Eligibility for other services.** Selection of the self-directed supports option by a recipient shall not restrict access to other medically necessary care and services furnished under the state plan medical assistance benefit, including home care targeted case management, except that a person receiving home and community-based waiver services, a family support grant, or a consumer support grant is not eligible for funding under the self-directed supports option.

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

(1) it shall be conducted by the county public health nurse or a certified public health nurse under contract with the county;

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

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

(b) The results of the assessment and recommendations shall be communicated to the commissioner and the recipient by the county public health nurse or certified public health nurse under contract with the county.

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

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

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

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

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

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

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

(3) the plan must include the total budget amount available divided into monthly amounts that cover the number of months of personal care assistance services authorization included in the budget. The amount used each month may vary, but additional funds shall not be provided above the annual personal care assistance services authorized amount unless a change in condition is documented.

(b) The commissioner shall:

(1) establish the format and criteria for the plan as well as the requirements for providers who assist with plan development;

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

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

(4) provide a copy of the plan to the fiscal support entity selected by the recipient.

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

(1) personal care assistance services under section 256B.0659; and

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

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

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

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

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

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

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

(5) home modifications that add square footage;

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

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

(8) experimental treatment;

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

(10) membership dues or costs, except when the service is necessary and appropriate to treat a physical condition or to improve or maintain the recipient's physical condition. The

condition must be identified in the recipient's plan of care and monitored by a Minnesota health care program enrolled physician;

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

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

(13) tickets and related costs to attend sporting or other recreational events; and

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

Subd. 8. **Self-directed budget requirements.** The budget for the provision of the self-directed service option shall be established based on:

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

(2) the personal care assistance unit rate:

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

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

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

(b) The commissioner shall provide ongoing technical assistance and resource and educational materials for families and recipients selecting the self-directed option.

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

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

(b) The fiscal support entity:

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

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

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

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

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

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

(c) The commissioner shall have authority to:

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

(2) limit the number of fiscal support entities;

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

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

Subd. 11. **Stakeholder consultation.** The commissioner shall consult with a statewide consumer-directed services stakeholder group, including representatives of all types of consumer-directed service users, advocacy organizations, counties, and consumer-directed

service providers. The commissioner shall seek recommendations from this stakeholder group in developing:

(1) the self-directed plan format;

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

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

(4) standards and requirements, including rates for the personal support plan development provider and the fiscal support entity; policies; training; and implementation. The stakeholder group shall provide recommendations on the repeal of the personal care assistance choice option, transition issues, and whether the consumer support grant program under section 256.476 should be modified. The stakeholder group shall meet at least three times each year to provide advice on policy, implementation, and other aspects of consumer and self-directed services.

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

**256B.075 DISEASE MANAGEMENT PROGRAMS.**

Subd. 4. **Report.** The commissioner of human services shall report to the legislature by January 15, 2005, on the status of disease management initiatives, and shall present recommendations to the legislature on any statutory changes needed to increase the effectiveness of these initiatives.

**256B.0757 COORDINATED CARE THROUGH A HEALTH HOME.**

Subd. 7. **State plan amendment.** The commissioner shall submit a state plan amendment to implement this section to the federal Centers for Medicare and Medicaid Services by January 1, 2011.

**256B.0913 ALTERNATIVE CARE PROGRAM.**

Subd. 9. **Contracting provisions for providers.** Alternative care funds paid to service providers are subject to audit by the commissioner for fiscal and utilization control.

The lead agency must select providers for contracts or agreements using the following criteria and other criteria established by the lead agency:

(1) the need for the particular services offered by the provider;

(2) the population to be served, including the number of clients, the length of time services will be provided, and the medical condition of clients;

(3) the geographic area to be served;

(4) quality assurance methods, including appropriate licensure, certification, or standards, and supervision of employees when needed;

(5) rates for each service and unit of service exclusive of lead agency administrative costs;

(6) evaluation of services previously delivered by the provider; and

(7) contract or agreement conditions, including billing requirements, cancellation, and indemnification.

The lead agency must evaluate its own agency services under the criteria established for other providers.

**256B.0916 EXPANSION OF HOME AND COMMUNITY-BASED SERVICES.**

Subd. 6. **Waiver request.** (a) The commissioner shall submit to the federal Health Care Financing Administration by September 1, 1999, a request for a waiver to include an option that would allow waiver service recipients to directly receive 95 percent of the funds that would be allocated to individuals based on written county criteria and procedures approved by the commissioner for the purchase of services to meet their long-term care needs. The waiver request must include a provision requiring recipients who receive funds directly to provide to the commissioner annually, a description of the type of services used, the amount paid for the services purchased, and the amount of unspent funds.

(b) The commissioner, in cooperation with county representatives, waiver service providers, recipients, recipients' families, legal guardians, and advocacy groups, shall develop criteria for:

(1) eligibility to receive funding directly;

(2) determination of the amount of funds made available to each eligible person based on need; and

(3) the accountability required of persons directly receiving funds.

(c) If this waiver is approved and implemented, any unspent money from the waiver services allocation, including the five percent not directly allocated to recipients and any unspent portion of the money that is directly allocated, shall be used to meet the needs of other eligible persons waiting for services funded through the waiver.

(d) The commissioner, in consultation with county social services agencies, waiver services providers, recipients, recipients' families, legal guardians, and advocacy groups shall evaluate the effectiveness of this option within two years of its implementation.

Subd. 6a. **Statewide availability of consumer-directed community support services.** (a) The commissioner shall submit to the federal Health Care Financing Administration by August 1, 2001, an amendment to the home and community-based waiver for persons with developmental disabilities to make consumer-directed community support services available in every county of the state by January 1, 2002.

(b) If a county declines to meet the requirements for provision of consumer-directed community supports, the commissioner shall contract with another county, a group of counties, or a private agency to plan for and administer consumer-directed community supports in that county.

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

**256B.0928 STATEWIDE CAREGIVER SUPPORT AND RESPITE CARE PROJECT.**

The commissioner shall establish and maintain a statewide caregiver support and respite care project. The project shall:

(1) provide information, technical assistance, and training statewide to county agencies and organizations on direct service models of caregiver support and respite care services;

(2) identify and address issues, concerns, and gaps in the statewide network for caregiver support and respite care;

(3) maintain a statewide caregiver support and respite care resource center;

(4) educate caregivers on the availability and use of caregiver and respite care services;

(5) promote and expand caregiver training and support groups using existing networks when possible; and

(6) apply for and manage grants related to caregiver support and respite care.

**256B.19 DIVISION OF COST.**

Subd. 3. **Study of medical assistance financial participation.** The commissioner shall study the feasibility and outcomes of implementing a variable medical assistance county financial participation rate for long-term care services to developmentally disabled persons in order to encourage the utilization of alternative services to long-term intermediate care for the developmentally disabled. The commissioner shall submit findings and recommendations to the legislature by January 20, 1984.

**256B.431 RATE DETERMINATION.**

Subd. 28. **Nursing facility rate increases beginning July 1, 1999, and July 1, 2000.** (a) For the rate years beginning July 1, 1999, and July 1, 2000, the commissioner shall make available to each nursing facility reimbursed under this section or section 256B.434 an adjustment to the total operating payment rate. For nursing facilities reimbursed under this section or section 256B.434, the July 1, 2000, operating payment rate increases provided in this subdivision shall be applied to each facility's June 30, 2000, operating payment rate. For each facility, total

operating costs shall be separated into costs that are compensation related and all other costs. Compensation-related costs include salaries, payroll taxes, and fringe benefits for all employees except management fees, the administrator, and central office staff.

(b) For the rate year beginning July 1, 1999, the commissioner shall make available a rate increase for compensation-related costs of 4.843 percent and a rate increase for all other operating costs of 3.446 percent.

(c) For the rate year beginning July 1, 2000, the commissioner shall make available:

(1) a rate increase for compensation-related costs of 3.632 percent;

(2) an additional rate increase for each case mix payment rate which must be used to increase the per-hour pay rate of all employees except management fees, the administrator, and central office staff by an equal dollar amount and to pay associated costs for FICA, the Medicare tax, workers' compensation premiums, and federal and state unemployment insurance, to be calculated according to clauses (i) to (iii):

(i) the commissioner shall calculate the arithmetic mean of the 11 June 30, 2000, operating rates for each facility;

(ii) the commissioner shall construct an array of nursing facilities from highest to lowest, according to the arithmetic mean calculated in clause (i). A numerical rank shall be assigned to each facility in the array. The facility with the highest mean shall be assigned a numerical rank of one. The facility with the lowest mean shall be assigned a numerical rank equal to the total number of nursing facilities in the array. All other facilities shall be assigned a numerical rank in accordance with their position in the array;

(iii) the amount of the additional rate increase shall be $1 plus an amount equal to $3.13 multiplied by the ratio of the facility's numeric rank divided by the number of facilities in the array; and

(3) a rate increase for all other operating costs of 2.585 percent.

Money received by a facility as a result of the additional rate increase provided under clause (2) shall be used only for wage increases implemented on or after July 1, 2000, and shall not be used for wage increases implemented prior to that date.

(d) The payment rate adjustment for each nursing facility must be determined under clause (1) or (2):

(1) for each nursing facility that reports salaries for registered nurses, licensed practical nurses, aides, orderlies, and attendants separately, the commissioner shall determine the payment rate adjustment using the categories specified in paragraph (a) multiplied by the rate increases specified in paragraph (b) or (c), and then dividing the resulting amount by the nursing facility's actual resident days. In determining the amount of a payment rate adjustment for a nursing facility reimbursed under section 256B.434, the commissioner shall determine the proportions of the facility's rates that are compensation-related costs and all other operating costs based on the facility's most recent cost report; and

(2) for each nursing facility that does not report salaries for registered nurses, licensed practical nurses, aides, orderlies, and attendants separately, the payment rate adjustment shall be computed using the facility's total operating costs, separated into the categories specified in paragraph (a) in proportion to the weighted average of all facilities determined under clause (1), multiplied by the rate increases specified in paragraph (b) or (c), and then dividing the resulting amount by the nursing facility's actual resident days.

(e) A nursing facility may apply for the compensation-related payment rate adjustment calculated under this subdivision. The application must be made to the commissioner and contain a plan by which the nursing facility will distribute the compensation-related portion of the payment rate adjustment to employees of the nursing facility. For nursing facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan. For the second rate year, a negotiated agreement constitutes the plan only if the agreement is finalized after the date of enactment of all rate increases for the second rate year. The commissioner shall review the plan to ensure that the payment rate adjustment per diem is used as provided in paragraphs (a) to (c). To be eligible, a facility must submit its plan for the compensation distribution by December 31 each year. A facility may amend its plan for the second rate year by submitting a revised plan by December 31, 2000. If a facility's plan for compensation distribution is effective for its employees after July 1 of the year that the funds are available, the payment rate adjustment per diem shall be effective the same date as its plan.

(f) A copy of the approved distribution plan must be made available to all employees. This must be done by giving each employee a copy or by posting it in an area of the nursing facility to which all employees have access. If an employee does not receive the compensation adjustment described in their facility's approved plan and is unable to resolve the problem with

the facility's management or through the employee's union representative, the employee may contact the commissioner at an address or phone number provided by the commissioner and included in the approved plan.

(g) If the reimbursement system under section 256B.435 is not implemented until July 1, 2001, the salary adjustment per diem authorized in subdivision 2i, paragraph (c), shall continue until June 30, 2001.

(h) For the rate year beginning July 1, 1999, the following nursing facilities shall be allowed a rate increase equal to 67 percent of the rate increase that would be allowed if subdivision 26, paragraph (a), was not applied:

(1) a nursing facility in Carver County licensed for 33 nursing home beds and four boarding care beds;

(2) a nursing facility in Faribault County licensed for 159 nursing home beds on September 30, 1998; and

(3) a nursing facility in Houston County licensed for 68 nursing home beds on September 30, 1998.

(i) For the rate year beginning July 1, 1999, the following nursing facilities shall be allowed a rate increase equal to 67 percent of the rate increase that would be allowed if subdivision 26, paragraphs (a) and (b), were not applied:

(1) a nursing facility in Chisago County licensed for 135 nursing home beds on September 30, 1998; and

(2) a nursing facility in Murray County licensed for 62 nursing home beds on September 30, 1998.

(j) For the rate year beginning July 1, 1999, a nursing facility in Hennepin County licensed for 134 beds on September 30, 1998, shall:

(1) have the prior year's allowable care-related per diem increased by $3.93 and the prior year's other operating cost per diem increased by $1.69 before adding the inflation in subdivision 26, paragraph (d), clause (2); and

(2) be allowed a rate increase equal to 67 percent of the rate increase that would be allowed if subdivision 26, paragraphs (a) and (b), were not applied.

The increases provided in paragraphs (h), (i), and (j) shall be included in the facility's total payment rates for the purposes of determining future rates under this section or any other section.

(k) For the rate years beginning on or after July 1, 2000, a nursing home facility in Goodhue County that was licensed for 104 beds on February 1, 2000, shall have its employee pension benefit costs reported on its Rule 50 cost report treated as PERA contributions for the purpose of computing its payment rates.

Subd. 31. **Nursing facility rate increases beginning July 1, 2001, and July 1, 2002.** For the rate years beginning July 1, 2001, and July 1, 2002, the commissioner shall provide to each nursing facility reimbursed under this section or section 256B.434 an adjustment equal to 3.0 percent of the total operating payment rate. The operating payment rates in effect on June 30, 2001, shall include the adjustment in subdivision 2i, paragraph (c).

Subd. 33. **Staged reduction in rate disparities.** (a) For the rate years beginning July 1, 2001, and July 1, 2002, the commissioner shall adjust the operating payment rates for low-rate nursing facilities reimbursed under this section or section 256B.434.

(b) For the rate year beginning July 1, 2001, for each case mix level, if the amount computed under subdivision 31 is less than the amount in clause (1), the commissioner shall make available the lesser of the amount in clause (1) or an increase of ten percent over the rate in effect on June 30, 2001, as an adjustment to the operating payment rate. For the rate year beginning July 1, 2002, for each case mix level, if the amount computed under subdivision 31 is less than the amount in clause (2), the commissioner shall make available the lesser of the amount in clause (2) or an increase of ten percent over the rate in effect on June 30, 2002, as an adjustment to the operating payment rate. For purposes of this subdivision, nursing facilities shall be considered to be metro if they are located in Anoka, Carver, Dakota, Hennepin, Olmsted, Ramsey, Scott, or Washington Counties; or in the cities of Moorhead or Breckenridge; or in St. Louis County, north of Toivola and south of Cook; or in Itasca County, east of a north south line two miles west of Grand Rapids:

(1) Operating Payment Rate Target Level for July 1, 2001:

| Case Mix Classification | Metro | Nonmetro |
|---|---|---|
| A | $ 76.00 | $ 68.13 |
| B | $ 83.40 | $ 74.46 |
| C | $ 91.67 | $ 81.63 |

| | | |
|---|---|---|
| D | $ 99.51 | $ 88.04 |
| E | $107.46 | $ 94.87 |
| F | $107.96 | $ 95.29 |
| G | $114.67 | $100.98 |
| H | $126.99 | $111.31 |
| I | $131.42 | $115.06 |
| J | $138.34 | $120.85 |
| K | $152.26 | $133.10 |

(2) Operating Payment Rate Target Level for July 1, 2002:

| Case Mix Classification | Metro | Nonmetro |
|---|---|---|
| A | $ 78.28 | $ 70.51 |
| B | $ 85.91 | $ 77.16 |
| C | $ 94.42 | $ 84.62 |
| D | $102.50 | $ 91.42 |
| E | $110.68 | $ 98.40 |
| F | $111.20 | $ 98.84 |
| G | $118.11 | $104.77 |
| H | $130.80 | $115.64 |
| I | $135.38 | $119.50 |
| J | $142.49 | $125.38 |
| K | $156.85 | $137.77 |

Subd. 34. **Nursing facility rate increases beginning July 1, 2001, and July 1, 2002.** (a) For the rate years beginning July 1, 2001, and July 1, 2002, two-thirds of the money resulting from the rate adjustment under subdivision 31 and one-half of the money resulting from the rate adjustment under subdivisions 32 and 33 must be used to increase the wages and benefits and pay associated costs of all employees except management fees, the administrator, and central office staff.

(b) Money received by a facility as a result of the rate adjustments provided in subdivisions 31 to 33, which must be used as provided in paragraph (a), must be used only for wage and benefit increases implemented on or after July 1, 2001, or July 1, 2002, respectively, and must not be used for wage increases implemented prior to those dates.

(c) Nursing facilities may apply for the portions of the rate adjustments under subdivisions 31 to 33, which must be used as provided in paragraph (a). The application must be made to the commissioner and contain a plan by which the nursing facility will distribute to employees of the nursing facility the funds, which must be used as provided in paragraph (a). For nursing facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan. A negotiated agreement may constitute the plan only if the agreement is finalized after the date of enactment of all increases for the rate year. The commissioner shall review the plan to ensure that the rate adjustments are used as provided in paragraph (a). To be eligible, a facility must submit its plan for the wage and benefit distribution by December 31 each year. If a facility's plan for wage and benefit distribution is effective for its employees after July 1 of the year that the funds are available, the portion of the rate adjustments, which must be used as provided in paragraph (a), are effective the same date as its plan.

(d) A hospital-attached nursing facility may include costs in their distribution plan for wages and benefits and associated costs of employees in the organization's shared services departments, provided that:

(1) the nursing facility and the hospital share common ownership; and

(2) adjustments for hospital services using the diagnostic-related grouping payment rates per admission under Medicare are less than three percent during the 12 months prior to the effective date of these rate adjustments.

If a hospital-attached facility meets the qualifications in this paragraph, the difference between the rate adjustments approved for nursing facility services and the rate increase approved for hospital services may be permitted as a distribution in the hospital-attached facility's plan

regardless of whether the use of those funds is shown as being attributable to employee hours worked in the nursing facility or employee hours worked in the hospital.

For the purposes of this paragraph, a hospital-attached nursing facility is one that meets the definition under subdivision 2j, or, in the case of a facility reimbursed under section 256B.434, met this definition at the time their last payment rate was established under Minnesota Rules, parts 9549.0010 to 9549.0080, and this section.

(e) A copy of the approved distribution plan must be made available to all employees by giving each employee a copy or by posting it in an area of the nursing facility to which all employees have access. If an employee does not receive the wage and benefit adjustment described in the facility's approved plan and is unable to resolve the problem with the facility's management or through the employee's union representative, the employee may contact the commissioner at an address or telephone number provided by the commissioner and included in the approved plan.

(f) Notwithstanding section 256B.48, subdivision 1, clause (a), upon the request of a nursing facility, the commissioner may authorize the facility to raise per diem rates for private-pay residents on July 1 by the amount anticipated to be required upon implementation of the rate adjustments allowable under subdivisions 31 to 33. The commissioner shall require any amounts collected under this paragraph, which must be used as provided in paragraph (a), to be placed in an escrow account established for this purpose with a financial institution that provides deposit insurance until the medical assistance rate is finalized. The commissioner shall conduct audits as necessary to ensure that:

(1) the amounts collected are retained in escrow until medical assistance rates are increased to reflect the wage-related adjustment; and

(2) any amounts collected from private-pay residents in excess of the final medical assistance rate are repaid to the private-pay residents with interest at the rate used by the commissioner of revenue for the late payment of taxes and in effect on the date the distribution plan is approved by the commissioner of human services.

Subd. 37. **Nursing home rate increases effective July 1, 2002.** For rate years beginning on or after July 1, 2002, the commissioner shall provide to each nursing home reimbursed under this section or section 256B.434 an increase in each case mix payment rate equal to the increase in the per-bed surcharge paid under section 256.9657, subdivision 1, paragraph (c), divided by 365 and further divided by .80. The increase under this subdivision shall be added following the determination of the payment rate for the home under this chapter. The increase shall not be subject to any annual percentage increase.

Subd. 38. **Nursing home rate increases effective in fiscal year 2003.** Effective June 1, 2003, the commissioner shall provide to each nursing home reimbursed under this section or section 256B.434, an increase in each case mix payment rate equal to the increase in the per-bed surcharge paid under section 256.9657, subdivision 1, paragraph (d), divided by 365 and further divided by .90. The increase shall not be subject to any annual percentage increase. The 30-day advance notice requirement in section 256B.47, subdivision 2, shall not apply to rate increases resulting from this section. The commissioner shall not adjust the rate increase under this subdivision unless the adjustment is greater than 1.5 percent of the monthly surcharge payment amount under section 256.9657, subdivision 4.

Subd. 39. **Facility rates beginning on or after July 1, 2003.** For rate years beginning on or after July 1, 2003, nursing facilities reimbursed under this section shall have their July 1 operating payment rate be equal to their operating payment rate in effect on the prior June 30th.

Subd. 40. **Designation of areas to receive metropolitan rates.** (a) For rate years beginning on or after July 1, 2004, and subject to paragraph (b), nursing facilities located in areas designated as metropolitan areas by the federal Office of Management and Budget using Census Bureau data shall be considered metro, in order to:

(1) determine rate increases under this section, section 256B.434, or any other section; and

(2) establish nursing facility reimbursement rates for the new nursing facility reimbursement system developed under Laws 2001, First Special Session chapter 9, article 5, section 35, as amended by Laws 2002, chapter 220, article 14, section 19.

(b) Paragraph (a) applies only if designation as a metro facility results in a level of reimbursement that is higher than the level the facility would have received without application of that paragraph.

Subd. 41. **Rate increases for October 1, 2005, and October 1, 2006.** (a) For the rate period beginning October 1, 2005, the commissioner shall make available to each nursing facility reimbursed under this section or section 256B.434 an adjustment equal to 2.2553 percent of the total operating payment rate, and for the rate year beginning October 1, 2006, the commissioner

shall make available to each nursing facility reimbursed under this section or section 256B.434 an adjustment equal to 1.2553 percent of the total operating payment rate.

(b) 75 percent of the money resulting from the rate adjustment under paragraph (a) must be used to increase wages and benefits and pay associated costs for all employees, except management fees, the administrator, and central office staff. Except as provided in paragraph (c), 75 percent of the money received by a facility as a result of the rate adjustment provided in paragraph (a) must be used only for wage, benefit, and staff increases implemented on or after the effective date of the rate increase each year, and must not be used for increases implemented prior to that date.

(c) With respect only to the October 1, 2005, rate increase, a nursing facility that incurred costs for salary and employee benefit increases first provided after July 1, 2003, may count those costs towards the amount required to be spent on salaries and benefits under paragraph (b). These costs must be reported to the commissioner in the form and manner specified by the commissioner.

(d) Nursing facilities may apply for the portion of the rate adjustment under paragraph (a) for employee wages and benefits and associated costs. The application must be made to the commissioner and contain a plan by which the nursing facility will distribute the funds according to paragraph (b). For nursing facilities in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the employer and the exclusive bargaining representative constitutes the plan. A negotiated agreement may constitute the plan only if the agreement is finalized after the date of enactment of all increases for the rate year and signed by both parties prior to submission to the commissioner. The commissioner shall review the plan to ensure that the rate adjustments are used as provided in paragraph (b). To be eligible, a facility must submit its distribution plan by March 31, 2006, and March 31, 2007, respectively. The commissioner may approve distribution plans on or before June 30, 2006, and June 30, 2007, respectively. The commissioner may waive the deadlines in this paragraph under extraordinary circumstances, either retroactively or prospectively, to be determined at the sole discretion of the commissioner. If a facility's distribution plan is effective after the first day of the applicable rate period that the funds are available, the rate adjustments are effective the same date as the facility's plan.

(e) A copy of the approved distribution plan must be made available to all employees by giving each employee a copy or by posting a copy in an area of the nursing facility to which all employees have access. If an employee does not receive the wage and benefit adjustment described in the facility's approved plan and is unable to resolve the problem with the facility's management or through the employee's union representative, the employee may contact the commissioner at an address or telephone number provided by the commissioner and included in the approved plan.

Subd. 43. **Rate increase for facilities in Stearns, Sherburne, and Benton Counties.** Effective July 1, 2006, operating payment rates of nursing facilities in Stearns, Sherburne, and Benton Counties that are reimbursed under this section, section 256B.434, or section 256B.441 shall be increased to be equal, for a RUG's rate with a weight of 1.00, to the geographic group III median rate for the same RUG's weight. The percentage of the operating payment rate for each facility to be case-mix adjusted shall be equal to the percentage that is case-mix adjusted in that facility's June 30, 2006, operating payment rate. This subdivision shall apply only if it results in a rate increase. Increases provided by this subdivision shall be added to the rate determined under any new reimbursement system established under section 256B.440.

**256B.434 ALTERNATIVE PAYMENT DEMONSTRATION PROJECT.**

Subd. 19. **Nursing facility rate increases beginning October 1, 2007.** (a) For the rate year beginning October 1, 2007, the commissioner shall make available to each nursing facility reimbursed under this section operating payment rate adjustments equal to 1.87 percent of the operating payment rates in effect on September 30, 2007.

(b) Seventy-five percent of the money resulting from the rate adjustment under paragraph (a) must be used for increases in compensation-related costs for employees directly employed by the nursing facility on or after the effective date of the rate adjustment, except:

(1) the administrator;

(2) persons employed in the central office of a corporation that has an ownership interest in the nursing facility or exercises control over the nursing facility; and

(3) persons paid by the nursing facility under a management contract.

(c) Two-thirds of the money available under paragraph (b) must be used for wage increases for all employees directly employed by the nursing facility on or after the effective date of the rate adjustment, except those listed in paragraph (b), clauses (1) to (3). The wage adjustment that

employees receive under this paragraph must be paid as an equal hourly percentage wage increase for all eligible employees. All wage increases under this paragraph must be effective on the same date. Only costs associated with the portion of the equal hourly percentage wage increase that goes to all employees shall qualify under this paragraph. Costs associated with wage increases in excess of the amount of the equal hourly percentage wage increase provided to all employees shall be allowed only for meeting the requirements in paragraph (b). This paragraph shall not apply to employees covered by a collective bargaining agreement.

(d) The commissioner shall allow as compensation-related costs all costs for:

(1) wages and salaries;

(2) FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation;

(3) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and pensions; and

(4) other benefits provided, subject to the approval of the commissioner.

(e) The portion of the rate adjustment under paragraph (a) that is not subject to the requirements in paragraphs (b) and (c) shall be provided to nursing facilities effective October 1, 2007.

(f) Nursing facilities may apply for the portion of the rate adjustment under paragraph (a) that is subject to the requirements in paragraphs (b) and (c). The application must be submitted to the commissioner within six months of the effective date of the rate adjustment, and the nursing facility must provide additional information required by the commissioner within nine months of the effective date of the rate adjustment. The commissioner must respond to all applications within three weeks of receipt. The commissioner may waive the deadlines in this paragraph under extraordinary circumstances, to be determined at the sole discretion of the commissioner. The application must contain:

(1) an estimate of the amounts of money that must be used as specified in paragraphs (b) and (c);

(2) a detailed distribution plan specifying the allowable compensation-related and wage increases the nursing facility will implement to use the funds available in clause (1);

(3) a description of how the nursing facility will notify eligible employees of the contents of the approved application, which must provide for giving each eligible employee a copy of the approved application, excluding the information required in clause (1), or posting a copy of the approved application, excluding the information required in clause (1), for a period of at least six weeks in an area of the nursing facility to which all eligible employees have access; and

(4) instructions for employees who believe they have not received the compensation-related or wage increases specified in clause (2), as approved by the commissioner, and which must include a mailing address, e-mail address, and the telephone number that may be used by the employee to contact the commissioner or the commissioner's representative.

(g) The commissioner shall ensure that cost increases in distribution plans under paragraph (f), clause (2), that may be included in approved applications, comply with the following requirements:

(1) costs to be incurred during the applicable rate year resulting from wage and salary increases effective after October 1, 2006, and prior to the first day of the nursing facility's payroll period that includes October 1, 2007, shall be allowed if they were not used in the prior year's application;

(2) a portion of the costs resulting from tenure-related wage or salary increases may be considered to be allowable wage increases, according to formulas that the commissioner shall provide, where employee retention is above the average statewide rate of retention of direct care employees;

(3) the annualized amount of increases in costs for the employer's share of health and dental insurance, life insurance, disability insurance, and workers' compensation shall be allowable compensation-related increases if they are effective on or after April 1, 2007, and prior to April 1, 2008; and

(4) for nursing facilities in which employees are represented by an exclusive bargaining representative, the commissioner shall approve the application only upon receipt of a letter of acceptance of the distribution plan, in regard to members of the bargaining unit, signed by the exclusive bargaining agent and dated after May 25, 2007. Upon receipt of the letter of acceptance, the commissioner shall deem all requirements of this section as having been met in regard to the members of the bargaining unit.

(h) The commissioner shall review applications received under paragraph (f) and shall provide the portion of the rate adjustment under paragraphs (b) and (c) if the requirements of this subdivision have been met. The rate adjustment shall be effective October 1. Notwithstanding

paragraph (a), if the approved application distributes less money than is available, the amount of the rate adjustment shall be reduced so that the amount of money made available is equal to the amount to be distributed.

**256B.440 RECOMMENDATION FOR A NEW REIMBURSEMENT SYSTEM.**

Subdivision 1. **In general.** The commissioner shall present to the legislature, by January 15, 2005, a recommendation to establish a new nursing facility reimbursement system that provides facility-specific, prospective payment rates for nursing facilities participating in the medical assistance program. The rates shall be determined using a statistical and cost report filed by each nursing facility. The total payment rate shall be composed of four rate components: direct-care services, support services, external fixed, and property-related costs. The payment rate shall be derived from statistical measures of actual costs incurred in the operation of nursing facilities. From this cost basis, the components of the total payment rate shall be adjusted for quality of services provided, actual costs of operation of each facility, geographic variation in labor costs, rental value, and resident acuity.

Subd. 2. **Recommendation for establishment beginning October 1, 2006.** The recommendation in subdivision 1 shall provide for the establishment of all or part of a nursing facility's rates under the new nursing facility reimbursement system beginning on October 1, 2006. Rates shall be rebased annually. Effective January 1, 2005, each cost reporting year shall begin on January 1 and end on the following December 31. A cost report shall be filed by each nursing facility by March 31. Notice of rates shall be distributed by August 1 and the rates shall go into effect on October 1 for one year.

Subd. 3. **Reporting of baseline statistical and cost information.** (a) Nursing facilities shall file a baseline statistical and cost report on or before August 31, 2004, for the reporting period ending either September 30, 2003, or December 31, 2003. After July 1, 2004, the report required under Minnesota Rules, part 9549.0041, subpart 1, shall no longer be required. For the period between January 1, 2004, and December 31, 2004, the commissioner may collect statistical and cost information from facilities in no greater detail than items collected from facilities under section 256B.431 or 256B.434, whichever is applicable, for the year ending September 30, 2003.

(b) All nursing facilities shall provide information to the commissioner in the form and manner specified by the commissioner. The commissioner shall consult with stakeholders in developing the baseline statistical and cost report that will be used to collect all data necessary to develop and model the new nursing facility reimbursement system.

(c) Nursing facilities shall report as costs of the nursing facility only costs directly related to the operation of the nursing facility. The facility shall not include costs that are separately reimbursed by residents, medical assistance, or other payors. The commissioner may grant to facilities one extension of up to ten days for the filing of this report, if the extension is requested by August 1. The commissioner may require facilities to submit separately, in the form and manner specified by the commissioner, documentation of statistical and cost information included in the report, in order to ensure accuracy in modeling payment rates and to perform audit and appeal review functions under this section. Facilities shall retain all records necessary to document statistical and cost information provided in the report for a period of no less than seven years.

(d) The commissioner may reject a report filed by a nursing facility under this section if the commissioner determines that the report has been filed in a form that is incomplete or inaccurate and the information is insufficient to model accurate payment rates. If a report is rejected or is not submitted in a timely manner, the commissioner shall reduce payments to a nursing facility to 85 percent of amounts due until the information is completely and accurately filed. The reinstatement of withheld payments shall be retroactive for no more than 90 days. A nursing facility whose report is rejected shall be given notice of the rejection, the reasons for the rejection, and an opportunity to correct the report prior to any payment reduction. A nursing facility that does not submit a report shall be given a prior written notice of the payment reduction.

(e) The commissioner shall use the baseline statistical and cost report data to model and simulate the new nursing facility reimbursement system. Modeling shall be done using both budget neutrality and additional funding assumptions.

(f) The data set in which statistical and cost reports are compiled shall, upon request, be released by the commissioner, once it has been used for statistical analyses for purposes of modeling rate setting.

(g) The commissioner shall determine, in consultation with stakeholders and experts, methods that shall be used to integrate quality measures into the new nursing facility reimbursement system. For the modeling and simulations of the baseline data, the quality measures shall include, at a minimum:

(1) direct care hours per standardized resident day;
(2) staff turnover;
(3) staff retention;
(4) use of pool staff;
(5) proportion of beds in single-bed rooms;
(6) quality indicators from the minimum data set; and
(7) survey deficiencies.

If data analysis of the modeling and simulations indicates that revisions, deletions, or additional indicators are needed, those modifications shall be made prior to the initial rate year. The quality measures used to determine a component of the payment rates shall be established for a rate year using data submitted in the statistical and cost report from the associated reporting year, and using data from other sources related to the reporting year.

**256B.441 VALUE-BASED NURSING FACILITY REIMBURSEMENT SYSTEM.**

Subd. 46. **Calculation of quality add-on.** The payment rate for the quality add-on shall be a variable amount based on each facility's quality score.

(a) For the rate year beginning October 1, 2006, the maximum quality add-on percent shall be 2.4 percent and this add-on shall not be subject to a phase-in. The determination of the quality score to be used in calculating the quality add-on for October 1, 2006, shall be based on a report which must be filed with the commissioner, according to the requirements in subdivision 43, for a six-month period ending January 31, 2006. This report shall be filed with the commissioner by February 28, 2006. The commissioner shall prorate the six months of data to a full year. When new quality measures are incorporated into the quality score methodology and when existing quality measures are updated or improved, the commissioner may increase the maximum quality add-on percent.

(b) For each facility, determine the operating payment rate.

(c) For each facility determine a ratio of the quality score of the facility determined in subdivision 44, less 40 and then divided by 60. If this value is less than zero, use the value zero.

(d) For each facility, the quality add-on shall be the value determined in paragraph (b) times the value determined in paragraph (c) times the maximum quality add-on percent.

Subd. 46a. **Calculation of quality add-on for the rate year beginning October 1, 2007.** (a) The payment rate for the rate year beginning October 1, 2007, for the quality add-on, is a variable amount based on each facility's quality score. For the rate year, the maximum quality add-on is .3 percent of the operating payment rate in effect on September 30, 2007. The commissioner shall determine the quality add-on for each facility according to paragraphs (b) to (d).

(b) For each facility, the commissioner shall determine the operating payment rate in effect on September 30, 2007.

(c) For each facility, the commissioner shall determine a ratio of the quality score of the facility determined in subdivision 44, subtract 40, and then divide by 60. If this value is less than zero, the commissioner shall use the value zero.

(d) For each facility, the quality add-on is the value determined in paragraph (b), multiplied by the value determined in paragraph (c), multiplied by .3 percent.

**256B.491 WAIVERED SERVICES.**

Subdivision 1. **Study.** The commissioner of human services shall prepare a study on the characteristics of providers who have the potential for offering home and community-based services under federal waivers authorized by United States Code, title 42, sections 1396 to 1396p. The study shall include, but not be limited to:

(a) An analysis of the characteristics of providers presently involved in offering services to the elderly, chronically ill children, disabled persons under age 65, and developmentally disabled persons;

(b) The potential for conversion to waivered services of facilities which currently provide services to the disability groups enumerated in clause (a);

(c) Proposals for system redesign to include (1) profiles of the types of providers best able, within reasonable fiscal constraints, to serve the needs of clients and to fulfill public policy goals in provision of waivered services, (2) methods for limiting concentration of facilities providing services under waiver, (3) methods for ensuring that services are provided by the widest array of provider groups.

The commissioner shall present the study to the legislature no later than March 15, 1985.

Subd. 2. **Control limited.** Until July 1, 1985, no one person shall control the delivery of waivered services to more than 50 persons receiving waivered services as authorized by section 256B.501. For the purposes of this section the following terms have the meanings given them:

(1) A "person" is an individual, a corporation, a partnership, an association, a trust, an unincorporated organization, a subsidiary of an organization, and an affiliate. A "person" does not include any governmental authority, agency or body.

(2) An "affiliate" is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with another person.

(3) "Control" including the terms "controlling," "controlled by," and "under the common control with" is the possession, direct or indirect, or the power to direct or cause the direction of the management, operations or policies of a person, whether through the ownership of voting securities, by contract, through consultation or otherwise.

Subd. 3. **Waivered services; salary adjustments.** For the fiscal year beginning July 1, 1991, the commissioner of human services shall increase the statewide reimbursement rates for home and community-based waivered services for persons with developmental disabilities to reflect a three percent increase in salaries, payroll taxes, and fringe benefits of personnel below top management employed by agencies under contract with the county board to provide these services. The specific rate increase made available to county boards shall be calculated based on the estimated portion of the fiscal year 1991 reimbursement rate that is attributable to these costs. County boards shall verify in writing to the commissioner that each waivered service provider has complied with this requirement. If a county board determines that a waivered service provider has not complied with this requirement for a specific contract period, the county board shall reduce the provider's payment rates for the next contract period to reflect the amount of money not spent appropriately. The commissioner shall modify reporting requirements for vendors and counties as necessary to monitor compliance with this provision.

**256B.501 RATES FOR COMMUNITY-BASED SERVICES FOR DISABLED.**

Subd. 3a. **Interim rates.** For rate years beginning October 1, 1988, and October 1, 1989, the commissioner shall establish an interim program operating cost payment rate for care of residents in intermediate care facilities for persons with developmental disabilities.

(a) For the rate year beginning October 1, 1988, the interim program operating cost payment rate is the greater of the facility's 1987 reporting year allowable program operating costs per resident day increased by the composite forecasted index in subdivision 3c, or the facility's January 1, 1988, program operating cost payment rate increased by the composite forecasted index in subdivision 3c, except that the composite forecasted index is established based on the midpoint of the period January 1, 1988, to September 30, 1988, to the midpoint of the following rate year.

(b) For the rate year beginning October 1, 1989, the interim program operating cost payment rate is the greater of the facility's 1988 reporting year allowable program operating costs per resident day increased by the composite forecasted index in subdivision 3c, or the facility's October 1, 1988, program operating cost payment rate increased by the composite forecasted index in subdivision 3c, except that the composite forecasted index is established based on the midpoint of the rate year beginning October 1, 1988, to the midpoint of the following rate year.

Subd. 3b. **Settle up of costs.** The facility's program operating costs are subject to a retroactive settle up for the 1988 and 1989 reporting years, determined by the following method:

(a) If a facility's program operating costs, including onetime adjustment program operating costs for the facility's 1988 or 1989 reporting year, are less than 98 percent of the facility's total program operating cost payments for facilities with 20 or fewer licensed beds, or less than 99 percent of the facility's total program operating cost payments for facilities with more than 20 licensed beds, then the facility must repay the difference to the state according to the desk audit adjustment procedures in Minnesota Rules, part 9553.0041, subpart 13, items B to E. For the purpose of determining the retroactive settle-up amounts, the facility's total program operating cost payments must be computed by multiplying the facility's program operating cost payment rates, including onetime program operating cost adjustment rates for those reporting years, by the prorated resident days that correspond to those program operating cost payment rates paid during those reporting years.

(b) If a facility's program operating costs, including onetime adjustment program operating costs for the facility's 1989 reporting year are between 102 and 105 percent of the amount computed by multiplying the facility's program operating cost payment rates, including onetime program operating cost adjustment rates for those reporting years, by the prorated resident days that correspond to those program operating cost payment rates paid during that reporting year, the

state must repay the difference to the facility according to the desk audit adjustment procedures in Minnesota Rules, part 9553.0041, subpart 13, items B to E.

A facility's retroactive settle up must be calculated by October 1, 1990.

Subd. 3h. **Waiving interest charges.** The commissioner may waive interest charges on overpayments incurred by intermediate care facilities for persons with developmental disabilities for the period October 1, 1987, to February 29, 1988, if the overpayments resulted from the continuation of the desk audit rate in effect on September 30, 1987, through the period.

Subd. 3j. **Rules.** The commissioner shall adopt rules to implement this section. The commissioner shall consult with provider groups, advocates, and legislators to develop these rules.

Subd. 3k. **Experimental project.** The commissioner of human services may conduct and administer experimental projects to determine the effects of competency-based wage adjustments for direct-care staff on the quality of care and active treatment for persons with developmental disabilities. The commissioner shall authorize one project under the following conditions:

(a) One service provider will participate in the project.

(b) The vendor must have an existing competency-based training curriculum and a proposed salary schedule that is coordinated with the training package.

(c) The University of Minnesota affiliated programs must approve the content of the training package and assist the vendor in studying the impact on service delivery and outcomes for residents under a competency-based salary structure. The study and its conclusions must be presented to the commissioner at the conclusion of the project.

(d) The project will last no more than 21 months from its inception.

(e) The project will be funded by Title XIX, medical assistance and the costs incurred shall be allowable program operating costs for future rate years under Minnesota Rules, parts 9553.0010 to 9553.0080. The project's total annual cost must not exceed $49,500. The commissioner shall establish an adjustment to the selected facility's per diem by dividing the $49,500 by the facility's actual resident days for the reporting year ending December 31, 1988. The facility's experimental training project per diem shall be effective on October 1, 1989, and shall remain in effect for the 21-month period ending June 30, 1991.

(f) Only service vendors who have submitted a determination of need pursuant to Minnesota Rules, parts 9525.0015 to 9525.0165, and Minnesota Statutes, section 252.28, requesting the competency-based training program cost increase are eligible. Furthermore, they are only eligible if their determination of need was approved prior to January 1, 1989, and funds were not available to implement the plan.

Subd. 3l. **Temporary payment rate provisions.** If an intermediate care facility for persons with developmental disabilities located in Kandiyohi County:

(1) was sold during 1994;

(2) is unable to obtain records necessary to complete the cost report from the former operator at no cost; and

(3) delicensed two beds during that year, then the commissioner shall determine the payment rate for the period May 1, 1995, through September 30, 1996, as provided in paragraphs (a) to (c).

(a) A temporary payment rate shall be paid which is equal to the rate in effect as of April 30, 1995.

(b) The payment rate in paragraph (a) shall be subject to a retroactive downward adjustment based on the provisions in paragraph (c).

(c) The temporary payment rate shall be limited to the lesser of the payment in paragraph (a) or the payment rate calculated based on the facility's cost report for the reporting year January 1, 1995, through December 31, 1995, and the provisions of this section and the reimbursement rules in effect on June 30, 1995, except that the provisions referred to in clauses (1) to (3) shall not apply:

(1) the inflation factor in subdivision 3c;

(2) Minnesota Rules, part 9553.0050, subpart 2, items A to E; and

(3) Minnesota Rules, part 9553.0041, subpart 16.

Subd. 5b. **ICF/DD operating cost limitation after September 30, 1995.** (a) For the rate year beginning on October 1, 1995, and for rate years beginning on or after October 1, 1997, the commissioner shall limit the allowable operating cost per diems, as determined under this subdivision and the reimbursement rules, for high cost ICFs/DD. Prior to indexing each facility's operating cost per diems for inflation, the commissioner shall group the facilities into eight groups. The commissioner shall then array all facilities within each grouping by their general operating cost per service unit per diems.

(b) The commissioner shall annually review and adjust the general operating costs incurred by the facility during the reporting year preceding the rate year to determine the facility's

allowable historical general operating costs. For this purpose, the term general operating costs means the facility's allowable operating costs included in the program, maintenance, and administrative operating costs categories, as well as the facility's related payroll taxes and fringe benefits, real estate insurance, and professional liability insurance. A facility's total operating cost payment rate shall be limited according to paragraphs (c) and (d) as follows:

(c) A facility's total operating cost payment rate shall be equal to its allowable historical operating cost per diems for program, maintenance, and administrative cost categories multiplied by the forecasted inflation index in subdivision 3c, clause (1), subject to the limitations in paragraph (d).

(d) For the rate years beginning on or after October 1, 1995, the commissioner shall establish maximum overall general operating cost per service unit limits for facilities according to clauses (1) to (8). Each facility's allowable historical general operating costs and client assessment information obtained from client assessments completed under subdivision 3g for the reporting year ending December 31, 1994 (the base year), shall be used for establishing the overall limits. If a facility's proportion of temporary care resident days to total resident days exceeds 80 percent, the commissioner must exempt that facility from the overall general operating cost per service unit limits in clauses (1) to (8). For this purpose, "temporary care" means care provided by a facility to a client for less than 30 consecutive resident days.

(1) The commissioner shall determine each facility's weighted service units for the reporting year by multiplying its resident days in each client classification level as established in subdivision 3g, paragraph (d), by the corresponding weights for that classification level, as established in subdivision 3g, paragraph (i), and summing the results. For the reporting year ending December 31, 1994, the commissioner shall use the service unit score computed from the client classifications determined by the Minnesota Department of Health's annual review, including those of clients admitted during that year.

(2) The facility's service unit score is equal to its weighted service units as computed in clause (1), divided by the facility's total resident days excluding temporary care resident days, for the reporting year.

(3) For each facility, the commissioner shall determine the facility's cost per service unit by dividing its allowable historical general operating costs for the reporting year by the facility's service unit score in clause (2) multiplied by its total resident days, or 85 percent of the facility's capacity days times its service unit score in clause (2), if the facility's occupancy is less than 85 percent of licensed capacity. If a facility reports temporary care resident days, the temporary care resident days shall be multiplied by the service unit score in clause (2), and the resulting weighted resident days shall be added to the facility's weighted service units in clause (1) prior to computing the facility's cost per service unit under this clause.

(4) The commissioner shall group facilities based on class A or class B licensure designation, number of licensed beds, and geographic location. For purposes of this grouping, facilities with six beds or less shall be designated as small facilities and facilities with more than six beds shall be designated as large facilities. If a facility has both class A and class B licensed beds, the facility shall be considered a class A facility for this purpose if the number of class A beds is more than half its total number of ICF/DD beds; otherwise the facility shall be considered a class B facility. The metropolitan geographic designation shall include Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington Counties. All other Minnesota counties shall be designated as the nonmetropolitan geographic group. These characteristics result in the following eight groupings:

(i) small class A metropolitan;

(ii) large class A metropolitan;

(iii) small class B metropolitan;

(iv) large class B metropolitan;

(v) small class A nonmetropolitan;

(vi) large class A nonmetropolitan;

(vii) small class B nonmetropolitan; and

(viii) large class B nonmetropolitan.

(5) The commissioner shall array facilities within each grouping in clause (4) by each facility's cost per service unit as determined in clause (3).

(6) In each array established under clause (5), facilities with a cost per service unit at or above the median shall be limited to the lesser of: (i) the current reporting year's cost per service unit; or (ii) the prior reporting year's allowable historical general operating cost per service unit plus the inflation factor as established in subdivision 3c, clause (2), increased by three percentage points.

(7) The overall operating cost per service unit limit for each group shall be established as follows:

(i) each array established under clause (5) shall be arrayed again after the application of clause (6);

(ii) in each array established in clause (5), two general operating cost limits shall be determined. The first cost per service unit limit shall be established at 0.5 and less than or equal to 1.0 standard deviation above the median of that array. The second cost per service unit limit shall be established at 1.0 standard deviation above the median of the array; and

(iii) the overall operating cost per service unit limits shall be indexed for inflation annually beginning with the reporting year ending December 31, 1995, using the forecasted inflation index in subdivision 3c, clause (2).

(8) Annually, facilities shall be arrayed using the method described in clauses (5) and (7). Each facility with a cost per service unit at or above its group's first cost per service unit limit, but less than the second cost per service unit limit for that group, shall be limited to 98 percent of its total operating cost per diems then add the forecasted inflation index in subdivision 3c, clause (1). Each facility with a cost per service unit at or above the second cost per service unit limit will be limited to 97 percent of its total operating cost per diems, then add the forecasted inflation index in subdivision 3c, clause (1). Facilities that have undergone a class A to class B conversion since January 1, 1990, are exempt from the limitations in this clause for six years after the completion of the conversion process.

(9) The commissioner may rebase these overall limits, using the method described in this subdivision but no more frequently than once every three years.

(e) For rate years beginning on or after October 1, 1995, the facility's efficiency incentive shall be determined as provided in the reimbursement rule.

(f) The total operating cost payment rate shall be the sum of paragraphs (c) and (e).

(g) For the rate year beginning on October 1, 1996, the commissioner shall exempt a facility from the reductions in this subdivision if the facility is involved in a bed relocation project where more than 25 percent of the facility's beds are transferred to another facility, the relocated beds are six or fewer, there is no change in the total number of ICF/DD beds for the parent organization of the facility, and the relocation is not part of an interim or settle-up rate.

Subd. 5e. **Rate adjustment for care provided to a medically fragile individual.** Beginning July 1, 1996, the commissioner shall increase reimbursement rates for a facility located in Chisholm and licensed as an intermediate care facility for persons with developmental disabilities since 1972, to cover the cost to the facility for providing 24-hour licensed practical nurse care to a medically fragile individual admitted on March 8, 1996. The commissioner shall include in this higher rate a temporary adjustment to reimburse the facility for costs incurred between March 8, 1996, and June 30, 1996. Once this resident is discharged, the commissioner shall reduce the facility's payment rate by the amount of the cost of the 24-hour licensed practical nurse care.

**256B.5016 ICF/MR MANAGED CARE OPTION.**

Subdivision 1. **Managed care pilot.** The commissioner may initiate a capitated risk-based managed care option for services in an intermediate care facility for persons with developmental disabilities according to the terms and conditions of the federal agreement governing the managed care pilot. The commissioner may grant a variance to any of the provisions in sections 256B.501 to 256B.5015 and Minnesota Rules, parts 9525.1200 to 9525.1330 and 9525.1580.

Subd. 2. **Report.** The commissioner shall report to the legislature financial and program results along with a recommendation as to whether the pilot should be expanded.

**256B.503 RULES.**

To implement Laws 1983, chapter 312, article 9, sections 1 to 7, the commissioner shall promulgate rules. Rules adopted to implement Laws 1983, chapter 312, article 9, section 5, must (1) set standards for case management which include, encourage, and enable flexible administration, (2) require the county boards to develop individualized procedures governing case management activities, (3) consider criteria promulgated under section 256B.092, subdivision 3, and the federal waiver plan, (4) identify cost implications to the state and to county boards, and (5) require the screening teams to make recommendations to the county case manager for development of the individual service plan.

The commissioner shall adopt rules to implement this section by July 1, 1986.

**256B.53 DENTAL ACCESS GRANTS.**

(a) The commissioner shall award grants to community clinics or other nonprofit community organizations, political subdivisions, professional associations, or other organizations that demonstrate the ability to provide dental services effectively to public program recipients. Grants may be used to fund the costs related to coordinating access for recipients, developing and implementing patient care criteria, upgrading or establishing new facilities, acquiring furnishings or equipment, recruiting new providers, or other development costs that will improve access to dental care in a region.

(b) In awarding grants, the commissioner shall give priority to applicants that plan to serve areas of the state in which the number of dental providers is not currently sufficient to meet the needs of recipients of public programs or uninsured individuals. The commissioner shall consider the following in awarding the grants:

(1) potential to successfully increase access to an underserved population;

(2) the long-term viability of the project to improve access beyond the period of initial funding;

(3) the efficiency in the use of the funding; and

(4) the experience of the applicants in providing services to the target population.

(c) The commissioner shall consider grants for the following:

(1) implementation of new programs or continued expansion of current access programs that have demonstrated success in providing dental services in underserved areas;

(2) a program for mobile or other types of outreach dental clinics in underserved geographic areas;

(3) a program for school-based dental clinics in schools with high numbers of children receiving medical assistance;

(4) a program testing new models of care that are sensitive to the cultural needs of the recipients;

(5) a program creating new educational campaigns that inform individuals of the importance of good oral health and the link between dental disease and overall health status;

(6) a program that organizes a network of volunteer dentists to provide dental services to public program recipients or uninsured individuals; and

(7) a program that tests new delivery models by creating partnerships between local providers and county public health agencies.

(d) The commissioner shall evaluate the effects of the dental access initiatives funded through the dental access grants and submit a report to the legislature by January 15, 2003.

**256B.69 PREPAID HEALTH PLANS.**

Subd. 5e. **Medical education and research payments.** For the calendar years 1999, 2000, and 2001, a hospital that participates in funding the federal share of the medical education and research trust fund payment under Laws 1998, chapter 407, article 1, section 3, shall not be held liable for any amounts attributable to this payment above the charge limit of section 256.969, subdivision 3a. The commissioner of human services shall assume liability for any corresponding federal share of the payments above the charge limit.

Subd. 6c. **Dental services demonstration project.** The commissioner shall establish a dental services demonstration project in Crow Wing, Todd, Morrison, Wadena, and Cass Counties for provision of dental services to medical assistance and MinnesotaCare recipients. The commissioner may contract on a prospective per capita payment basis for these dental services with an organization licensed under chapter 62C, 62D, or 62N in accordance with section 256B.037 or may establish and administer a fee-for-service system for the reimbursement of dental services.

Subd. 24a. **Social service and public health costs.** The commissioner shall report on recommendations to the legislature by January 15, 1997, identifying county social services and public health administrative costs for each target population that should be excluded from the overall capitation rate.

**256B.692 COUNTY-BASED PURCHASING.**

Subd. 10. **Report to the legislature.** The commissioner shall submit a report to the legislature by February 1, 1998, on the preliminary proposals submitted on or before September 1, 1997.

**256C.29 COMMUNICATIONS DEVICES REQUIRED IN BUS TERMINALS.**

The operator of a bus terminal in the city of Minneapolis or St. Paul that serves intercity buses, defined in section 168.002, subdivision 4, shall provide, in public areas in the terminal, public pay telephones with telecommunications devices, commonly known as "TDD's," that permit a person who has a communication disability to communicate with others by telephone. The operator shall place signs at strategic locations in and about the terminal indicating where the telephones are available.

**256D.02 DEFINITIONS.**

Subd. 19. **Cost-effective.** "Cost-effective" means that the amount paid by the state for premiums, coinsurance, deductibles, other cost-sharing obligations under a health insurance plan, and other administrative costs is likely to be less than the amount paid for an equivalent set of services by general assistance medical care.

**256D.05 ELIGIBILITY FOR GENERAL ASSISTANCE.**

Subd. 4. **Consent to review records.** No person shall be eligible for general assistance medical care unless the person has authorized the commissioner of human services in writing to examine all personal medical records developed while receiving general assistance for the purpose of investigating whether or not a vendor has submitted a claim for reimbursement, a cost report or a rate application which the vendor knows to be false in whole or in part, or in order to determine whether or not the medical care provided was medically necessary. The vendor of medical care shall receive notification from the commissioner at least 24 hours before the commissioner gains access to such records. A vendor of medical care shall require presentation of this authorization before the state agency can obtain access to such records unless the vendor already has received written authorization. Notwithstanding any other law to the contrary, a vendor of medical care shall not be subject to any civil or criminal liability for providing access to medical records to the commissioner pursuant to this subdivision.

**256D.46 EMERGENCY MINNESOTA SUPPLEMENTAL AID.**

Subdivision 1. **Eligibility.** Applicants for or recipients of SSI or Minnesota supplemental aid who have emergency need may apply for emergency general assistance under section 256D.06, subdivision 2.

Subd. 2. **Income and resource test.** All income and resources available to the recipient must be considered in determining the recipient's ability to meet the emergency need. Property that can be liquidated in time to resolve the emergency and income, excluding an amount equal to the Minnesota supplemental aid standard of assistance, that is normally disregarded or excluded under the Minnesota supplemental aid program must be considered available to meet the emergency need.

Subd. 3. **Payment amount.** The amount of assistance granted under emergency Minnesota supplemental aid is limited to the amount necessary to resolve the emergency. An emergency Minnesota supplemental aid grant is available to a recipient no more than once in any 12-month period. Funding for emergency Minnesota supplemental aid is limited to the appropriation. Each fiscal year, the commissioner shall allocate to counties the money appropriated for emergency Minnesota supplemental aid grants based on each county agency's average share of state's emergency Minnesota supplemental aid expenditures for the immediate past three fiscal years as determined by the commissioner, and may reallocate any unspent amounts to other counties. Any emergency Minnesota supplemental aid expenditures by a county above the amount of the commissioner's allocation to the county must be made from county funds.

**256I.05 MONTHLY RATES.**

Subd. 1b. **Rates for uncertified boarding care homes.** Effective July 1, 1992, the maximum rate specified in subdivision 1 does not apply to a facility which was licensed by the Minnesota Department of Health as a boarding care home before March 1, 1985, and which is not certified to receive medical assistance.

Subd. 5. **Adult foster care rates.** The commissioner shall annually establish statewide maintenance and difficulty of care limits for adults in foster care.

**256I.07 RESPITE CARE PILOT PROJECT; FAMILY ADULT FOSTER CARE.**

Subdivision 1. **Program established.** The state recognizes the importance of developing and maintaining quality family foster care resources. In order to accomplish that goal, the commissioner shall establish a two-year respite care pilot project for family adult foster care providers in three counties. This pilot project is intended to provide support to caregivers of family adult foster care residents. The commissioner shall establish a state-funded pilot project to accomplish the provisions in subdivisions 2 to 4.

Subd. 2. **Eligibility.** A family adult foster care home provider as defined under section 144D.01, subdivision 7, who has been licensed for six months is eligible for up to 30 days of respite care per calendar year. In cases of emergency, a county social services agency may waive the six-month licensing requirement. In order to be eligible to receive respite payment, a provider must take time off away from their foster care residents.

Subd. 3. **Payment structure.** (a) The rate of payment for respite care for an adult foster care resident eligible for only group residential housing shall be based on the current monthly group residential housing base room and board rate and the current maximum monthly group residential housing difficulty of care rate.

(b) The rate of payment for respite care for an adult foster care resident eligible for alternative care funds shall be based on the resident's alternative care foster care rate.

(c) The rate of payment for respite care for an adult foster care resident eligible for Medicaid home and community-based services waiver funds shall be based on the group residential housing base room and board rate.

(d) The total amount available to pay for respite care for a family adult foster care provider shall be based on the number of residents currently served in the foster care home. Respite care must be paid for on a per diem basis and for a full day.

Subd. 4. **Private pay residents.** Payment for respite care for private pay foster care residents must be arranged between the provider and the resident or the resident's family.

**256J.24 FAMILY COMPOSITION; ASSISTANCE STANDARDS; EXIT LEVEL.**

Subd. 10. **MFIP exit level.** The commissioner shall adjust the MFIP earned income disregard to ensure that most participants do not lose eligibility for MFIP until their income reaches at least 115 percent of the federal poverty guidelines at the time of the adjustment. The adjustment to the disregard shall be based on a household size of three, and the resulting earned income disregard percentage must be applied to all household sizes. The adjustment under this subdivision must be implemented whenever a Supplemental Nutrition Assistance Program adjustment is reflected in the food portion of the MFIP transitional standard as required under subdivision 5a.

**256K.35 AT-RISK YOUTH OUT-OF-WEDLOCK PREGNANCY PREVENTION PROGRAM.**

Subdivision 1. **Establishment and purpose.** The commissioner shall establish a statewide grant program to prevent or reduce the incidence of out-of-wedlock pregnancies among homeless, runaway, or thrown-away youth who are at risk of being prostituted or currently being used in prostitution. The goal of the out-of-wedlock pregnancy prevention program is to significantly increase the number of existing short-term shelter beds for these youth in the state. By providing street outreach and supportive services for emergency shelter, transitional housing, and services to reconnect the youth with their families where appropriate, the number of youth at risk of being sexually exploited or actually being sexually exploited, and thus at risk of experiencing an out-of-wedlock pregnancy, will be reduced.

Subd. 2. **Funds available.** The commissioner shall make funds for street outreach and supportive services for emergency shelter and transitional housing for out-of-wedlock pregnancy prevention available to eligible nonprofit corporations or government agencies to provide supportive services for emergency and transitional housing for at-risk youth. The commissioner shall consider the need for emergency and transitional housing supportive services throughout the state, and must give priority to applicants who offer 24-hour emergency facilities.

Subd. 3. **Application; eligibility.** (a) A nonprofit corporation or government agency must submit an application to the commissioner in the form and manner the commissioner establishes. The application must describe how the applicant meets the eligibility criteria under paragraph (b). The commissioner may also require an applicant to provide additional information.

(b) To be eligible for funding under this section, an applicant must meet the following criteria:

(1) the applicant must have a commitment to helping the community, children, and preventing juvenile prostitution. If the applicant does not have any past experience with youth involved in or at risk of being used in prostitution, the applicant must demonstrate knowledge of best practices in this area and develop a plan to follow those practices;

(2) the applicant must present a plan to communicate with local law enforcement officials, social services, and the commissioner consistent with state and federal law; and

(3) the applicant must present a plan to encourage homeless, runaway, or thrown-away youth to either reconnect with family or to transition into long-term housing.

Subd. 4. **Uses of funds.** (a) Funds available under this section must be used to create and maintain supportive services for emergency shelter and transitional housing for homeless, runaway, and thrown-away youth. Federal TANF funds must be used to serve youth and their families with household income below 200 percent of the federal poverty guidelines. If other funds are available, services may be provided to youth outside of TANF-eligible families.

(b) Funds available under this section shall not be used to conduct general education or awareness programs unrelated to the operation of an emergency shelter or transitional housing.

**259.85 POSTADOPTION SERVICE GRANTS PROGRAM.**

Subdivision 1. **Purpose.** The commissioner of human services shall establish and supervise a postadoption service grants program to be administered by local social service agencies for the purpose of preserving and strengthening adoptive families. The program will provide financial assistance to adoptive parents who are not receiving adoption assistance under chapter 259A to meet the special needs of an adopted child that cannot be met by other resources available to the family.

Subd. 2. **Eligibility criteria.** A child may be certified by the local social services agency as eligible for a postadoption service grant after a final decree of adoption if:

(1) the child was a ward of the commissioner or a Minnesota licensed child-placing agency before adoption;

(2) the child had special needs at the time of adoption. For the purposes of this section, "special needs" means a child who had a physical, mental, emotional, or behavioral disability at the time of an adoption or has a preadoption background to which the current development of such disabilities can be attributed;

(3) the adoptive parents have exhausted all other available resources. Available resources include public income support programs, medical assistance, health insurance coverage, services available through community resources, and any other private or public benefits or resources available to the family or to the child to meet the child's special needs; and

(4) the child is under 18 years of age, or if the child is under 22 years of age and remains dependent on the adoptive parent or parents for care and financial support and is enrolled in a secondary education program as a full-time student.

Subd. 3. **Certification statement.** The local social services agency shall certify a child's eligibility for a postadoption service grant in writing to the commissioner. The certification statement shall include:

(1) a description and history of the special needs upon which eligibility is based;

(2) separate certification for each of the eligibility criteria under subdivision 2, that the criteria are met; and

(3) applicable supporting documentation including:

(i) the child's individual service plan;

(ii) medical, psychological, or special education evaluations;

(iii) documentation that all other resources have been exhausted; and

(iv) an estimate of the costs necessary to meet the special needs of the child.

Subd. 4. **Commissioner review.** The commissioner shall review the facts upon which eligibility is based and shall award postadoption service grants to eligible adoptive parents to the extent funds are appropriated consistent with subdivision 5.

Subd. 5. **Grant payments.** The amount of the postadoption service grant payment shall be based on the special needs of the child and the determination that other resources to meet those special needs are not available. The amount of any grant payments shall be based on the severity of the child's disability and the effect of the disability on the family and must not exceed $10,000 annually. Adoptive parents are eligible for grant payments until their child's 18th birthday, or if the child is under 22 years of age and remains dependent on the adoptive parent or parents for care and financial support and is enrolled in a secondary education program as a full-time student.

Permissible expenses that may be paid from grants shall be limited to:

(1) medical expenses not covered by the family's health insurance or medical assistance;

(2) therapeutic expenses, including individual and family therapy; and

(3) nonmedical services, items, or equipment required to meet the special needs of the child.

The grants under this section shall not be used for maintenance for out-of-home placement of the child in substitute care.

**518A.53 INCOME WITHHOLDING.**

Subd. 7. **Subsequent income withholding.** (a) This subdivision applies to support orders that do not contain provisions for income withholding.

(b) For cases in which the public authority is providing child support enforcement services to the parties, the income withholding under this subdivision shall take effect without prior judicial notice to the obligor and without the need for judicial or administrative hearing. Withholding shall result when:

(1) the obligor requests it in writing to the public authority;

(2) the obligee or obligor serves on the public authority a copy of the notice of income withholding, a copy of the court's order, an application, and the fee to use the public authority's collection services; or

(3) the public authority commences withholding according to section 518A.46, subdivision 5, paragraph (a), clause (5).

(c) For cases in which the public authority is not providing child support services to the parties, income withholding under this subdivision shall take effect when an obligee requests it by making a written motion to the court and the court finds that previous support has not been paid on a timely consistent basis or that the obligor has threatened expressly or otherwise to stop or reduce payments.

(d) Within two days after the public authority commences withholding under this subdivision, the public authority shall send to the obligor at the obligor's last known address, notice that withholding has commenced. The notice shall include the information provided to the payor of funds in the notice of withholding.

**518A.74 PUBLICATION OF NAMES OF DELINQUENT CHILD SUPPORT OBLIGORS.**

Subdivision 1. **Making names public.** At least once each year, the commissioner of human services, in consultation with the attorney general, may publish a list of the names and other identifying information of no more than 25 persons who (1) are child support obligors, (2) are at least $10,000 in arrears, (3) are not in compliance with a written payment agreement regarding both current support and arrearages approved by the court, a child support magistrate, or the public authority, (4) cannot currently be located by the public authority for the purposes of enforcing a support order, and (5) have not made a support payment except tax intercept payments, in the preceding 12 months.

Identifying information may include the obligor's name, last known address, amount owed, date of birth, photograph, the number of children for whom support is owed, and any additional information about the obligor that would assist in identifying or locating the obligor. The commissioner and attorney general may use posters, media presentations, electronic technology, and other means that the commissioner and attorney general determine are appropriate for dissemination of the information, including publication on the Internet. The commissioner and attorney general may make any or all of the identifying information regarding these persons public. Information regarding an obligor who meets the criteria in this subdivision will only be made public subsequent to that person's selection by the commissioner and attorney general.

Before making public the name of the obligor, the Department of Human Services shall send a notice to the obligor's last known address which states the department's intention to make public information on the obligor. The notice must also provide an opportunity to have the obligor's name removed from the list by paying the arrearage or by entering into an agreement to pay the arrearage, or by providing information to the public authority that there is good cause not to make the information public. The notice must include the final date when the payment or agreement can be accepted.

The Department of Human Services shall obtain the written consent of the obligee to make the name of the obligor public.

Subd. 2. **Names published in error.** If the commissioner makes public a name under subdivision 1 which is in error, the commissioner must also offer to publish a printed retraction and a public apology acknowledging that the name was made public in error. If the person whose

name was made public in error elects the public retraction and apology, the retraction and apology must appear in the same medium and the same format as the original notice with the name listed in error. In addition to the right of a public retraction and apology, a person whose name was made public in error has a civil action for damages caused by the error.

**626.557 REPORTING OF MALTREATMENT OF VULNERABLE ADULTS.**

Subd. 16. **Implementation authority.** (a) By September 1, 1995, the attorney general and the commissioners of health and human services, in coordination with representatives of other entities that receive or investigate maltreatment reports, shall develop the common report form described in subdivision 9. The form may be used by mandated reporters, county social service agencies, law enforcement entities, licensing agencies, or ombudsman offices.

(b) The commissioners of health and human services shall as soon as possible promulgate rules necessary to implement the requirements of this section.

(c) By December 31, 1995, the commissioners of health, human services, and public safety shall develop criteria for the design of a statewide database utilizing data collected on the common intake form of the common entry point. The statewide database must be accessible to all entities required to conduct investigations under this section, and must be accessible to ombudsman and advocacy programs.

(d) By September 1, 1995, each lead investigative agency shall develop the guidelines required in subdivision 9b.

**626.5593 PEER REVIEW OF LOCAL AGENCY RESPONSE.**

Subdivision 1. **Establishment.** By January 1, 1991, the commissioner of human services shall establish a pilot program for peer review of local agency responses to child maltreatment reports made under section 626.556. The peer review program shall examine agency assessments of maltreatment reports and delivery of child protection services in at least two counties. The commissioner shall designate the local agencies to be reviewed, and shall appoint a peer review panel composed of child protection workers, as defined in section 626.559, and law enforcement personnel who are responsible for investigating reports of child maltreatment under section 626.556, subdivision 10, within the designated counties.

Subd. 2. **Duties.** The peer review panel shall meet at least quarterly to review case files representative of child maltreatment reports that were investigated or assessed by the local agency. These cases shall be selected randomly from local welfare agency files by the commissioner. Not public data, as defined in section 13.02, subdivision 8, may be shared with panel members in connection with a case review.

The panel shall review each case for compliance with relevant laws, rules, agency policies, appropriateness of agency actions, and case determinations. The panel shall issue a report to the designated agencies after each meeting which includes findings regarding the agency's compliance with relevant laws, rules, policies, case practice, and any recommendations to be considered by the agency. The panel shall also issue a semiannual report concerning its activities. This semiannual report shall be available to the public, but may not include any information that is classified as not public data.

Subd. 3. **Report to legislature.** By January 1, 1992, the commissioner shall report to the legislature regarding the activities of the peer review panel, compliance findings, barriers to the effective delivery of child protection services, and recommendations for the establishment of a permanent peer review system for child protection services.

Subd. 4. **Funds.** The commissioner may use funds allocated for child protection services, training, and grants to pay administrative expenses associated with the peer review panel pilot program created by this section.

**9549.0020 DEFINITIONS.**

Subp. 2. **Actual allowable historical operating cost.** "Actual allowable historical operating cost" means the operating costs incurred by the nursing facility and allowed by the commissioner for the most recent reporting year.

**9549.0020 DEFINITIONS.**

Subp. 12. **Cost category.** "Cost category" means the classification or grouping of similar or related costs for purposes of reporting, audit, cost control, and the determination of cost limitations.

**9549.0020 DEFINITIONS.**

Subp. 13. **Cost report.** "Cost report" means the document and supporting material specified by the commissioner and prepared by the nursing facility. The cost report includes the statistical, financial, and other relevant information required in part 9549.0041for rate determination.

**9549.0020 DEFINITIONS.**

Subp. 20. **Direct cost.** "Direct cost" means a cost that can be identified within a specific cost category without the use of allocation methods.

**9549.0020 DEFINITIONS.**

Subp. 23. **Fringe benefits.** "Fringe benefits" means workers' compensation insurance, group health or dental insurance, group life insurance, retirement benefits or plans, and an allowance for uniforms.

**9549.0020 DEFINITIONS.**

Subp. 24. **General and administrative costs.** "General and administrative costs" means the costs of administering the nursing facility as specified in part 9549.0040.

**9549.0020 DEFINITIONS.**

Subp. 25. **Historical operating costs.** "Historical operating costs" means the allowable operating costs incurred by the nursing facility during the reporting year immediately preceding the rate year for which the payment rate becomes effective, after the commissioner has reviewed those costs and determined them to be allowable costs under the medical assistance program, and after the commissioner has applied the limit on general and administrative costs.

**9549.0020 DEFINITIONS.**

Subp. 26. **Hospital-attached nursing facility.** "Hospital-attached nursing facility" means a nursing facility which is under common ownership and operation with a licensed hospital and shares with the hospital the cost of common service areas such as nursing, dietary, housekeeping, laundry, plant operations, or administrative services and which is required to use the stepdown method of allocation by the Medicare program, title XVIII of the Social Security Act, provided that the stepdown results in part of the cost of the shared areas to be allocated between the hospital and the nursing facility, and that the stepdown numbers are the numbers used for Medicare reimbursement.

**9549.0020 DEFINITIONS.**

Subp. 27. **Indirect cost.** "Indirect cost" means a cost that is incurred for a common or joint purpose and is identified with more than one cost category but is not readily identified with a specific cost category.

**9549.0020 DEFINITIONS.**

Subp. 30. **Necessary service.** "Necessary service" means a function pertinent to the nursing facility's operation which if not performed by the assigned individual would have required the nursing facility to employ or assign another individual to perform it.

**9549.0020 DEFINITIONS.**

Subp. 31. **Nursing facility.** "Nursing facility" means a facility licensed under Minnesota Statutes, chapter 144A or a boarding care facility licensed under Minnesota Statutes, sections 144.50 to 144.56.

**9549.0020 DEFINITIONS.**

Subp. 32. **Operating costs.** "Operating costs" means the costs of operating the nursing facility in compliance with licensure and certification standards. Operating cost categories are:

A. nursing, including nurses and nursing assistants training;

B. dietary;

C. laundry and linen;

D. housekeeping;

E. plant operation and maintenance;

F. other care-related services;

G. general and administrative;

H. payroll taxes, fringe benefits, and clerical training; and

I. real estate taxes and actual special assessments paid.

**9549.0020 DEFINITIONS.**

Subp. 33. **Payroll taxes.** "Payroll taxes" means the employer's share of social security withholding taxes, governmentally required retirement contributions, and state and federal unemployment compensation taxes or costs.

**9549.0020 DEFINITIONS.**

Subp. 34. **Preopening costs.** "Preopening costs" means the operating costs incurred prior to the admission of a resident to a newly constructed nursing facility.

**9549.0020 DEFINITIONS.**

Subp. 35. **Private paying resident.** "Private paying resident" means a nursing facility resident who is not a medical assistance program recipient for the date of service and whose payment rate is not established by another third party, including the Veterans Administration or Medicare.

**9549.0020 DEFINITIONS.**

Subp. 36. **Rate year.** "Rate year" means the state of Minnesota's fiscal year for which a payment rate is effective, from July 1 through the following June 30.

**9549.0020 DEFINITIONS.**

Subp. 38. **Related organization.** "Related organization" means a person that furnishes goods or services to a nursing facility and that is a close relative of a nursing facility, an affiliate of a nursing facility, a close relative of an affiliate of a nursing facility, or an affiliate of a close relative of an affiliate of a nursing facility. As used in this subpart:

A. An "affiliate" is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with another person.

B. A "person" is an individual, a corporation, a partnership, an association, a trust, an unincorporated organization, or a government or political subdivision.

C. A "close relative of an affiliate of a nursing facility" is an individual whose relationship by blood, marriage, or adoption to an individual who is an affiliate of a nursing facility is no more remote than first cousin.

D. "Control" including the terms "controlling," "controlled by," and "under common control with" is the possession, direct or indirect, of the power to direct or cause the direction of the management, operations, or policies of a person, whether through the ownership of voting securities, by contract, or otherwise.

**9549.0020 DEFINITIONS.**

Subp. 41. **Reporting year.** "Reporting year" means the period from October 1 to September 30, immediately preceding the rate year, for which the nursing facility submits its cost report, and which is the basis for the determination of the payment rate for the following rate year.

**9549.0020 DEFINITIONS.**

Subp. 42. **Resident day or actual resident day.** "Resident day" or "actual resident day" means a day for which nursing services are rendered and billable, or a day for which a bed is held and billed.

**9549.0020 DEFINITIONS.**

Subp. 43. **Top management personnel.** "Top management personnel" means owners, board members, corporate officers, general, regional, and district managers, administrators and the nursing facility administrator, according to Minnesota Statutes, section 144A.04, subdivision 5 and any other person performing the function of such personnel. Persons performing functions only as nursing facility department heads are not included in this definition.

**9549.0020 DEFINITIONS.**

Subp. 44. **Total payment rate.** "Total payment rate" means the addition of the operating cost payment rate, the property-related payment rate, and the real estate tax and special assessments payment rate as established by the commissioner to pay for the care of residents in nursing facilities.

**9549.0020 DEFINITIONS.**

Subp. 46. **Utility vehicle.** "Utility vehicle" means a vehicle specially equipped for purposes of nursing facility operations and not readily adaptable to personal use.

**9549.0020 DEFINITIONS.**

Subp. 47. **Vested.** "Vested" means the existence of a legally fixed unconditional right to a present or future benefit.

**9549.0030 COST ALLOCATION PROCEDURES.**

Subpart 1. **Classification.** Classification of costs is the process of charging costs to the appropriate cost categories and compiling a total for each cost category to be recorded on the cost report. Nursing facilities shall classify their costs in accordance with the cost categories in part 9549.0040. Costs that cannot be specifically classified in a cost category, such as the cost of generic supplies, must be classified in the general and administrative cost category.

Subp. 2. **Identification.** Except for the salary costs of individuals with multiple duties, costs must be directly identified, without allocation, by routine classification of transactions when costs are recorded in the books and records of the nursing facility.

Subp. 3. **Personnel with multiple duties.** When a person other than top management personnel has multiple duties, the person's salary cost must be allocated to the cost categories on the basis of time distribution records that show actual time spent, or an accurate estimate of time spent on various activities. In a nursing facility of 60 or fewer beds, part of the salary or salaries of top management personnel may be allocated to other cost categories to the extent justified in time distribution records which show the actual time spent, or an accurate estimate of time spent on various activities. A nursing facility that chooses to estimate time spent must use a statistically valid method. Persons who serve in a dual capacity, including those who have only nominal top management responsibilities, shall directly identify their salaries to the appropriate cost categories. The salary of any person having more than nominal top management responsibilities must not be allocated.

Subp. 4. **Central, affiliated, or corporate office costs.** Cost allocation for central, affiliated, or corporate offices shall be governed by items A to F.

A. Central, affiliated, or corporate office costs representing services of consultants required by law or rule in areas including dietary, pharmacy, social services, or other resident care related activities may be allocated to the appropriate cost category, but only to the extent that those costs are directly identified by the nursing facility.

B. Except as provided in item A, central, affiliated, or corporate office costs must be allocated to the general and administrative cost category of each nursing facility within the group served by the central, affiliated, or corporate office according to subitems (1) to (5).

(1) All costs which can be directly identified with a specific nursing facility must be allocated to that nursing facility.

(2) All costs which can be directly identified with an operation unrelated to the nursing facility operations must be allocated to that unrelated operation.

(3) After the costs which can be directly identified pursuant to subitems (1) and (2) have been allocated, the remaining central, affiliated, or corporate office costs must be allocated between nursing facility operations and unrelated operations based on the ratio of expenses.

(4) Next, operations which have nursing facilities both in Minnesota and outside of Minnesota must allocate the central, affiliated, or corporate office costs to Minnesota based on the ratio of total resident days in Minnesota nursing facilities to the total resident days in all nursing facility operations.

(5) Finally, the central, affiliated, or corporate costs allocated to all Minnesota nursing facilities must be allocated to each nursing facility based on resident days.

C. Central, affiliated, or corporate office property-related costs of capital assets used directly by the nursing facility in the provision of nursing facility services must be allocated to the nursing facilities which use the capital asset and must be reimbursed under part 9549.0060. Central, affiliated, or corporate office property-related costs of capital assets which are not used directly by the nursing facility in the provision of nursing facility services must be allocated to the general and administrative cost category of each nursing facility using the methods described in item B.

D. The useful life of a new capital asset maintained by a central, affiliated, or corporate office must be determined by applying one of the following schedules in subitem (1) or (2):

(1) the useful life of a building is 35 years; of land improvement is 20 years; of a major building improvement is the greater of 15 years or the remaining life of the principal capital asset; of depreciable equipment except vehicles is ten years; and of a vehicle is four years; or

(2) the depreciation guidelines.

E. The useful life of used capital assets maintained by a central, affiliated, or corporate office must be determined based on the physical condition of the used capital asset but the useful life of the used capital asset must not be less than one-half the useful life determined under item D.

F. The useful life of leasehold improvements maintained by a central, affiliated, or corporate office must be either the useful life of the improvement determined under item D or the remaining term of the lease, including renewal periods, whichever is shorter.

Subp. 5. **General and administrative costs.** Except as provided in subparts 3 and 4, general and administrative costs must not be allocated as direct or indirect costs to other cost categories.

**9549.0035 DETERMINATION OF ALLOWABLE COSTS.**

Subp. 4. **Compensation for personal services.** Compensation for personal services includes all the remuneration paid currently, accrued or deferred, for services rendered by the nursing facility's owners or employees. Only compensation costs for the current reporting period are allowable subject to the requirements of parts 9549.0010 to 9549.0080.

A. Compensation includes:

(1) salaries, wages, bonuses, vested vacations, vested sick leave, and fringe benefits paid for managerial, administrative, professional, and other services;

(2) amounts paid by the nursing facility for the personal benefit of the owners or employees;

(3) the costs of assets and services which the owner or employee receives from the nursing facility;

(4) deferred compensation, individual retirement plans such as individual retirement accounts, pension plans, and profit-sharing plans;

(5) the annual cost of supplies, use of capital assets, services for personal use, or any other in kind benefits received by the owners or employees; and

(6) payment to organizations of nonpaid workers, that have arrangements with the nursing facility for the performance of services by the nonpaid workers.

B. The nursing facility must have a written policy for payment of compensation for personal services. The policy must relate the individual's compensation to the performance of specified duties and to the number of hours worked. Compensation payable under the plan must be consistent with the compensation paid to persons performing similar duties in the nursing facility industry. Employees covered by collective bargaining agreements are not required to be covered by the policy if the collective bargaining agreement otherwise meets the essentials of the policy required by this item.

C. Only necessary services shall be compensated.

D. Except for accrued vested vacation, accrued vested sick leave, or compensation claims subject to litigation or employer-employee dispute resolution, compensation must be actually paid, whether by cash or negotiable instrument, within 107 days after the close of the reporting period. If payment is not made within the 107 days, the unpaid compensation shall be disallowed in that reporting year.

**9549.0035 DETERMINATION OF ALLOWABLE COSTS.**

Subp. 5. **Licensure and certification costs.** Subject to parts 9549.0010 to 9549.0080all operating costs of meeting the licensure and certification standards in items A to C are allowable operating costs for the purpose of setting nursing facility payment rates. The standards are:

A. standards set by federal regulations for skilled nursing facilities and intermediate care facilities;

B. requirements established by the Minnesota Department of Health for meeting health standards as set out by state rules and federal regulations; and

C. other requirements for licensing under state and federal law, state rules, or federal regulations that must be met to provide nursing and boarding care services.

**9549.0035 DETERMINATION OF ALLOWABLE COSTS.**

Subp. 6. **Routine service costs.** Subject to parts 9549.0010 to 9549.0080 all operating costs of routine services including nursing, dietary, and support services are allowable operating costs for the purpose of setting nursing facility payment rates.

**9549.0036 NONALLOWABLE COSTS.**

The costs listed in items A to EE are not allowable for purposes of setting payment rates but must be identified on the nursing facility's cost report.

A. All contributions, including charitable contributions, and contributions to political action committees or campaigns.

B. Salaries and expenses of a lobbyist.

C. Legal and related expenses for unsuccessful challenges to decisions by governmental agencies.

D. Assessments made by or the portion of dues charged by associations or professional organizations for litigation except for successful challenges to decisions by agencies of the state of Minnesota; lobbying costs; or contributions to political action committees or campaigns. Where the breakdown of dues charged to a nursing facility is not provided, the entire cost shall be disallowed.

E. Advertising designed to encourage potential residents to select a particular nursing facility. This item does not apply to a total expenditure of $2,000 for all notices placed in the telephone yellow pages for the purpose of stating the nursing facility's name, location, phone number, and general information about services in the nursing facility.

F. Assessments levied by the commissioner of the Minnesota Department of Health for uncorrected violations.

G. Employee or owner's membership or other fees for social, fraternal, sports, health, or similar organizations.

H. Cost incurred for activities directly related to influencing employees with respect to unionization.

I. Costs of activities not related to resident care such as flowers or gifts for employees or owners, employee parties, and business meals except as in part 9549.0040, subpart 7, item X.

J. Costs related to purchase of and care for pets in excess of $5 per year per licensed bed.

K. Penalties including interest charged on the penalty, interest charges which result from an overpayment, and bank overdraft or late payment charges.

L. Costs of sponsoring employee, youth, or adult activities such as athletic teams and beauty contests.

M. Premiums on owner's or board member's life insurance policies, except that such premiums shall be allowed if the policy is included within a group policy provided for all employees, or if such a policy is required as a condition of mortgage or loan and the mortgagee or lending institution is listed as the beneficiary.

N. Personal expenses of owners and employees, such as vacations, boats, airplanes, personal travel or vehicles, and entertainment.

O. Costs of training programs for anyone other than employees or volunteers in the nursing facility.

P. Costs of training programs to meet the minimum educational requirements of a position, education that leads to a degree, or education that qualifies the employee for a new trade or profession. This item does not apply to training or education of nursing aides or training to meet the requirements of laws, rules, or regulations for keeping an employee's salary, status, or position or to maintain or update skills needed in performing the employee's present duties.

Q. Bad debts and related bad debt collection fees except as provided in part 9549.0040, subpart 7, item V.

R. Costs of fund raising activities.

S. Costs associated with the management of investments which may produce interest income, dividend income, or other investment income or losses.

T. Costs of functions normally paid by charges to residents, employees, visitors, or others such as the direct and indirect costs of operating a pharmacy, congregate dining program, home delivered meals program, gift shop, coffee shop, apartment, or day care center.

U. Operating costs for activities to the extent that the activities are financed by gifts or grants from public funds. A transfer of funds from a local governmental unit to its governmentally owned nursing facility is not a gift or grant under this item.

V. Telephone, television, and radio service provided in a resident's room except as in part 9549.0040, subpart 6, item D.

W. Costs of covenants not to compete.

X. Identifiable costs of services provided by a licensed medical therapeutic or rehabilitation practitioner or any other vendor of medical care which are billed separately on a fee for service basis, including:

(1) the purchase of service fees paid to the vendor or his or her agent who is not an employee of the nursing facility or the compensation of the practitioner who is an employee of the nursing facility;

(2) allocated compensation and related costs of any nursing facility personnel assisting in providing these services; and

(3) allocated operating or property cost for providing these services such as housekeeping, laundry, maintenance, medical records, payroll taxes, space, utilities, equipment, supplies, bookkeeping, secretarial, insurance, supervision and administration, and real estate taxes and special assessments.

If any of the costs in subitems (1) to (3) are incurred by the nursing facility, these costs must be reported as nonreimbursable expenses, together with any of the income received or anticipated by the nursing facility including any charges by the nursing facility to the vendor.

Y. Costs for which adequate documentation is not maintained or provided as required by parts 9549.0010 to 9549.0080.

Z. Fringe benefits or payroll taxes associated with disallowed salary costs.

AA. Costs associated with sales or reorganizations of nursing facilities.

BB. Accruals of vacation and sick leave for employees which are not fully vested.

CC. Payments made in lieu of real estate taxes, unless such payments are made under a legally enforceable irrevocable written contract entered into prior to June 17, 1985.

DD. Adverse judgments, settlements, and repayments of escrow accounts resulting from the enforcement of Minnesota Statutes, section 256B.48 and related costs and expenses.

EE. Costs including legal fees, accounting fees, administrative costs, travel costs, and the costs of feasibility studies attributed to the negotiation or settlement of a sale or purchase of any capital asset by acquisition or merger for which any payment has previously been made under parts 9549.0010 to 9549.0080.

**9549.0040 REPORTING BY COST CATEGORY.**

Subpart 1. **Dietary services.** The costs listed in items A to D are to be reported in the dietary services cost category:

A. direct costs of normal and special diet food including raw food, dietary supplies, food preparation and serving, and special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, even if written as a prescription item by a physician;

B. the salaries and wages of the supervisor, dietitians, chefs, cooks, dishwashers, and other employees assigned to the kitchen and dining room including the salaries or fees of dietary consultants;

C. the costs of training including the cost of lodging and meals to meet the requirements of laws, rules, or regulations for keeping an employee's salary, status, or position or to maintain or update skills needed in performing the employee's present duties; and

D. the costs of travel necessary for training programs for dietitians required to maintain licensure, certification, or professional standards.

Subp. 2. **Laundry and linen services.** The costs listed in items A and B are to be reported in the laundry and linen services cost category:

A. direct costs of linen and bedding, the laundering of resident clothing, other laundering, and laundry supplies; and

B. the salaries and wages of the supervisor, menders, ironers, and other laundry employees.

Subp. 3. **Housekeeping services.** The costs listed in items A and B are to be reported in the housekeeping services cost category:

A. direct costs of housekeeping supplies, including cleaning and lavatory supplies; and

B. the salaries and wages of the supervisor, housekeepers, and other cleaning personnel.

Subp. 4. **Plant operation and maintenance services.** The costs listed in items A to C are to be reported in the plant operations and maintenance cost category:

A. direct costs for maintenance and operation of the building and grounds, including fuel, electricity, water, sewer, supplies, tools, and repairs which are not capitalized;

B. the salaries and wages of the supervisor, engineers, heating-plant employees, independent contractors, and other maintenance personnel; and

C. the cost of required licenses and permits required for operation of the nursing facility.

Subp. 5. **Nursing services.** Direct costs associated with nursing services identified in items A to Y, are to be included in the nursing services cost category:

A. nursing assessment of the health status of the resident and planning of appropriate interventions to overcome identified problems and maximize resident strengths;

B. bedside care and services;

C. care and services according to the order of the attending physicians;

D. monitoring procedures such as vital signs, urine testing, weight, intake and output, and observation of the body system;

E. administration of oral, sublingual, rectal, and local medications topically applied, and appropriate recording of the resident's responses;

F. drawing blood and collecting specimens for submission to laboratories;

G. prevention of skin irritation and decubitus ulcers;

H. routine changing of dressings;

I. training, assistance, and encouragement for self-care as required for feeding, grooming, ambulation, toilet, and other activities of daily living including movement within the nursing facility;

J. supportive assistance and training in resident transfer techniques including transfer from bed to wheelchair or wheelchair to commode;

K. care of residents with casts, braces, splints, and other appliances requiring nursing care or supervision;

L. care of residents with behavior problems and severe emotional problems requiring nursing care or supervision;

M. administration of oxygen;

N. use of nebulizers;

O. maintenance care of resident's colostomy, ileostomy, and urostomy;

P. administration of parenteral medications, including intravenous solutions;

Q. administration of tube feedings;

R. nasopharyngeal aspiration required for maintenance of a clean airway;

S. care of suprapubic catheters and urethral catheters;

T. care of tracheostomy, gastrostomy, and other tubes in a body;

U. costs of equipment and supplies that are used to complement the services in the nursing services cost category, including items stocked at nursing stations or on the floor and distributed or used individually, including: alcohol, applicators, cotton balls, incontinence pads, disposable ice bags, dressings, bandages, water pitchers, tongue depressors, disposable gloves, enemas, enema equipment, soap and water, medication cups, diapers, plastic waste bags, sanitary products, thermometers, hypodermic needles and syringes, and clinical reagents or similar diagnostic agents, and drugs which are not paid on a separate fee schedule by the medical assistance program or any other payer;

V. costs for education or training including the cost of lodging and meals of nursing service personnel. Educational costs are limited to either meeting the requirements of laws or rules or keeping an employee's salary, status, or position or for maintaining or updating skills needed in performing the employee's present duties, except that training to become a nurses aid is an allowable cost;

W. the salaries and wages of persons performing nursing services including salaries of the director, and assistant director of nursing, supervising nurses, medical records personnel, registered professional nurses, licensed practical nurses, nurses aides, orderlies, and attendants;

X. the salaries or fees of medical director, physicians, or other professionals performing consulting services on medical care which are not reimbursed separately on a fee for service basis; and

Y. the costs of travel necessary for training programs for nursing personnel required to maintain licensure, certification, or professional standards.

Subp. 6. **Other care-related services.** The costs listed in items A to D are to be reported in the other care-related services cost category:

A. direct costs of other care-related services, such as recreational or religious activities, arts and crafts, pets, and social services which are not reimbursed separately on a fee for service basis;

B. the salaries and wages of recreational therapists and aides, rehabilitation therapists and aides, chaplains, arts and crafts instructors and aides, social workers and aides, and other care-related personnel including salaries or fees of professionals performing consultation services in these areas which are not reimbursed separately on a fee for service basis;

C. the costs of training including the cost of lodging and meals to meet the requirements of laws or rules for keeping an employee's salary, status, or position, or to maintain or update skills needed in performing the employee's present duties; and

D. telephone, television, and radio services provided in areas designated for use by the general resident population, such as lounges and recreation rooms and the charge of transferring a resident's phone from one room to another within the same nursing facility.

Subp. 7. **General and administrative services.** Direct costs for administering the overall activities of the nursing facility are included in the general and administrative cost category. These direct costs include:

A. business office functions;

B. travel expenses other than travel expenses reported under subparts 1, item D, and 5, item Y;

C. all motor vehicle operating expenses;

D. telephone and telegraph charges;

E. office supplies;

F. insurance, except as included as a fringe benefit;

G. personnel recruitment costs including help wanted advertising;

H. the salaries, wages, or fees of administrators, assistant administrators, accounting and clerical personnel, data processing personnel, and receptionists;

I. professional fees for services such as legal, accounting, and data processing services;

J. management fees, and the cost of management and administrative consultants;

K. central, affiliated, or corporate office costs excluding the cost of depreciable equipment used by individual nursing facilities which are included in the computation of the

property-related payment rate under part 9549.0060 and those costs specified in part 9549.0030, subpart 4, items A and B;

L. business meetings and seminars;

M. postage;

N. training including the cost of lodging and meals for management personnel and personnel not related to direct resident care if the training either meets the requirements of laws, rules, or regulations to keep an employee's salary, status, or position or maintains or updates skills needed to perform the employee's present duties;

O. membership fees for associations and professional organizations which are directly related to resident care;

P. subscriptions to periodicals which are directly related to the operation of the nursing facility;

Q. security services or security personnel;

R. joint commission on accreditation of hospitals survey;

S. advertising;

T. board of director's fees;

U. interest on working capital debt;

V. bad debts and fees paid for collection of bad debts provided that the conditions in subitems (1) to (4) are met:

(1) the bad debt results from nonpayment of the payment rate or part of the payment rate;

(2) the nursing facility documents that reasonable collection efforts have been made, the debt was uncollectible, and there is no likelihood of future recovery;

(3) the collection fee does not exceed the amount of the bad debt; and

(4) the debt does not result from the nursing facility's failure to comply with federal and state laws, state rules, and federal regulations;

W. the portion of preopening costs capitalized as a deferred charge and amortized over a period of 120 consecutive months beginning with the month in which a resident first resides in a newly constructed nursing facility;

X. the cost of meals incurred as a result of required overnight business related travel; and

Y. any costs which cannot be specifically classified to another cost category.

Subp. 8. **Payroll taxes, fringe benefits, and clerical training.** Only the costs identified in items A to I are to be reported in the payroll taxes, fringe benefits, and clerical training cost category:

A. the employer's share of the social security withholding tax;

B. state and federal unemployment compensation taxes or costs;

C. group life insurance;

D. group health and dental insurance;

E. workers' compensation insurance;

F. either a pension plan or profit-sharing plan, approved by the United States Internal Revenue Service, but not both for the same employee;

G. governmentally required retirement contributions;

H. uniform allowance; and

I. costs of training clerical personnel including the cost of meals and lodging.

Subp. 9. **Real estate taxes and special assessments.** Real estate taxes and special assessments for each nursing facility are to be reported in the real estate taxes and special assessments cost category. In addition, payments permitted under part 9549.0036, item CC must be reported in this cost category.

**9549.0041 GENERAL REPORTING REQUIREMENTS.**

Subpart 1. **Required cost reports.** No later than December 31 of each year, the nursing facility shall submit an annual cost report for the reporting year ending September 30 on forms supplied by the commissioner in order to receive medical assistance program payments. In addition, the nursing facility shall obtain an annual audit of its financial records from an independent certified public accountant or licensed public accountant. The examination must

be conducted in accordance with generally accepted auditing standards as adopted by the American Institute of Certified Public Accountants and generally accepted accounting principles. A governmentally owned nursing facility may comply with these auditing requirements by submitting the audit report prepared by the state auditor.

**9549.0041 GENERAL REPORTING REQUIREMENTS.**

Subp. 2. **Required information.** A complete annual report must include the following items.

A. General nursing facility information and statistical data as requested on the cost report form.

B. Reports of historical costs with supporting calculations, worksheets, and an explanation of the historical costs as requested on the cost report form.

C. A complete statement of fees and charges, including the rate or rates charged to private paying residents, as audited by a certified or licensed public accountant as defined by Minnesota Statutes, section 412.222 for the fiscal year of the nursing facility.

D. A copy of the nursing facility's audited financial statements for its fiscal year ending during the reporting year. The audited financial statements must include a balance sheet, income statement, statement of retained earnings, statement of changes in financial position (cash and working capital methods), appropriate notes to the financial statements, any applicable supplemental information, and the certified or licensed public accountant's opinion. If the financial statements are not sufficiently detailed or the nursing facility's fiscal year is different from the reporting year, the nursing facility shall provide supplemental information that reconciles costs on the financial statements with the cost report.

E. A statement of ownership for the nursing facility, including the name, address, and proportion of ownership of each owner.

If a privately held or closely held corporation or partnership has an ownership interest in the nursing facility, the nursing facility must report the name, address, and proportion of ownership of all owners of the corporation or partnership who have an ownership interest of five percent or more, except that any owner whose compensation or portion of compensation is claimed for reimbursement in the nursing facility's cost report must be identified regardless of the proportion of ownership interest.

If a publicly held corporation has an ownership interest of 15 percent or more in the nursing facility, the nursing facility must report the name, address, and proportion of ownership of all owners of the publicly held corporation who have an ownership interest of ten percent or more.

F. Copies of leases, purchase agreements, and other documents related to the lease or purchase of the nursing facility if not previously submitted.

G. A listing of nursing facility debt outstanding during the reporting year, and the name of the lender, the term of debt, interest rate of debt, interest and principal payments for the current year and all remaining years, and the original amount of debt and any portion of debt as required by part 9549.0060, subpart 5.

H. An explanation of all adjustments to the historical costs.

I. The nursing facility's statement of property tax payable according to subpart 5.

**9549.0041 GENERAL REPORTING REQUIREMENTS.**

Subp. 3. **Information which may be required.** In addition to the reports required in subpart 2, the commissioner may require the following:

A. Access to certified and licensed public accountant's audit workpapers which support the audited financial statements and cost reports.

B. Separate audited financial statements that correspond to the fiscal year ended during the reporting year for any other Minnesota nursing facility owned in whole or part by the same owners.

C. Separate audited financial statements which correspond to the fiscal year ended during the reporting year for any related organization doing business with the nursing facility if the related organization has not previously had an audited financial statement. At the commissioner's request, the related organization shall provide audited financial statements within 90 days after the end of the related organization's fiscal year in which the request is made.

D. Copies of leases, purchase agreements, or other documents related to the purchase or acquisition of equipment, goods, and services which are claimed as allowable costs.

E. Access to federal and state income tax returns for the nursing facility, related organization, and any individual or corporation having an ownership interest in the nursing facility as specified in subpart 2, item E.

F. Other relevant information necessary to support a payment request.

**9549.0041 GENERAL REPORTING REQUIREMENTS.**

Subp. 4. **Additional information required from hospital-attached nursing facilities.** In addition to the reports required in subparts 2 and 3, hospital-attached nursing facilities shall provide a copy of the most recent Medicare cost report filed with the Medicare program intermediary for the reporting year. If the Medicare cost report covers a period other than the nursing facility's reporting year, the nursing facility shall provide a copy of the Medicare cost report prepared using costs for the nursing facility's reporting period in addition to supplemental information which reconciles costs on the financial statements with the reporting period costs. The nursing facility must provide individual stepdowns for each cost category in part 9549.0040. The individual stepdowns must be prepared in accordance with instructions provided by the commissioner.

**9549.0041 GENERAL REPORTING REQUIREMENTS.**

Subp. 5. **Reporting real estate taxes and special assessments.** The nursing facility shall submit a copy of its statement of property tax payable for the calendar year in which the rate year begins by April 5 of that calendar year. Except as provided in this subpart, the commissioner shall disallow the costs of real estate taxes if the documentation is not submitted by April 5. The disallowance shall remain in effect until the nursing facility provides the documentation and amends the cost report under subpart 14. If the county has not provided to the nursing facility a statement of property tax payable by April 5, the commissioner shall use the property tax payable during the previous reporting year until the statement is received by the department. Upon receipt of the statement of property tax payable, the commissioner shall adjust the payment rate accordingly. Special assessments and related interest paid during the reporting year must be shown on the cost report.

**9549.0041 GENERAL REPORTING REQUIREMENTS.**

Subp. 7. **Records.** The nursing facility shall maintain statistical and accounting records in sufficient detail to support information contained in the nursing facility's cost reports and audited statement for at least five years including the year following submission of an annual cost report.

**9549.0041 GENERAL REPORTING REQUIREMENTS.**

Subp. 8. **Conflicts.** If conflicts occur between parts 9549.0010 to 9549.0080 and generally accepted accounting principles, parts 9549.0010 to 9549.0080 shall prevail.

**9549.0041 GENERAL REPORTING REQUIREMENTS.**

Subp. 9. **Certification of reports.** Reports required in this part must be accompanied by a certification of the person having over 50 percent effective ownership or the chief financial officer if there is no majority owner, and the administrator or chief operating executive. If reports have been prepared by a person other than these individuals, a separate statement signed by the preparer must accompany the report.

**9549.0041 GENERAL REPORTING REQUIREMENTS.**

Subp. 10. **Deadlines and extensions.** The deadline for submission of reports and the extension of the deadline is governed by items A to C.

A. The nursing facility shall submit the required annual cost report to the commissioner by December 31. The annual cost report must cover the reporting year ending on September 30 of that year.

B. The commissioner may reject any annual cost report filed by a nursing facility that is incomplete or inaccurate or may require additional information necessary to support the payment rate request. The corrected report or the additional information requested must be returned to the commissioner within 20 days of the request or the report must be rejected. The commissioner may extend this time if the nursing facility makes a showing of good cause in writing and if the commissioner determines that the delay in receipt of the information will not prevent the commissioner from establishing rates in a timely manner as required by law. Failure to file the required cost report and other required information or to correct the form of an incomplete or

inaccurate report shall result in its rejection and in a reduction of the payment rate in subpart 12. The failure to provide additional information shall also result in a reduction of the payment rate in subpart 12 unless the total payment rate can be calculated by the disallowance of the cost for which additional information was requested, in which case no rate reduction as specified in subpart 12 shall occur.

C. The commissioner may grant one 15-day extension of the reporting deadline. To receive an extension, a nursing facility must submit a written request by December 1. The commissioner must notify the nursing facility of the decision to grant or deny an extension by December 15.

**9549.0041 GENERAL REPORTING REQUIREMENTS.**

Subp. 11. **Effective date of total payment rate.** The commissioner shall provide to all nursing facilities notice of the total payment rate by May 1 of each year. The total payment rate is effective from July 1 of that year to June 30 of the following year.

**9549.0041 GENERAL REPORTING REQUIREMENTS.**

Subp. 12. **Noncompliance.** A nursing facility's failure to comply with reporting requirements subjects the nursing facility to items A to C.

A. If a nursing facility fails to provide reports, documentation, and worksheets required in this part, the commissioner shall reduce the nursing facility's total payment rate to 80 percent of the total payment rate as provided in item B.

B. The reduced total payment rate is effective:

(1) 21 days after a written request for additional information under subpart 3, items A to D, is sent by the commissioner or at the expiration of any additional time period the commissioner may allow under subpart 10, item B.

(2) For failure to provide the information required in subpart 1, 2, 4, or 9. On January 1, if no extension has been granted; on January 15, if the extension was granted; or 21 days after a written request for the correction or completion of inaccurate reports of financial statements, or at the expiration of a further time period that the commissioner allows under subpart 10, item B.

C. Reinstatement of the total payment rate upon remedy of the failure or inadequacy is not retroactive.

**9549.0041 GENERAL REPORTING REQUIREMENTS.**

Subp. 13. **Audits.** Nursing facility audits are subject to items A to D.

A. The department shall subject all reports and supporting documentation to desk and field audits to determine compliance with parts 9549.0010 to 9549.0080. Retroactive adjustments may be made as a result of desk or field audit findings. If a field audit reveals inadequacies in a nursing facility's record keeping or accounting practices, the commissioner may require the nursing facility to engage competent professional assistance to correct those inadequacies within 90 days so that the field audit may proceed.

B. Field audits may cover the four most recent annual cost reports for which desk audits have been completed and payment rates have been established. The field audit must be an independent review of the nursing facility's cost report. All transactions, invoices, or other documentation that support or relate to the costs claimed on the annual cost reports are subject to review by the field auditor. If the provider fails to provide the field auditor access to supporting documentation related to the information reported on the cost report within the time period specified by the commissioner, the commissioner may calculate the total payment rate by disallowing the cost of the items for which access to the supporting documentation is not provided or apply the penalty in subpart 12, item A, whichever would result in the least amount of change in the total payment rate.

C. Changes in the total payment rate which result from desk or field audit adjustments to cost reports for reporting years beyond the four most recent annual cost reports must be made to the four most recent annual cost reports, the current cost report, and future cost reports to the extent that those adjustments affect the total payment rate established by those reporting years.

D. The commissioner may extend the period for retention of records under part 9549.0035, subpart 3, item A, subitem (5), for purposes of performing field audits as necessary to enforce Minnesota Statutes, section 256B.48.

**9549.0041 GENERAL REPORTING REQUIREMENTS.**

Subp. 14. **Amended reports.** Amendments to previously filed annual cost reports are governed by items A and B.

A. Nursing facilities may file amendments to previously filed annual cost reports when:

(1) Errors or omissions in the annual cost report are discovered and an amendment would result in at least a five-cent per resident day or $2,000 adjustment, whichever is less for each reporting year. The commissioner shall make retroactive adjustments to the total payment rate of an individual nursing facility if the amendment is filed within 14 months of the original cost report to be amended. An error or omission for purposes of this item does not include a nursing facility's determination that a prior election between alternative methods of reporting costs permitted under parts 9549.0010to 9549.0080 was not advantageous and should be changed. Errors or omissions that do not meet the threshold amount required for amended cost reports, or errors or omissions discovered after the 14-month time limitation specified in this item, may be claimed at the time of the field audit.

(2) A nursing facility which qualifies for a special reappraisal under part 9549.0060, subpart 3 to adjust its property related payment rate.

B. Nursing facilities must not amend a previously filed cost report for the purpose of removing costs of services for which the nursing facility seeks separate billing.

**9549.0041 GENERAL REPORTING REQUIREMENTS.**

Subp. 15. **False reports.** If a nursing facility knowingly supplies inaccurate or false information in a required report that results in an overpayment, the commissioner shall:

A. immediately adjust the nursing facility's payment rate to recover the entire overpayment within the rate year;

B. terminate the commissioner's agreement with the nursing facility;

C. prosecute under applicable state or federal law; or

D. use any combination of items A, B, and C.

**9549.0050 SCOPE.**

Parts 9549.0050 to 9549.0059 establish procedures for determining the operating cost payment rates for all nursing facilities participating in the medical assistance program. Parts 9549.0050 to 9549.0059 are effective for rate years beginning on or after July 1, 1987. Procedures for assessment and classification of residents by the Department of Health in accordance with parts 9549.0050 to 9549.0059 are found in parts 4656.0010to 4656.0090.

**9549.0051 DEFINITIONS.**

Subpart 1. **Applicability.** As used in parts 9549.0050 to 9549.0059, the following terms have the meanings given them.

**9549.0051 DEFINITIONS.**

Subp. 2. **Assessment form.** "Assessment form" means the form developed by the Department of Health Quality Assurance and Review Program under parts 4656.0010 to 4656.0090 and used for performing resident assessments.

**9549.0051 DEFINITIONS.**

Subp. 3. **Base year.** "Base year" means the reporting year ending September 30, 1984.

**9549.0051 DEFINITIONS.**

Subp. 4. **Case mix operating costs.** "Case mix operating costs" means the operating costs listed in part 9549.0040, subpart 5, and the portion of fringe benefits and payroll taxes allocated to the nursing services cost category under part 9549.0053.

**9549.0051 DEFINITIONS.**

Subp. 5. **Discharge.** "Discharge" means a termination of placement in the nursing facility that is documented in the discharge summary signed by the physician. For the purposes of this definition, discharge does not include:

A. a transfer within the nursing facility unless the transfer is to a different licensure level; or

B. a leave of absence from the nursing facility for treatment, therapeutic, or personal purposes when the resident is expected to return to the same nursing facility.

**9549.0051 DEFINITIONS.**

Subp. 6. **Medical plan of care.** "Medical plan of care" means documentation signed by the resident's physician which includes the resident's primary diagnoses, secondary diagnoses, orders for treatment and medications, rehabilitation potential, rehabilitation procedures if ordered, clinical monitoring procedures, and discharge potential.

**9549.0051 DEFINITIONS.**

Subp. 7. **Other care-related operating costs.** "Other care-related operating costs" means the operating costs listed in part 9549.0040, subpart 6, and the portion of fringe benefits and payroll taxes allocated to the other care related cost category, the cost of food, and the dietitian consulting fees calculated under part 9549.0053.

**9549.0051 DEFINITIONS.**

Subp. 8. **Other operating costs.** "Other operating costs" means the operating costs listed in part 9549.0040, subparts 1, 2, 3, 4, and 7, excluding the cost of food and dietitian consulting fees, and the portion of fringe benefits and payroll taxes allocated to each of these operating costs categories under part 9549.0053.

**9549.0051 DEFINITIONS.**

Subp. 9. **Productive nursing hours.** "Productive nursing hours" means all on duty hours of nurses, aides, orderlies, and attendants. The on duty hours of the director of nursing for facilities with more than 60 licensed beds and the on duty hours of any medical records personnel are not included. Vacation, holidays, sick leave, classroom training, and lunches are not included in productive nursing hours.

**9549.0051 DEFINITIONS.**

Subp. 10. **Quality assurance and review or QA&R.** "Quality assurance and review" or "QA&R" means the program established under Minnesota Statutes, sections 144.072 and 144.0721.

**9549.0051 DEFINITIONS.**

Subp. 11. **Resident class.** "Resident class" means each of the 11 categories established in part 9549.0058.

**9549.0051 DEFINITIONS.**

Subp. 12. **Resident plan of care.** "Resident plan of care" for residents of nursing facilities means the comprehensive care plan as set forth in Code of Federal Regulations, title 42, section 483.20, paragraph (d), as amended through October 1, 1992.

**9549.0051 DEFINITIONS.**

Subp. 14. **Standardized resident days.** "Standardized resident days" means the sum of the number of resident days in the nursing facility in each resident class multiplied by the weight for that resident class listed in part 9549.0058. Standardized resident days must be determined under part 9549.0054, subpart 2.

**9549.0053 DETERMINATION AND ALLOCATION OF FRINGE BENEFITS AND PAYROLL TAXES, FOOD COSTS, AND DIETITIAN CONSULTING FEES.**

Subpart 1. **Fringe benefits and payroll taxes.** Fringe benefits and payroll taxes must be allocated to case mix, other care related costs, and other operating costs according to items A to E.

A. For the rate year beginning July 1, 1987, the allocation method in items B to E must be used. For the rate years beginning on or after July 1, 1988, all of the nursing facility's fringe benefits and payroll taxes must be classified to the operating cost categories in part 9549.0040, subparts 1 to 6, based on direct identification. If direct identification cannot be used for all the nursing facility's fringe benefits and payroll taxes, the allocation method in items B to E must be used.

B. Fringe benefits and payroll taxes must be allocated to case mix operating costs in the same proportion to salaries reported under part 9549.0040, subpart 5.

C. Fringe benefits and payroll taxes must be allocated to other care related costs in the same proportion to salaries reported under part 9549.0040, subpart 6.

D. Fringe benefits and payroll taxes must be allocated to other operating costs in the same proportion to salaries reported under part 9549.0040, subparts 1, 2, 3, 4, and 7.

E. For any nursing facility that cannot separately report each salary component of an operating cost category, the commissioner shall determine the fringe benefits and payroll taxes to be allocated under this subpart according to subitems (1), (2), (3), and (4).

(1) The commissioner shall sum the allowable salaries for all nursing facilities separately reporting allowable salaries in each cost category, by cost category and in total.

(2) The commissioner shall determine the ratio of the total allowable salaries in each cost category to the total allowable salaries in all cost categories, based on the totals in subitem (1).

(3) The nursing facility's total allowable fringe benefits and payroll taxes must be multiplied by each ratio determined in subitem (2) to determine the amount of payroll taxes and fringe benefits allocated to each cost category for the nursing facility under this item.

(4) If a nursing facility's salary cost for any operating cost category in part 9549.0020, subpart 32, items A to G, is zero and the services provided to the nursing facility in that operating cost category are not performed by a related organization, the nursing facility must reclassify one dollar to a salary cost line in the operating cost category.

Subp. 2. **Determination of food costs.** The commissioner shall determine the costs of food to be included in other care related costs according to items A and B.

A. For any nursing facility separately reporting food costs, food costs shall be the allowable food costs reported under part 9549.0040, subpart 1.

B. For any nursing facility that cannot separately report the cost of food under part 9549.0040, subpart 1, the commissioner shall determine the average ratio of food costs to total dietary costs for all nursing facilities that separately reported food costs. The nursing facility's total allowable dietary costs must be multiplied by the average ratio to determine the food costs for the nursing facility.

Subp. 3. **Determination of dietitian consulting fees.** The commissioner shall determine the dietitian consulting fees to be included in other care related costs according to items A and B.

A. For any nursing facility separately reporting dietitian consulting fees, the dietitian consulting fees shall be the allowable dietitian consulting fees reported under part 9549.0040, subpart 1.

B. For any nursing facility that has not separately reported dietitian consulting fees, the commissioner shall determine the average cost per licensed bed of allowable dietitian consulting fees for all nursing facilities that separately reported dietitian consulting fees. The nursing facility's total number of licensed beds must be multiplied by the average cost per bed to determine the dietitian consulting fees for the nursing facility.

**9549.0054 DETERMINATION OF THE ALLOWABLE HISTORICAL OPERATING COSTS PER DIEMS.**

Subpart 1. **Review and adjustment of costs.** The commissioner shall annually review and adjust the operating costs reported by the nursing facility during the reporting year preceding the rate year to determine the nursing facility's actual allowable historical operating costs. The review and adjustment must comply with the provisions of parts 9549.0010 to 9549.0080.

Subp. 2. **Standardized resident days for rate years beginning on or after July 1, 1987.** For rate years beginning on or after July 1, 1987, each nursing facility's standardized resident days must be determined in accordance with items A to C.

A. The nursing facility's resident days for the reporting year in each resident class must be multiplied by the weight for that resident class listed in part 9549.0058.

B. The amounts determined in item A must be summed to determine the nursing facility's standardized resident days for the reporting year.

C. For the rate year beginning July 1, 1987, only, the nursing facility's standardized resident days determined in item B must be multiplied by .99897.

Subp. 3. **Allowable historical case mix operating cost standardized per diem.** The allowable historical case mix operating cost standardized per diem must be computed by dividing

the allowable historical case mix operating cost by the standardized resident days determined in subpart 2.

Subp. 4. **Allowable historical other care related operating cost per diem.** The allowable historical other care related operating cost per diem must be computed by dividing the allowable historical other care related operating costs by the number of resident days in the nursing facility's reporting year.

Subp. 5. **Allowable historical other operating cost per diem.** The allowable historical other operating cost per diem must be computed by dividing the allowable historical other operating costs by the number of resident days in the nursing facility's reporting year.

**9549.0055 DETERMINATION OF OPERATING COST ADJUSTMENT FACTORS AND LIMITS.**

Subp. 4. **Incorporations by reference.** The indexes specified in items A to D are incorporated by reference and are available through the Minitex interlibrary loan system. They are subject to frequent change.

A. The index for average hourly earnings of employees in nursing and personal care facilities is published monthly in "Employment and Earnings," Bureau of Labor Statistics, United States Department of Labor. Standard Industrial Code 805 (SIC 805) is the code used for employees in nursing and personal care facilities in this publication.

B. The Employment Cost Index for Service Workers and the Employment Cost Index for wages and salaries of professional and technical workers are published monthly in "Current Wage Developments," Bureau of Labor Statistics, United States Department of Labor.

C. The Consumer Price Index for nonprescription medical equipment and supplies and the Consumer Price Index for maintenance and repair commodities are published in the "Monthly Labor Review," Bureau of Labor Statistics, United States Department of Labor.

D. The Producer Price Index for consumer foods, the Producer Price Index for natural gas, and the Producer Price Index for commercial power in west north central states are published monthly in "Producer Prices and Price Indexes," Bureau of Labor Statistics, United States Department of Labor.

**9549.0056 DETERMINATION OF OPERATING COST PAYMENT RATE.**

Subpart 1. **Nonadjusted case mix and other care related payment rate.** For each nursing facility, the nonadjusted case mix and other care related payment rate for each resident class must be determined according to items A to D.

A. The nursing facility's allowable historical case mix operating cost standardized per diem established in part 9549.0054, subpart 3, must be multiplied by the weight for each resident class listed in part 9549.0058.

B. The allowable historical other care related operating cost per diem established in part 9549.0054, subpart 4, must be added to each weighted per diem established in item A.

C. If the amount determined in item B for each resident class is below the limit for that resident class and group established in part 9549.0055, subpart 2, item C, as indexed in part 9549.0055, subpart 3, the nursing facility's nonadjusted case mix and other care related payment rate must be the amount determined in item B for each resident class.

D. If the amount determined in item B for each resident class is at or above the limit for that resident class and group established in part 9549.0055, subpart 2, item C, as indexed in part 9549.0055, subpart 3, the nursing facility's nonadjusted case mix and other care related payment rate must be set at the limit.

Subp. 2. **Adjusted prospective case mix and other care-related payment rate.** For each nursing facility, the adjusted prospective case mix and other care-related payment rate for each resident class must be the nonadjusted case mix and other care-related payment rate multiplied by the case mix and other care-related adjustment factor determined in part 9549.0055, subpart 1, item A. If the nursing facility is eligible to receive the phase in in subpart 7, the phase in reduced by the amount of the efficiency incentive, if any, must be added to the adjusted prospective case mix and other care-related payment rate.

Subp. 3. **Nonadjusted other operating cost payment rate.** The nonadjusted other operating cost payment rate must be determined according to items A and B.

A. If the allowable historical other operating cost per diem determined in part 9549.0054, subpart 5, is below the limit for that group established in part 9549.0055, subpart 2, item E, as

indexed in part 9549.0055, subpart 3, the nursing facility's nonadjusted other operating cost payment rate must be the allowable historical other operating cost per diem.

B. If the allowable historical other operating cost per diem determined in part 9549.0054, subpart 5, is at or above the limit for that group established in part 9549.0055, subpart 2, item E, as indexed in part 9549.0055, subpart 3, the nursing facility's nonadjusted other operating cost payment rate must be set at that limit.

Subp. 4. **Adjusted prospective other operating cost payment rate.** The adjusted prospective other operating cost payment rate must be determined according to items A to D.

A. Except as provided in item B, if the nursing facility's nonadjusted other operating cost payment rate is below the limit for that group established in part 9549.0055, subpart 2, item E, as indexed in part 9549.0055, subpart 3, the nursing facility's adjusted prospective other operating cost payment rate must be the nonadjusted other operating cost payment rate determined in subpart 3, item A, multiplied by the other operating cost adjustment factor determined in part 9549.0055, subpart 1, item B, plus an efficiency incentive equal to the difference between the limit in part 9549.0055, subpart 2, item E, as indexed in part 9549.0055, subpart 3, and the nonadjusted other operating cost payment rate in subpart 3 up to a maximum of two dollars per resident day.

B. For any short length of stay facility and any nursing facility licensed on June 1, 1983, by the commissioner to provide residential services for persons with physical disabilities under parts 9570.2000 to 9570.3600 that is under the limits established in part 9549.0055, subpart 2, item E, subitem (3), as indexed in part 9549.0055, subpart 3, the nursing facility's adjusted prospective other operating cost payment rate must be the nonadjusted other operating cost payment rate determined in subpart 3, item A, multiplied by the other operating cost adjustment factor determined in part 9549.0055, subpart 1, item B, plus an efficiency incentive equal to the difference between the limit in part 9549.0055, subpart 2, item E, subitem (2), as indexed in part 9549.0055, subpart 3, and the nonadjusted other operating cost payment rate in subpart 3, up to a maximum of two dollars per resident day.

C. If the nursing facility's nonadjusted other operating cost payment rate is at or above the limit for that group established in part 9549.0055, subpart 2, item E, as indexed in part 9549.0055, subpart 3, the nursing facility's adjusted prospective other operating cost payment rate must be the nonadjusted other operating cost payment rate determined in subpart 3, item B, multiplied by the other operating cost adjustment factor determined in part 9549.0055, subpart 1, item B, except as provided in subpart 7.

D. If the nursing facility is eligible to receive the phase in in subpart 7, the phase in must be added to the adjusted prospective other operating cost payment rate.

Subp. 5. **Total operating cost payment rate.** The nursing facility's total operating cost payment rate must be the sum of the adjusted prospective case mix and other care related payment rate determined in subpart 2 and the adjusted other operating cost payment rate determined in subpart 4.

Subp. 6. **One-time adjustment.** Items A to F set forth the procedure to be applied to establish a one-time adjustment to the nursing facility's case mix operating costs per diem for the period October 1, 1986, to September 30, 1987.

A. To qualify for a one-time adjustment to the case mix operating costs per diem, the nursing facility or portion of the nursing facility for which the adjustment is requested must be licensed under Minnesota Statutes, chapter 144A and the nursing facility must not have received an interim or settle up payment rate during the reporting year ending September 30, 1985.

B. To apply for the one-time adjustment to case mix operating costs per diem, the nursing facility must have submitted a written request to the commissioner on or before July 31, 1986. The written request must include the information required in subitems (1) to (3).

(1) Documentation indicating that based on the productive nursing hours and standardized resident days for the reporting period, ending September 30, 1985, the nursing facility cannot provide a minimum of 0.95 productive nursing hours per standardized resident day by reallocating existing staff and costs and that the nursing facility cannot use other available resources, including any efficiency incentives effective July 1, 1986, to increase productive nursing hours to meet the minimum of 0.95 productive nursing hours per standardized resident day.

(2) A list of the number and type of staff positions including annual hours worked, and related fringe benefits and payroll taxes for the reporting years ending September 30, 1984 and September 30, 1985.

(3) A written nursing plan describing how the nursing facility will meet the minimum of 0.95 productive nursing hours per standardized resident day if the nursing facility receives

a one-time adjustment. The plan must include the number and types of staff to be added to the current staff complement and the projected cost of the salary and related fringe benefits and payroll taxes for the additional staff. The plan must also specify any other increases in case mix operating costs.

C. The commissioner of human services and the commissioner of health shall review the documentation submitted by the nursing facility under item B to determine if the nursing facility meets the criteria in subitems (1) to (5).

(1) The nursing facility meets the criteria in item A.

(2) The nursing facility has submitted the documentation required in item B.

(3) The nursing facility provided less than a minimum of 0.95 productive nursing hours per standardized resident day for the reporting period ending September 30, 1985.

(4) The nursing facility cannot meet the minimum of 0.95 productive nursing hours per standardized resident day by reallocating staff and costs including efficiency incentives.

(5) The nursing facility's allowable historical case mix and other care related operating cost per diem plus the one-time adjustment is less than the case mix and other care related operating cost limit.

D. If the request meets the criteria in item C, the commissioner shall make a one-time adjustment to the nursing facility's payment rate. The one-time adjustment must be determined according to subitems (1) to (9) and must not exceed the amount computed in subitem (3).

(1) The nursing facility's productive nursing hours per standardized resident day for the reporting period ending September 30, 1985, must be subtracted from 0.95 and the result must be multiplied by the nursing facility's standardized resident days for the period beginning October 1, 1984, and ending September 30, 1985.

(2) The nursing facility's nursing cost per hour must be determined by dividing the nursing facility's total allowable historical case mix operating costs by the nursing facility's total productive nursing hours for the reporting period ending September 30, 1985.

(3) The amount determined in subitem (1) must be multiplied by the amount determined in subitem (2) to determine the total maximum nursing costs required to meet the minimum of 0.95 productive nursing hours per standardized resident day.

(4) If the amount requested in the nursing hours plan submitted under item B is less than the amount in subitem (3) the difference must be subtracted from the amount in subitem (3).

(5) The amount determined in subitem (4) must be divided by the nursing facility's standardized resident days for the reporting period ending September 30, 1985, to compute the maximum standardized case mix per diem costs to be allowed under this subpart.

(6) Any efficiency incentive included in the nursing facility's total operating costs payment on July 1, 1986, must be subtracted from the amounts in subitem (5).

(7) Any further reduction that the commissioner determines would be possible by reallocating the nursing facility's staff and costs must be subtracted from the amount computed in subitem (6).

(8) The amount computed in subitem (7) must be multiplied by the weight for each resident class contained in part 9549.0058, subpart 2.

(9) The amount computed in subitem (8) must be added to the adjusted prospective case mix and other care related payment rates for each corresponding resident class.

E. The one-time adjustment determined in item D, subitem (9) shall be implemented beginning October 1, 1986. No portion of the adjustment may be used to provide services that are not case mix operating costs according to part 9549.0051, subpart 5. The commissioner shall perform a fiscal review of the nursing facility's cost report submitted for the reporting period ending September 30, 1987, and of any additional documentation required by the commissioner to determine if the nursing facility provided 0.95 productive nursing hours per standardized resident day and to determine whether the nursing facility has implemented the provisions of the plan specified in item B. The commissioner shall consult with the commissioner of health to verify compliance with any applicable care related licensing or certification standards. Based on the results of the fiscal review and the information provided by the commissioner of health, the commissioner shall implement either subitem (1), (2), or (3).

(1) If the nursing facility has failed to implement the plan required in item B, the commissioner shall recover the total amount paid under this subpart in accordance with part 9549.0070, subpart 4 and shall disallow any increases in costs incurred by the nursing facility under this subpart in establishing the payment rate for the rate year beginning July 1, 1988.

(2) If the nursing facility has implemented or partially implemented the plan specified in item B and the actual case mix operating costs incurred during the reporting year ending September 30, 1987, are below the payment made under this subpart, the commissioner shall reduce the adjustment to the nursing facility's payment rate and recover any overpayments in accordance with part 9549.0070, subpart 4. The reduced adjustment to the nursing facility's total payment rate shall continue to be paid to the nursing facility until June 30, 1988.

(3) If the actual costs of implementing the plan specified in item B, subitem (3) incurred during the reporting period ending September 30, 1987, exceed the payments made under this subpart there shall be no retroactive cost settle up. The adjustment to the nursing facility's total payment rate shall continue to be paid to the nursing facility at the same level until June 30, 1988.

F. The nursing facility must record the costs associated with this subpart separately from other nursing facility costs until the commissioner's fiscal and compliance review under item E establishes that the nursing facility has implemented the plan required in item B and has provided at least 0.95 productive nursing hours per standardized resident day during the reporting period ending September 30, 1987. To prevent duplicate payments, the case mix operating costs associated with this subpart are nonallowable until after the commissioner has reviewed and approved the costs under item E. If the commissioner approves the costs, the additional case mix operating costs incurred under this subpart are allowable costs and must be included in the computation of the allowable historical case mix operating cost per diem for the rate year beginning July 1, 1988.

Subp. 7. **Phase in of rates.** Nursing facility rate limits shall be phased in in accordance with Minnesota Statutes, section 256B.431, subdivision 2h.

**9549.0058 RESIDENT CLASSES AND CLASS WEIGHTS.**

Subpart 1. **Resident classes.** Each resident or applicant must be assessed according to items A to E based on the information on the assessment form completed in accordance with part 9549.0059.

A. A resident or applicant must be assessed as dependent in an activity of daily living or ADL according to the following table:

| ADL | Dependent if Score At or Above |
|---|---|
| Dressing | 2 |
| Grooming | 2 |
| Bathing | 4 |
| Eating | 2 |
| Bed mobility | 2 |
| Transferring | 2 |
| Walking | 2 |
| Toileting | 1 |

B. A resident or applicant assessed as dependent in fewer than four of the ADLs in item A must be defined as Low ADL. A resident or applicant assessed as dependent in four through six of the ADLs in item A must be defined as Medium ADL. Each resident or applicant assessed as dependent in seven or eight of the ADLs in item A must be defined as High ADL.

C. A resident or applicant must be defined as special nursing if the resident or applicant meets the criteria in subitem (1) or (2):

(1) the resident or applicant is assessed to require tube feeding; or

(2) the resident or applicant is assessed to require clinical monitoring every day on each shift and the resident is assessed to require one or more of the following special treatments:

(a) oxygen and respiratory therapy;

(b) ostomy/catheter care;

(c) wound or decubitus care;

(d) skin care;

(e) intravenous therapy;

(f) drainage tubes;

(g) blood transfusions;

(h) hyperalimentation;

(i) symptom control for the terminally ill; or

(j) isolation precautions.

D. A resident or applicant must be defined as having a neuromuscular condition if the resident or applicant is assessed to have one or more of the diagnoses coded to the categories in subitems (1) to (8) according to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), as published by the Commission on Professional and Hospital Activities, 1968 Green Road, Ann Arbor, Michigan (1978). This publication is incorporated by reference. The publication is available through the Minitex interlibrary loan system and is not subject to frequent change.

(1) diseases of nervous system excluding sense organs (320-359 excluding 331.0);

(2) cerebrovascular disease (430-438 excluding 437);

(3) fracture of skull (800-804), excluding cases without intracranial injury;

(4) intercranial injury, excluding those with skull fracture (850-854);

(5) fracture of vertebral column with spinal cord injury (806);

(6) spinal cord injury without evidence of spinal bone injury (952);

(7) injury to nerve roots and spinal plexus (953); or

(8) neoplasms of the brain and spine (170.2, 170.6, 191, 192, 198.3, 198.4, 213.2, 213.6, 225, 237.5, 237.6, and 239.6).

E. A resident or applicant must be defined as having a behavioral condition if the resident's or applicant's assessment score is two or more for behavior on the assessment form.

Subp. 2. **Resident classes.** The commissioner shall establish resident classes according to items A to K. The resident classes must be established based on the definitions in subpart 1.

A. A resident must be assigned to class A if the resident is assessed as:

(1) Low ADL;

(2) not defined behavioral condition; and

(3) not defined special nursing.

B. A resident must be assigned to class B if the resident is assessed as:

(1) Low ADL;

(2) defined behavioral condition; and

(3) not defined special nursing.

C. A resident must be assigned to class C if the resident is assessed as:

(1) Low ADL; and

(2) defined special nursing.

D. A resident must be assigned to class D if the resident is assessed as:

(1) Medium ADL;

(2) not defined behavioral condition; and

(3) not defined special nursing.

E. A resident must be assigned to class E if the resident is assessed as:

(1) Medium ADL;

(2) defined behavioral condition; and

(3) not defined special nursing.

F. A resident must be assigned to class F if the resident is assessed as:

(1) Medium ADL; and

(2) defined special nursing.

G. A resident must be assigned to class G if the resident is assessed as:

(1) High ADL;

(2) scoring less than three on the eating ADL;

(3) not defined special nursing; and

(4) not defined behavioral condition.

H. A resident must be assigned to class H if the resident is assessed as:

(1) High ADL;

(2) scoring less than three on the eating ADL;

(3) defined behavioral condition; and

(4) not defined special nursing.

I. A resident must be assigned to class I if the resident is assessed as:

(1) High ADL;

(2) scoring three or four on the eating ADL;

(3) not defined special nursing; and

(4) not defined neuromuscular condition.

J. A resident must be assigned to class J if the resident is assessed as:

(1) High ADL;

(2) scoring three or four on the eating ADL;

(3) not defined special nursing; and

(4) defined neuromuscular condition or scoring three or four on behavior.

K. A resident must be assigned to class K if the resident is assessed as:

(1) High ADL; and

(2) defined special nursing.

Subp. 3. **Class weights.** The commissioner shall assign weights to each resident class established in subpart 2 according to items A to K.

A. Class A, 1.00;

B. Class B, 1.30;

C. Class C, 1.64;

D. Class D, 1.95;

E. Class E, 2.27;

F. Class F, 2.29;

G. Class G, 2.56;

H. Class H, 3.07;

I. Class I, 3.25;

J. Class J, 3.53;

K. Class K, 4.12.

**9549.0059 RESIDENT ASSESSMENT.**

Subpart 1. **Assessment of nursing facility applicants and newly admitted residents.** Each nursing facility applicant or newly admitted resident must be assessed for the purpose of determining the applicant's or newly admitted resident's class. The assessment must be conducted according to the procedures in items A to I.

A. The county preadmission screening team or hospital screening team under contract with the county must assess all nursing facility applicants for whom preadmission screening is required by Minnesota Statutes, section 256B.0911, and any applicant for whom a preadmission screening is not required but who voluntarily requests such a screening in accordance with Minnesota Statutes, section 256B.0911, except as provided in subitems (1) and (2).

(1) The public health nurse as defined in Minnesota Statutes, section 145A.02, subdivision 18, of the county preadmission screening team or the registered nurse case manager shall assess a nursing facility applicant, if the applicant was previously screened by the county preadmission screening team and the applicant is receiving services under the Alternative Care Grants program defined in part 9505.2340 or under the medical assistance program.

(2) An applicant whose admission to the nursing facility is for the purpose of receiving respite care services need not be reassessed more than once every six months for the purpose of computing resident days under part 9549.0054, subpart 2, if the applicant has been classified by the Department of Health within the prior six month period. In this case, the resident class established by the Department of Health within the prior six month period may be the resident class of the applicant. A resident must not receive more than one assessment per respite care stay.

B. Except as provided in item A, subitem 2, the nursing facility must assess each applicant or newly admitted resident for whom a preadmission screening is not required by Minnesota Statutes, section 256B.0911, or is not requested voluntarily in accordance with Minnesota Statutes, section 256B.0911. For the purposes of this item, the term newly admitted resident includes a resident who moves to a section of the nursing facility that is licensed

differently than the section the resident previously was placed in or a resident who has been transferred from another nursing facility.

C. Except as provided in item D, the assessment required by this subpart must be performed within ten working days before or ten working days after the date the applicant is admitted to the nursing facility.

D. Any resident who is required to be assessed by the preadmission screening team under item A or who has received a prior preadmission screening, and for whom the assessment required under this subpart has not been performed by the preadmission screening team within ten working days before or ten working days after the date the applicant is admitted to the nursing facility must be assessed by the nursing facility. The nursing facility must perform the assessment and submit the forms to the Department of Health within 15 working days after admission.

E. Each assessment that the nursing facility is required to perform must be completed by a registered nurse. The registered nurse performing the assessment must sign the assessment form.

F. The assessment of each applicant or newly admitted resident must be based on the QA&R procedures of the Department of Health including physical observation of the applicant or newly admitted resident and review of available medical records, and must be recorded on the assessment form.

G. Within five working days following the assessment, the preadmission screening team or hospital screening team under contract with the county must send the completed assessment form to the Department of Health, and provide a copy to the nursing facility.

H. Except as provided in item D, each assessment completed under items A to G and a completed medical plan of care or interagency transfer form must be submitted to the Department of Health by the nursing facility as a request for classification within ten working days after admission or after the assessment, whichever is later.

I. The resident class for applicants or newly admitted residents must be effective on the date of the person's admission to the nursing facility.

Subp. 2. **Semiannual assessment by nursing facilities.** Semiannual assessments of residents by the nursing facility must be completed in accordance with items A to D.

A. A nursing facility must assess each of its residents no earlier than 162 days and no later than 182 days after the date of the most recent annual assessment by the Department of Health's QA&R team.

B. A registered nurse shall assess each resident according to QA&R procedures established by the Department of Health including physical observation of the resident, review of the medical plan of care, and review of the resident's plan of care, and shall record the assessment on the assessment form. The Physician's Statement of General Condition (item 10), Individual Dependencies (items 21 to 24 and 28), Medications (items 31 to 34), and Primary, Secondary, and Tertiary Diagnoses (on the back of the form) do not require completion. The registered nurse performing the assessment shall sign the assessment form on the day the assessment is completed.

C. Within five working days of the completion of the nursing facility's semiannual resident assessments, the nursing facility must forward to the Department of Health requests for classification for all residents assessed for the semiannual assessment. These requests must include the assessment forms and the nursing facility's daily census for the date on which the assessments were completed including an explanation of any discrepancy between the daily census and the number of assessments submitted. The nursing facility must provide additional information to the Department of Health if the Department of Health requests the information in order to determine a resident's classification.

D. Any change in resident class due to a semiannual assessment must be effective on the first day of the month following the date of the completion of the semiannual assessments.

Subp. 3. **Change in classification due to annual assessment by Department of Health.** Any change in resident class due to an annual assessment by the Department of Health's QA&R team will be effective as of the first day of the month following the date of completion of the Department of Health's assessments. QA&R shall not establish classifications for residents who experience an admission, transfer, hospital return, or discharge occurring during the QA&R team visit.

Subp. 4. **Assessment upon return to the nursing facility from a hospital.** Residents returning to a nursing facility after hospitalization must be assessed according to items A to D.

A. A nursing facility must assess any resident who has returned to the same nursing facility after a hospital admission. The assessment must occur no more than five working days after the resident returns to the same nursing facility.

B. In addition to the assessment required in item A, residents who have returned to the same nursing facility after hospital admission must be reassessed by the nursing facility no less than 30 days and no more than 35 days after return from the hospital unless the nursing facility's annual or semiannual reassessment occurs during the specified time period.

C. A registered nurse shall perform the assessment on each resident according to QA&R procedures established by the Department of Health, including physical observation of the resident, review of the medical plan of care, and review of the resident's plan of care, and shall record the assessment on the assessment form. The registered nurse who performs the assessment shall sign the assessment form. Within five working days of the completion of the assessment, the nursing facility must forward to the Department of Health a request for a classification for any resident assessed upon return to the nursing facility after a hospital admission. This request must include the assessment form and the resident's medical plan of care or interagency transfer form. Upon request, the nursing facility must furnish the Department of Health with additional information needed to determine a resident's classification.

D. Any change in resident class due to an assessment provided under item A must be effective on the date the resident returns to the nursing facility from the hospital. Any change in resident class due to a reassessment provided under item B must be effective as of the first of the month following the assessment.

Subp. 5. **Change in resident class due to audits of assessments of nursing facility residents.** Any change in resident class due to a reclassification required by part 4656.0050 must be retroactive to the effective date of the assessment audited.

Subp. 6. **False information.** If the nursing facility knowingly supplies inaccurate or false information in an assessment or a request for reconsideration, the commissioner shall apply the penalties in part 9549.0041, subpart 15.

Subp. 7. **Reconsideration of resident classification.** Any request for reconsideration of a resident classification must be made under part 4656.0070.

Subp. 8. **Change in resident class due to request for reconsideration of resident classification.** Any change in a resident class due to a request for reconsideration of the classification must be made in accordance with items A and B.

A. The resident classification established by the Department of Health must be the classification that applies to the resident while any request for reconsideration under part 4656.0070 is pending.

B. Any change in a resident class due to a reclassification under part 4656.0070must be effective as of the effective date of the classification established by the original assessment for which a reconsideration was requested.

Subp. 9. **Resident access to assessments and documentation.** The nursing facility must provide access to information regarding rates, assessments, and other documentation provided to the Department of Health in support of the resident's assessments to each nursing facility resident or the resident's authorized representative according to items A to D.

A. The nursing facility must post a notice of its current rates for each resident class in a conspicuous place. The rates must be posted no later than five days after receipt by the nursing facility. The nursing facility must include a notice that the nursing facility has chosen to appeal the rates under part 9549.0080.

B. The nursing facility must provide written notice to each private paying resident or the person responsible for payment of any increase in the total payment rate established by the commissioner 30 days before the increase takes effect as required by Minnesota Statutes, section 256B.47, subdivision 2. The notice must specify the current classification of the resident. This item does not apply to adjustments in rates due to a necessary change in the resident's classification as a result of an assessment required in this part.

C. The nursing facility must provide each nursing facility resident or the person responsible for payment with each classification letter received from the Department of Health within five days of the receipt of the classification letter. When the private paying resident is not the person responsible for payment, the classification letter must be sent to the person responsible for payment. If the resident's classification has changed, the nursing facility must include the current rate for the new classification with the classification letter.

D. The nursing facility must provide each nursing facility resident or the resident's authorized representative with a copy of the assessment form and any other documentation provided to the Department of Health in support of the assessment within three working days of receipt of a written request from the resident or the resident's authorized representative.

**9549.0060 DETERMINATION OF THE PROPERTY-RELATED PAYMENT RATE.**

Subpart 1. **Initial appraised value.** For the rate year beginning July 1, 1985, the commissioner shall contract with a property appraisal firm which shall use the depreciated replacement cost method to determine the appraised value of each nursing facility participating in the medical assistance program as of June 30, 1985. The initial appraised value of each nursing facility and any subsequent reappraisal under subparts 2 and 3 must be limited to the value of buildings, attached fixtures, and land improvements used by the nursing facility and must be subject to the limits in subpart 4.

For hospital attached nursing facilities, the commissioner shall require the appraisal of those portions of buildings, attached fixtures, and land improvements in service areas shared between the nursing facility and the hospital. The appraised value of the shared service areas must be allocated between the nursing facility and the hospital or other nonnursing home areas using the Medicare worksheet B-1 statistics in effect on September 30, 1984. The appraised value of the shared service areas must be allocated by stepdown placing the appraised values on the appropriate line of column 1 on the Medicare worksheet B. The appraised value of the shared service areas allocated to the nursing facility shall be added to the appraised value of the nursing facility's buildings, attached fixtures, and land improvements.

For a newly constructed nursing facility applying to participate in the medical assistance program which commenced construction after June 30, 1985, or a nursing facility with an increase in licensed beds of 50 percent or more, the commissioner shall require an initial appraisal upon completion of the construction. The construction is considered complete upon issuance of a certificate of occupancy or, if no certification of occupancy is required, when available for resident use. The property-related payment rate is effective on the earlier of either the first day a resident is admitted or on the date the nursing facility is certified for medical assistance.

**9549.0060 DETERMINATION OF THE PROPERTY-RELATED PAYMENT RATE.**

Subp. 2. **Routine updating of appraised value.** For rate years beginning after June 30, 1986, the commissioner shall routinely update the appraised value according to items A to C.

A. The commissioner shall contract with a property appraisal firm which shall use the depreciated replacement cost method to perform reappraisals. Each calendar year, the commissioner shall select a random sample of not less than 15 percent of the total number of nursing facilities participating in the medical assistance program as of July 1 of that year. The sample must not include nursing facilities receiving an interim payment rate under subpart 14. All nursing facilities in the sample must be reappraised during the last six months of the calendar year. Incomplete additions or replacements must not be included in the reappraisals. An incomplete addition or replacement is one for which a certificate of occupancy is not yet issued, or if a certificate of occupancy is not required, the addition or replacement is not available for use.

The updated appraised value for hospital attached nursing facilities resulting from a reappraisal of shared service areas must be allocated to the nursing facility in the same ratio indicated by the Medicare stepdown in effect on September 30 of the rate year in which the reappraisal is conducted. The method described in subpart 1, is to be used to determine allocation of the updated appraised value. The reappraised value of the shared service areas allocated to the nursing facility must be added to the reappraised value of the nursing facility's buildings, attached fixtures, and land improvements.

B. The commissioner shall compute the average percentage change in appraised values for the nursing facilities in the sample. The appraised value of each nursing facility not in the sample, and not reappraised under subpart 3, must be increased or decreased by the average percentage change subject to the limits in subpart 4. No redetermination of the average percentage change in appraised values shall be made as a result of changes in the appraised value of individual nursing facilities in the sample made after the commissioner's computation of the average percentage change.

C. For hospital attached nursing facilities not in the sample, the allocation of the appraised value of the shared service areas must be recomputed if the hospital involved experiences a cumulative change in total patient days as defined by the Medicare program of more than 15 percent from the reporting year in which the most recently used set of allocation statistics were determined. The allocation using the method described in subpart 1 must be based on the Medicare stepdown in effect on September 30 of the rate year in which the updating of the appraised value is performed.

D. The adjustment to the property-related payment rate which results from updating the appraised value is effective for the rate year immediately following the rate year in which the updating takes place except as provided in subpart 14.

E. Each calendar year that a random sample is selected in item A to compute the average percentage change in appraised values in item B, the commissioner shall evaluate the adequacy of the sample size according to subitems (1) to (6).

(1) The tolerance level for an acceptable error rate must be plus or minus three percentage points.

(2) The confidence level for evaluating the sample size must be 95 percent.

(3) The sample size required to be within the tolerance level in subitem (1) must be computed using standard statistical methods for determination of a sample size.

(4) If the required sample size in subitem (3) is greater than the sample size used in item A, additional appraisals must be performed until the number of appraisals is equal to the required sample size in subitem (3). The additional nursing facilities needed to complete the required sample size must be randomly selected. A nursing facility that received a special reappraisal under subpart 3, or one that is receiving an interim payment rate under subpart 14, or one that was appraised in the original sample in item A must be excluded. The average percentage change in appraised values in item B must be recomputed based on the increased sample size in subitem (3).

(5) If the tolerance level in subitem (1) continues to be exceeded after applying the procedures in subitems (3) and (4), the procedures in subitems (3) and (4) must be repeated until the error rate is within the tolerance level.

(6) If the required sample size in subitem (3) is equal to or less than the sample size used in item A, the average percentage change in appraised values must be the percentage determined in item B.

**9549.0060 DETERMINATION OF THE PROPERTY-RELATED PAYMENT RATE.**

Subp. 3. **Special reappraisals.** Special reappraisals are subject to the requirements of items A to F.

A. A nursing facility which makes an addition to or replacement of buildings, attached fixtures, or land improvements may request the commissioner to conduct a reappraisal upon project completion.

Upon receipt of a written request, the commissioner shall conduct a reappraisal within 60 days provided that all conditions of this subpart are met. The total historical cost of the addition or replacement, exclusive of the proceeds from disposals of capital assets or applicable credits such as public grants and insurance proceeds, must exceed the lesser of $200,000 or ten percent of the most recent appraised value determined under subparts 1 to 4. The addition or replacement must be complete and a certificate of occupancy issued, or if a certificate of occupancy is not required, the addition or replacement must be available for use. Special reappraisals under this item are limited to one per 12-month period.

B. A nursing facility which retires buildings, attached fixtures, land improvements, or portions thereof without replacement, shall report the deletion to the commissioner within 30 days if the historical cost of the deletion exceeds $200,000. The commissioner shall conduct a reappraisal of the nursing facility to establish the new appraised value and adjust the property-related payment rate accordingly.

C. The adjusted property-related payment rate computed as a result of reappraisals in items A and B is effective on the first day of the month following the month in which the addition or replacement was completed or when the deletion occurred.

D. The commissioner shall reappraise every nursing facility at least once every seven calendar years following the initial appraisal. The commissioner shall reappraise a nursing facility if at the end of seven calendar years the nursing facility has not been reappraised at least once under subpart 2 or 3. The commissioner shall adjust the property-related payment rate to reflect the change in appraised value. The adjustment of the property-related payment rate is effective on the first day of the rate year immediately following the reappraisal.

E. The commissioner may require the reappraisal of a nursing facility within 60 days of receipt of information provided by the Minnesota Department of Health regarding the violation of standards and rules relating to the condition of capital assets.

F. Changes in appraised value computed in this subpart must not be used to compute the average percentage change in subpart 2, item B.

**9549.0060 DETERMINATION OF THE PROPERTY-RELATED PAYMENT RATE.**

Subp. 8. **Building capital allowance for owner operated nursing facilities or nursing facilities with capital leases.** Except as provided in subpart 14, for the rate years beginning after June 30, 1985, the building capital allowance for owner operated nursing facilities or nursing facilities with capital leases must be computed as follows:

A. The rental factor is 5.33 percent.

B. The difference between the nursing facility's allowable appraised value determined under subparts 1 to 4 and the allowable debt determined in subpart 5 is multiplied by the rental factor.

C. The amount determined in item B must be added to the total allowable interest expense determined under subparts 6 and 7.

D. Except as in item E, the amount determined in item C must be divided by 96 percent of capacity days.

E. If the average length of stay in the skilled level of care within a nursing facility is 180 days or less, the nursing facility shall divide the amount in item C by the greater of resident days or 80 percent of capacity days but in no event shall the divisor exceed 96 percent of capacity days.

For purposes of this item, the nursing facility shall compute its average length of stay for the skilled level of care by dividing the nursing facility's skilled resident days for the reporting year by the nursing facility's total skilled level of care discharges for that reporting year.

**9549.0060 DETERMINATION OF THE PROPERTY-RELATED PAYMENT RATE.**

Subp. 9. **Building capital allowance for nursing facilities with operating leases.** Except as provided in subpart 14, for rate years beginning after June 30, 1985, the building capital allowance for nursing facilities with operating lease costs incurred for buildings must be paid as determined by items A to C.

A. The allowable appraised value of the nursing facility must be established according to subparts 1 to 4.

B. The allowable interest expense determined under subparts 6 and 7 and the allowable debt determined under subpart 5 for the leased nursing facility must be considered zero.

C. Except as in item D, the building capital allowance must be the lesser of the operating lease expense divided by 96 percent of capacity days, or the allowable appraised value multiplied by the rental factor and then divided by 96 percent of capacity days.

D. A nursing facility with an average length of stay of 180 days or less as defined in subpart 8, item E, shall use the divisor determined in subpart 8, item E, instead of 96 percent of capacity days.

E. The phrase "operating lease" does not include a nominal lease. For purposes of this subpart, a lease that meets the following conditions is considered a nominal lease:

(1) the annual lease payment in comparison to the rental value of the physical plant and depreciable equipment is a nominal amount, usually $1 per year;

(2) the length of the lease, including renewal provisions, reflects the intent of the lessor and lessee to lease the physical plant and depreciable equipment for the remainder of their useful lives;

(3) the lease agreement imposes a duty upon the lessee to make necessary improvements and to properly maintain the nursing facility;

(4) the lease agreement has no restrictions on the free use of the nursing facility by the lessee other than it must be used as a licensed nursing facility; and

(5) the lease agreement must not require the furnishing of any indirect benefits to the lessor.

A nursing facility leased with a nominal lease shall have its building capital allowance computed as in subpart 8. This item is effective for rate years beginning on or after July 1, 1988.

**9549.0060 DETERMINATION OF THE PROPERTY-RELATED PAYMENT RATE.**

Subp. 12. **Capitalization.** For rate years after June 30, 1985, the cost of purchasing or repairing capital assets shall be capitalized under items A to D.

A. The cost of purchasing a capital asset listed in the depreciation guidelines must be capitalized. The cost of purchasing any other capital asset not included in the depreciation

guidelines must be capitalized if the asset has a useful life of more than two years and costs more than $500.

B. The nursing facility may consider as an expense a repair that costs $500 or less. Repairs that are considered as an expense must be classified in the plant operation and maintenance cost category. If the cost of a repair to a capital asset is $500 or more, and the estimated useful life of the capital asset is extended beyond its original estimated useful life by at least two years, or if the productivity of the capital asset is increased significantly over its original productivity, then the cost of the repair must be capitalized.

C. The property-related expenditures related to capital assets such as lease or depreciation, interest, and real estate taxes which are used by central, affiliated, or corporate offices must be classified in the nursing facility's general and administrative cost category.

D. Construction period interest expense, feasibility studies, and other costs related to the construction period must be capitalized.

**9549.0060 DETERMINATION OF THE PROPERTY-RELATED PAYMENT RATE.**

Subp. 13. **Determination of the property-related payment rate.** The commissioner shall determine the property-related payment rate according to items A to H.

A. Except as provided in subpart 14, the building capital allowance of each nursing facility shall be added to the equipment allowance.

B. The allowable historical property-related per diem shall be established according to subitems (1) and (2).

(1) For the rate year beginning July 1, 1985, the nursing facility's historical property-related per diem shall be determined by adding the allowable historical property-related costs used to compute the property-related payment rate effective on June 30, 1985, and dividing the sum by 96 percent capacity days. A nursing facility with an average length of stay of 180 days or less as defined in subpart 8, item E, shall use the divisor determined in subpart 8, item E, instead of 96 percent of capacity days.

(2) For rate years beginning after June 30, 1986, the historical property-related cost per diem shall be the property-related payment rate established for the previous rate year unless the nursing facility's capacity days change. If the nursing facility's capacity days change from one reporting year to the next for any reason including a change in the number of licensed nursing facility beds, a change in the election for computing capacity days as provided in subpart 11, or a change in the number of days in the reporting year, the historical property-related per diem must be recalculated using the capacity days for the reporting year in which the change occurred.

C. For rate years beginning after June 30, 1985, the property-related payment rate shall be the lesser of the amount computed in item A or the historical property-related per diem in item B increased by six percent for each rate year beginning July 1, 1985 through July 1, 1989, except as provided in items D to G.

D. A nursing facility whose allowable historical property-related per diem determined in item B is less than or equal to $2.25 shall receive a property-related payment rate equal to the greater of $2.25 or its allowable historical property-related per diem increased by six percent for each rate year beginning July 1, 1985 through July 1, 1989, except that the property-related payment rate shall not exceed the amount determined in item A.

E. A nursing facility whose allowable historical property-related per diem determined in item B is greater than the amount determined in item A shall receive a property-related payment rate equal to its allowable historical property-related per diem.

F. In the event of a change of ownership or reorganization of the provider entity occurring after June 30, 1985, the nursing facility's property-related payment rate must be the lesser of the property-related payment rate in effect at the time of sale or reorganization or the amount determined in item A. Changes in the property-related payment rate as a result of this item shall be effective on the date of the sale or reorganization of the provider entity.

G. The property-related payment rate for a nursing facility which qualifies for the special reappraisal in subpart 3, item A shall be determined according to subitems (1) and (2).

(1) If the amount computed according to item A using the reappraised value is equal to or less than the property-related payment rate in effect prior to the reappraisal, the property-related payment rate in effect prior to the reappraisal shall not be adjusted.

(2) If the amount computed according to item A using the reappraised value is greater than the property-related payment rate in effect prior to the reappraisal, the property-related payment in effect prior to the reappraisal shall be added to the difference between the amount

computed according to item A using the reappraised value and the amount computed according to item A using the most recent appraised value prior to the reappraisal. This sum must not exceed the amount computed in item A using the reappraised value. If the difference between the amount computed according to item A using the reappraised value and the amount computed according to item A using the most recent appraised value prior to the reappraisal is equal to or less than zero, the difference shall be considered zero.

H. For rate years beginning after June 30, 1990, the property-related payment rate shall be the sum of the building capital allowance and the equipment allowance.

**9549.0061 PAYMENT FOR REAL ESTATE TAXES AND SPECIAL ASSESSMENTS.**

The total real estate taxes and actual special assessments and payments permitted under part 9549.0036, item CC, must be divided by actual resident days to compute the payment rate for real estate taxes and special assessments.

**9549.0070 COMPUTATION OF TOTAL PAYMENT RATE.**

Subpart 1. **Total payment rate.** The total payment rate is the sum of the operating cost payment rate, the property-related payment rate, and the real estate tax and special assessments payment rate. The total payment rate becomes effective on July 1 of the rate year following the reporting year.

**9549.0070 COMPUTATION OF TOTAL PAYMENT RATE.**

Subp. 4. **Adjustment of total payment rate.** If the commissioner finds nonallowable costs, errors, or omissions in the nursing facility's historical costs, the nursing facility's affected total payment rates must be adjusted. If the adjustment results in an underpayment to the nursing facility, the commissioner shall pay to the nursing facility the underpayment amount within 120 days of written notification to the nursing facility. If the adjustment results in an overpayment to the nursing facility, the nursing facility shall pay to the commissioner the entire overpayment within 120 days of receiving the written notification from the commissioner. Interest charges must be assessed on underpayment or overpayment balances outstanding after 120 days written notification of the total payment rate determination.

If an appeal has been filed under part 9549.0080, any payments owed by the nursing facility or by the commissioner must be made within 120 days of written notification to the nursing facility of the commissioner's ruling on the appeal. Interest charges must be assessed on balances outstanding after 120 days of written notification of the commissioner's ruling on the appeal. The annual interest rate charged must be the rate charged by the commissioner of the Department of Revenue for late payment of taxes, which is in effect on the 121st day after the written notification.