State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-FIFTH
SESSION

HOUSE FILE NO. 1991

March 12, 2007
Authored by Loeffler and Thissen
The bill was read for the first time and referred to the Committee on Health and Human Services
March 27, 2007
Committee Recommendation and Adoption of Report:
To Pass as Amended and re-referred to the Committee on Finance

A bill for an act

relating to human services; making technical changes; chemical and mental health; continuing care; health care; extending certain alternative care pilot projects; amending Minnesota Statutes 2006, sections 245.4874; 252.32, subdivision 3; 253B.185, subdivision 2; 254A.03, subdivision 3; 254A.16, subdivision 2; 254B.02, subdivisions 1, 5; 254B.03, subdivisions 1, 3; 254B.06, subdivision 3; 256.476, subdivisions 1, 2, 3, 4, 5, 10; 256.974; 256.9744, subdivision 1; 256B.0625, subdivisions 13c, 23; 256B.0911, subdivision 4c; 256B.0913, subdivisions 4, 5, 5a, 8, 9, 10, 11, 12, 13, 14; 256B.0919, subdivision 3; 256B.0943, subdivisions 6, 9, 11, 12; 256B.431, subdivisions 1, 3f, 17e; 256D.03, subdivision 4; 256E.35, subdivision 2; 256L.03, subdivision 5; 256L.04, subdivisions 1, 12; Laws 2000, chapter 340, section 19; Laws 2005, chapter 98, article 3, section 25; repealing Minnesota Statutes 2006, sections 252.21; 252.22; 252.23; 252.24; 252.25; 252.261; 252.275, subdivision 5; 254A.02, subdivisions 7, 9, 12, 14, 15, 16; 254A.085; 254A.086; 254A.12; 254A.14; 254A.15; 254A.16, subdivision 5; 254A.175; 254A.18; 256B.0913, subdivisions 5b, 5c, 5d, 5e, 5f, 5g, 5h; 256J.561, subdivision 1; 256J.62, subdivision 9; 256J.65; Minnesota Rules, part 9503.0035, subpart 2.

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

ARTICLE 1
CHEMICAL AND MENTAL HEALTH

Section 1. Minnesota Statutes 2006, section 245.4874, is amended to read:

245.4874 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 245.4887;

(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 245.4887;

(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 245.4887 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) 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) 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) prudently administer grants and purchase-of-service contracts that the county board determines are necessary to fulfill its responsibilities under sections 245.487 to 245.4887;

(11) 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) 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) assure that culturally informed 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) consistent with section 245.486, arrange for or provide a children's mental health screening to a child receiving child protective services or a child in out-of-home placement, a child for whom parental rights have been terminated, a child found to be delinquent, and a child found to have committed a juvenile petty offense for the third or subsequent time, unless 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. 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. 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, and 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 training in the administration of the instrument, the interpretation of its validity given the child's current circumstances, the state and federal data practices laws and confidentiality standards, the parental consent requirement, and 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.

(b) 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. 2. Minnesota Statutes 2006, section 252.32, subdivision 3, is amended to read:

Subd. 3. **Amount of support grant; use.** Support grant amounts shall be determined by the county social service agency. Services and items purchased with a support grant must:

(1) be over and above the normal costs of caring for the dependent if the dependent did not have a disability;

(2) be directly attributable to the dependent's disabling condition; and

(3) enable the family to delay or prevent the out-of-home placement of the dependent.

The design and delivery of services and items purchased under this section must ~~suit the dependent's chronological age and~~ be provided in the least restrictive environment possible, consistent with the needs identified in the individual service plan.

Items and services purchased with support grants must be those for which there are no other public or private funds available to the family. Fees assessed to parents for health or human services that are funded by federal, state, or county dollars are not reimbursable through this program.

In approving or denying applications, the county shall consider the following factors:

(1) the extent and areas of the functional limitations of the disabled child;

(2) the degree of need in the home environment for additional support; and

(3) the potential effectiveness of the grant to maintain and support the person in the family environment.

The maximum monthly grant amount shall be $250 per eligible dependent, or $3,000 per eligible dependent per state fiscal year, within the limits of available funds. The county social service agency may consider the dependent's supplemental security income in determining the amount of the support grant.

Any adjustments to their monthly grant amount must be based on the needs of the family and funding availability.

Sec. 3. Minnesota Statutes 2006, section 253B.185, subdivision 2, is amended to read:

Subd. 2. **Transfer to correctional facility.** (a) If a person has been committed under this section and later is committed to the custody of the commissioner of corrections for any reason, including but not limited to, being sentenced for a crime or revocation of the person's supervised release or conditional release under section 244.05~~, 609.108, subdivision 6,~~ or 609.109, subdivision 7, the person shall be transferred to a facility designated by the commissioner of corrections without regard to the procedures provided in section 253B.18.

(b) If a person is committed under this section after a commitment to the commissioner of corrections, the person shall first serve the sentence in a facility

designated by the commissioner of corrections. After the person has served the sentence, the person shall be transferred to a treatment program designated by the commissioner of human services.

Sec. 4. Minnesota Statutes 2006, section 254A.03, subdivision 3, is amended to read:

Subd. 3. **Rules for chemical dependency care.** The commissioner of human services shall establish by rule criteria to be used in determining the appropriate level of chemical dependency care~~, whether outpatient, inpatient or short-term treatment programs,~~ for each recipient of public assistance seeking treatment for alcohol or other drug dependency and abuse problems. ~~The criteria shall address, at least, the family relationship, past treatment history, medical or physical problems, arrest record, and employment situation.~~

Sec. 5. Minnesota Statutes 2006, section 254A.16, subdivision 2, is amended to read:

Subd. 2. **Program and service guidelines.** (a) The commissioner shall provide program and service guidelines and technical assistance to the county boards in carrying out services authorized under ~~sections~~ section 254A.08~~, 254A.12, 254A.14, and their responsibilities under chapter 256E~~.

(b) The commissioner shall recommend to the governor means of improving the efficiency and effectiveness of comprehensive program services in the state and maximizing the use of nongovernmental funds for providing comprehensive programs.

Sec. 6. Minnesota Statutes 2006, section 254B.02, subdivision 1, is amended to read:

Subdivision 1. **Chemical dependency treatment allocation.** The chemical dependency funds appropriated for allocation shall be placed in a special revenue account. The commissioner shall annually transfer funds from the chemical dependency fund to pay for operation of the drug and alcohol abuse normative evaluation system and to pay for all costs incurred by adding two positions for licensing of chemical dependency treatment and rehabilitation programs located in hospitals for which funds are not otherwise appropriated. ~~For each year of the biennium ending June 30, 1999, the commissioner shall allocate funds to the American Indian chemical dependency tribal account for treatment of American Indians by eligible vendors under section 254B.05, equal to the amount allocated in fiscal year 1997.~~ Six percent of the remaining money must be reserved for tribal allocation under section 254B.09, subdivisions 4 and 5. The commissioner shall annually divide the money available in the chemical dependency fund that is not held in reserve by counties from a previous allocation, or allocated to the American Indian

chemical dependency tribal account. Six percent of the remaining money must be reserved for the nonreservation American Indian chemical dependency allocation for treatment of American Indians by eligible vendors under section 254B.05, subdivision 1. The remainder of the money must be allocated among the counties according to the following formula, using state demographer data and other data sources determined by the commissioner:

(a) For purposes of this formula, American Indians and children under age 14 are subtracted from the population of each county to determine the restricted population.

(b) The amount of chemical dependency fund expenditures for entitled persons for services not covered by prepaid plans governed by section 256B.69 in the previous year is divided by the amount of chemical dependency fund expenditures for entitled persons for all services to determine the proportion of exempt service expenditures for each county.

(c) The prepaid plan months of eligibility is multiplied by the proportion of exempt service expenditures to determine the adjusted prepaid plan months of eligibility for each county.

(d) The adjusted prepaid plan months of eligibility is added to the number of restricted population fee for service months of eligibility for the Minnesota family investment program, general assistance, and medical assistance and divided by the county restricted population to determine county per capita months of covered service eligibility.

(e) The number of adjusted prepaid plan months of eligibility for the state is added to the number of fee for service months of eligibility for the Minnesota family investment program, general assistance, and medical assistance for the state restricted population and divided by the state restricted population to determine state per capita months of covered service eligibility.

(f) The county per capita months of covered service eligibility is divided by the state per capita months of covered service eligibility to determine the county welfare caseload factor.

(g) The median married couple income for the most recent three-year period available for the state is divided by the median married couple income for the same period for each county to determine the income factor for each county.

(h) The county restricted population is multiplied by the sum of the county welfare caseload factor and the county income factor to determine the adjusted population.

(i) $15,000 shall be allocated to each county.

(j) The remaining funds shall be allocated proportional to the county adjusted population.

Sec. 7. Minnesota Statutes 2006, section 254B.02, subdivision 5, is amended to read:

Subd. 5. **Administrative adjustment.** The commissioner may make payments to local agencies from money allocated under this section to support administrative activities under sections 254B.03 and 254B.04. The administrative payment must not exceed five percent of the first $50,000, four percent of the next $50,000, and three percent of the remaining payments for services from the allocation. ~~Twenty-five percent of the administrative allowance shall be advanced at the beginning of each quarter, based on the payments for services made in the most recent quarter for which data is available. Adjustment of any overestimate or underestimate based on actual expenditures shall be made by the state agency by adjusting the administrative allowance for any succeeding quarter.~~

Sec. 8. Minnesota Statutes 2006, section 254B.03, subdivision 1, is amended to read:

Subdivision 1. **Local agency duties.** (a) Every local agency shall provide chemical dependency services to persons residing within its jurisdiction who meet criteria established by the commissioner for placement in a chemical dependency residential or nonresidential treatment service. Chemical dependency money must be administered by the local agencies according to law and rules adopted by the commissioner under sections 14.001 to 14.69.

(b) In order to contain costs, the county board shall, with the approval of the commissioner of human services, select eligible vendors of chemical dependency services who can provide economical and appropriate treatment. Unless the local agency is a social services department directly administered by a county or human services board, the local agency shall not be an eligible vendor under section 254B.05. The commissioner may approve proposals from county boards to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. If a county implements a demonstration or experimental medical services funding plan, the commissioner shall transfer the money as appropriate. If a county selects a vendor located in another state, the county shall ensure that the vendor is in compliance with the rules governing licensure of programs located in the state.

~~(c) The calendar year 2002 rate for vendors may not increase more than three percent above the rate approved in effect on January 1, 2001. The calendar year 2003 rate for vendors may not increase more than three percent above the rate in effect on January 1, 2002. The calendar years 2004 and 2005 rates may not exceed the rate in effect on January 1, 2003.~~

~~(d)~~ (c) A culturally specific vendor that provides assessments under a variance under Minnesota Rules, part 9530.6610, shall be allowed to provide assessment services to persons not covered by the variance.

Sec. 9. Minnesota Statutes 2006, section 254B.03, subdivision 3, is amended to read:

Subd. 3. **Local agencies to pay state for county share.** ~~Local agencies shall submit invoices to the state on forms supplied by the commissioner and according to procedures established by the commissioner.~~ Local agencies shall pay the state for the county share of the ~~invoiced~~ services authorized by the local agency. ~~Payments shall be made at the beginning of each month for services provided in the previous month. The commissioner shall bill the county monthly for services, based on the most recent month for which expenditure information is available. Adjustment of any overestimate or underestimate based on actual expenditures shall be made by the state agency by adjusting the estimate for any succeeding month.~~

Sec. 10. Minnesota Statutes 2006, section 254B.06, subdivision 3, is amended to read:

Subd. 3. **Payment; denial.** The commissioner shall pay eligible vendors for placements made by local agencies under section 254B.03, subdivision 1, and placements by tribal designated agencies according to section 254B.09. The commissioner may reduce or deny payment of the state share when services are not provided according to the placement criteria established by the commissioner. The commissioner may pay for all or a portion of improper county chemical dependency placements and bill the county for the entire payment made when the placement did not comply with criteria established by the commissioner. The commissioner may make payments to vendors and charge the county 100 percent of the payments if documentation of a county approved placement is received more than 30 working days, exclusive of weekends and holidays, after the date services began~~; or if the county approved invoice is received by the commissioner more than 120 days after the last date of service provided.~~ The commissioner shall not pay vendors until private insurance company claims have been settled.

Sec. 11. Minnesota Statutes 2006, section 256B.0943, subdivision 6, is amended to read:

Subd. 6. **Provider entity clinical infrastructure requirements.** (a) To be an eligible provider entity under this section, a provider entity must have a clinical infrastructure that utilizes diagnostic assessment, an individualized treatment plan, service delivery, and individual treatment plan review that are culturally competent,

child-centered, and family-driven to achieve maximum benefit for the client. The provider entity must review and update the clinical policies and procedures every three years and must distribute the policies and procedures to staff initially and upon each subsequent update.

(b) The clinical infrastructure written policies and procedures must include policies and procedures for:

(1) providing or obtaining a client's diagnostic assessment that identifies acute and chronic clinical disorders, co-occurring medical conditions, sources of psychological and environmental problems, and a functional assessment. The functional assessment must clearly summarize the client's individual strengths and needs;

(2) developing an individual treatment plan that is:

(i) based on the information in the client's diagnostic assessment;

(ii) developed no later than the end of the first psychotherapy session after the completion of the client's diagnostic assessment by the mental health professional who provides the client's psychotherapy;

(iii) developed through a child-centered, family-driven planning process that identifies service needs and individualized, planned, and culturally appropriate interventions that contain specific treatment goals and objectives for the client and the client's family or foster family;

(iv) reviewed at least once every 90 days and revised, if necessary; and

(v) signed by the client or, if appropriate, by the client's parent or other person authorized by statute to consent to mental health services for the client;

(3) developing an individual behavior plan that documents services to be provided by the mental health behavioral aide. The individual behavior plan must include:

(i) detailed instructions on the service to be provided;

(ii) time allocated to each service;

(iii) methods of documenting the child's behavior;

(iv) methods of monitoring the child's progress in reaching objectives; and

(v) goals to increase or decrease targeted behavior as identified in the individual treatment plan;

(4) clinical supervision of the mental health practitioner and mental health behavioral aide. A mental health professional must document the clinical supervision the professional provides by cosigning individual treatment plans and making entries in the client's record on supervisory activities. Clinical supervision does not include the authority to make or terminate court-ordered placements of the child. A clinical supervisor must be available for urgent consultation as required by the individual client's needs or the situation. Clinical

supervision may occur individually or in a small group to discuss treatment and review progress toward goals. The focus of clinical supervision must be the client's treatment needs and progress and the mental health practitioner's or behavioral aide's ability to provide services;

(4a) CTSS certified provider entities providing day treatment programs must meet the conditions in items (i) to (iii):

(i) the ~~provider~~ supervisor must be present and available on the premises more than 50 percent of the time in a five-working-day period during which the supervisee is providing a mental health service;

(ii) the diagnosis and the client's individual treatment plan or a change in the diagnosis or individual treatment plan must be made by or reviewed, approved, and signed by the ~~provider~~ supervisor; and

(iii) every 30 days, the supervisor must review and sign the record of the client's care for all activities in the preceding 30-day period;

(4b) for all other services provided under CTSS, clinical supervision standards provided in items (i) to (iii) must be used:

(i) medical assistance shall reimburse a mental health practitioner who maintains a consulting relationship with a mental health professional who accepts full professional responsibility and is present on site for at least one observation during the first 12 hours in which the mental health practitioner provides the individual, family, or group skills training to the child or the child's family;

(ii) thereafter, the mental health professional is required to be present on site for observation as clinically appropriate when the mental health practitioner is providing individual, family, or group skills training to the child or the child's family; and

(iii) the observation must be a minimum of one clinical unit. The on-site presence of the mental health professional must be documented in the child's record and signed by the mental health professional who accepts full professional responsibility;

(5) providing direction to a mental health behavioral aide. For entities that employ mental health behavioral aides, the clinical supervisor must be employed by the provider entity or other certified children's therapeutic supports and services provider entity to ensure necessary and appropriate oversight for the client's treatment and continuity of care. The mental health professional or mental health practitioner giving direction must begin with the goals on the individualized treatment plan, and instruct the mental health behavioral aide on how to construct therapeutic activities and interventions that will lead to goal attainment. The professional or practitioner giving direction must also instruct the mental health behavioral aide about the client's diagnosis, functional status,

and other characteristics that are likely to affect service delivery. Direction must also include determining that the mental health behavioral aide has the skills to interact with the client and the client's family in ways that convey personal and cultural respect and that the aide actively solicits information relevant to treatment from the family. The aide must be able to clearly explain the activities the aide is doing with the client and the activities' relationship to treatment goals. Direction is more didactic than is supervision and requires the professional or practitioner providing it to continuously evaluate the mental health behavioral aide's ability to carry out the activities of the individualized treatment plan and the individualized behavior plan. When providing direction, the professional or practitioner must:

(i) review progress notes prepared by the mental health behavioral aide for accuracy and consistency with diagnostic assessment, treatment plan, and behavior goals and the professional or practitioner must approve and sign the progress notes;

(ii) identify changes in treatment strategies, revise the individual behavior plan, and communicate treatment instructions and methodologies as appropriate to ensure that treatment is implemented correctly;

(iii) demonstrate family-friendly behaviors that support healthy collaboration among the child, the child's family, and providers as treatment is planned and implemented;

(iv) ensure that the mental health behavioral aide is able to effectively communicate with the child, the child's family, and the provider; and

(v) record the results of any evaluation and corrective actions taken to modify the work of the mental health behavioral aide;

(6) providing service delivery that implements the individual treatment plan and meets the requirements under subdivision 9; and

(7) individual treatment plan review. The review must determine the extent to which the services have met the goals and objectives in the previous treatment plan. The review must assess the client's progress and ensure that services and treatment goals continue to be necessary and appropriate to the client and the client's family or foster family. Revision of the individual treatment plan does not require a new diagnostic assessment unless the client's mental health status has changed markedly. The updated treatment plan must be signed by the client, if appropriate, and by the client's parent or other person authorized by statute to give consent to the mental health services for the child.

Sec. 12. Minnesota Statutes 2006, section 256B.0943, subdivision 9, is amended to read:

Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a certified provider entity must ensure that:

(1) each individual provider's caseload size permits the provider to deliver services to both clients with severe, complex needs and clients with less intensive needs. The provider's caseload size should reasonably enable the provider to play an active role in service planning, monitoring, and delivering services to meet the client's and client's family's needs, as specified in each client's individual treatment plan;

(2) site-based programs, including day treatment and preschool programs, provide staffing and facilities to ensure the client's health, safety, and protection of rights, and that the programs are able to implement each client's individual treatment plan;

(3) a day treatment program is provided to a group of clients by a multidisciplinary team under the clinical supervision of a mental health professional. The day treatment program must be provided in and by: (i) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55; (ii) a community mental health center under section 245.62; and (iii) an entity that is under contract with the county board to operate a program that meets the requirements of sections 245.4712, subdivision 2, and 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment program must stabilize the client's mental health status while developing and improving the client's independent living and socialization skills. The goal of the day treatment program must be to reduce or relieve the effects of mental illness and provide training to enable the client to live in the community. The program must be available at least one day a week for a ~~minimum~~ three-hour time block. The three-hour time block must include at least one hour, but no more than two hours, of individual or group psychotherapy. The remainder of the three-hour time block may include recreation therapy, socialization therapy, or independent living skills therapy, but only if the therapies are included in the client's individual treatment plan. Day treatment programs are not part of inpatient or residential treatment services; and

(4) a preschool program is a structured treatment program offered to a child who is at least 33 months old, but who has not yet reached the first day of kindergarten, by a preschool multidisciplinary team in a day program licensed under Minnesota Rules, parts 9503.0005 to 9503.0175. The program must be available at least one day a week for a minimum two-hour time block. The structured treatment program may include individual or group psychotherapy and recreation therapy, socialization therapy, or independent living skills therapy, if included in the client's individual treatment plan.

(b) A provider entity must deliver the service components of children's therapeutic services and supports in compliance with the following requirements:

(1) individual, family, and group psychotherapy must be delivered as specified in Minnesota Rules, part 9505.0323;

(2) individual, family, or group skills training must be provided by a mental health professional or a mental health practitioner who has a consulting relationship with a mental health professional who accepts full professional responsibility for the training;

(3) crisis assistance must be time-limited and designed to resolve or stabilize crisis through arrangements for direct intervention and support services to the child and the child's family. Crisis assistance must utilize resources designed to address abrupt or substantial changes in the functioning of the child or the child's family as evidenced by a sudden change in behavior with negative consequences for well being, a loss of usual coping mechanisms, or the presentation of danger to self or others;

(4) medically necessary services that are provided by a mental health behavioral aide must be designed to improve the functioning of the child and support the family in activities of daily and community living. A mental health behavioral aide must document the delivery of services in written progress notes. The mental health behavioral aide must implement goals in the treatment plan for the child's emotional disturbance that allow the child to acquire developmentally and therapeutically appropriate daily living skills, social skills, and leisure and recreational skills through targeted activities. These activities may include:

(i) assisting a child as needed with skills development in dressing, eating, and toileting;

(ii) assisting, monitoring, and guiding the child to complete tasks, including facilitating the child's participation in medical appointments;

(iii) observing the child and intervening to redirect the child's inappropriate behavior;

(iv) assisting the child in using age-appropriate self-management skills as related to the child's emotional disorder or mental illness, including problem solving, decision making, communication, conflict resolution, anger management, social skills, and recreational skills;

(v) implementing deescalation techniques as recommended by the mental health professional;

(vi) implementing any other mental health service that the mental health professional has approved as being within the scope of the behavioral aide's duties; or

(vii) assisting the parents to develop and use parenting skills that help the child achieve the goals outlined in the child's individual treatment plan or individual behavioral plan. Parenting skills must be directed exclusively to the child's treatment; and

(5) direction of a mental health behavioral aide must include the following:

(i) a total of one hour of on-site observation by a mental health professional during the first 12 hours of service provided to a child;

(ii) ongoing on-site observation by a mental health professional or mental health practitioner for at least a total of one hour during every 40 hours of service provided to a child; and

(iii) immediate accessibility of the mental health professional or mental health practitioner to the mental health behavioral aide during service provision.

Sec. 13. Minnesota Statutes 2006, section 256B.0943, subdivision 11, is amended to read:

Subd. 11. **Documentation and billing.** (a) A provider entity must document the services it provides under this section. The provider entity must ensure that the entity's documentation standards meet the requirements of federal and state laws. Services billed under this section that are not documented according to this subdivision shall be subject to monetary recovery by the commissioner. <u>The provider entity may not bill for anything other than direct service time.</u>

(b) An individual mental health provider must promptly document the following in a client's record after providing services to the client:

(1) each occurrence of the client's mental health service, including the date, type, length, and scope of the service;

(2) the name of the person who gave the service;

(3) contact made with other persons interested in the client, including representatives of the courts, corrections systems, or schools. The provider must document the name and date of each contact;

(4) any contact made with the client's other mental health providers, case manager, family members, primary caregiver, legal representative, or the reason the provider did not contact the client's family members, primary caregiver, or legal representative, if applicable; and

(5) required clinical supervision, as appropriate.

Sec. 14. Minnesota Statutes 2006, 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) children's therapeutic services and supports provided in violation of medical assistance policy in Minnesota Rules, part 9505.0220;

(3) 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;

(4) 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~~

(5) 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) prevention or education programs provided to the community; and

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

(6) activities that are not direct service time.

ARTICLE 2
CONTINUING CARE

Section 1. Minnesota Statutes 2006, section 256.476, subdivision 1, is amended to read:

Subdivision 1. **Purpose and goals.** The commissioner of human services shall establish a consumer support grant program for individuals with functional limitations and their families who wish to purchase and secure their own supports. ~~The commissioner and local agencies shall jointly develop an implementation plan which must include a way to resolve the issues related to county liability.~~ The program shall:

(1) make support grants available to individuals or families as an effective alternative to the ~~developmental disability~~ family support program, personal care attendant services, home health aide services, and private duty nursing services;

(2) provide consumers more control, flexibility, and responsibility over their services and supports;

(3) promote local program management and decision making; and

(4) encourage the use of informal and typical community supports.

Sec. 2. Minnesota Statutes 2006, section 256.476, subdivision 2, is amended to read:

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

(a) "County board" means the county board of commissioners for the county of financial responsibility as defined in section 256G.02, subdivision 4, or its designated representative. When a human services board has been established under sections 402.01 to 402.10, it shall be considered the county board for the purposes of this section.

(b) "Family" means the person's birth parents, adoptive parents or stepparents, siblings or stepsiblings, children or stepchildren, grandparents, grandchildren, niece, nephew, aunt, uncle, or spouse. For the purposes of this section, a family member is at least 18 years of age.

(c) "Functional limitations" means the long-term inability to perform an activity or task in one or more areas of major life activity, including self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living. For the purpose of this section, the inability to perform an activity or task results from a mental, emotional, psychological, sensory, or physical disability, condition, or illness.

(d) "Informed choice" means a voluntary decision made by the person ~~or~~, the person's legal representative, or other authorized representative after becoming familiarized with the alternatives to:

(1) select a preferred alternative from a number of feasible alternatives;

(2) select an alternative which may be developed in the future; and

(3) refuse any or all alternatives.

(e) "Local agency" means the local agency authorized by the county board or, for counties not participating in the consumer grant program by July 1, 2002, the commissioner, to carry out the provisions of this section.

(f) "Person" or "persons" means a person or persons meeting the eligibility criteria in subdivision 3.

(g) "Authorized representative" means an individual designated by the person or their legal representative to act on their behalf. This individual may be a family member, guardian, representative payee, or other individual designated by the person or their legal representative, if any, to assist in purchasing and arranging for supports. For the purposes of this section, an authorized representative is at least 18 years of age.

(h) "Screening" means the screening of a person's service needs under sections 256B.0911 and 256B.092.

(i) "Supports" means services, care, aids, environmental modifications, or assistance purchased by the person ~~or the person's family~~, the person's legal representative, or other authorized representative. Examples of supports include respite care, assistance with daily living, and assistive technology. For the purpose of this section, notwithstanding the provisions of section 144A.43, supports purchased under the consumer support program are not considered home care services.

(j) "Program of origination" means the program the individual transferred from when approved for the consumer support grant program.

Sec. 3. Minnesota Statutes 2006, section 256.476, subdivision 3, is amended to read:

Subd. 3. **Eligibility to apply for grants.** (a) A person is eligible to apply for a consumer support grant if the person meets all of the following criteria:

(1) the person is eligible for and has been approved to receive services under medical assistance as determined under sections 256B.055 and 256B.056 or the person has been approved to receive a grant under the ~~developmental disability~~ family support program under section 252.32;

(2) the person is able to direct and purchase the person's own care and supports, or the person has a family member, legal representative, or other authorized representative who can purchase and arrange supports on the person's behalf;

(3) the person has functional limitations, requires ongoing supports to live in the community, and is at risk of or would continue institutionalization without such supports; and

(4) the person will live in a home. For the purpose of this section, "home" means the person's own home or home of a person's family member. These homes are natural home settings and are not licensed by the Department of Health or Human Services.

(b) Persons may not concurrently receive a consumer support grant if they are:

(1) receiving personal care attendant and home health aide services, or private duty nursing under section 256B.0625; a ~~developmental disability~~ family support grant; or alternative care services under section 256B.0913; or

(2) residing in an institutional or congregate care setting.

(c) A person or person's family receiving a consumer support grant shall not be charged a fee or premium by a local agency for participating in the program.

(d) Individuals receiving home and community-based waivers under United States Code, title 42, section 1396h(c), are not eligible for the consumer support grant, except for individuals receiving consumer support grants before July 1, 2003, as long as other eligibility criteria are met.

(e) The commissioner shall establish a budgeted appropriation each fiscal year for the consumer support grant program. The number of individuals participating in the program will be adjusted so the total amount allocated to counties does not exceed the amount of the budgeted appropriation. The budgeted appropriation will be adjusted annually to accommodate changes in demand for the consumer support grants.

Sec. 4. Minnesota Statutes 2006, section 256.476, subdivision 4, is amended to read:

Subd. 4. **Support grants; criteria and limitations.** (a) A county board may choose to participate in the consumer support grant program. If a county has not chosen to participate by July 1, 2002, the commissioner shall contract with another county or other entity to provide access to residents of the nonparticipating county who choose the consumer support grant option. The commissioner shall notify the county board in a county that has declined to participate of the commissioner's intent to enter into a contract with another county or other entity at least 30 days in advance of entering into the contract. The local agency shall establish written procedures and criteria to determine the amount and use of support grants. These procedures must include, at least, the availability of respite care, assistance with daily living, and adaptive aids. The local agency may establish monthly or annual maximum amounts for grants and procedures where exceptional resources may be required to meet the health and safety needs of the person on a time-limited basis, however, the total amount awarded to each individual may not exceed the limits established in subdivision 11.

(b) Support grants to a person ~~or a person's family~~, a person's legal representative, or other authorized representative will be provided through a monthly subsidy payment and be in the form of cash, voucher, or direct county payment to vendor. Support grant amounts must be determined by the local agency. Each service and item purchased with a support grant must meet all of the following criteria:

(1) it must be over and above the normal cost of caring for the person if the person did not have functional limitations;

(2) it must be directly attributable to the person's functional limitations;

(3) it must enable the person ~~or the person's family~~, a person's legal representative, or other authorized representative to delay or prevent out-of-home placement of the person; and

(4) it must be consistent with the needs identified in the service agreement, when applicable.

(c) Items and services purchased with support grants must be those for which there are no other public or private funds available to the person ~~or the person's family~~, a person's legal representative, or other authorized representative. Fees assessed to the person or the person's family for health and human services are not reimbursable through the grant.

(d) In approving or denying applications, the local agency shall consider the following factors:

(1) the extent and areas of the person's functional limitations;

(2) the degree of need in the home environment for additional support; and

(3) the potential effectiveness of the grant to maintain and support the person in the family environment or the person's own home.

(e) At the time of application to the program or screening for other services, the person ~~or the person's family~~, a person's legal representative, or other authorized representative shall be provided sufficient information to ensure an informed choice of alternatives by the person, the person's legal representative, or other authorized representative, if any~~, or the person's family~~. The application shall be made to the local agency and shall specify the needs of the person and family, the form and amount of grant requested, the items and services to be reimbursed, and evidence of eligibility for medical assistance.

(f) Upon approval of an application by the local agency and agreement on a support plan for the person or person's family, the local agency shall make grants to the person or the person's family. The grant shall be in an amount for the direct costs of the services or supports outlined in the service agreement.

(g) Reimbursable costs shall not include costs for resources already available, such as special education classes, day training and habilitation, case management, other services to which the person is entitled, medical costs covered by insurance or other health programs, or other resources usually available at no cost to the person or the person's family.

(h) The state of Minnesota, the county boards participating in the consumer support grant program, or the agencies acting on behalf of the county boards in the implementation and administration of the consumer support grant program shall not be liable for damages, injuries, or liabilities sustained through the purchase of support by the individual, the individual's family, or the authorized representative under this section

with funds received through the consumer support grant program. Liabilities include but are not limited to: workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA). For purposes of this section, participating county boards and agencies acting on behalf of county boards are exempt from the provisions of section 268.04.

Sec. 5. Minnesota Statutes 2006, section 256.476, subdivision 5, is amended to read:

Subd. 5. **Reimbursement, allocations, and reporting.** (a) For the purpose of transferring persons to the consumer support grant program from the ~~developmental disability~~ family support program and personal care assistant services, home health aide services, or private duty nursing services, the amount of funds transferred by the commissioner between the ~~developmental disability~~ family support program account, the medical assistance account, or the consumer support grant account shall be based on each county's participation in transferring persons to the consumer support grant program from those programs and services.

(b) At the beginning of each fiscal year, county allocations for consumer support grants shall be based on:

(1) the number of persons to whom the county board expects to provide consumer supports grants;

(2) their eligibility for current program and services;

(3) the amount of nonfederal dollars allowed under subdivision 11; and

(4) projected dates when persons will start receiving grants. County allocations shall be adjusted periodically by the commissioner based on the actual transfer of persons or service openings, and the nonfederal dollars associated with those persons or service openings, to the consumer support grant program.

(c) The amount of funds transferred by the commissioner from the medical assistance account for an individual may be changed if it is determined by the county or its agent that the individual's need for support has changed.

(d) The authority to utilize funds transferred to the consumer support grant account for the purposes of implementing and administering the consumer support grant program will not be limited or constrained by the spending authority provided to the program of origination.

(e) The commissioner may use up to five percent of each county's allocation, as adjusted, for payments for administrative expenses, to be paid as a proportionate addition to reported direct service expenditures.

(f) The county allocation for each individual or individual's family cannot exceed the amount allowed under subdivision 11.

(g) The commissioner may recover, suspend, or withhold payments if the county board, local agency, or grantee does not comply with the requirements of this section.

(h) Grant funds unexpended by consumers shall return to the state once a year. The annual return of unexpended grant funds shall occur in the quarter following the end of the state fiscal year.

Sec. 6. Minnesota Statutes 2006, section 256.476, subdivision 10, is amended to read:

Subd. 10. **Consumer responsibilities.** Persons receiving grants under this section shall:

(1) spend the grant money in a manner consistent with their agreement with the local agency;

(2) notify the local agency of any necessary changes in the grant or the items on which it is spent;

(3) notify the local agency of any decision made by the person, ~~the~~ a person's legal representative, ~~or the person's family~~ or other authorized representative that would change their eligibility for consumer support grants;

(4) arrange and pay for supports; and

(5) inform the local agency of areas where they have experienced difficulty securing or maintaining supports.

Sec. 7. Minnesota Statutes 2006, section 256.974, is amended to read:

256.974 OFFICE OF OMBUDSMAN FOR ~~OLDER MINNESOTANS~~ LONG-TERM CARE; LOCAL PROGRAMS.

The ombudsman for ~~older Minnesotans~~ long-term care serves in the classified service under section 256.01, subdivision 7, in an office within the Minnesota Board on Aging that incorporates the long-term care ombudsman program required by the Older Americans Act, ~~Public Law 100-75~~ as amended, United States Code, title 42, section 3027(a)~~(12)~~ (9) and 3058g (a), and established within the Minnesota Board on Aging. The Minnesota Board on Aging may make grants to and designate local programs for the provision of ombudsman services to clients in county or multicounty areas. The local program may not be an agency engaged in the provision of nursing home care, hospital care, or home care services either directly or by contract, or have the responsibility for planning, coordinating, funding, or administering nursing home care, hospital care, or home care services.

Sec. 8. Minnesota Statutes 2006, section 256.9744, subdivision 1, is amended to read:

Subdivision 1. **Classification.** Except as provided in this section, data maintained by the office under sections 256.974 to 256.9744 are private data on individuals or nonpublic data as defined in section 13.02, subdivision 9 or 12, and must be maintained in accordance with the requirements of ~~Public Law 100-75~~ the Older Americans Act, as amended, United States Code, title 42, section ~~3027(a)(12)(D)~~ 3058g(d).

Sec. 9. Minnesota Statutes 2006, section 256B.0625, subdivision 23, is amended to read:

Subd. 23. **Day treatment services.** Medical assistance covers day treatment services as specified in sections 245.462, subdivision 8, and 245.4871, subdivision 10, that are provided under contract with the county board. Notwithstanding Minnesota Rules, part 9505.0323, subpart 15, the commissioner may set authorization thresholds for day treatment for adults according to section 256B.0625, subdivision 25. Notwithstanding Minnesota Rules, part 9505.0323, subpart 15, effective July 1, 2004, medical assistance covers day treatment services for children as specified under section 256B.0943.

Sec. 10. Minnesota Statutes 2006, section 256B.0911, subdivision 4c, is amended to read:

Subd. 4c. **Screening requirements.** (a) A person may be screened for nursing facility admission by telephone or in a face-to-face screening interview. Consultation team members shall identify each individual's needs using the following categories:

(1) the person needs no face-to-face screening interview to determine the need for nursing facility level of care based on information obtained from other health care professionals;

(2) the person needs an immediate face-to-face screening interview to determine the need for nursing facility level of care and complete activities required under subdivision 4a; or

(3) the person may be exempt from screening requirements as outlined in subdivision 4b, but will need transitional assistance after admission or in-person follow-along after a return home.

(b) Persons admitted on a nonemergency basis to a Medicaid-certified nursing facility must be screened prior to admission.

~~(c) The long-term care consultation team shall recommend a case mix classification for persons admitted to a certified nursing facility when sufficient information is received to make that classification. The nursing facility is authorized to conduct all case mix~~

~~assessments for persons who have been screened prior to admission for whom the county did not recommend a case mix classification. The nursing facility is authorized to conduct all case mix assessments for persons admitted to the facility prior to a preadmission screening. The county retains the responsibility of distributing appropriate case mix forms to the nursing facility.~~

~~(d)~~ (c) The county screening or intake activity must include processes to identify persons who may require transition assistance as described in subdivision 3b.

Sec. 11. Minnesota Statutes 2006, section 256B.0913, subdivision 4, is amended to read:

Subd. 4. **Eligibility for funding for services for nonmedical assistance recipients.** (a) Funding for services under the alternative care program is available to persons who meet the following criteria:

(1) the person has been determined by a community assessment under section 256B.0911 to be a person who would require the level of care provided in a nursing facility, but for the provision of services under the alternative care program;

(2) the person is age 65 or older;

(3) the person would be eligible for medical assistance within 135 days of admission to a nursing facility;

(4) the person is not ineligible for the medical assistance program due to an asset transfer penalty;

(5) the person needs long-term care services that are not funded through other state or federal funding;

(6) the monthly cost of the alternative care services funded by the program for this person does not exceed 75 percent of the monthly limit described under section 256B.0915, subdivision 3a. This monthly limit does not prohibit the alternative care client from payment for additional services, but in no case may the cost of additional services purchased under this section exceed the difference between the client's monthly service limit defined under section 256B.0915, subdivision 3, and the alternative care program monthly service limit defined in this paragraph. If ~~medical~~ care-related supplies and equipment or environmental modifications and adaptations are or will be purchased for an alternative care services recipient, the costs may be prorated on a monthly basis for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's other alternative care services exceeds the monthly limit established in this paragraph, the annual cost of the alternative care services shall be determined. In this

event, the annual cost of alternative care services shall not exceed 12 times the monthly limit described in this paragraph; and

(7) the person is making timely payments of the assessed monthly fee.

A person is ineligible if payment of the fee is over 60 days past due, unless the person agrees to:

(i) the appointment of a representative payee;

(ii) automatic payment from a financial account;

(iii) the establishment of greater family involvement in the financial management of payments; or

(iv) another method acceptable to the ~~county~~ lead agency to ensure prompt fee payments.

The ~~county shall~~ lead agency may extend the client's eligibility as necessary while making arrangements to facilitate payment of past-due amounts and future premium payments. Following disenrollment due to nonpayment of a monthly fee, eligibility shall not be reinstated for a period of 30 days.

(b) Alternative care funding under this subdivision is not available for a person who is a medical assistance recipient or who would be eligible for medical assistance without a spenddown or waiver obligation. A person whose initial application for medical assistance and the elderly waiver program is being processed may be served under the alternative care program for a period up to 60 days. If the individual is found to be eligible for medical assistance, medical assistance must be billed for services payable under the federally approved elderly waiver plan and delivered from the date the individual was found eligible for the federally approved elderly waiver plan. Notwithstanding this provision, alternative care funds may not be used to pay for any service the cost of which: (i) is payable by medical assistance; (ii) is used by a recipient to meet a waiver obligation; or (iii) is used to pay a medical assistance income spenddown for a person who is eligible to participate in the federally approved elderly waiver program under the special income standard provision.

(c) Alternative care funding is not available for a person who resides in a licensed nursing home, certified boarding care home, hospital, or intermediate care facility, except for case management services which are provided in support of the discharge planning process for a nursing home resident or certified boarding care home resident to assist with a relocation process to a community-based setting.

(d) Alternative care funding is not available for a person whose income is greater than the maintenance needs allowance under section 256B.0915, subdivision 1d, but is equal to or less than 120 percent of the federal poverty guideline effective July 1 in the

fiscal year for which alternative care eligibility is determined, who would be eligible for the elderly waiver with a waiver obligation.

Sec. 12. Minnesota Statutes 2006, section 256B.0913, subdivision 5, is amended to read:

Subd. 5. **Services covered under alternative care.** Alternative care funding may be used for payment of costs of:

(1) adult day care;

(2) home health aide;

(3) homemaker services;

(4) personal care;

(5) case management;

(6) respite care;

(7) care-related supplies and equipment;

(8) meals delivered to the home;

(9) nonmedical transportation;

(10) nursing services;

(11) chore services;

(12) companion services;

(13) nutrition services;

(14) training for direct informal caregivers;

(15) telehome care to provide services in their own homes in conjunction with in-home visits;

(16) ~~discretionary services, for which counties may make payment from their alternative care program allocation or services not otherwise defined in this section or section 256B.0625, following approval by the commissioner~~ consumer-directed community services under the alternative care programs which are available statewide and limited to the average monthly expenditures representative of all alternative care program participants for the same case mix resident class assigned in the most recent fiscal year for which complete expenditure data is available;

(17) environmental modifications and adaptations; and

(18) ~~direct cash payments for which counties may make payment from their alternative care program allocation to clients for the purpose of purchasing services, following approval by the commissioner, and subject to the provisions of subdivision 5h, until approval and implementation of consumer-directed services through the federally approved elderly waiver plan. Upon implementation, consumer-directed services under~~

~~the alternative care program are available statewide and limited to the average monthly expenditures representative of all alternative care program participants for the same case mix resident class assigned in the most recent fiscal year for which complete expenditure data is available~~ discretionary services, for which lead agencies may make payment from their alternative care program allocation for services not otherwise defined in this section or section 256B.0625, following approval by the commissioner.

Total annual payments for discretionary services ~~and direct cash payments, until the federally approved consumer-directed service option is implemented statewide,~~ for all clients ~~within a county may~~ served by a lead agency must not exceed 25 percent of that ~~county's~~ lead agency's annual alternative care program base allocation. ~~Thereafter, discretionary services are limited to 25 percent of the county's annual alternative care program base allocation.~~

Sec. 13. Minnesota Statutes 2006, 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 for transitional support services, assisted living services, adult foster care services, and residential care services.

(b) The ~~county~~ lead agency must ensure that the funds are not used to supplant services available through other public assistance or services programs. 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 ~~county~~ 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 ~~county~~ lead agency may contract with 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 ~~county~~ 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. 14. Minnesota Statutes 2006, section 256B.0913, subdivision 8, is amended to read:

Subd. 8. **Requirements for individual care plan.** (a) The case manager shall implement the plan of care for each alternative care client and ensure that a client's service needs and eligibility are reassessed at least every 12 months. The plan shall include any services prescribed by the individual's attending physician as necessary to allow the individual to remain in a community setting. In developing the individual's care plan, the case manager should include the use of volunteers from families and neighbors, religious organizations, social clubs, and civic and service organizations to support the formal home care services. The ~~county~~ lead agency shall be held harmless for damages or injuries sustained through the use of volunteers under this subdivision including workers' compensation liability. The ~~county of service~~ case manager shall provide documentation in each individual's plan of care and, if requested, to the commissioner that the most cost-effective alternatives available have been offered to the individual and that the individual was free to choose among available qualified providers, both public and private, including qualified case management or service coordination providers other than those employed by any county; however, the county or tribe maintains responsibility for prior authorizing services in accordance with statutory and administrative requirements. The case manager must give the individual a ten-day written notice of any denial, termination, or reduction of alternative care services.

(b) The county of service or tribe must provide access to and arrange for case management services, including assuring implementation of the plan. "County of service" has the meaning given it in Minnesota Rules, part 9505.0015, subpart 11. The county of service must notify the county of financial responsibility of the approved care plan and the amount of encumbered funds.

Sec. 15. Minnesota Statutes 2006, section 256B.0913, subdivision 9, is amended to read:

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 ~~county~~ 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 ~~county~~ 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 ~~county~~ lead agency must evaluate its own agency services under the criteria established for other providers.

Sec. 16. Minnesota Statutes 2006, section 256B.0913, subdivision 10, is amended to read:

Subd. 10. **Allocation formula.** (a) ~~The alternative care appropriation for fiscal years 1992 and beyond shall cover only alternative care eligible clients.~~ By July ~~1~~ 15 of each year, the commissioner shall allocate to county agencies the state funds available for alternative care for persons eligible under subdivision 2.

(b) The adjusted base for each ~~county~~ lead agency is the ~~county's~~ lead agency's current fiscal year base allocation plus any targeted funds approved during the current fiscal year. Calculations for paragraphs (c) and (d) are to be made as follows: for each ~~county~~ lead agency, the determination of alternative care program expenditures shall be based on payments for services rendered from April 1 through March 31 in the base year, to the extent that claims have been submitted and paid by June 1 of that year.

(c) If the alternative care program expenditures as defined in paragraph (b) are 95 percent or more of the ~~county's~~ lead agency's adjusted base allocation, the allocation for the next fiscal year is 100 percent of the adjusted base, plus inflation to the extent that inflation is included in the state budget.

(d) If the alternative care program expenditures as defined in paragraph (b) are less than 95 percent of the ~~county's~~ lead agency's adjusted base allocation, the allocation for the next fiscal year is the adjusted base allocation less the amount of unspent funds below the 95 percent level.

(e) If the annual legislative appropriation for the alternative care program is inadequate to fund the combined ~~county~~ lead agency allocations for a biennium, the

commissioner shall distribute to each ~~county~~ lead agency the entire annual appropriation as that ~~county's~~ lead agency's percentage of the computed base as calculated in paragraphs (c) and (d).

(f) On agreement between the commissioner and the lead agency, the commissioner may have discretion to reallocate alternative care base allocations distributed to lead agencies in which the base amount exceeds program expenditures.

Sec. 17. Minnesota Statutes 2006, section 256B.0913, subdivision 11, is amended to read:

Subd. 11. **Targeted funding.** (a) The purpose of targeted funding is to make additional money available to ~~counties~~ lead agencies with the greatest need. Targeted funds are not intended to be distributed equitably among all ~~counties~~ lead agencies, but rather, allocated to those with long-term care strategies that meet state goals.

(b) The funds available for targeted funding shall be the total appropriation for each fiscal year minus ~~county~~ lead agency allocations determined under subdivision 10 as adjusted for any inflation increases provided in appropriations for the biennium.

(c) The commissioner shall allocate targeted funds to ~~counties~~ lead agencies that demonstrate to the satisfaction of the commissioner that they have developed feasible plans to increase alternative care spending. In making targeted funding allocations, the commissioner shall use the following priorities:

(1) ~~counties~~ lead agencies that received a lower allocation in fiscal year 1991 than in fiscal year 1990. Counties remain in this priority until they have been restored to their fiscal year 1990 level plus inflation;

(2) ~~counties~~ lead agencies that sustain a base allocation reduction for failure to spend 95 percent of the allocation if they demonstrate that the base reduction should be restored;

(3) ~~counties~~ lead agencies that propose projects to divert community residents from nursing home placement or convert nursing home residents to community living; and

(4) ~~counties~~ lead agencies that can otherwise justify program growth by demonstrating the existence of waiting lists, demographically justified needs, or other unmet needs.

(d) ~~Counties~~ Lead agencies that would receive targeted funds according to paragraph (c) must demonstrate to the commissioner's satisfaction that the funds would be appropriately spent by showing how the funds would be used to further the state's alternative care goals as described in subdivision 1, and that the county has the administrative and service delivery capability to use them.

(e) The commissioner shall ~~request applications~~ make applications available for targeted funds by November 1 of each year. The ~~counties~~ lead agencies selected for targeted funds shall be notified of the amount of their additional funding. Targeted funds allocated to a ~~county~~ lead agency in one year shall be treated as part of the ~~county's~~ lead agency's base allocation for that year in determining allocations for subsequent years. No reallocations between ~~counties~~ lead agencies shall be made.

Sec. 18. Minnesota Statutes 2006, section 256B.0913, subdivision 12, is amended to read:

Subd. 12. **Client fees.** (a) A fee is required for all alternative care eligible clients to help pay for the cost of participating in the program. The amount of the fee for the alternative care client shall be determined as follows:

(1) when the alternative care client's income less recurring and predictable medical expenses is less than 100 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the fee is being computed, and total assets are less than $10,000, the fee is zero;

(2) when the alternative care client's income less recurring and predictable medical expenses is equal to or greater than 100 percent but less than 150 percent of the federal poverty guideline effective on July 1 of the state fiscal year in which the fee is being computed, and total assets are less than $10,000, the fee is five percent of the cost of alternative care services;

(3) when the alternative care client's income less recurring and predictable medical expenses is equal to or greater than 150 percent but less than 200 percent of the federal poverty guidelines effective on July 1 of the state fiscal year in which the fee is being computed and assets are less than $10,000, the fee is 15 percent of the cost of alternative care services;

(4) when the alternative care client's income less recurring and predictable medical expenses is equal to or greater than 200 percent of the federal poverty guidelines effective on July 1 of the state fiscal year in which the fee is being computed and assets are less than $10,000, the fee is 30 percent of the cost of alternative care services; and

(5) when the alternative care client's assets are equal to or greater than $10,000, the fee is 30 percent of the cost of alternative care services.

For married persons, total assets are defined as the total marital assets less the estimated community spouse asset allowance, under section 256B.059, if applicable. For married persons, total income is defined as the client's income less the monthly spousal allotment, under section 256B.058.

All alternative care services shall be included in the estimated costs for the purpose of determining the fee.

Fees are due and payable each month alternative care services are received unless the actual cost of the services is less than the fee, in which case the fee is the lesser amount.

(b) The fee shall be waived by the commissioner when:

(1) a person ~~who~~ is residing in a nursing facility ~~is receiving case management only~~;

(2) a married couple is requesting an asset assessment under the spousal impoverishment provisions;

(3) a person is found eligible for alternative care, but is not yet receiving alternative care services including case management services; or

(4) a person has chosen to participate in a consumer-directed service plan for which the cost is no greater than the total cost of the person's alternative care service plan less the monthly fee amount that would otherwise be assessed.

(c) The ~~county agency must record in the state's receivable system the client's assessed fee amount or the reason the fee has been waived. The~~ commissioner will bill and collect the fee from the client. Money collected must be deposited in the general fund and is appropriated to the commissioner for the alternative care program. The client must supply the ~~county~~ lead agency with the client's Social Security number at the time of application. The ~~county~~ lead agency shall supply the commissioner with the client's Social Security number and other information the commissioner requires to collect the fee from the client. The commissioner shall collect unpaid fees using the Revenue Recapture Act in chapter 270A and other methods available to the commissioner. The commissioner may require ~~counties~~ lead agencies to inform clients of the collection procedures that may be used by the state if a fee is not paid. This paragraph does not apply to alternative care pilot projects authorized in Laws 1993, First Special Session chapter 1, article 5, section 133, if a county operating under the pilot project reports the following dollar amounts to the commissioner quarterly:

(1) total fees billed to clients;

(2) total collections of fees billed; and

(3) balance of fees owed by clients.

If a ~~county~~ lead agency does not adhere to these reporting requirements, the commissioner may terminate the billing, collecting, and remitting portions of the pilot project and require the ~~county~~ lead agency involved to operate under the procedures set forth in this paragraph.

Sec. 19. Minnesota Statutes 2006, section 256B.0913, subdivision 13, is amended to read:

Subd. 13. ~~**County**~~ **Lead agency biennial plan.** The ~~county~~ lead agency biennial plan for long-term care consultation services under section 256B.0911, the alternative care program under this section, and waivers for the elderly under section 256B.0915, shall be submitted by the lead agency as the home and community-based services quality assurance plan on a form provided by the commissioner.

Sec. 20. Minnesota Statutes 2006, 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 ~~county~~ lead agency or vendor must submit invoices within 12 months following the date of service. The ~~county~~ lead agency and its vendors under contract shall not be reimbursed for services which exceed the county allocation.

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

Sec. 21. Minnesota Statutes 2006, section 256B.0919, subdivision 3, is amended to read:

Subd. 3. **County certification of persons providing adult foster care to related persons.** A person exempt from licensure under section 245A.03, subdivision 2, who

provides adult foster care to a related individual age 65 and older, and who meets the requirements in Minnesota Rules, parts 9555.5105 to 9555.6265, may be certified by the county to provide adult foster care. A person certified by the county to provide adult foster care may be reimbursed for services provided and eligible for funding under ~~sections 256B.0913 and~~ section 256B.0915, if the relative would suffer a financial hardship as a result of providing care. For purposes of this subdivision, financial hardship refers to a situation in which a relative incurs a substantial reduction in income as a result of resigning from a full-time job or taking a leave of absence without pay from a full-time job to care for the client.

Sec. 22. Minnesota Statutes 2006, section 256B.431, subdivision 1, is amended to read:

Subdivision 1. **In general.** The commissioner shall determine prospective payment rates for resident care costs. For rates established on or after July 1, 1985, the commissioner shall develop procedures for determining operating cost payment rates that take into account the mix of resident needs, geographic location, and other factors as determined by the commissioner. The commissioner shall consider whether the fact that a facility is attached to a hospital or has an average length of stay of 180 days or less should be taken into account in determining rates. The commissioner shall consider the use of the standard metropolitan statistical areas when developing groups by geographic location. The commissioner shall provide notice to each nursing facility on or before ~~May 1~~ August 15 of the rates effective for the following rate year except that if legislation is pending on ~~May 1~~ August 15 that may affect rates for nursing facilities, the commissioner shall set the rates after the legislation is enacted and provide notice to each facility as soon as possible.

Compensation for top management personnel shall continue to be categorized as a general and administrative cost and is subject to any limits imposed on that cost category.

Sec. 23. Minnesota Statutes 2006, section 256B.431, subdivision 3f, is amended to read:

Subd. 3f. **Property costs after July 1, 1988.** (a) **Investment per bed limit.** For the rate year beginning July 1, 1988, the replacement-cost-new per bed limit must be $32,571 per licensed bed in multiple bedrooms and $48,857 per licensed bed in a single bedroom. For the rate year beginning July 1, 1989, the replacement-cost-new per bed limit for a single bedroom must be $49,907 adjusted according to Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1). Beginning January 1, 1990, the replacement-cost-new per bed limits must be adjusted annually as specified in Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1). Beginning January 1, 1991, the replacement-cost-new per

bed limits will be adjusted annually as specified in Minnesota Rules, part 9549.0060, subpart 4, item A, subitem (1), except that the index utilized will be the Bureau of ~~the Census: Composite fixed-weighted price index as published in the C30 Report, Value of New Construction Put in Place~~ Economic Analysis: Price Indexes for Private Fixed Investments in Structures; Special Care.

(b) **Rental factor.** For the rate year beginning July 1, 1988, the commissioner shall increase the rental factor as established in Minnesota Rules, part 9549.0060, subpart 8, item A, by 6.2 percent rounded to the nearest 100th percent for the purpose of reimbursing nursing facilities for soft costs and entrepreneurial profits not included in the cost valuation services used by the state's contracted appraisers. For rate years beginning on or after July 1, 1989, the rental factor is the amount determined under this paragraph for the rate year beginning July 1, 1988.

(c) **Occupancy factor.** For rate years beginning on or after July 1, 1988, in order to determine property-related payment rates under Minnesota Rules, part 9549.0060, for all nursing facilities except those whose average length of stay in a skilled level of care within a nursing facility is 180 days or less, the commissioner shall use 95 percent of capacity days. For a nursing facility whose average length of stay in a skilled level of care within a nursing facility is 180 days or less, the commissioner shall use the greater of resident days or 80 percent of capacity days but in no event shall the divisor exceed 95 percent of capacity days.

(d) **Equipment allowance.** For rate years beginning on July 1, 1988, and July 1, 1989, the commissioner shall add ten cents per resident per day to each nursing facility's property-related payment rate. The ten-cent property-related payment rate increase is not cumulative from rate year to rate year. For the rate year beginning July 1, 1990, the commissioner shall increase each nursing facility's equipment allowance as established in Minnesota Rules, part 9549.0060, subpart 10, by ten cents per resident per day. For rate years beginning on or after July 1, 1991, the adjusted equipment allowance must be adjusted annually for inflation as in Minnesota Rules, part 9549.0060, subpart 10, item E. For the rate period beginning October 1, 1992, the equipment allowance for each nursing facility shall be increased by 28 percent. For rate years beginning after June 30, 1993, the allowance must be adjusted annually for inflation.

(e) **Post chapter 199 related-organization debts and interest expense.** For rate years beginning on or after July 1, 1990, Minnesota Rules, part 9549.0060, subpart 5, item E, shall not apply to outstanding related organization debt incurred prior to May 23, 1983, provided that the debt was an allowable debt under Minnesota Rules, parts 9510.0010 to 9510.0480, the debt is subject to repayment through annual principal payments, and

the nursing facility demonstrates to the commissioner's satisfaction that the interest rate on the debt was less than market interest rates for similar arm's-length transactions at the time the debt was incurred. If the debt was incurred due to a sale between family members, the nursing facility must also demonstrate that the seller no longer participates in the management or operation of the nursing facility. Debts meeting the conditions of this paragraph are subject to all other provisions of Minnesota Rules, parts 9549.0010 to 9549.0080.

(f) **Building capital allowance for nursing facilities with operating leases.** For rate years beginning on or after July 1, 1990, a nursing facility with operating lease costs incurred for the nursing facility's buildings shall receive its building capital allowance computed in accordance with Minnesota Rules, part 9549.0060, subpart 8. If an operating lease provides that the lessee's rent is adjusted to recognize improvements made by the lessor and related debt, the costs for capital improvements and related debt shall be allowed in the computation of the lessee's building capital allowance, provided that reimbursement for these costs under an operating lease shall not exceed the rate otherwise paid.

Sec. 24. Minnesota Statutes 2006, section 256B.431, subdivision 17e, is amended to read:

Subd. 17e. **Replacement-costs-new per bed limit effective July 1, 2001.** Notwithstanding Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), for a total replacement, as defined in ~~paragraph (f)~~ subdivision 17d, authorized under section 144A.071 or 144A.073 after July 1, 1999, or any building project that is a relocation, renovation, upgrading, or conversion completed on or after July 1, 2001, the replacement-costs-new per bed limit shall be $74,280 per licensed bed in multiple-bed rooms, $92,850 per licensed bed in semiprivate rooms with a fixed partition separating the resident beds, and $111,420 per licensed bed in single rooms. Minnesota Rules, part 9549.0060, subpart 11, item C, subitem (2), does not apply. These amounts must be adjusted annually as specified in subdivision 3f, paragraph (a), beginning January 1, 2000.

Sec. 25. Laws 2000, chapter 340, section 19, is amended to read:

Sec. 19. **ALTERNATIVE CARE PILOT PROJECTS.**

(a) Expenditures for housing with services and adult foster care shall be excluded when determining average monthly expenditures per client for alternative care pilot projects authorized in Laws 1993, First Special Session chapter 1, article 5, section 133.

(b) Alternative care pilot projects shall not expire on June 30, 2001, but shall continue until June 30, ~~2005~~ 2007.

EFFECTIVE DATE. This section is effective retroactively from June 29, 2005, for activities related to discontinuing pilot projects under this section.

ARTICLE 3
HEALTH CARE

Section 1. Minnesota Statutes 2006, section 256B.0625, subdivision 13c, is amended to read:

Subd. 13c. **Formulary committee.** The commissioner, after receiving recommendations from professional medical associations and professional pharmacy associations, and consumer groups shall designate a Formulary Committee to carry out duties as described in subdivisions 13 to 13g. The Formulary Committee shall be comprised of four licensed physicians actively engaged in the practice of medicine in Minnesota one of whom must be actively engaged in the treatment of persons with mental illness; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota; and one consumer representative; the remainder to be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. Members of the Formulary Committee shall not be employed by the Department of Human Services, but the committee shall be staffed by an employee of the department who shall serve as an ex officio, nonvoting member of the ~~board~~ committee. The department's medical director shall also serve as an ex officio, nonvoting member for the committee. Committee members shall serve three-year terms and may be reappointed by the commissioner. The Formulary Committee shall meet at least quarterly. The commissioner may require more frequent Formulary Committee meetings as needed. An honorarium of $100 per meeting and reimbursement for mileage shall be paid to each committee member in attendance.

Sec. 2. Minnesota Statutes 2006, section 256D.03, subdivision 4, is amended to read:

Subd. 4. **General assistance medical care; services.** (a)(i) For a person who is eligible under subdivision 3, paragraph (a), clause (2), item (i), general assistance medical care covers, except as provided in paragraph (c):

(1) inpatient hospital services;

(2) outpatient hospital services;

(3) services provided by Medicare certified rehabilitation agencies;

(4) prescription drugs and other products recommended through the process established in section 256B.0625, subdivision 13;

(5) equipment necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood sugar level;

(6) eyeglasses and eye examinations provided by a physician or optometrist;

(7) hearing aids;

(8) prosthetic devices;

(9) laboratory and X-ray services;

(10) physician's services;

(11) medical transportation except special transportation;

(12) chiropractic services as covered under the medical assistance program;

(13) podiatric services;

(14) dental services as covered under the medical assistance program;

(15) outpatient services provided by a mental health center or clinic that is under contract with the county board and is established under section 245.62;

(16) day treatment services for mental illness provided under contract with the county board;

(17) prescribed medications for persons who have been diagnosed as mentally ill as necessary to prevent more restrictive institutionalization;

(18) psychological services, medical supplies and equipment, and Medicare premiums, coinsurance and deductible payments;

(19) medical equipment not specifically listed in this paragraph when the use of the equipment will prevent the need for costlier services that are reimbursable under this subdivision;

(20) services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if (1) the service is otherwise covered under this chapter as a physician service, (2) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate, and (3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171;

(21) services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health nurse's license as a registered nurse, as defined in section 148.171;

(22) telemedicine consultations, to the extent they are covered under section 256B.0625, subdivision 3b; and

(23) mental health telemedicine and psychiatric consultation as covered under section 256B.0625, subdivisions 46 and 48.

(ii) Effective October 1, 2003, for a person who is eligible under subdivision 3, paragraph (a), clause (2), item (ii), general assistance medical care coverage is limited to inpatient hospital services, including physician services provided during the inpatient hospital stay. A $1,000 deductible is required for each inpatient hospitalization.

(b) Effective August 1, 2005, sex reassignment surgery is not covered under this subdivision.

(c) In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall where possible contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for prepaid health plans, competitive bidding programs, block grants, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. Before implementing prepaid programs in counties with a county operated or affiliated public teaching hospital or a hospital or clinic operated by the University of Minnesota, the commissioner shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the opportunity to participate in the program in a manner that reflects the risk of adverse selection and the nature of the patients served by the hospital, provided the terms of participation in the program are competitive with the terms of other participants considering the nature of the population served. Payment for services provided pursuant to this subdivision shall be as provided to medical assistance vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For payments made during fiscal year 1990 and later years, the commissioner shall consult with an independent actuary in establishing prepayment rates, but shall retain final control over the rate methodology.

(d) Effective January 1, 2008, drug coverage under general assistance medical care is limited to prescription drugs that:

(i) are covered under the medical assistance program as described in section 256B.0625, subdivisions 13 and 13d; and

(ii) are provided by manufacturers that have fully executed general assistance medical care rebate agreements with the commissioner and comply with the agreements. Prescription drug coverage under general assistance medical care must conform to coverage under the medical assistance program according to section 256B.0625, subdivisions 13 to 13g.

~~(d)~~ (e) Recipients eligible under subdivision 3, paragraph (a), shall pay the following co-payments for services provided on or after October 1, 2003:

(1) $25 for eyeglasses;

(2) $25 for nonemergency visits to a hospital-based emergency room;

(3) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness; and

(4) 50 percent coinsurance on restorative dental services.

~~(e)~~ (f) Co-payments shall be limited to one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room. Recipients of general assistance medical care are responsible for all co-payments in this subdivision. The general assistance medical care reimbursement to the provider shall be reduced by the amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has reached the $12 per month maximum for prescription drug co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment, except as provided in paragraph (f).

~~(f)~~ (g) If it is the routine business practice of a provider to refuse service to an individual with uncollected debt, the provider may include uncollected co-payments under this section. A provider must give advance notice to a recipient with uncollected debt before services can be denied.

~~(g)~~ (h) Any county may, from its own resources, provide medical payments for which state payments are not made.

~~(h)~~ (i) Chemical dependency services that are reimbursed under chapter 254B must not be reimbursed under general assistance medical care.

~~(i)~~ (j) The maximum payment for new vendors enrolled in the general assistance medical care program after the base year shall be determined from the average usual and customary charge of the same vendor type enrolled in the base year.

~~(j)~~ (k) The conditions of payment for services under this subdivision are the same as the conditions specified in rules adopted under chapter 256B governing the medical assistance program, unless otherwise provided by statute or rule.

~~(k)~~ (l) Inpatient and outpatient payments shall be reduced by five percent, effective July 1, 2003. This reduction is in addition to the five percent reduction effective July 1, 2003, and incorporated by reference in paragraph (i).

~~(l)~~ (m) Payments for all other health services except inpatient, outpatient, and pharmacy services shall be reduced by five percent, effective July 1, 2003.

~~(m)~~ (n) Payments to managed care plans shall be reduced by five percent for services provided on or after October 1, 2003.

~~(n)~~ (o) A hospital receiving a reduced payment as a result of this section may apply the unpaid balance toward satisfaction of the hospital's bad debts.

~~(o)~~ (p) Fee-for-service payments for nonpreventive visits shall be reduced by $3 for services provided on or after January 1, 2006. For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, advance practice nurse, audiologist, optician, or optometrist.

~~(p)~~ (q) Payments to managed care plans shall not be increased as a result of the removal of the $3 nonpreventive visit co-payment effective January 1, 2006.

Sec. 3. Minnesota Statutes 2006, section 256E.35, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Family asset account" means a savings account opened by a household participating in the Minnesota family assets for independence initiative.

(c) "Fiduciary organization" means:

(1) a community action agency that has obtained recognition under section ~~268.53~~ 256E.31;

(2) a federal community development credit union serving the seven-county metropolitan area; or

(3) a women-oriented economic development agency serving the seven-county metropolitan area.

(d) "Financial institution" means a bank, bank and trust, savings bank, savings association, or credit union, the deposits of which are insured by the Federal Deposit Insurance Corporation or the National Credit Union Administration.

(e) "Permissible use" means:

(1) postsecondary educational expenses at an accredited public postsecondary institution including books, supplies, and equipment required for courses of instruction;

(2) acquisition costs of acquiring, constructing, or reconstructing a residence, including any usual or reasonable settlement, financing, or other closing costs;

(3) business capitalization expenses for expenditures on capital, plant, equipment, working capital, and inventory expenses of a legitimate business pursuant to a business plan approved by the fiduciary organization; and

(4) acquisition costs of a principal residence within the meaning of section 1034 of the Internal Revenue Code of 1986 which do not exceed 100 percent of the average area purchase price applicable to the residence determined according to section 143(e)(2) and (3) of the Internal Revenue Code of 1986.

(f) "Household" means all individuals who share use of a dwelling unit as primary quarters for living and eating separate from other individuals.

Sec. 4. Minnesota Statutes 2006, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Co-payments and coinsurance.** (a) Except as provided in paragraphs (b) and (c), the MinnesotaCare benefit plan shall include the following co-payments and coinsurance requirements for all enrollees:

(1) ten percent of the paid charges for inpatient hospital services for adult enrollees, subject to an annual inpatient out-of-pocket maximum of $1,000 per individual and $3,000 per family;

(2) $3 per prescription for adult enrollees;

(3) $25 for eyeglasses for adult enrollees;

(4) $3 per nonpreventive visit. For purposes of this subdivision, a "visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist; and

(5) $6 for nonemergency visits to a hospital-based emergency room.

(b) Paragraph (a), clause (1), does not apply to parents and relative caretakers of children under the age of 21 in households with family income equal to or less than 175 percent of the federal poverty guidelines. Paragraph (a), clause (1), does not apply to parents and relative caretakers of children under the age of 21 in households with family income greater than 175 percent of the federal poverty guidelines for inpatient hospital admissions occurring on or after January 1, 2001.

(c) Paragraph (a)~~, clauses (1) to (4), do~~ does not apply to pregnant women and children under the age of 21.

(d) Adult enrollees with family gross income that exceeds 175 percent of the federal poverty guidelines and who are not pregnant shall be financially responsible for the coinsurance amount, if applicable, and amounts which exceed the $10,000 inpatient hospital benefit limit.

(e) When a MinnesotaCare enrollee becomes a member of a prepaid health plan, or changes from one prepaid health plan to another during a calendar year, any charges

submitted towards the $10,000 annual inpatient benefit limit, and any out-of-pocket expenses incurred by the enrollee for inpatient services, that were submitted or incurred prior to enrollment, or prior to the change in health plans, shall be disregarded.

Sec. 5. Minnesota Statutes 2006, section 256L.04, subdivision 1, is amended to read:

Subdivision 1. **Families with children.** (a) Families with children with family income equal to or less than 275 percent of the federal poverty guidelines for the applicable family size shall be eligible for MinnesotaCare according to this section. All other provisions of sections 256L.01 to 256L.18, including the insurance-related barriers to enrollment under section 256L.07, shall apply unless otherwise specified.

(b) Parents who enroll in the MinnesotaCare program must also enroll their children, if the children are eligible. Children may be enrolled separately without enrollment by parents. However, if one parent in the household enrolls, both parents must enroll, unless other insurance is available. If one child from a family is enrolled, all children must be enrolled, unless other insurance is available. If one spouse in a household enrolls, the other spouse in the household must also enroll, unless other insurance is available. Families cannot choose to enroll only certain uninsured members.

(c) Beginning October 1, 2003, the dependent sibling definition no longer applies to the MinnesotaCare program. These persons are no longer counted in the parental household and may apply as a separate household.

(d) Beginning July 1, 2003, or upon federal approval, whichever is later, parents are not eligible for MinnesotaCare if their gross income exceeds ~~$50,000~~ $25,000 for the six-month period of eligibility.

Sec. 6. Minnesota Statutes 2006, section 256L.04, subdivision 12, is amended to read:

Subd. 12. **Persons in detention.** Beginning January 1, 1999, an applicant residing in a correctional or detention facility is not eligible for MinnesotaCare. An enrollee residing in a correctional or detention facility is not eligible at renewal of eligibility under section 256L.05, subdivision ~~3b~~ 3a.

ARTICLE 4
MISCELLANEOUS

Section 1. Laws 2005, chapter 98, article 3, section 25, is amended to read:

Sec. 25. **REPEALER.**

Minnesota Statutes 2004, sections 245.713, ~~subdivisions 2 and~~ subdivision 4; 245.716; and 626.5551, subdivision 4, are repealed.

EFFECTIVE DATE. This section is effective retroactively from August 1, 2005.

Sec. 2. **REVISOR'S INSTRUCTION.**

The revisor of statutes shall change the terms in column A to the terms in column B wherever they appear in Minnesota Statutes,

Column A	Column B
"Office of Ombudsman for Older Minnesotans" and "Office of the Ombudsman for Older Minnesotans"	"Office of Ombudsman for Long-Term Care"
"ombudsman for older Minnesotans"	"ombudsman for long-term care"

Sec. 3. **MINNESOTA RULES.**

The Department of Administration shall publish adopted rules in the State Register making the terminology changes specified in section 2 in Minnesota Rules. Upon publication in the State Register, the terminology changes for Minnesota Rules are adopted without further administrative action.

Sec. 4. **REPEALER.**

(a) Minnesota Statutes 2006, sections 252.21; 252.22; 252.23; 252.24; 252.25; 252.261; 252.275, subdivision 5; 254A.02, subdivisions 7, 9, 12, 14, 15, and 16; 254A.085; 254A.086; 254A.12; 254A.14; 254A.15; 254A.16, subdivision 5; 254A.175; 254A.18; 256B.0913, subdivisions 5b, 5c, 5d, 5e, 5f, 5g, and 5h; 256J.561, subdivision 1; 256J.62, subdivision 9; and 256J.65, are repealed.

(b) Minnesota Rules, part 9503.0035, subpart 2, is repealed.

252.21 COUNTY BOARDS MAY MAKE GRANTS FOR DEVELOPMENTAL ACHIEVEMENT CENTER SERVICES FOR CHILDREN WITH DEVELOPMENTAL DISABILITIES.

In order to assist county boards in carrying out responsibilities for the provision of daytime developmental achievement center services for eligible children, the county board or boards are hereby authorized to make grants, within the limits of the money appropriated, to developmental achievement centers for services to children with developmental disabilities. In order to fulfill its responsibilities to children with developmental disabilities as required by sections 125A.03 to 125A.48, and 125A.65, a county board may, beginning January 1, 1983, contract with developmental achievement centers or other providers.

252.22 APPLICANTS FOR ASSISTANCE; TAX LEVY.

Any city, town, governmental entity, nonprofit corporation, or any combination thereof, may apply to the county board for assistance in establishing and operating a developmental achievement center and program for children with developmental disabilities. Application for such assistance shall be on forms supplied by the board. Each applicant shall annually submit to the board its plan and budget for the next fiscal year. No applicant shall be eligible for a grant hereunder unless its plan and budget have been approved by the board.

Any city, town, or county is authorized, at the discretion of its governing body, to make grants from special tax revenues or from its general revenue fund to any nonprofit organization, governmental or corporate, within or outside its jurisdiction, that has established a developmental achievement center for children with developmental disabilities. Nothing contained herein shall in any way preclude the use of funds available for this purpose under any existing statute or charter provision relating to cities, towns, and counties.

252.23 ELIGIBILITY REQUIREMENTS.

A developmental achievement center shall:

(1) provide developmental services to children with developmental disabilities who can benefit from the program of services; and

(2) comply with all rules duly adopted by the commissioner of human services.

252.24 DUTIES OF COUNTY BOARDS.

Subdivision 1. **Selection of developmental achievement centers.** The county board shall administer developmental achievement services. The county board shall ensure that transportation is provided for children who fulfill the eligibility requirements of section 252.23, clause (1), utilizing the most efficient and reasonable means available. The county board may contract for developmental achievement services and transportation from a center which is licensed under the provisions of sections 245A.01 to 245A.16, 252.28, and 257.175, and in the board's opinion, best provides daytime developmental achievement services for children with developmental disabilities within the appropriation and resources made available for this purpose. Daytime developmental achievement services administered by the county board shall comply with standards established by the commissioner pursuant to subdivision 2 and applicable federal regulations.

Subd. 2. **Supervision of projects; promulgation of rules.** The commissioner of human services shall closely supervise any developmental achievement center receiving a grant under sections 252.21 to 252.25. The commissioner shall promulgate rules in the manner provided by law as necessary to carry out the purposes of sections 252.21 to 252.25, including but not limited to rules pertaining to facilities for housing developmental achievement centers, administration of centers, and eligibility requirements for admission and participation in activities of the center.

Subd. 3. **Payment procedure.** The board at the beginning of each year, shall allocate available money for developmental achievement services for disbursement during the year to those centers that have been selected to receive grants and whose plans and budgets have been approved. The board shall, from time to time during the fiscal year, review the budgets, expenditures and programs of the various centers and if it determines that any amount of funds are not needed for any particular center to which they were allocated, it may, after 30 days' notice, withdraw such funds as are unencumbered and reallocate them to other centers. It may withdraw all funds from any center upon 90 days' notice whose program is not being administered in accordance with its approved plan and budget.

Subd. 4. **Fees.** The county board may, with the approval of the commissioner, establish a schedule of fees for daytime developmental achievement services. No child, or family of a child, with developmental disabilities shall be denied daytime developmental achievement services because of an inability to pay such a fee.

Subd. 5. **Developmental achievement centers: salary adjustment per diem.** The commissioner shall approve a two percent increase in the payment rates for day training and habilitation services vendors effective July 1, 1991. All revenue generated shall be used by vendors to increase salaries, fringe benefits, and payroll taxes by at least three percent for personnel below top management. County boards shall amend contracts with vendors to require that all revenue generated by this provision is expended on salary increases to staff below top management. County boards shall verify in writing to the commissioner that each vendor has complied with this requirement. If a county board determines that a vendor has not complied with this requirement for a specific contract period, the county board shall reduce the vendor'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.

252.25 BOARD OF DIRECTORS.

Every city, town, governmental entity, nonprofit corporation, or combination thereof, establishing a developmental achievement center for children with developmental disabilities shall, before it comes under the terms of sections 252.21 to 252.25, appoint a board of directors for the center program. When any city or town singly establishes such a center, such board shall be appointed by the chief executive officer of the city or the chair of the governing board of the town. When any combination of cities, towns, or nonprofit corporations, establishes such a center, the chief executive officers of the cities or nonprofit corporations and the chair of the governing bodies of the towns shall appoint the board of directors. If a nonprofit corporation singly establishes such a center, its chief executive officer shall appoint the board of directors of the center. Membership on a board of directors while not mandatory, should be representative of local health, education and welfare departments, medical societies, mental health centers, associations concerned with developmental disabilities, civic groups, and the general public. Nothing in sections 252.21 to 252.25 shall be construed to preclude the appointment of elected or appointed public officials or members of the board of directors of the sponsoring nonprofit corporation to such board of directors, or public schools from administering programs under their present administrative structure.

252.261 EXISTENCE.

Any daytime activity center in existence on September 1, 1977, shall be deemed to be a developmental achievement center for the purposes of sections 252.21 to 252.25.

252.275 SEMI-INDEPENDENT LIVING SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES.

Subd. 5. **Displaced hospital workers.** Providers of semi-independent living services shall make reasonable efforts to hire qualified employees of regional treatment center developmental disability units who have been displaced by reorganization, closure, or consolidation of regional treatment center developmental disability units.

254A.02 DEFINITIONS.

Subd. 7. **Intoxicated person.** "Intoxicated person" means a person whose mental or physical functioning is substantially impaired as a result of the use of alcohol, or other drugs.

Subd. 9. **Program director.** "Program director" means the director of any approved treatment program responsible under Laws 1973, chapter 572 for the examination, treatment or making of recommendations with respect to care and treatment of any person subject to the provisions of Laws 1973, chapter 572.

Subd. 12. **Area mental health board or area board.** "Area mental health board" or "area board" means a board established pursuant to sections 245.61 to 245.69.

Subd. 14. **Youth.** "Youth" means any person 18 years of age or under.

Subd. 15. **Underserved populations.** "Underserved populations" means identifiable groups of significant numbers which do not have available to them sufficient programs and services designed to meet their special alcoholism and chemical dependency needs.

Subd. 16. **Affected employee.** "Affected employee" means an employee whose job performance is substantially affected by chemical dependency.

254A.085 HENNEPIN COUNTY PILOT ALTERNATIVE FOR CHEMICAL DEPENDENCY SERVICES.

The commissioner of human services shall grant variances from the requirements of Minnesota Rules, parts 9530.4100 to 9530.4450, and the commissioner of health shall grant variances from the requirements of Minnesota Rules, parts 4665.0100 to 4665.9900, that are consistent with the provisions of this section and do not compromise the health or safety of the clients, to establish a nonmedical detoxification pilot program in Hennepin County. The program shall be designed to provide care in a secure shelter for persons diverted or referred from detoxification facilities, so as to prevent chronic recidivism and ensure appropriate treatment referrals for persons who are chemically dependent. For purposes of this section, a "secure shelter" is a facility licensed by the commissioner of human services under Minnesota Rules, parts 9530.4100 to 9530.4450, and this section, and by the commissioner of health as a supervised living facility to provide care for chemically dependent persons. A secure shelter is considered a treatment facility under section 253B.02, subdivision 19. The secure facility authorized by this section shall be licensed by the commissioner of human services only after the county has entered into a contract for the detoxification program authorized by section 254A.086.

The pilot program established under this section must have standards for using video and advocacy group members for monitoring and surveillance to ensure the safety of clients and staff. In addition, in hiring staff, the program must ensure that the criminal background check requirements of Minnesota Rules, part 9543.3040, are met; and the commissioner of human services must ensure compliance with chapter 245C. The program administrator and all staff of a secure shelter who observe or have personal knowledge of violations of section 626.556 or 626.557 must report to the Office of the Ombudsman for Mental Health and Developmental Disabilities within 24 hours of its occurrence, any serious injury, as defined in section 245.91, subdivision 6, or the death of a person admitted to the shelter. The ombudsman shall acknowledge in writing the receipt of all reports made to the ombudsman's office under this section. Acknowledgment must be mailed to the facility and to the county social service agency within five working days of the day the report was made. In addition, the program administrator and staff of the facility must comply with all of the requirements of section 626.557, the Vulnerable Adults Act. If the program administrator does not suspend the alleged perpetrator during the pendency of the investigation, reasons for not doing so must be given to the ombudsman in writing.

The licenseholder, in coordination with the commissioner of human services, shall keep detailed records of admissions, length of stay, client outcomes according to standards set by the commissioner, discharge destinations, referrals, and costs of the program. The commissioner of human services shall report to the legislature by February 15, 1996, on the operation of the program and shall include recommendations on whether such a program has been shown to be an effective, safe, and cost-efficient way to serve clients.

254A.086 CULTURALLY TARGETED DETOXIFICATION PROGRAM.

The commissioner of human services shall provide technical assistance to enable development of a special program designed to provide culturally targeted detoxification services in accordance with section 254A.08, subdivision 2. The program must meet the standards of Minnesota Rules, parts 9530.4100 to 9530.4450, as they apply to detoxification programs. The program established under this section must have standards for using video and advocacy group members for monitoring and surveillance to ensure the safety of clients and staff. In addition, in hiring staff, the program must ensure that the criminal background check requirements of Minnesota Rules, part 9543.3040, are met; and the commissioner of human services must ensure compliance with chapter 245C. The program administrator and all staff of the facility must report to the Office of the Ombudsman for Mental Health and Developmental Disabilities within 24 hours of its occurrence, any serious injury, as defined in section 245.91, subdivision 6, or the death of a person admitted to the shelter. The ombudsman shall acknowledge in writing the receipt of all reports made to the ombudsman's office under this section. Acknowledgment must be mailed to the facility and to the county social service agency within five working days of the day the report was made. In addition, the program administrator and staff of the facility must comply with all of the requirements of section 626.557, the Vulnerable Adults Act. The program shall be

designed with a community outreach component and shall provide services to clients in a safe environment and in a culturally specific manner.

254A.12 AFFECTED EMPLOYEES.

County boards may enter into one or more purchase of service agreements to provide services to employers to develop personnel practices for prevention of alcoholism and other chemical dependency, and to assist affected employees in gaining access to care through identification and referral services.

254A.14 SERVICES TO YOUTH AND OTHER UNDERSERVED POPULATIONS.

Subdivision 1. **Identification.** County boards may enter into one or more purchase of service agreements to provide services related to the prevention of chemical dependency to persons and groups which have responsibility for, and access to, youth and other underserved populations. The boards may also enter into purchase of service agreements to assist youth and other underserved populations in gaining access to care.

Subd. 2. **Treatment facilities.** If, as a result of programs authorized under subdivision 1, significant numbers of persons are identified for whom treatment and aftercare programs are not available, county boards may request funds from the commissioner to develop treatment and aftercare capabilities.

Subd. 3. **Grants for treatment of high-risk youth.** The commissioner of human services shall award grants on a pilot project basis to develop culturally specific chemical dependency treatment programs for minority and other high-risk youth, including those enrolled in area learning centers, those presently in residential chemical dependency treatment, and youth currently under commitment to the commissioner of corrections or detained under chapter 260. Proposals submitted under this section shall include an outline of the treatment program components, a description of the target population to be served, and a protocol for evaluating the program outcomes.

254A.15 AFFIRMATIVE OUTREACH.

The commissioner shall design and implement a plan of affirmative outreach to encourage utilization of the services authorized in sections 254A.031, 254A.12, and 254A.14. The plan may include purchase of services by the commissioner to carry out the plan.

254A.16 RESPONSIBILITIES OF THE COMMISSIONER.

Subd. 5. **Professional standards.** The commissioner may by rule adopt any or all of the standards for chemical dependency professionals established by the Institute for Chemical Dependency Professionals of Minnesota, Inc., when professional standards are necessary in the regulation of chemical dependency programs, treatment facilities, or services or whenever the commissioner may require individuals involved in providing chemical dependency treatment to be qualified and have demonstrated competence in assessment and treatment skills. The commissioner may also by rule provide that persons certified by the Institute for Chemical Dependency Professionals of Minnesota, Inc., are deemed competent to perform the functions of chemical dependency professionals.

254A.175 CHEMICAL DEPENDENCY TREATMENT MODELS FOR FAMILIES WITH POTENTIAL CHILD PROTECTION PROBLEMS.

The commissioner shall explore and experiment with different chemical dependency service models for parents with children who are found to be in need of chemical dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision 6, or 260C.212. The commissioner shall tailor services to better serve this high-risk population, which may include long-term treatment that allows the children to stay with the parent at the treatment facility.

254A.18 STATE CHEMICAL HEALTH INDEX MODEL.

The commissioner of human services, in consultation with the Chemical Abuse Prevention Resource Council, shall develop and test a chemical health index model to help assess the state's chemical health and coordinate state policy and programs relating to chemical abuse prevention

and treatment. The chemical health index model shall assess a variety of factors known to affect the use and abuse of chemicals in different parts of the state including, but not limited to, demographic factors, risk factors, health care utilization, drug-related crime, productivity, resource availability, and overall health.

256B.0913 ALTERNATIVE CARE PROGRAM.

Subd. 5b. **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 rate shall be negotiated between the county agency and the foster care provider. The alternative care payment for the foster care service in combination with the payment for other alternative care services, including case management, must not exceed the limit specified in subdivision 4, paragraph (a), clause (6).

Subd. 5c. **Residential care services; supportive services; health-related services.** For purposes of this section, residential care services are services which are provided to individuals living in residential care homes. Residential care homes are currently licensed as board and lodging establishments under section 157.16, and are registered with the Department of Health as providing special services under section 157.17 except settings that are currently registered under chapter 144D. Residential care services are defined as "supportive services" and "health-related services." "Supportive services" means services as defined in section 157.17, subdivision 1, paragraph (a). "Health-related services" means services covered in section 157.17, subdivision 1, paragraph (b). Individuals receiving residential care services cannot receive homemaking services funded under this section.

Subd. 5d. **Assisted living services.** For the purposes of this section, "assisted living" refers to supportive services provided by a single vendor to clients who reside in the same apartment building of three or more units which are not subject to registration under chapter 144D and are licensed by the Department of Health as a class A home care provider or a class E home care provider. Assisted living services are defined as up to 24-hour supervision, oversight, and supportive services as defined in section 157.17, subdivision 1, paragraph (a), individualized home care aide tasks as defined in Minnesota Rules, part 4668.0110, and individualized home management tasks as defined in Minnesota Rules, part 4668.0120, provided to residents of a residential center living in their units or apartments with a full kitchen and bathroom. A full kitchen includes a stove, oven, refrigerator, food preparation counter space, and a kitchen utensil storage compartment. Assisted living services must be provided by the management of the residential center or by providers under contract with the management or with the county.

Subd. 5e. **Further assisted living requirements.** (a) Individuals receiving assisted living services shall not receive both assisted living services and homemaking services. Individualized means services are chosen and designed specifically for each resident's needs, rather than provided or offered to all residents regardless of their illnesses, disabilities, or physical conditions. Assisted living services as defined in this section shall not be authorized in boarding and lodging establishments licensed according to sections 157.011 and 157.15 to 157.22.

(b) For establishments registered under chapter 144D, assisted living services under this section means either the services described in subdivision 5d and delivered by a class E home care provider licensed by the Department of Health or the services described under section 144A.4605 and delivered by an assisted living home care provider or a class A home care provider licensed by the commissioner of health.

Subd. 5f. **Payment rates for assisted living services and residential care.** (a) Payment for assisted living services and residential care services shall be a monthly rate negotiated and authorized by the county agency based on an individualized service plan for each resident and may not cover direct rent or food costs.

(b) The individualized monthly negotiated payment for assisted living services as described in subdivision 5d or 5e, paragraph (b), and residential care services as described in subdivision 5c, shall not exceed the nonfederal share in effect on July 1 of the state fiscal year for which the rate limit is being calculated of the greater of either the statewide or any of the geographic groups according to subdivision 4, paragraph (a), clause (6).

(c) The individualized monthly negotiated payment for assisted living services described under section 144A.4605 and delivered by a provider licensed by the Department of Health as a class A home care provider or an assisted living home care provider and provided in a building that is registered as a housing with services establishment under chapter 144D and that provides 24-hour supervision in combination with the payment for other alternative care services, including case management, must not exceed the limit specified in subdivision 4, paragraph (a), clause (6).

Subd. 5g. **Provisions governing direct cash payments.** A county agency may make payment from their alternative care program allocation for direct cash payments to the client for the purpose of purchasing the services. The following provisions apply to payments under this subdivision:

(1) a cash payment to a client under this provision cannot exceed the monthly payment limit for that client as specified in subdivision 4, paragraph (a), clause (6); and

(2) a county may not approve any cash payment for a client who meets either of the following:

(i) has been assessed as having a dependency in orientation, unless the client has an authorized representative. An "authorized representative" means an individual who is at least 18 years of age and is designated by the person or the person's legal representative to act on the person's behalf. This individual may be a family member, guardian, representative payee, or other individual designated by the person or the person's legal representative, if any, to assist in purchasing and arranging for supports; or

(ii) is concurrently receiving adult foster care, residential care, or assisted living services.

Subd. 5h. **Cash payments to persons.** (a) Cash payments to a person or a person's family will be provided through a monthly payment and be in the form of cash, voucher, or direct county payment to a vendor. Fees or premiums assessed to the person for eligibility for health and human services are not reimbursable through this service option. Services and goods purchased through cash payments must be identified in the person's individualized care plan and must meet all of the following criteria:

(1) they must be over and above the normal cost of caring for the person if the person did not have functional limitations;

(2) they must be directly attributable to the person's functional limitations;

(3) they must have the potential to be effective at meeting the goals of the program; and

(4) they must be consistent with the needs identified in the individualized service plan. The service plan shall specify the needs of the person and family, the form and amount of payment, the items and services to be reimbursed, and the arrangements for management of the individual grant.

(b) The person, the person's family, or the legal representative shall be provided sufficient information to ensure an informed choice of alternatives. The local agency shall document this information in the person's care plan, including the type and level of expenditures to be reimbursed.

(c) Persons receiving grants under this section shall have the following responsibilities:

(1) spend the grant money in a manner consistent with their individualized service plan with the local agency;

(2) notify the local agency of any necessary changes in the grant expenditures;

(3) arrange and pay for supports; and

(4) inform the local agency of areas where they have experienced difficulty securing or maintaining supports.

(d) The county shall report client outcomes, services, and costs under this paragraph in a manner prescribed by the commissioner.

256J.561 UNIVERSAL PARTICIPATION REQUIRED.

Subdivision 1. **Implementation of universal participation requirements.** (a) All caregivers whose applications were received July 1, 2004, or after, are immediately subject to the requirements in subdivision 2.

(b) For all MFIP participants who were exempt from participating in employment services under section 256J.56 as of June 30, 2004, between July 1, 2004, and June 30, 2005, the county, as part of the participant's recertification under section 256J.32, subdivision 6, shall determine whether a new employment plan is required to meet the requirements in subdivision 2. Counties shall notify each participant who is in need of an employment plan that the participant must meet with a job counselor within ten days to develop an employment plan. Until a participant's employment plan is developed, the participant shall be considered in compliance with the participation requirements in this section if the participant continues to meet the criteria for an exemption under section 256J.56 as in effect on June 30, 2004, and is cooperating in the development of the new plan.

256J.62 UNIVERSAL PARTICIPATION IN EMPLOYMENT SERVICES.

Subd. 9. **Continuation of certain services.** Only if services were approved as part of an employment plan prior to June 30, 2003, at the request of the participant, the county may continue to provide case management, counseling, or other support services to a participant:

(1) who has achieved the employment goal; or

(2) who under section 256J.42 is no longer eligible to receive MFIP but whose income is below 115 percent of the federal poverty guidelines for a family of the same size.

These services may be provided for up to 12 months following termination of the participant's eligibility for MFIP.

256J.65 SELF-EMPLOYMENT INVESTMENT DEMONSTRATION PROGRAM.

(a) A caregiver who enrolls and participates in the SEID program as specified in section 268.95, may, at county option, be exempted from other employment and training participation requirements for a period of up to 24 months, except for the school attendance requirements as specified in section 256J.54.

(b) The following income and resource considerations apply to SEID participants:

(1) an unencumbered cash reserve fund, composed of proceeds from a SEID business, is not counted against the grant if those funds are reinvested in the business and the value of the business does not exceed $3,000. The value of the business is determined by deducting outstanding encumbrances from retained business profit; and

(2) the purchase of capital equipment and durable goods of an amount up to $3,000 during a 24-month project period is allowed as a business expense.

(c) SEID participants with a county-approved employment plan are also eligible for employment and training services, including child care and transportation.