

2.1 Sec. 3. Minnesota Statutes 2006, section 256.9742, subdivision 3, is amended to read:

2.2 Subd. 3. **Posting.** Every long-term care facility and acute care facility shall post in a
2.3 conspicuous place the address and telephone number of the office. A home care service
2.4 provider shall provide all recipients, including those in ~~elderly~~ housing with services
2.5 under chapter 144D, with the address and telephone number of the office. Counties shall
2.6 provide clients receiving ~~a consumer support grant or a service allowance~~ long-term care
2.7 consultation services under section 256B.0911 or home and community-based services
2.8 through a state or federally funded program with the name, address, and telephone number
2.9 of the office. The posting or notice is subject to approval by the ombudsman.

2.10 Sec. 4. Minnesota Statutes 2006, section 256.9742, subdivision 4, is amended to read:

2.11 Subd. 4. **Access to long-term care and acute care facilities and clients.** The
2.12 ombudsman or designee may:

2.13 (1) enter any long-term care facility without notice at any time;

2.14 (2) enter any acute care facility without notice during normal business hours;

2.15 (3) enter any acute care facility without notice at any time to interview a patient or
2.16 observe services being provided to the patient as part of an investigation of a matter that is
2.17 within the scope of the ombudsman's authority, but only if the ombudsman's or designee's
2.18 presence does not intrude upon the privacy of another patient or interfere with routine
2.19 hospital services provided to any patient in the facility;

2.20 (4) communicate privately and without restriction with any client ~~in accordance~~
2.21 ~~with section 144.651~~, as long as the ombudsman has the client's consent for such
2.22 communication;

2.23 (5) inspect records of a long-term care facility, home care service provider, or acute
2.24 care facility that pertain to the care of the client according to ~~sections~~ section 144.335 and
2.25 ~~144.651~~; and

2.26 (6) with the consent of a client or client's legal guardian, the ombudsman or
2.27 designated staff shall have access to review records pertaining to the care of the client
2.28 according to ~~sections~~ section 144.335 and 144.651. If a client cannot consent and has no
2.29 legal guardian, access to the records is authorized by this section.

2.30 A person who denies access to the ombudsman or designee in violation of this
2.31 subdivision or aids, abets, invites, compels, or coerces another to do so is guilty of a
2.32 misdemeanor.

2.33 Sec. 5. Minnesota Statutes 2006, section 256.9742, subdivision 6, is amended to read:

3.1 Subd. 6. **Prohibition against discrimination or retaliation.** (a) No entity shall take
3.2 discriminatory, disciplinary, or retaliatory action against an employee or volunteer, or a
3.3 patient, resident, or guardian or family member of a patient, resident, or guardian for filing
3.4 in good faith a complaint with or providing information to the ombudsman or designee
3.5 including volunteers. A person who violates this subdivision or who aids, abets, invites,
3.6 compels, or coerces another to do so is guilty of a misdemeanor.

3.7 (b) There shall be a rebuttable presumption that any adverse action, as defined below,
3.8 within 90 days of report, is discriminatory, disciplinary, or retaliatory. For the purpose
3.9 of this clause, the term "adverse action" refers to action taken by the entity involved in a
3.10 report against the person making the report or the person with respect to whom the report
3.11 was made because of the report, and includes, but is not limited to:

- 3.12 (1) discharge or transfer from a facility;
- 3.13 (2) termination of service;
- 3.14 (3) restriction or prohibition of access to the facility or its residents;
- 3.15 (4) discharge from or termination of employment;
- 3.16 (5) demotion or reduction in remuneration for services; and
- 3.17 (6) any restriction of rights set forth in section 144.651 ~~or~~, 144A.44, or 144A.751.

3.18 Sec. 6. Minnesota Statutes 2006, section 256B.0911, subdivision 4b, is amended to
3.19 read:

3.20 Subd. 4b. **Exemptions and emergency admissions.** (a) Exemptions from the
3.21 federal screening requirements outlined in subdivision 4a, paragraphs (b) and (c), are
3.22 limited to:

3.23 (1) a person who, having entered an acute care facility from a certified nursing
3.24 facility, is returning to a certified nursing facility;

3.25 (2) a person transferring from one certified nursing facility in Minnesota to another
3.26 certified nursing facility in Minnesota; and

3.27 (3) a person, 21 years of age or older, who satisfies the following criteria, as specified
3.28 in Code of Federal Regulations, title 42, section 483.106(b)(2):

3.29 (i) the person is admitted to a nursing facility directly from a hospital after receiving
3.30 acute inpatient care at the hospital;

3.31 (ii) the person requires nursing facility services for the same condition for which
3.32 care was provided in the hospital; and

3.33 (iii) the attending physician has certified before the nursing facility admission that
3.34 the person is likely to receive less than 30 days of nursing facility services.

4.1 (b) Persons who are exempt from preadmission screening for purposes of level of
4.2 care determination include:

4.3 (1) persons described in paragraph (a);

4.4 (2) an individual who has a contractual right to have nursing facility care paid for
4.5 indefinitely by the veterans' administration;

4.6 (3) an individual enrolled in a demonstration project under section 256B.69,
4.7 subdivision 8, at the time of application to a nursing facility; and

4.8 (4) an individual currently being served under the alternative care program or under
4.9 a home and community-based services waiver authorized under section 1915(c) of the
4.10 federal Social Security Act; ~~and.~~

4.11 ~~(5) individuals admitted to a certified nursing facility for a short-term stay, which
4.12 is expected to be 14 days or less in duration based upon a physician's certification, and
4.13 who have been assessed and approved for nursing facility admission within the previous
4.14 six months. This exemption applies only if the consultation team member determines at
4.15 the time of the initial assessment of the six-month period that it is appropriate to use the
4.16 nursing facility for short-term stays and that there is an adequate plan of care for return to
4.17 the home or community-based setting. If a stay exceeds 14 days, the individual must be
4.18 referred no later than the first county working day following the 14th resident day for a
4.19 screening, which must be completed within five working days of the referral. The payment
4.20 limitations in subdivision 7 apply to an individual found at screening to not meet the level
4.21 of care criteria for admission to a certified nursing facility.~~

4.22 (c) Persons admitted to a Medicaid-certified nursing facility from the community
4.23 on an emergency basis as described in paragraph (d) or from an acute care facility on a
4.24 nonworking day must be screened the first working day after admission.

4.25 (d) Emergency admission to a nursing facility prior to screening is permitted when
4.26 all of the following conditions are met:

4.27 (1) a person is admitted from the community to a certified nursing or certified
4.28 boarding care facility during county nonworking hours;

4.29 (2) a physician has determined that delaying admission until preadmission screening
4.30 is completed would adversely affect the person's health and safety;

4.31 (3) there is a recent precipitating event that precludes the client from living safely in
4.32 the community, such as sustaining an injury, sudden onset of acute illness, or a caregiver's
4.33 inability to continue to provide care;

4.34 (4) the attending physician has authorized the emergency placement and has
4.35 documented the reason that the emergency placement is recommended; and

5.1 (5) the county is contacted on the first working day following the emergency
5.2 admission.

5.3 Transfer of a patient from an acute care hospital to a nursing facility is not considered
5.4 an emergency except for a person who has received hospital services in the following
5.5 situations: hospital admission for observation, care in an emergency room without hospital
5.6 admission, or following hospital 24-hour bed care.

5.7 (e) A nursing facility must provide a written ~~notice to persons who satisfy the criteria~~
5.8 ~~in paragraph (a), clause (3);~~ information to all persons admitted regarding the person's
5.9 right to request and receive long-term care consultation services as defined in subdivision
5.10 1a. The ~~notice~~ information must be provided prior to the person's discharge from the
5.11 facility and in a format specified by the commissioner.

5.12 Sec. 7. Minnesota Statutes 2006, section 256B.0911, subdivision 6, is amended to read:

5.13 Subd. 6. **Payment for long-term care consultation services.** (a) The total payment
5.14 for each county must be paid monthly by certified nursing facilities in the county. The
5.15 monthly amount to be paid by each nursing facility for each fiscal year must be determined
5.16 by dividing the county's annual allocation for long-term care consultation services by 12
5.17 to determine the monthly payment and allocating the monthly payment to each nursing
5.18 facility based on the number of licensed beds in the nursing facility. Payments to counties
5.19 in which there is no certified nursing facility must be made by increasing the payment
5.20 rate of the two facilities located nearest to the county seat.

5.21 (b) The commissioner shall include the total annual payment determined under
5.22 paragraph (a) for each nursing facility reimbursed under section 256B.431 or 256B.434
5.23 according to section 256B.431, subdivision 2b, paragraph (g), ~~or 256B.435.~~

5.24 (c) In the event of the layaway, delicensure and decertification, or removal from
5.25 layaway of 25 percent or more of the beds in a facility, the commissioner may adjust
5.26 the per diem payment amount in paragraph (b) and may adjust the monthly payment
5.27 amount in paragraph (a). The effective date of an adjustment made under this paragraph
5.28 shall be on or after the first day of the month following the effective date of the layaway,
5.29 delicensure and decertification, or removal from layaway.

5.30 (d) Payments for long-term care consultation services are available to the county
5.31 or counties to cover staff salaries and expenses to provide the services described in
5.32 subdivision 1a. The county shall employ, or contract with other agencies to employ, within
5.33 the limits of available funding, sufficient personnel to provide long-term care consultation
5.34 services while meeting the state's long-term care outcomes and objectives as defined in
5.35 section 256B.0917, subdivision 1. The county shall be accountable for meeting local

6.1 objectives as approved by the commissioner in the biennial home and community-based
6.2 services quality assurance plan on a form provided by the commissioner.

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

6.5 (f) The commissioner of human services shall amend the Minnesota medical
6.6 assistance plan to include reimbursement for the local consultation teams.

6.7 (g) The county may bill, as case management services, assessments, support
6.8 planning, and follow-along provided to persons determined to be eligible for case
6.9 management under Minnesota health care programs. No individual or family member
6.10 shall be charged for an initial assessment or initial support plan development provided
6.11 under subdivision 3a or 3b.

6.12 Sec. 8. Minnesota Statutes 2006, section 256B.0911, is amended by adding a
6.13 subdivision to read:

6.14 Subd. 6a. **Withholding.** If any provider obligated to pay the long-term care
6.15 consultation amount as described in subdivision 6 is more than two months delinquent in
6.16 the timely payment of the monthly installment, the commissioner may withhold payments,
6.17 penalties, and interest in accordance with the methods outlined in section 256.9657,
6.18 subdivision 7a. Any amount withheld under this provision must be returned to the county
6.19 to whom the delinquent payments were due.

6.20 Sec. 9. Minnesota Statutes 2006, section 256B.0911, subdivision 7, is amended to read:

6.21 **Subd. 7. Reimbursement for certified nursing facilities.** (a) Medical assistance
6.22 reimbursement for nursing facilities shall be authorized for a medical assistance recipient
6.23 only if a preadmission screening has been conducted prior to admission or the county has
6.24 authorized an exemption. Medical assistance reimbursement for nursing facilities shall
6.25 not be provided for any recipient who the local screener has determined does not meet the
6.26 level of care criteria for nursing facility placement or, if indicated, has not had a level II
6.27 OBRA evaluation as required under the federal Omnibus Budget Reconciliation Act of
6.28 1987 completed unless an admission for a recipient with mental illness is approved by the
6.29 local mental health authority or an admission for a recipient with developmental disability
6.30 is approved by the state developmental disability authority.

6.31 (b) The nursing facility must not bill a person who is not a medical assistance
6.32 recipient for resident days that preceded the date of completion of screening activities as
6.33 required under subdivisions 4a, 4b, and 4c. The nursing facility must include unreimbursed
6.34 resident days in the nursing facility resident day totals reported to the commissioner.

7.1 ~~(c) The commissioner shall make a request to the Centers for Medicare and Medicaid~~
7.2 ~~Services for a waiver allowing team approval of Medicaid payments for certified nursing~~
7.3 ~~facility care. An individual has a choice and makes the final decision between nursing~~
7.4 ~~facility placement and community placement after the screening team's recommendation;~~
7.5 ~~except as provided in subdivision 4a, paragraph (c).~~

7.6 Sec. 10. Minnesota Statutes 2006, section 256B.0913, subdivision 4, is amended to
7.7 read:

7.8 Subd. 4. **Eligibility for funding for services for nonmedical assistance recipients.**

7.9 (a) Funding for services under the alternative care program is available to persons who
7.10 meet the following criteria:

7.11 (1) the person has been determined by a community assessment under section
7.12 256B.0911 to be a person who would require the level of care provided in a nursing
7.13 facility, but for the provision of services under the alternative care program;

7.14 (2) the person is age 65 or older;

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

7.17 (4) the person is not ineligible for the payment of long-term care services by the
7.18 medical assistance program due to an asset transfer penalty under section 256B.0595 or
7.19 equity interest in the home exceeding \$500,000 as stated in section 256B.056;

7.20 (5) the person needs services that are not funded through other state or federal
7.21 funding;

7.22 (6) the monthly cost of the alternative care services funded by the program for
7.23 this person does not exceed 75 percent of the monthly limit described under section
7.24 256B.0915, subdivision 3a. This monthly limit does not prohibit the alternative care client
7.25 from payment for additional services, but in no case may the cost of additional services
7.26 purchased under this section exceed the difference between the client's monthly service
7.27 limit defined under section 256B.0915, subdivision 3, and the alternative care program
7.28 monthly service limit defined in this paragraph. If medical supplies and equipment or
7.29 environmental modifications are or will be purchased for an alternative care services
7.30 recipient, the costs may be prorated on a monthly basis for up to 12 consecutive months
7.31 beginning with the month of purchase. If the monthly cost of a recipient's other alternative
7.32 care services exceeds the monthly limit established in this paragraph, the annual cost of the
7.33 alternative care services shall be determined. In this event, the annual cost of alternative
7.34 care services shall not exceed 12 times the monthly limit described in this paragraph; and

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

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

8.3 (i) the appointment of a representative payee;

8.4 (ii) automatic payment from a financial account;

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

8.7 (iv) another method acceptable to the county to ensure prompt fee payments.

8.8 The county shall extend the client's eligibility as necessary while making
8.9 arrangements to facilitate payment of past-due amounts and future premium payments.

8.10 Following disenrollment due to nonpayment of a monthly fee, eligibility shall not be
8.11 reinstated for a period of 30 days.

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

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

8.30 (d) Alternative care funding is not available for a person whose income is greater
8.31 than the maintenance needs allowance under section 256B.0915, subdivision 1d, but
8.32 equal to or less than 120 percent of the federal poverty guideline effective July 1 in the
8.33 year for which alternative care eligibility is determined, who would be eligible for the
8.34 elderly waiver with a waiver obligation.

9.1 Sec. 11. Minnesota Statutes 2006, section 256B.0913, subdivision 5a, is amended to
9.2 read:

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

9.10 (b) The county agency must ensure that the funds are not used to supplant or
9.11 supplement services available through other public assistance or services programs,
9.12 including supplementation of client co-pays, deductibles, premiums, or other cost-sharing
9.13 arrangements for health-related benefits and services or entitlement programs and services
9.14 that are available to the person, but in which they have elected not to enroll. For a provider
9.15 of supplies and equipment when the monthly cost of the supplies and equipment is less
9.16 than \$250, persons or agencies must be employed by or under a contract with the county
9.17 agency or the public health nursing agency of the local board of health in order to receive
9.18 funding under the alternative care program. Supplies and equipment may be purchased
9.19 from a vendor not certified to participate in the Medicaid program if the cost for the
9.20 item is less than that of a Medicaid vendor.

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

9.32 Sec. 12. Minnesota Statutes 2006, section 256B.0915, is amended to read:

9.33 **256B.0915 MEDICAID WAIVER FOR ELDERLY SERVICES.**

9.34 Subdivision 1. **Authority.** The commissioner is authorized to apply for a home
9.35 and community-based services waiver for the elderly, authorized under section 1915(c)

10.1 of the Social Security Act, in order to obtain federal financial participation to expand
10.2 the availability of services for persons who are eligible for medical assistance. The
10.3 commissioner may apply for additional waivers or pursue other federal financial
10.4 participation which is advantageous to the state for funding home care services for the
10.5 frail elderly who are eligible for medical assistance. The provision of waived services
10.6 to elderly and disabled medical assistance recipients must comply with the criteria for
10.7 service definitions and provider standards approved in the waiver.

10.8 Subd. 1a. **Elderly waiver case management services.** (a) Elderly case management
10.9 services under the home and community-based services waiver for elderly individuals are
10.10 available from providers meeting qualification requirements and the standards specified
10.11 in subdivision 1b. Eligible recipients may choose any qualified provider of elderly case
10.12 management services.

10.13 Case management services assist individuals who receive waiver services in gaining
10.14 access to needed waiver and other state plan services, as well as needed medical, social,
10.15 educational, and other services regardless of the funding source for the services to which
10.16 access is gained.

10.17 A case aide shall provide assistance to the case manager in carrying out
10.18 administrative activities of the case management function. The case aide may not assume
10.19 responsibilities that require professional judgment including assessments, reassessments,
10.20 and care plan development. The case manager is responsible for providing oversight of
10.21 the case aide.

10.22 Case managers shall be responsible for ongoing monitoring of the provision of
10.23 services included in the individual's plan of care. Case managers shall initiate and oversee
10.24 the process of assessment and reassessment of the individual's care and review plan of
10.25 care at intervals specified in the federally approved waiver plan.

10.26 (b) The county of service or tribe must provide access to and arrange for case
10.27 management services. County of service has the meaning given it in Minnesota Rules,
10.28 part 9505.0015, subpart 11.

10.29 Subd. 1b. **Provider qualifications and standards.** The commissioner must
10.30 enroll qualified providers of elderly case management services under the home
10.31 and community-based waiver for the elderly under section 1915(c) of the Social
10.32 Security Act. The enrollment process shall ensure the provider's ability to meet the
10.33 qualification requirements and standards in this subdivision and other federal and state
10.34 requirements of this service. An elderly case management provider is an enrolled medical
10.35 assistance provider who is determined by the commissioner to have all of the following
10.36 characteristics:

11.1 (1) the demonstrated capacity and experience to provide the components of
 11.2 case management to coordinate and link community resources needed by the eligible
 11.3 population;

11.4 (2) administrative capacity and experience in serving the target population for
 11.5 whom it will provide services and in ensuring quality of services under state and federal
 11.6 requirements;

11.7 (3) a financial management system that provides accurate documentation of services
 11.8 and costs under state and federal requirements;

11.9 (4) the capacity to document and maintain individual case records under state and
 11.10 federal requirements; and

11.11 (5) the ~~county~~ lead agency may allow a case manager employed by the ~~county~~ lead
 11.12 agency to delegate certain aspects of the case management activity to another individual
 11.13 employed by the ~~county~~ lead agency provided there is oversight of the individual by
 11.14 the case manager. The case manager may not delegate those aspects which require
 11.15 professional judgment including assessments, reassessments, and care plan development.
 11.16 Lead agencies include counties, health plans, and federally recognized tribes who
 11.17 authorize services under this section.

11.18 ~~Subd. 1c. **Case management activities under the state plan.** The commissioner~~
 11.19 ~~shall seek an amendment to the home and community-based services waiver for the~~
 11.20 ~~elderly to implement the provisions of subdivisions 1a and 1b. If the commissioner~~
 11.21 ~~is unable to secure the approval of the secretary of health and human services for the~~
 11.22 ~~requested waiver amendment by December 31, 1993, the commissioner shall amend~~
 11.23 ~~the medical assistance state plan to provide that case management provided under the~~
 11.24 ~~home and community-based services waiver for the elderly is performed by counties~~
 11.25 ~~as an administrative function for the proper and effective administration of the state~~
 11.26 ~~medical assistance plan. The state shall reimburse counties for the nonfederal share of~~
 11.27 ~~costs for case management performed as an administrative function under the home and~~
 11.28 ~~community-based services waiver for the elderly.~~

11.29 **Subd. 1d. Posteligibility treatment of income and resources for elderly waiver.**
 11.30 Notwithstanding the provisions of section 256B.056, the commissioner shall make the
 11.31 following amendment to the medical assistance elderly waiver program effective July 1,
 11.32 1999, or upon federal approval, whichever is later.

11.33 A recipient's maintenance needs will be an amount equal to the Minnesota
 11.34 supplemental aid equivalent rate as defined in section 256I.03, subdivision 5, plus the
 11.35 medical assistance personal needs allowance as defined in section 256B.35, subdivision
 11.36 1, paragraph (a), when applying posteligibility treatment of income rules to the gross

12.1 income of elderly waiver recipients, except for individuals whose income is in excess of
12.2 the special income standard according to Code of Federal Regulations, title 42, section
12.3 435.236. Recipient maintenance needs shall be adjusted under this provision each July 1.

12.4 Subd. 2. **Spousal impoverishment policies.** The commissioner shall ~~seek to amend~~
12.5 ~~the federal waiver and the medical assistance state plan to allow~~ apply:

12.6 (1) the spousal impoverishment criteria as authorized under United States Code, title
12.7 42, section 1396r-5, and as implemented in sections 256B.0575, 256B.058, and 256B.059;
12.8 ~~except that the amendment shall seek to add to;~~

12.9 (2) the personal needs allowance permitted in section 256B.0575;; and

12.10 (3) an amount equivalent to the group residential housing rate as set by section
12.11 256I.03, subdivision 5, and according to the approved federal waiver and medical
12.12 assistance state plan.

12.13 Subd. 3. **Limits of cases.** The number of medical assistance waiver recipients that
12.14 a county lead agency may serve must be allocated according to the number of medical
12.15 assistance waiver cases open on July 1 of each fiscal year. Additional recipients may be
12.16 served with the approval of the commissioner.

12.17 Subd. 3a. **Elderly waiver cost limits.** (a) The monthly limit for the cost of waived
12.18 services to an individual elderly waiver client shall be the weighted average monthly
12.19 nursing facility rate of the case mix resident class to which the elderly waiver client would
12.20 be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's
12.21 maintenance needs allowance as described in subdivision 1d, paragraph (a), until the first
12.22 day of the state fiscal year in which the resident assessment system as described in section
12.23 256B.437 for nursing home rate determination is implemented. Effective on the first day
12.24 of the state fiscal year in which the resident assessment system as described in section
12.25 256B.437 for nursing home rate determination is implemented and the first day of each
12.26 subsequent state fiscal year, the monthly limit for the cost of waived services to an
12.27 individual elderly waiver client shall be the rate of the case mix resident class to which the
12.28 waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059,
12.29 in effect on the last day of the previous state fiscal year, adjusted by the greater of any
12.30 legislatively adopted home and community-based services percentage rate increase or the
12.31 average statewide percentage increase in nursing facility payment rates.

12.32 (b) If extended medical supplies and equipment or environmental modifications are
12.33 or will be purchased for an elderly waiver client, the costs may be prorated for up to
12.34 12 consecutive months beginning with the month of purchase. If the monthly cost of a
12.35 recipient's waived services exceeds the monthly limit established in paragraph (a), the
12.36 annual cost of all waived services shall be determined. In this event, the annual cost of

13.1 all waived services shall not exceed 12 times the monthly limit of waived services as
13.2 described in paragraph (a).

13.3 Subd. 3b. **Cost limits for elderly waiver applicants who reside in a nursing**
13.4 **facility.** (a) For a person who is a nursing facility resident at the time of requesting a
13.5 determination of eligibility for elderly waived services, a monthly conversion limit for
13.6 the cost of elderly waived services may be requested. The monthly conversion limit for
13.7 the cost of elderly waiver services shall be the resident class assigned under Minnesota
13.8 Rules, parts 9549.0050 to 9549.0059, for that resident in the nursing facility where
13.9 the resident currently resides until July 1 of the state fiscal year in which the resident
13.10 assessment system as described in section 256B.437 for nursing home rate determination
13.11 is implemented. Effective on July 1 of the state fiscal year in which the resident
13.12 assessment system as described in section 256B.437 for nursing home rate determination
13.13 is implemented, the monthly conversion limit for the cost of elderly waiver services
13.14 shall be the per diem nursing facility rate as determined by the resident assessment
13.15 system as described in section 256B.437 for that resident in the nursing facility where
13.16 the resident currently resides multiplied by 365 and divided by 12, less the recipient's
13.17 maintenance needs allowance as described in subdivision 1d. The initially approved
13.18 conversion rate may be adjusted by the greater of any subsequent legislatively adopted
13.19 home and community-based services percentage rate increase or the average statewide
13.20 percentage increase in nursing facility payment rates. The limit under this subdivision
13.21 only applies to persons discharged from a nursing facility after a minimum 30-day stay
13.22 and found eligible for waived services on or after July 1, 1997. For conversions from the
13.23 nursing home to the elderly waiver with consumer directed community support services,
13.24 the conversion rate limit is equal to the nursing facility rate reduced by a percentage equal
13.25 to the percentage difference between the consumer directed services budget limit that
13.26 would be assigned according to the federally approved waiver plan and the corresponding
13.27 community case mix cap, but not to exceed 50 percent.

13.28 (b) The following costs must be included in determining the total monthly costs
13.29 for the waiver client:

13.30 (1) cost of all waived services, including extended medical supplies and equipment
13.31 and environmental modifications and adaptations; and

13.32 (2) cost of skilled nursing, home health aide, and personal care services reimbursable
13.33 by medical assistance.

13.34 Subd. 3c. **Service approval and contracting provisions.** (a) Medical assistance
13.35 funding for skilled nursing services, private duty nursing, home health aide, and personal

14.1 care services for waiver recipients must be approved by the case manager and included in
14.2 the individual care plan.

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

14.5 Subd. 3d. **Adult foster care rate.** The adult foster care rate shall be considered
14.6 a difficulty of care payment and shall not include room and board. The adult foster
14.7 care service rate shall be negotiated between the ~~county~~ lead agency and the foster care
14.8 provider. The elderly waiver payment for the foster care service in combination with
14.9 the payment for all other elderly waiver services, including case management, must not
14.10 exceed the limit specified in subdivision 3a, paragraph (a).

14.11 Subd. 3e. ~~Assisted living~~ **Customized living service rate.** (a) Payment for ~~assisted~~
14.12 ~~living service~~ customize living services shall be a monthly rate negotiated and authorized
14.13 by the ~~county agency based on an individualized service plan for each resident and may~~
14.14 ~~not cover direct rent or food costs.~~ lead agency within the parameters established by
14.15 the commissioner. The payment agreement must delineate the services that have been
14.16 customized for each recipient and specify the amount of each service to be provided. The
14.17 lead agency shall ensure that there is a documented need for all services authorized.
14.18 Customized living services must not include rent or raw food costs. The negotiated
14.19 payment rate must be based on services to be provided. Negotiated rates must not exceed
14.20 payment rates for comparable elderly waiver or medical assistance services and must
14.21 reflect economies of scale.

14.22 (b) The individualized monthly negotiated payment for ~~assisted living~~ customized
14.23 living services as described in section 256B.0913, subdivisions 5d to 5f, and residential
14.24 care services as described in section 256B.0913, subdivision 5e, shall not exceed the
14.25 nonfederal share, in effect on July 1 of the state fiscal year for which the rate limit
14.26 is being calculated, of the greater of either the statewide or any of the geographic
14.27 groups' weighted average monthly nursing facility rate of the case mix resident class
14.28 to which the elderly waiver eligible client would be assigned under Minnesota Rules,
14.29 parts 9549.0050 to 9549.0059, less the maintenance needs allowance as described in
14.30 subdivision 1d, paragraph (a), until the July 1 of the state fiscal year in which the resident
14.31 assessment system as described in section 256B.437 for nursing home rate determination
14.32 is implemented. Effective on July 1 of the state fiscal year in which the resident
14.33 assessment system as described in section 256B.437 for nursing home rate determination
14.34 is implemented and July 1 of each subsequent state fiscal year, the individualized monthly
14.35 negotiated payment for the services described in this clause shall not exceed the limit
14.36 described in this clause which was in effect on June 30 of the previous state fiscal year

15.1 and which has been adjusted by the greater of any legislatively adopted home and
15.2 community-based services cost-of-living percentage increase or any legislatively adopted
15.3 statewide percent rate increase for nursing facilities.

15.4 (c) ~~The individualized monthly negotiated payment for assisted~~ Customized living
15.5 services ~~described in section 144A.4605 and~~ are delivered by a provider licensed by the
15.6 Department of Health as a class A or class F home care provider ~~or an assisted living~~
15.7 ~~home care provider~~ and provided in a building that is registered as a housing with services
15.8 establishment under chapter 144D ~~and that provides 24-hour supervision in combination~~
15.9 ~~with the payment for other elderly waiver services, including case management, must not~~
15.10 ~~exceed the limit specified in subdivision 3a.~~

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

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

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

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

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

15.33 Subd. 4. **Termination notice.** The case manager must give the individual a ten-day
15.34 written notice of any denial, reduction, or termination of waived services.

15.35 Subd. 5. **Assessments and reassessments for waiver clients.** Each client shall
15.36 receive an initial assessment of strengths, informal supports, and need for services in

16.1 accordance with section 256B.0911, subdivisions 3, 3a, and 3b. A reassessment of a
16.2 client served under the elderly waiver must be conducted at least every 12 months and
16.3 at other times when the case manager determines that there has been significant change
16.4 in the client's functioning. This may include instances where the client is discharged
16.5 from the hospital.

16.6 Subd. 6. **Implementation of care plan.** Each elderly waiver client shall be provided
16.7 a copy of a written care plan that meets the requirements outlined in section 256B.0913,
16.8 subdivision 8. The care plan must be implemented by the county ~~administering waived~~
16.9 ~~services~~ of service when it is different than the county of financial responsibility. The
16.10 county of service administering waived services must notify the county of financial
16.11 responsibility of the approved care plan.

16.12 Subd. 7. **Prepaid elderly waiver services.** An individual for whom a prepaid health
16.13 plan is liable for nursing home services or elderly waiver services according to section
16.14 256B.69, subdivision 6a, is not eligible to also receive county-administered elderly waiver
16.15 services ~~under this section~~.

16.16 Subd. 8. **Services and supports.** (a) Services and supports shall meet the
16.17 requirements set out in United States Code, title 42, section 1396n.

16.18 (b) Services and supports shall promote consumer choice and be arranged and
16.19 provided consistent with individualized, written care plans.

16.20 (c) The state of Minnesota, county, managed care organization, or tribal government
16.21 under contract to administer the elderly waiver shall not be liable for damages, injuries,
16.22 or liabilities sustained through the purchase of direct supports or goods by the person,
16.23 the person's family, or the authorized representatives with funds received through
16.24 consumer-directed community support services under the federally approved waiver plan.
16.25 Liabilities include, but are not limited to, workers' compensation liability, the Federal
16.26 Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA).

16.27 Subd. 9. **Tribal management of elderly waiver.** Notwithstanding contrary
16.28 provisions of this section, or those in other state laws or rules, the commissioner may
16.29 develop a model for tribal management of the elderly waiver program and implement this
16.30 model through a contract between the state and any of the state's federally recognized tribal
16.31 governments. The model shall include the provision of tribal waiver case management,
16.32 assessment for personal care assistance, and administrative requirements otherwise carried
16.33 out by ~~counties~~ lead agencies but shall not include tribal financial eligibility determination
16.34 for medical assistance.

16.35 Sec. 13. **REPORT; CATASTROPHIC LOSS COVERAGE.**

17.1 The commissioner shall present to the legislature on January 15, 2008, a plan for
17.2 providing catastrophic loss coverage to businesses with fewer than 25 employees.

17.3 Sec. 14. **REPEALER.**

17.4 (a) Minnesota Statutes 2006, section 256.9743, is repealed.

17.5 (b) Minnesota Rules, part 9505.0335, is repealed.