

**Senate Counsel, Research,
and Fiscal Analysis**

G-17 STATE CAPITOL
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Senate

State of Minnesota

S.F. No. 1101 - Medical Assistance Payment for Swing Bed Services

Author: Senator Thomas Bakk

Prepared by: David Giel, Senate Research (296-7178)



Date: March 7, 2005

S.F. No. 1101 establishes an exception to the requirement in state law that nursing care provided in a nonpublic hospital swing bed may only be reimbursed by Medical Assistance (MA) if the hospital qualifies as a sole community provider. An exception is granted for hospitals that were approved to provide MA swing bed services as of January 1, 2004. The bill applies to swing bed services provided on or after March 5, 2005.

DG:rdr

Senators Bakk, Saxhaug, Skoe and Stumpf introduced--
S.F. No. 1101: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; modifying requirements for the
provision of medical assistance swing bed services;
amending Minnesota Statutes 2004, section 256B.0625,
subdivision 2.

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

Section 1. Minnesota Statutes 2004, section 256B.0625,
subdivision 2, is amended to read:

Subd. 2. [SKILLED AND INTERMEDIATE NURSING CARE.] Medical
assistance covers skilled nursing home services and services of
intermediate care facilities, including training and
habilitation services, as defined in section 252.41, subdivision
3, for persons with mental retardation or related conditions who
are residing in intermediate care facilities for persons with
mental retardation or related conditions. Medical assistance
must not be used to pay the costs of nursing care provided to a
patient in a swing bed as defined in section 144.562, unless (a)
the facility in which the swing bed is located is eligible as a
sole community provider, as defined in Code of Federal
Regulations, title 42, section 412.92, or the facility is a
public hospital owned by a governmental entity with 15 or fewer
licensed acute care beds; (b) the Centers for Medicare and
Medicaid Services approves the necessary state plan amendments;
(c) the patient was screened as provided by law; (d) the patient
no longer requires acute care services; and (e) no nursing home

1 beds are available within 25 miles of the facility. The
2 commissioner shall exempt a facility from compliance with the
3 sole community provider requirement in clause (a) if, as of
4 January 1, 2004, the facility had an agreement with the
5 commissioner to provide medical assistance swing bed services.
6 Medical assistance also covers up to ten days of nursing care
7 provided to a patient in a swing bed if: (1) the patient's
8 physician certifies that the patient has a terminal illness or
9 condition that is likely to result in death within 30 days and
10 that moving the patient would not be in the best interests of
11 the patient and patient's family; (2) no open nursing home beds
12 are available within 25 miles of the facility; and (3) no open
13 beds are available in any Medicare hospice program within 50
14 miles of the facility. The daily medical assistance payment for
15 nursing care for the patient in the swing bed is the statewide
16 average medical assistance skilled nursing care per diem as
17 computed annually by the commissioner on July 1 of each year.

18 [EFFECTIVE DATE.] This section is effective the day
19 following final enactment and applies to medical assistance
20 payments for swing bed services provided on or after March 5,
21 2005.

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**S.F. No. 870 - Establishing a Crises Nursery Grant
Program**

Author: Senator Yvonne Prettner Solon

Prepared by: Joan White, Senate Counsel (651/296-3814)

Date: March 3, 2005



In the 2003 legislative session, crisis nursery funding was consolidated into the children and community services grant and the crisis nursery statute was repealed.

S.F. No. 870, subdivision 1, requires the commissioner to establish a grant program to assist private and public agencies and organizations to provide crisis nurseries to offer services and temporary care to families experiencing crisis situations. The services must be provided without a fee for a maximum of 30 days in a year, and must provide short-term case management, family support services, parent education, crisis intervention, referrals, and resources, as needed. This bill also lists 15 components that the crisis nurseries must include.

Subdivision 2 requires the commissioner to give funding priority to agencies and organizations with experience in working with abused or neglected children and their families, and with children at high risk of abuse and neglect, and serve communities that demonstrate the greatest need for the services. Funds must be distributed according to a formula developed by the commissioner in consultation with the Minnesota Crisis Nursery Association. The formula must include funding for all crisis nursery programs that have previously been funded and that meet the requirements of subdivision 1. This subdivision also specifies other requirements for the funding formula.

JW:rdr

Senators Solon, Higgins, Lourey, Hottinger and Senjem introduced—

S. F. No. 870 Referred to the Committee on Health & Family Security

1 A bill for an act

2 relating to human services; establishing a crisis
3 nursery grant program; proposing coding for new law in
4 Minnesota Statutes, chapter 256F.

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

6 Section 1. [256F.15] [GRANT PROGRAM FOR CRISIS NURSERIES.]

7 Subdivision 1. [CRISIS NURSERIES.] The commissioner of
8 human services shall establish a grant program to assist private
9 and public agencies and organizations to provide crisis
10 nurseries to offer services and temporary care to families
11 experiencing crisis situations including children who are at
12 high risk of abuse and neglect, children who have been abused
13 and neglected, and children who are in families receiving child
14 protective services. This service shall be provided without a
15 fee for a maximum of 30 days in any year. Crisis nurseries
16 shall provide short-term case management, family support
17 services, parent education, crisis intervention, referrals, and
18 resources, as needed.

19 (a) The crisis nurseries must:

20 (1) be available 24 hours a day, seven days a week;

21 (2) provide services for children up to 72 hours at any one
22 time;

23 (3) provide short-term case management to bridge the gap
24 between crisis and successful living;

25 (4) make referrals for parents to counseling services and

1 other community resources to help alleviate the underlying cause
2 of the precipitating stress or crisis;

3 (5) provide services without a fee for a maximum of 30 days
4 in any year;

5 (6) provide services to families with children from birth
6 through 12 years of age;

7 (7) provide an immediate response to family needs and
8 strengths with an initial assessment and intake interview, make
9 referrals to appropriate agencies or programs, and provide
10 temporary care of children, as needed;

11 (8) maintain the clients' confidentiality to the extent
12 required by law, and also comply with statutory reporting
13 requirements which may mandate a report to child protective
14 services;

15 (9) contain a volunteer component and support for
16 volunteers;

17 (10) provide preservice training and ongoing training to
18 providers and volunteers;

19 (11) evaluate the services provided by documenting use of
20 services, the result of family referrals made to community
21 resources, and how the services reduced the risk of
22 maltreatment;

23 (12) provide developmental assessments;

24 (13) provide medical assessments as determined by using a
25 risk screening tool;

26 (14) provide parent education classes or programs that
27 include parent-child interaction either on site or in
28 collaboration with other community agencies; and

29 (15) have a multidisciplinary advisory board which may
30 include one or more parents who have used the crisis nursery
31 services.

32 (b) The crisis nurseries are encouraged to provide
33 opportunities for parents to volunteer, if appropriate.

34 (c) Parents shall retain custody of their children during
35 placement in a crisis facility.

36 Subd. 2. [FUND DISTRIBUTION.] In distributing funds, the

1 commissioner shall give priority consideration to agencies and
2 organizations with experience in working with abused or
3 neglected children and their families, and with children at high
4 risk of abuse and neglect and their families, and serve
5 communities which demonstrate the greatest need for these
6 services. Funds shall be distributed to crisis nurseries
7 according to a formula developed by the commissioner in
8 consultation with the Minnesota Crisis Nursery Association. The
9 formula shall include funding for all existing crisis nursery
10 programs that have been previously funded through the Department
11 of Human Services and that meet program requirements as
12 specified in subdivision 1, paragraph (a), and consideration of
13 factors reflecting the need for services in each service area,
14 including, but not limited to, the number of children 18 years
15 of age and under living in the service area, the percent of
16 children 18 years of age and under living in poverty in the
17 service area, and factors reflecting the cost of providing
18 services, including, but not limited to, the number of hours of
19 service provided in the previous year.

Consequences to Crisis Nurseries from Choices Made in the '03-'04 Legislative Sessions

Crisis nurseries are 24-hour family-support services that include crisis lines, and emergency day-and-night care for children from 0-12 years.

Parents, who are dealing with emergencies or crises such as sudden illness, housing problems, divorce or separation, or financial strains, can need time to resolve the crisis.

Crisis nurseries are a vital component in reducing child abuse by providing parents a safe place for their child and distance from emotional turmoil which can, sometimes, escalate to violence.

Parents can request emergency care for up to 3 days, by calling a 24-hour crisis hotline. Trained staff provide referrals, counseling, support, and emergency supplies.

What choices did the 2003-2004 Legislatures make?

Following a 27% reduction in funding, crisis nursery grants were added to the Community Services Block Grant distributed to each of the 87 counties. As a result, funds previously distributed to the 21 crisis nurseries, are now split 87 ways thinning resources even further.

Funding was reduced by 30-50% for the majority of nurseries.

Non-profits can be there to help as this story from an LSS crisis shelters illustrates:

A Mom called our Crisis Nursery a week before Christmas because she had just found out that the daycare she uses was closing for the holidays.

She is struggling to make ends meet for her 8-month-old and 4 year-old by working the second shift at her job. Her employer allowed her to take Christmas Eve off to be with her family, but she was required to work on Christmas day and New Years day.

With her own parents out of town, she didn't know anyone else who could care for her kids at night. She feared losing her job if she couldn't find care for the children. LSS provided her with that care on both Christmas and New Years.

But emergency help like this is cannot be sustained without stable funding

How were children served by other funding choices in '03-'04?

- Grants for children at risk, including early interventions, were reduced by 27%
- 485 children will be without a sympathetic senior to help with school & behavior issues
- Early Childhood and School Readiness were cut by \$9.3 million
- State funding of after-school programs (ASE) for high-risk kids was eliminated
- Head Start was cut by \$3.1 million
- There are 200 fewer AmeriCorps volunteers to help children with school & housing needs
- State funding for essential nutrition to infants and pregnant women (WIC) was eliminated
- 1,200 working families lost child care support and, in addition,
- Funding for families fleeing domestic abuse has decreased by 46% since 2001.

“Government continues to turn to social services nonprofits to help... But those nonprofits and their beneficiaries also have borne the brunt of government cuts in recent years that have not been made up by private philanthropy.” Star Tribune 12-12-04

Who has been affected, and how?

Children and families in crisis all over the state have been affected by not having access to 24-hour hotlines and by being turned away when their need is great. As these families are nearly impossible to track, the following reports from agencies will capture some of the effects.

LSS Crisis Nurseries

Bethany LSS in Duluth

The nursery has had to turn people away which is painful in the face of parents who say that, without Bethany LSS, they "would not have been able to make it."

St. Cloud Area LSS Crisis Nursery

One paid staff person supervises volunteers and interns from St. Cloud State. 50% of the budget was cut. One-time grants and the "grace of God" allowed them to remain open. Although more grant applications are in, some grants expire August 1, 2004.

They are receiving increasing calls for child-care because of reduction in child-care assistance.

CAP Crisis Nursery (Scott/Carver Counties)

- eliminated a program designed for teen parents, an especially high-risk population

Children's Home Society (Anoka, Chisago/Isanti, Dakota, Ramsey, Washington, Wright Counties)

- 20% (\$342,000) cut from their crisis nursery budget meant closing 2 centers & eliminating positions.

Chisago/Isanti County Crisis Nursery

- increased demand for basic needs, items that may have previously been obtained through WIC
- cuts to other area programs and non-profits have brought families on the edge closer to crisis.

Itasca Area Crisis Nursery (serving Itasca & Koochiching Counties)

- lost 60% of their \$90,000 budget & eliminated a parent & a grandparent support program
- Appealing to the community and churches, going through the phone book and sending fundraising letters out to the community netted checks for \$5-\$10 dollars "*but our community has nothing more to give*"

Pillsbury Crisis Nursery, Minneapolis

- 33% budget reduction meant relocating and eliminating their family violence program.

2005 information from Crisis Nurseries, Inc:

Crisis Nursery Programs in

- *Dakota, Ramsey, Washington, Anoka, Chisago, Isanti, and Wright Counties* have changed their placement eligibility requirements and serve fewer children at risk for abuse and neglect.
- *Kanabec County* was forced to close due to lack of funds.
- *Greater Minneapolis Crisis Nursery* is serving 1,095 fewer children per year due to cuts.
- *Lincoln, Lyon, Murray, Redwood, Scott, Carver, Mower, Freeborn, Benton, & Stearns Counties* have cut back on the services they provide to families and children in crisis due to budget cuts.
- *Lincoln, Lyon, Murray, Redwood, Benton, and Stearns Counties* have had to deny families in crisis placement of their children because of lack of funding.

As of July 1, 2004, only 5 of the 21 Crisis Nurseries in the State of Minnesota are receiving funding through the Department of Human Services.

In 2004, **only 3** of the Crisis Nurseries were able to serve all qualified families needing assistance.

Who is our government serving when, as the *Rochester Post Bulletin* reported, "It has resulted in putting **serious holes in the social safety net that, in the past, has protected children and low income families during hard times.** Middle and upper income families will not be affected, and that is deliberate discrimination." 5-31-03


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**S.F. No. 227 - Cancer Drug Repository Program
(Delete-Everything Amendment)**

Author: Senator Yvonne Prettner Solon

Prepared by: Katie Cavanor, Senate Counsel (651/296-3801) 

Date: March 4, 2005

Section 1 (144.707) establishes the cancer drug repository program.

Subdivision 1 defines the following terms: “cancer drug,” “cancer drug repository,” “cancer supply,” “commissioner,” “dispense,” “distribute,” “medical facility,” “medical supplies,” “pharmacist,” “pharmacy,” “practitioner,” “prescription drug,” “side effects of cancer,” “single-unit-dose packaging,” and “tamper-evident unit dose packaging.”

Subdivision 2 requires the Commissioner of Health to establish and maintain a cancer drug repository program. Under the program, a person may donate a cancer or medical supply for use by an individual who meets certain eligibility requirements. Donations may be made to a medical facility or a pharmacy that elects to participate in the program and meets the requirements for participation. These donations may be dispensed to an eligible individual or distributed to another participating medical facility or pharmacy.

Subdivision 3 establishes the requirements for participation by pharmacies and medical facilities. States that participation in the program is voluntary.

Subdivision 4 states that any individual who is diagnosed with cancer is eligible to receive drugs or supplies under this program and that the drugs and supplies will be dispensed in accordance with **subdivision 6**.

Subdivision 5 establishes requirements that must be met before a cancer drug or medical supply can be accepted and dispensed under this program. States that any individual 18 years of age or older or a pharmacy, medical facility, drug manufacturer, or wholesale drug distributor may donate drugs. States that a drug or supply may be donated if:

- (1) it is accompanied by a donor form;
- (2) bear an expiration date that is later than six months after the date the drug was donated;
- (3) it is in its original, unopened, sealed, and tamper-evident unit dose packaging, or, if packaged in single-unit-doses, unopened; and
- (4) not be adulterated or misbranded, as determined by a pharmacist who has inspected the drug or supply before it is dispensed.

Requires the donor to fill out a donor form and describes the contents of the form. States that drugs and supplies may be donated on premises of a drug repository to a designated pharmacist, and that a drop box may not be used. Requires that donated drugs and supplies must be stored separately under a secure storage area under conditions appropriate for the drug or supply.

Subdivision 6 requires that the drugs or supplies be dispensed by a licensed pharmacist pursuant to a prescription by a practitioner in accordance with Minnesota Statutes, chapter 151. Requires the pharmacist to visually inspect the drug or supply before dispensing. Requires that before a drug or supply be dispensed to an individual, the individual must sign a recipient form. Establishes the priority in which the drugs or supplies are to be dispensed.

Subdivision 7 states that the medical facility or pharmacy may charge a handling fee to the individual who receives the drug or supply that does not exceed more than 250 percent of the medical assistance program dispensing fee.

Subdivision 8 permits cancer drug repositories to distribute donated drugs and supplies to other repositories if requested by a participating repository, and requires a repository that has elected not to dispense donated drugs or supplies to distribute any donated drug or supply to a participating repository upon request of a participating repository. A repository that distributes drugs or supplies to another repository must complete a donor form and must provide a copy of the donor form that was completed by the original donor to the participating repository at the time of distribution.

Subdivision 9 states that donated drugs and supplies may not be resold.

Subdivision 10 states that donor or recipient forms must be maintained for at least five years. Requires a record of destruction to be maintained for at least five years for any drug or supply that was not dispensed. States what information must be included in the form.

Subdivision 11 provides that a medical facility, pharmacist, pharmacy or practitioner participating in the program or a donor of a cancer drug or supply are immune from civil liability for injury to or the death of the individual to whom the drug or supply is dispensed and may not be disciplined for unprofessional conduct for their acts or omissions relating to donating, accepting, distributing, or dispensing a cancer drug or supply under this program. This immunity does not apply if the act or omission involves reckless, wanton, or intentional misconduct.

KC:ph

Senators Solon, Berglin, Kiscaden, Lourey and Rosen introduced--
S.F. No. 227: Referred to the Committee on Health and Family Security.

1 A bill for an act
2 relating to health; establishing a cancer drug
3 repository program; requiring rulemaking; proposing
4 coding for new law in Minnesota Statutes, chapter 144.
5 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:
6 Section 1. [144.707] [CANCER DRUG REPOSITORY PROGRAM.]
7 Subdivision 1. [DEFINITIONS.] (a) For the purposes of this
8 section, the terms defined in this subdivision have the meanings
9 given.
10 (b) "Cancer drug" means a prescription drug that is used to
11 treat:
12 (1) cancer or the side effects of cancer; or
13 (2) the side effects of any prescription drug that is used
14 to treat cancer or the side effects of cancer.
15 (c) "Dispense" has the meaning given in section 151.01,
16 subdivision 30.
17 (d) "Medical facility" means an institution defined in
18 section 144.50, subdivision 2.
19 (e) "Medical supplies" means any medical supply needed to
20 administer a cancer drug.
21 (f) "Pharmacist" has the meaning given in section 151.01,
22 subdivision 3.
23 (g) "Pharmacy" means any pharmacy registered with the Board
24 of Pharmacy according to section 151.19, subdivision 1.
25 (h) "Practitioner" has the meaning given in section 151.01,

1 subdivision 23.

2 (i) "Prescription drug" means a legend drug as defined in
3 section 151.01, subdivision 17.

4 Subd. 2. [ESTABLISHMENT.] The commissioner of health shall
5 establish and maintain a cancer drug repository program, under
6 which any person may donate a cancer drug or medical supply for
7 use by an individual who meets eligibility criteria specified by
8 rule. Under the program, donations may be made on the premises
9 of a medical facility or pharmacy that elects to participate in
10 the program and meets the requirements specified by rule. A
11 medical facility or pharmacy that accepts a donated cancer drug
12 or supply may dispense the drug or supply to an eligible
13 individual or may distribute the cancer drug or supply to
14 another participating medical facility or pharmacy.

15 Subd. 3. [REQUIREMENTS TO BE MET.] A cancer drug or
16 medical supply may be accepted and dispensed as part of this
17 program only if the following requirements are met:

18 (1) the cancer drug or medical supply is in its original,
19 unopened, sealed, and tamper-evident unit dose packaging or, if
20 packaged in single-unit doses, the single-unit-dose packaging is
21 unopened;

22 (2) the cancer drug bears an expiration date that is later
23 than six months after the date that the drug is donated;

24 (3) the cancer drug or supply is not adulterated or
25 misbranded, as determined by a pharmacist employed by, or under
26 contract with, the medical facility or pharmacy accepting the
27 donation. The pharmacist shall inspect the drug or supply
28 before the drug or supply is dispensed; and

29 (4) the cancer drug or supply is prescribed by a
30 practitioner for use by an eligible individual and is dispensed
31 to that individual by a pharmacist.

32 Subd. 4. [ADMINISTRATION COST.] No cancer drug or supply
33 that is donated for use under this section shall be resold. The
34 medical facility or pharmacy may charge the individual who
35 receives a cancer drug or supply under the program a handling
36 fee that may not exceed an amount specified by the commissioner.

1 Subd. 5. [PARTICIPATION.] Nothing in this section requires
2 that a medical facility, pharmacy, pharmacist, or practitioner
3 participate in the program.

4 Subd. 6. [LIABILITY.] (a) Unless a manufacturer of a drug
5 or supply exercises bad faith, the manufacturer is not subject
6 to criminal or civil liability for injury, death, or loss to a
7 person or property for matters related to the donation,
8 acceptance, or dispensing of a cancer drug or supply
9 manufactured by the manufacturer that is donated by any
10 individual under this section, including liability for failure
11 to transfer or communicate product or consumer information or
12 the expiration date of the donated cancer drug or supply.

13 (b) A medical facility, pharmacy, pharmacist, or
14 practitioner participating in the program is immune from civil
15 liability for injury to or for the death of an individual to
16 whom the cancer drug or supply is dispensed and no disciplinary
17 action shall be taken for unprofessional conduct for acts or
18 omissions related to donating, accepting, distributing, or
19 dispensing a cancer drug or supply under this section, unless
20 the act or omission involves reckless, wanton, or intentional
21 misconduct.

22 Subd. 7. [RULES.] The commissioner shall adopt rules to
23 implement the program, including:

24 (1) requirements for medical facilities and pharmacies to
25 accept, distribute, and dispense donated cancer drugs and
26 supplies under this section, including:

27 (i) eligibility criteria;

28 (ii) standards and procedures for accepting, safely
29 storing, and dispensing donated cancer drugs and supplies;

30 (iii) standards and procedures for inspecting donated
31 cancer drugs and supplies to determine if the cancer drug or
32 supply is in its original, unopened, sealed, and tamper-evident
33 unit dose packaging or, if packaged in single-unit doses, the
34 single-unit-dose packaging is unopened; and

35 (iv) standards and procedures for inspecting donated cancer
36 drugs and supplies to determine that the cancer drug or supply

1 is not adulterated or misbranded;

2 (2) eligibility criteria for individuals to receive donated
3 cancer drugs or supplies under the program. The standards shall
4 prioritize dispensation to individuals who are uninsured or
5 indigent but must permit dispensation to others if an uninsured
6 or indigent individual is unavailable;

7 (3) a maximum handling fee that a medical facility or
8 pharmacy may charge for accepting, distributing, or dispensing
9 donated cancer drugs or supplies; and

10 (4) a list of cancer drugs and supplies arranged by
11 category or by individual cancer drug or supply that will be
12 accepted under the program and a list of cancer drugs and
13 supplies that will not be accepted under the program. The list
14 shall include a statement that specifies the reason that a
15 cancer drug or supply is ineligible for donation.

1 Senator *Higgin* moves to amend S.F. No. 227 as follows:

2 Delete everything after the enacting clause and insert:

3 "Section 1. [144.707] [CANCER DRUG REPOSITORY PROGRAM.]

4 Subdivision 1. [DEFINITIONS.] (a) For the purposes of this
5 section, the terms defined in this subdivision have the meanings
6 given.

7 (b) "Cancer drug" means a prescription drug that is used to
8 treat:

9 (1) cancer or the side effects of cancer; or

10 (2) the side effects of any prescription drug that is used
11 to treat cancer or the side effects of cancer.

12 (c) "Cancer drug repository" means a medical facility or
13 pharmacy that has notified the commissioner of its election to
14 participate in the cancer drug repository program.

15 (d) "Cancer supply" or "supplies" means prescription and
16 nonprescription cancer supplies needed to administer a cancer
17 drug.

18 (e) "Commissioner" means the commissioner of health.

19 (f) "Dispense" has the meaning given in section 151.01,
20 subdivision 30.

21 (g) "Distribute" means to deliver, other than by
22 administering or dispensing.

23 (h) "Medical facility" means an institution defined in
24 section 144.50, subdivision 2.

25 (i) "Medical supplies" means any prescription and
26 nonprescription medical supply needed to administer a cancer
27 drug.

28 (j) "Pharmacist" has the meaning given in section 151.01,
29 subdivision 3.

30 (k) "Pharmacy" means any pharmacy registered with the Board
31 of Pharmacy according to section 151.19, subdivision 1.

32 (l) "Practitioner" has the meaning given in section 151.01,
33 subdivision 23.

34 (m) "Prescription drug" means a legend drug as defined in
35 section 151.01, subdivision 17.

36 (n) "Side effects of cancer" means symptoms of cancer.

1 (o) "Single-unit-dose packaging" means a single-unit
2 container for articles intended for administration as a single
3 dose, direct from the container.

4 (p) "Tamper-evident unit dose packaging" means a container
5 within which a drug is sealed so that the contents cannot be
6 opened without obvious destruction of the seal.

7 Subd. 2. [ESTABLISHMENT.] The commissioner of health shall
8 establish and maintain a cancer drug repository program, under
9 which any person may donate a cancer drug or supply for use by
10 an individual who meets the eligibility criteria specified under
11 subdivision 4. Under the program, donations may be made on the
12 premises of a medical facility or pharmacy that elects to
13 participate in the program and meets the requirements specified
14 under subdivision 3.

15 Subd. 3. [REQUIREMENTS FOR PARTICIPATION BY PHARMACIES AND
16 MEDICAL FACILITIES.] (a) To be eligible for participation in the
17 cancer drug repository program, a pharmacy or medical facility
18 must be licensed and in compliance with all applicable federal
19 and state laws and administrative rules.

20 (b) Participation in the cancer drug repository program is
21 voluntary. A pharmacy or medical facility may elect to
22 participate in the cancer drug repository program by submitting
23 the following information to the commissioner, in a form
24 provided by the commissioner:

25 (1) the name, street address, and telephone number of the
26 pharmacy or medical facility;

27 (2) the name and telephone number of a pharmacist who is
28 employed by or under contract with the pharmacy or medical
29 facility, or other contact person who is familiar with the
30 pharmacy's or medical facility's participation in the cancer
31 drug repository program; and

32 (3) a statement indicating that the pharmacy or medical
33 facility meets the eligibility requirements under paragraph (a)
34 and the chosen level of participation under paragraph (c).

35 (c) A pharmacy or medical facility may fully participate in
36 the cancer drug repository program by accepting, storing, and

1 dispensing donated drugs and supplies, or may limit its
2 participation to only accepting and storing donated drugs and
3 supplies. If a pharmacy or facility chooses to limit its
4 participation, the pharmacy or facility shall distribute any
5 donated drugs to a fully participating cancer drug repository in
6 accordance with subdivision 8.

7 (d) A pharmacy or medical facility may withdraw from
8 participation in the cancer drug repository program at any time
9 upon notification to the commissioner. A notice to withdraw
10 from participation may be given by telephone or regular mail.

11 Subd. 4. [INDIVIDUAL ELIGIBILITY REQUIREMENTS.] Any
12 Minnesota resident who is diagnosed with cancer is eligible to
13 receive drugs or supplies under the cancer drug repository
14 program. Drugs and supplies shall be dispensed according to the
15 priority given under subdivision 6, paragraph (d).

16 Subd. 5. [DONATIONS OF CANCER DRUGS AND SUPPLIES.] (a) Any
17 one of the following persons may donate legally obtained cancer
18 drugs or supplies to a cancer drug repository, if the drugs or
19 supplies meet the requirements under paragraph (b) or (c) as
20 determined by a pharmacist who is employed by or under contract
21 with a cancer drug repository:

22 (1) an individual who is 18 years old or older; or
23 (2) a pharmacy, medical facility, drug manufacturer, or
24 wholesale drug distributor, if the donated drugs have not been
25 previously dispensed.

26 (b) A cancer drug is eligible for donation under the cancer
27 drug repository program only if the following requirements are
28 met:

29 (1) the donation is accompanied by a cancer drug repository
30 donor form described under paragraph (d) that is signed by the
31 person making the donation or that person's authorized
32 representative;

33 (2) the drug's expiration date is at least six months later
34 than the date that the drug was donated;

35 (3) the drug is in its original, unopened, tamper-evident
36 unit dose packaging that includes the drug's lot number and

1 expiration date. Single-unit dose drugs may be accepted if the
2 single-unit-dose packaging is unopened; and

3 (4) the drug is not adulterated or misbranded.

4 (c) Cancer supplies are eligible for donation under the
5 cancer drug repository program only if the following
6 requirements are met:

7 (1) the supplies are not adulterated or misbranded;

8 (2) the supplies are in their original, unopened, sealed
9 packaging; and

10 (3) the donation is accompanied by a cancer drug repository
11 donor form described under paragraph (d) that is signed by the
12 person making the donation or that person's authorized
13 representative.

14 (d) The cancer drug repository donor form must be provided
15 by the commissioner and shall state that to the best of the
16 donor's knowledge the donated drug or supply has been properly
17 stored and that the drug or supply has never been opened, used,
18 tampered with, adulterated, or misbranded. The commissioner
19 shall make the cancer drug repository donor form available on
20 the Department of Health's Web site.

21 (e) Controlled substances and drugs and supplies that do
22 not meet the criteria under this subdivision are not eligible
23 for donation or acceptance under the cancer drug repository
24 program.

25 (f) Drugs and supplies may be donated on the premises of a
26 cancer drug repository to a pharmacist designated by the
27 repository. A drop box may not be used to deliver or accept
28 donations.

29 (g) Cancer drugs and supplies donated under the cancer drug
30 repository program must be stored in a secure storage area under
31 environmental conditions appropriate for the drugs or supplies
32 being stored. Donated drugs and supplies may not be stored with
33 nondonated inventory.

34 Subd. 6. [DISPENSING REQUIREMENTS.] (a) Drugs and supplies
35 must be dispensed by a licensed pharmacist pursuant to a
36 prescription by a practitioner and in accordance with the

1 requirements of chapter 151.

2 (b) Cancer drugs and supplies shall be visually inspected
3 by the pharmacist before dispensed for adulteration,
4 misbranding, and date of expiration. Drugs or supplies that
5 have expired or appear upon visual inspection to be adulterated,
6 misbranded, or tampered with in any way may not be dispensed.

7 (c) Before a cancer drug or supply may be dispensed to an
8 individual, the individual must sign a cancer drug repository
9 recipient form provided by the commissioner acknowledging that
10 the individual understands the information stated on the form.
11 The form shall include the following information:

12 (1) that the drug or supply being dispensed has been
13 donated and may have been previously dispensed;

14 (2) that a visual inspection has been conducted by the
15 pharmacist to ensure that the drug has not expired, has not been
16 adulterated or misbranded, and is in its original, unopened
17 packaging; and

18 (3) that the dispensing pharmacist, the cancer drug
19 repository, the state Department of Health, and any other
20 participant of the cancer drug repository program cannot
21 guarantee the safety of the drug or supply being dispensed and
22 that the pharmacist has determined that the drug or supply is
23 safe to dispense based on the accuracy of the donor's form
24 submitted with the donated drug or supply and the visual
25 inspection required to be performed by the pharmacist before
26 dispensing.

27 The commissioner shall make the cancer drug repository form
28 available on the Department of Health's Web site.

29 (d) Drugs and supplies shall only be dispensed to
30 individuals who meet the eligibility requirements in subdivision
31 4 and in the following order of priority:

32 (1) individuals who are uninsured;

33 (2) individuals who are enrolled in medical assistance,
34 general assistance medical care, MinnesotaCare, Medicare, or
35 other public assistance health care; and

36 (3) all other individuals who are otherwise eligible under

1 subdivision 4 to receive drugs or supplies from a cancer drug
2 repository.

3 Subd. 7. [HANDLING FEES.] A cancer drug repository may
4 charge the individual receiving a drug or supply a handling fee
5 of no more than 250 percent of the medical assistance program
6 dispensing fee for each cancer drug or supply dispensed.

7 Subd. 8. [DISTRIBUTION OF DONATED CANCER DRUGS AND
8 SUPPLIES.] (a) Cancer drug repositories may distribute drugs and
9 supplies donated under the cancer drug repository program to
10 other repositories if requested by a participating repository.

11 (b) A cancer drug repository that has elected not to
12 dispense donated drugs or supplies shall distribute any donated
13 drugs and supplies to a participating repository upon request of
14 the repository.

15 (c) If a cancer drug repository distributes drugs or
16 supplies under paragraph (a) or (b), the repository shall
17 complete a cancer drug repository donor form provided by the
18 commissioner. The completed form and a copy of the donor form
19 that was completed by the original donor under subdivision 5
20 shall be provided to the fully participating cancer drug
21 repository at the time of distribution.

22 Subd. 9. [RESALE OF DONATED DRUGS OR SUPPLIES.] Donated
23 drugs and supplies may not be resold.

24 Subd. 10. [RECORD-KEEPING REQUIREMENTS.] (a) Cancer drug
25 repository donor and recipient forms shall be maintained for at
26 least five years.

27 (b) A record of destruction of donated drugs and supplies
28 that are not dispensed under subdivision 6 shall be maintained
29 by the dispensing repository for at least five years. For each
30 drug or supply destroyed, the record shall include the following
31 information:

32 (1) the date of destruction;

33 (2) the name, strength, and quantity of the cancer drug
34 destroyed;

35 (3) the name of the person or firm that destroyed the drug;
36 and

1 (4) the source of the drugs or supplies destroyed.

2 Subd. 11. [LIABILITY.] A medical facility, pharmacy,
3 pharmacist, or practitioner participating in the program, or the
4 donor of a cancer drug or supply is immune from civil liability
5 for an act or omission that causes injury to or the death of an
6 individual to whom the cancer drug or supply is dispensed and no
7 disciplinary action shall be taken against a pharmacist or
8 practitioner so long as the drug or supply is donated, accepted,
9 distributed, and dispensed in accordance with the requirements
10 of this section. This immunity does not apply if the act or
11 omission involves reckless, wanton, or intentional misconduct."

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S.F. No. 984 - Services for Persons With Disabilities

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Date: March 8, 2005

S.F. No. 984 modifies a variety of programs affecting persons with disabilities. It reduces parental fees at certain income levels for the parents of certain disabled children on Medical Assistance (MA). It increases MA asset limits for recipients who are aged, blind, or disabled. It modifies targeted case management services and case management services. It restores MA, GAMC, and MinnesotaCare dental benefits for adults to their pre-2003 level. It authorizes a onetime payment of \$3,000 to assist waived services clients moving from a licensed facility to a community setting. It increases the MA personal needs allowance. It provides an unspecified rate increase for intermediate care facilities for persons with mental retardation and for a variety of community-based providers.

Section 1 (252.27, subdivision 2a) modifies the contribution amount for children who are eligible for medical assistance without consideration of parental income due to the children's disabilities. The changes to this statute are in paragraphs (2), (3), and (4).

Under paragraph (2), if the household's adjusted gross income is equal or greater than 175 percent of the federal poverty guidelines (FPG) and less than or equal to 545 percent of FPG, the parental contribution is determined using a sliding fee scale, beginning at one percent and increasing to 7.5 percent. Current law imposes an income ceiling of 375 percent of FPG.

Under paragraph (3), if the parental income is greater than 575 percent, instead of 375 percent, and less than 675 percent, the parental contribution is 7.5 percent of adjusted gross income.

Under paragraph (4), if parental income is equal to or greater than 675 percent but less than 975 percent, the parental contribution is determined using a sliding fee scale, beginning at 7.5 percent and increasing to ten percent of adjusted gross income. Current law requires a flat ten percent fee for incomes between 675 percent and 975 percent of FPG.

Section 2 (256.4825) creates a Disability Services Coordination Commission, states its objectives, establishes commission membership, outlines duties, requires the Council on Disability to provide staff support, and requires a report in 2007.

Section 3 (256B.04, subdivision 20) requires the Department of Human Services (DHS) to consult with private sector health plan companies and develop an incentive program to encourage MA recipients with disabilities to have regular wellness exams.

Section 4 (256B.056, subdivision 3) increases the asset limits for MA eligibility for the aged, blind, or disabled from \$3,000 to \$6,000 for an individual and from \$6,000 to \$18,000 for a family.

Section 5 (256B.056, subdivision 5c) states that the excess income standard for the aged, blind or disabled is 100 percent of FPG.

Section 6 (256B.057, subdivision 9) states that in the MA employed persons with disabilities program for enrollees who are also enrolled in Medicare, the commissioner will reimburse the enrollee for Medicare part B premiums part B. This section also states that increases in benefits under Title II of the Social Security Act shall not be counted as income until July 1 of each year.

Section 7 (256B.0575) lengthens the period of time for allocating income to an MA recipient who is institutionalized but expected to return home eventually. Under current law, income is allocated to the person rather than to the cost of institutional care for up to three months. Under this bill, the allocation would be for up to six months. This section also changes terminology.

Sections 8 to 10 modify the MA covered services for targeted case management.

Section 8 (256B.0621, subdivision 4) requires the commissioner to ensure that each eligible person is given a choice of county and private agency relocation targeted case management service providers. (Relocation targeted case management assists recipients in gaining access to services when moving from an institution to the community.) This section also requires that a subcontracted provider of relocation targeted case management must have a procedure in place that provides full disclosure to the recipient, instead of notifies the recipient, of any conflict of interest if the provider provides or will provide the recipient's housing, services, or supports. This section is effective July 1, 2005, or, if federal waiver is required, on the date the federal waiver is granted.

Section 9 (256B.0621, subdivision 6) modifies MA-eligible services by striking language that stated the assessment of a recipient's need for targeted case management services is eligible for medical assistance reimbursement. This section creates a new paragraph for targeted relocation case management administrative activities. The new language provides that these activities are the responsibility of the county or the agency under contract, and they include: (1) assessment of the recipient's need for targeted case management services; (2) eligibility determination; (3) providing information and assistance to the recipient sufficient to choose a provider of targeted case management services; (4) approval of service plans and necessary contracts; and (5) monitoring spending and evaluating health, safety, welfare, and service outcomes.

Section 10 (256B.0621, subdivision 11) adds a new subdivision, which requires the commissioner, upon admission and annually thereafter, to provide notification to MA-eligible persons who are residing in institutions of the availability of relocation targeted case management services.

Section 11 (256B.0625, subdivision 9) removes the \$500 annual benefit limit on dental services for adults in the MA program and restores the benefits to what they were prior to 2003.

Section 12 (256B.0916, subdivision 10) authorizes a transitional supports allowance for persons receiving waiver services for persons with mental retardation and related conditions who are moving from a licensed setting to a community setting. The allowance is a one-time payment of up to \$3,000 to pay for items not covered by other sources, including rent and security deposits, utility set-up costs, essential furnishings and supplies, and personal supports and transportation needed to locate and transition to community settings.

Sections 13 and 14 (256B.092, subdivision 2a; 256B.092, subdivision 4b) amend the statute dealing with MA for case management activities under the state plan Medicaid option and the statute dealing with case management for persons receiving home and community-based services, respectively. The sections require the commissioner to ensure that each eligible person is given a choice of county and private agency case management services coordination vendors. Further, the commissioner is required, with consumer input, to develop standards, notice requirements, and basic consumer rights so that full disclosure is provided in cases in which a case manager may be providing relocation services, housing, and other support services to the same individual. These sections are effective July 1, 2005, or if a federal waiver is required, on the date the federal waiver is granted.

Section 15 (256B.35, subdivision 1) increases the MA personal needs allowance to \$150.

Section 16 (256B.49, subdivision 13) amends the home and community-based waiver for chronically ill children and disabled persons by requiring the recipient of services to choose a vendor of case management services coordination among qualified public and private vendors. Current law requires the recipient to be provided with a vendor for services. This section also provides case management service "coordination" activities, which include assessing the needs of the individual "as changes occur, but at least annually." Current law requires that case management service activities include assessing the individual within 20 working days of the recipient's request.

A new paragraph is added creating case management administrative activities, which are the responsibility of the county or agency under contract. Case management administrative functions include: (1) screening; (2) assistance with obtaining diagnoses and necessary medical or health reports; (3) eligibility determination; (4) initial assessment within 20 days of request for waiver services; (5) providing information and assistance to the person sufficient to allow the person to choose a vendor of case management services coordination; (6) determination of resources needed to meet assessed needs; (7) approval of services plans and necessary contracts; and (8) monitoring spending and evaluating health, safety, welfare, and service outcomes. This section is effective July 1, 2005, or, if a federal waiver is required, on the date the federal waiver is granted.

Section 17 (256B.49, subdivision 16) authorizes a transitional supports allowance for persons receiving waiver services under one of three waiver programs (Community Alternatives for Disabled Individuals (CADI); Community Alternative Care (CAC); and the Traumatic Brain Injury (TBI) waiver), who are moving from a licensed setting to a community setting. The allowance is a onetime payment of up to \$3,000 to pay for items not covered by other sources, including rent and security deposits, utility set-up costs, essential furnishings and supplies, and personal supports and transportation needed to locate and transition to community settings.

Section 18 (256B.5012, subdivision 6) provides an unspecified rate increase for intermediate care facilities for persons with mental retardation (ICFs/MR) effective January 1, 2006, and January 1, 2007. At least two-thirds of the increase must be used to increase employee salaries and benefits and pay related costs. Facilities must report to DHS on how the additional funding was used.

Section 19 (256B.69, subdivision 23) requires DHS to seek federal approval to expand the Minnesota Disability Health Options (MnDHO) Program in stages, beginning with population centers outside the seven-county metro area and then expanding to all areas of the state.

Section 20 (256B.765) provides an unspecified rate increase each year of the upcoming biennium for a variety of community-based providers. At least two-thirds of the increase must be used to increase employee salaries and benefits and pay related costs. Providers must report to DHS on how the additional funding was used.

Section 21 (256D.03, subdivision 4) removes the \$500 annual benefit limit on dental services and the 50 percent co-payment on restorative dental services for individuals in the general assistance medical care program, restoring the benefits to what they were prior to 2003.

Sections 22 , 23, and 24 (256L.03) restore the adult dental benefits in MinnesotaCare as follows: for adult enrollees with income no greater than 75 percent of FPG, dental coverage is the same as in the MA program, except there is no coverage for orthodontic services and a 50 percent co-payment for services other than preventive care. For pregnant women and children, dental services are the same as in the medical assistance program.

Section 25 requires DHS to request any federal approvals and plan amendments necessary to implement the transitional supports allowance and the case management service coordination choices authorized under this bill.

JW/KC/DG:rdr

Senator Lourey introduced--

S.F. No. 984: Referred to the Committee on Health and Family Security.

1 A bill for an act

2 relating to human services; modifying programs and
 3 services for persons with disabilities; amending
 4 Minnesota Statutes 2004, sections 252.27, subdivision
 5 2a; 256B.04, by adding a subdivision; 256B.056,
 6 subdivisions 3, 5c; 256B.057, subdivision 9;
 7 256B.0575; 256B.0621, subdivisions 4, 6, by adding a
 8 subdivision; 256B.0625, subdivision 9; 256B.0916, by
 9 adding a subdivision; 256B.092, subdivisions 2a, 4b;
 10 256B.35, subdivision 1; 256B.49, subdivisions 13, 16;
 11 256B.5012, by adding a subdivision; 256B.69,
 12 subdivision 23; 256B.765; 256D.03, subdivision 4;
 13 256L.03, subdivisions 1, 5, by adding a subdivision;
 14 proposing coding for new law in Minnesota Statutes,
 15 chapter 256.

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

17 Section 1. Minnesota Statutes 2004, section 252.27,
 18 subdivision 2a, is amended to read:

19 Subd. 2a. [CONTRIBUTION AMOUNT.] (a) The natural or
 20 adoptive parents of a minor child, including a child determined
 21 eligible for medical assistance without consideration of
 22 parental income, must contribute to the cost of services used by
 23 making monthly payments on a sliding scale based on income,
 24 unless the child is married or has been married, parental rights
 25 have been terminated, or the child's adoption is subsidized
 26 according to section 259.67 or through title IV-E of the Social
 27 Security Act.

28 (b) For households with adjusted gross income equal to or
 29 greater than 100 percent of federal poverty guidelines, the
 30 parental contribution shall be computed by applying the

1 following schedule of rates to the adjusted gross income of the
2 natural or adoptive parents:

3 (1) if the adjusted gross income is equal to or greater
4 than 100 percent of federal poverty guidelines and less than 175
5 percent of federal poverty guidelines, the parental contribution
6 is \$4 per month;

7 (2) if the adjusted gross income is equal to or greater
8 than 175 percent of federal poverty guidelines and less than or
9 equal to ~~375~~ 545 percent of federal poverty guidelines, the
10 parental contribution shall be determined using a sliding fee
11 scale established by the commissioner of human services which
12 begins at one percent of adjusted gross income at 175 percent of
13 federal poverty guidelines and increases to 7.5 percent of
14 adjusted gross income for those with adjusted gross income up to
15 ~~375~~ 545 percent of federal poverty guidelines;

16 (3) if the adjusted gross income is greater than ~~375~~ 545
17 percent of federal poverty guidelines and less than 675 percent
18 of federal poverty guidelines, the parental contribution shall
19 be 7.5 percent of adjusted gross income;

20 (4) if the adjusted gross income is equal to or greater
21 than 675 percent of federal poverty guidelines and less than 975
22 percent of federal poverty guidelines, the parental contribution
23 shall be determined using a sliding fee scale established by the
24 commissioner of human services which begins at 7.5 percent of
25 adjusted gross income at 675 percent of federal poverty
26 guidelines and increases to ten percent of adjusted gross income
27 for those with adjusted gross income up to 975 percent of
28 federal poverty guidelines; and

29 (5) if the adjusted gross income is equal to or greater
30 than 975 percent of federal poverty guidelines, the parental
31 contribution shall be 12.5 percent of adjusted gross income.

32 If the child lives with the parent, the annual adjusted
33 gross income is reduced by \$2,400 prior to calculating the
34 parental contribution. If the child resides in an institution
35 specified in section 256B.35, the parent is responsible for the
36 personal needs allowance specified under that section in

1 addition to the parental contribution determined under this
2 section. The parental contribution is reduced by any amount
3 required to be paid directly to the child pursuant to a court
4 order, but only if actually paid.

5 (c) The household size to be used in determining the amount
6 of contribution under paragraph (b) includes natural and
7 adoptive parents and their dependents, including the child
8 receiving services. Adjustments in the contribution amount due
9 to annual changes in the federal poverty guidelines shall be
10 implemented on the first day of July following publication of
11 the changes.

12 (d) For purposes of paragraph (b), "income" means the
13 adjusted gross income of the natural or adoptive parents
14 determined according to the previous year's federal tax form,
15 except, effective retroactive to July 1, 2003, taxable capital
16 gains to the extent the funds have been used to purchase a home
17 shall not be counted as income.

18 (e) The contribution shall be explained in writing to the
19 parents at the time eligibility for services is being
20 determined. The contribution shall be made on a monthly basis
21 effective with the first month in which the child receives
22 services. Annually upon redetermination or at termination of
23 eligibility, if the contribution exceeded the cost of services
24 provided, the local agency or the state shall reimburse that
25 excess amount to the parents, either by direct reimbursement if
26 the parent is no longer required to pay a contribution, or by a
27 reduction in or waiver of parental fees until the excess amount
28 is exhausted.

29 (f) The monthly contribution amount must be reviewed at
30 least every 12 months; when there is a change in household size;
31 and when there is a loss of or gain in income from one month to
32 another in excess of ten percent. The local agency shall mail a
33 written notice 30 days in advance of the effective date of a
34 change in the contribution amount. A decrease in the
35 contribution amount is effective in the month that the parent
36 verifies a reduction in income or change in household size.

1 (g) Parents of a minor child who do not live with each
2 other shall each pay the contribution required under paragraph
3 (a). An amount equal to the annual court-ordered child support
4 payment actually paid on behalf of the child receiving services
5 shall be deducted from the adjusted gross income of the parent
6 making the payment prior to calculating the parental
7 contribution under paragraph (b).

8 (h) The contribution under paragraph (b) shall be increased
9 by an additional five percent if the local agency determines
10 that insurance coverage is available but not obtained for the
11 child. For purposes of this section, "available" means the
12 insurance is a benefit of employment for a family member at an
13 annual cost of no more than five percent of the family's annual
14 income. For purposes of this section, "insurance" means health
15 and accident insurance coverage, enrollment in a nonprofit
16 health service plan, health maintenance organization,
17 self-insured plan, or preferred provider organization.

18 Parents who have more than one child receiving services
19 shall not be required to pay more than the amount for the child
20 with the highest expenditures. There shall be no resource
21 contribution from the parents. The parent shall not be required
22 to pay a contribution in excess of the cost of the services
23 provided to the child, not counting payments made to school
24 districts for education-related services. Notice of an increase
25 in fee payment must be given at least 30 days before the
26 increased fee is due.

27 (i) The contribution under paragraph (b) shall be reduced
28 by \$300 per fiscal year if, in the 12 months prior to July 1:

29 (1) the parent applied for insurance for the child;

30 (2) the insurer denied insurance;

31 (3) the parents submitted a complaint or appeal, in writing
32 to the insurer, submitted a complaint or appeal, in writing, to
33 the commissioner of health or the commissioner of commerce, or
34 litigated the complaint or appeal; and

35 (4) as a result of the dispute, the insurer reversed its
36 decision and granted insurance.

1 For purposes of this section, "insurance" has the meaning
2 given in paragraph (h).

3 A parent who has requested a reduction in the contribution
4 amount under this paragraph shall submit proof in the form and
5 manner prescribed by the commissioner or county agency,
6 including, but not limited to, the insurer's denial of
7 insurance, the written letter or complaint of the parents, court
8 documents, and the written response of the insurer approving
9 insurance. The determinations of the commissioner or county
10 agency under this paragraph are not rules subject to chapter 14.

11 Sec. 2. [256.4825] [DISABILITY SERVICES COORDINATION
12 COMMISSION.]

13 Subdivision 1. [PURPOSE.] The Disability Services
14 Coordination Commission is established for the purposes of
15 obtaining stakeholder input for planning and monitoring the
16 services, programs, and funding aimed at helping people with
17 disabilities to live in more independent settings. The
18 commission's objectives include, but are not limited to:

19 (1) promoting development of affordable and accessible
20 housing;

21 (2) improving the recruitment and retention of direct care
22 support staff;

23 (3) providing information and referral as well as
24 person-centered assessments;

25 (4) allowing funding to follow the individual, rather than
26 the providers;

27 (5) reducing the waiting lists for home and community-based
28 services;

29 (6) increasing employment opportunities for people with
30 disabilities;

31 (7) enhancing data collection activities and systems;

32 (8) improving transportation that complies with the
33 Americans with Disabilities Act; and

34 (9) assuring quality of services based on outcomes.

35 Subd. 2. [MEMBERSHIP.] The governor must appoint ten
36 members to the Disability Services Coordination Commission. The

1 speaker of the house of representatives must appoint three
 2 members of the house of representatives to the commission. The
 3 president of the senate must appoint three members of the senate
 4 to the commission. The commission membership appointed by the
 5 governor must include the following individuals:

6 (1) the commissioner of the Department of Human Services;

7 (2) the commissioner of the Department of Health;

8 (3) the commissioner of the Department of Corrections;

9 (4) the commissioner of the Department of Finance;

10 (5) the commissioner of the Department of Employment and
 11 Economic Development;

12 (6) the commissioner of the Department of Education;

13 (7) the commissioner of the Minnesota Housing Finance
 14 Agency;

15 (8) the Metropolitan Council housing planner;

16 (9) a representative of a public housing authority; and

17 (10) a representative of the counties.

18 Subd. 3. [COMMISSION DUTIES.] The duties of the Disability
 19 Services Coordination commission include, but are not limited to:

20 (1) developing Minnesota's statewide vision and goals,
 21 including specific timelines and targets for community
 22 placement, related to the number of individuals who will receive
 23 nursing home relocation services and transition into community
 24 settings;

25 (2) assessing, coordinating, and tracking current
 26 activities and outcomes as proposed under the various federal
 27 grants provided to support Minnesota's efforts to support
 28 persons with disabilities living more independently in community
 29 settings;

30 (3) ensuring the state budget reflects the planning and
 31 coordination goals;

32 (4) establishing a planning mechanism to ensure ongoing
 33 annual review of disability services plans and goals;

34 (5) appointing individuals within various state agencies to
 35 continue ongoing coordination efforts and annual reports to the
 36 legislature and the Disability Services Coordination Commission;

1 (6) developing a forum for integrating state agency work
 2 plans to implement Minnesota's coordinated plan and ensure open,
 3 regular, public discussion of the plans; and

4 (7) identifying and advocating for integrated strategies to
 5 provide more supportive housing, services, and employment
 6 options to individuals transitioning into community settings.

7 Subd. 4. [MEETINGS.] At a minimum, meetings of the
 8 commission must be conducted in accordance with chapter 13D.
 9 During the 2006-2007 biennium, the commission must meet at least
 10 quarterly.

11 Subd. 5. [COMMISSION STAFF.] Staff support must be
 12 provided by the Minnesota Council on Disability under section
 13 256.482.

14 Subd. 6. [REPORT.] The commission must report to the
 15 legislature on recommended law and policy changes necessary to
 16 meet the objectives under subdivision 1 by November 1, 2007.

17 Sec. 3. Minnesota Statutes 2004, section 256B.04, is
 18 amended by adding a subdivision to read:

19 Subd. 20. [INCENTIVE FOR WELLNESS VISITS.] The
 20 commissioner of human services shall consult with private sector
 21 health plan companies and shall develop an incentive program to
 22 encourage medical assistance enrollees with disabilities to have
 23 regular wellness exams conducted by a primary care physician.
 24 The commissioner shall implement the incentive program beginning
 25 January 1, 2006.

26 Sec. 4. Minnesota Statutes 2004, section 256B.056,
 27 subdivision 3, is amended to read:

28 Subd. 3. [ASSET LIMITATIONS FOR INDIVIDUALS-AND
 29 FAMILIES THE AGED, BLIND, OR DISABLED.] To be eligible for
 30 medical assistance, a person eligible under section 256B.055,
 31 subdivision 7, 7a, or 12 must not individually own more
 32 than ~~\$37,000~~ \$10,000 in assets, or if a member of a household
 33 with two family-members, ~~husband-and-wife, or parent-and~~
 34 ~~child~~ or more persons, the household must not own more
 35 than ~~\$67,000~~ \$18,000 in assets, ~~plus-\$200-for-each-additional~~
 36 ~~legal-dependent.~~ In addition to these maximum amounts, an

1 eligible individual or family may accrue interest on these
2 amounts, but they must be reduced to the maximum at the time of
3 an eligibility redetermination. The accumulation of the
4 clothing and personal needs allowance according to section
5 256B.35 must also be reduced to the maximum at the time of the
6 eligibility redetermination. The value of assets that are not
7 considered in determining eligibility for medical assistance is
8 the value of those assets excluded under the supplemental
9 security income program for aged, blind, and disabled persons,
10 with the following exceptions:

11 (a) Household goods and personal effects are not considered.

12 (b) Capital and operating assets of a trade or business
13 that the local agency determines are necessary to the person's
14 ability to earn an income are not considered.

15 (c) Motor vehicles are excluded to the same extent excluded
16 by the supplemental security income program.

17 (d) Assets designated as burial expenses are excluded to
18 the same extent excluded by the supplemental security income
19 program. Burial expenses funded by annuity contracts or life
20 insurance policies must irrevocably designate the individual's
21 estate as contingent beneficiary to the extent proceeds are not
22 used for payment of selected burial expenses.

23 (e) Effective upon federal approval, for a person who no
24 longer qualifies as an employed person with a disability due to
25 loss of earnings, assets allowed while eligible for medical
26 assistance under section 256B.057, subdivision 9, are not
27 considered for 12 months, beginning with the first month of
28 ineligibility as an employed person with a disability, to the
29 extent that the person's total assets remain within the allowed
30 limits of section 256B.057, subdivision 9, paragraph (b).

31 Sec. 5. Minnesota Statutes 2004, section 256B.056,
32 subdivision 5c, is amended to read:

33 Subd. 5c. [EXCESS INCOME STANDARD.] (a) The excess income
34 standard for families with children is the standard specified in
35 subdivision 4.

36 (b) The excess income standard for a person whose

1 eligibility is based on blindness, disability, or age of 65 or
 2 more years is 70 100 percent of the federal poverty guidelines
 3 for the family size. ~~Effective July 1, 2002, the excess income~~
 4 ~~standard for this paragraph shall equal 75 percent of the~~
 5 ~~federal poverty guidelines.~~

6 Sec. 6. Minnesota Statutes 2004, section 256B.057,
 7 subdivision 9, is amended to read:

8 Subd. 9. [EMPLOYED PERSONS WITH DISABILITIES.] (a) Medical
 9 assistance may be paid for a person who is employed and who:

- 10 (1) meets the definition of disabled under the supplemental
 11 security income program;
 12 (2) is at least 16 but less than 65 years of age;
 13 (3) meets the asset limits in paragraph (b); and
 14 (4) effective November 1, 2003, pays a premium and other
 15 obligations under paragraph (d).

16 Any spousal income or assets shall be disregarded for purposes
 17 of eligibility and premium determinations.

18 After the month of enrollment, a person enrolled in medical
 19 assistance under this subdivision who:

- 20 (1) is temporarily unable to work and without receipt of
 21 earned income due to a medical condition, as verified by a
 22 physician, may retain eligibility for up to four calendar
 23 months; or
 24 (2) effective January 1, 2004, loses employment for reasons
 25 not attributable to the enrollee, may retain eligibility for up
 26 to four consecutive months after the month of job loss. To
 27 receive a four-month extension, enrollees must verify the
 28 medical condition or provide notification of job loss. All
 29 other eligibility requirements must be met and the enrollee must
 30 pay all calculated premium costs for continued eligibility.

31 (b) For purposes of determining eligibility under this
 32 subdivision, a person's assets must not exceed \$20,000,
 33 excluding:

- 34 (1) all assets excluded under section 256B.056;
 35 (2) retirement accounts, including individual accounts,
 36 401(k) plans, 403(b) plans, Keogh plans, and pension plans; and

1 (3) medical expense accounts set up through the person's
2 employer.

3 (c)(1) Effective January 1, 2004, for purposes of
4 eligibility, there will be a \$65 earned income disregard. To be
5 eligible, a person applying for medical assistance under this
6 subdivision must have earned income above the disregard level.

7 (2) Effective January 1, 2004, to be considered earned
8 income, Medicare, Social Security, and applicable state and
9 federal income taxes must be withheld. To be eligible, a person
10 must document earned income tax withholding.

11 (d)(1) A person whose earned and unearned income is equal
12 to or greater than 100 percent of federal poverty guidelines for
13 the applicable family size must pay a premium to be eligible for
14 medical assistance under this subdivision. The premium shall be
15 based on the person's gross earned and unearned income and the
16 applicable family size using a sliding fee scale established by
17 the commissioner, which begins at one percent of income at 100
18 percent of the federal poverty guidelines and increases to 7.5
19 percent of income for those with incomes at or above 300 percent
20 of the federal poverty guidelines. Annual adjustments in the
21 premium schedule based upon changes in the federal poverty
22 guidelines shall be effective for premiums due in July of each
23 year.

24 (2) Effective January 1, 2004, all enrollees must pay a
25 premium to be eligible for medical assistance under this
26 subdivision. An enrollee shall pay the greater of a \$35 premium
27 or the premium calculated in clause (1).

28 (3) Effective November 1, 2003, all enrollees who receive
29 unearned income must pay one-half of one percent of unearned
30 income in addition to the premium amount.

31 (4) Effective ~~November 17, 2003~~ July 1, 2005, for
32 enrollees whose ~~income does not exceed 200 percent of the~~
33 ~~federal poverty guidelines and~~ who are also enrolled in
34 Medicare, the commissioner must reimburse the enrollee for
35 Medicare Part B premiums under section 256B.0625, subdivision
36 15, paragraph (a).

1 (5) Increases in benefits under title II of the Social
2 Security Act shall not be counted as income for purposes of this
3 subdivision until July 1 of each year.

4 (e) A person's eligibility and premium shall be determined
5 by the local county agency. Premiums must be paid to the
6 commissioner. All premiums are dedicated to the commissioner.

7 (f) Any required premium shall be determined at application
8 and redetermined at the enrollee's six-month income review or
9 when a change in income or household size is reported.

10 Enrollees must report any change in income or household size
11 within ten days of when the change occurs. A decreased premium
12 resulting from a reported change in income or household size
13 shall be effective the first day of the next available billing
14 month after the change is reported. Except for changes
15 occurring from annual cost-of-living increases, a change
16 resulting in an increased premium shall not affect the premium
17 amount until the next six-month review.

18 (g) Premium payment is due upon notification from the
19 commissioner of the premium amount required. Premiums may be
20 paid in installments at the discretion of the commissioner.

21 (h) Nonpayment of the premium shall result in denial or
22 termination of medical assistance unless the person demonstrates
23 good cause for nonpayment. Good cause exists if the
24 requirements specified in Minnesota Rules, part 9506.0040,
25 subpart 7, items B to D, are met. Except when an installment
26 agreement is accepted by the commissioner, all persons
27 disenrolled for nonpayment of a premium must pay any past due
28 premiums as well as current premiums due prior to being
29 reenrolled. Nonpayment shall include payment with a returned,
30 refused, or dishonored instrument. The commissioner may require
31 a guaranteed form of payment as the only means to replace a
32 returned, refused, or dishonored instrument.

33 Sec. 7. Minnesota Statutes 2004, section 256B.0575, is
34 amended to read:

35 256B.0575 [AVAILABILITY OF INCOME FOR INSTITUTIONALIZED
36 PERSONS.]

1 When an institutionalized person is determined eligible for
2 medical assistance, the income that exceeds the deductions in
3 paragraphs (a) and (b) must be applied to the cost of
4 institutional care.

5 (a) The following amounts must be deducted from the
6 institutionalized person's income in the following order:

7 (1) the personal needs allowance under section 256B.35 or,
8 for a veteran who does not have a spouse or child, or a
9 surviving spouse of a veteran having no child, the amount of an
10 improved pension received from the veteran's administration not
11 exceeding \$90 per month;

12 (2) the personal allowance for disabled individuals under
13 section 256B.36;

14 (3) if the institutionalized person has a legally appointed
15 guardian or conservator, five percent of the recipient's gross
16 monthly income up to \$100 as reimbursement for guardianship or
17 conservatorship services;

18 (4) a monthly income allowance determined under section
19 256B.058, subdivision 2, but only to the extent income of the
20 institutionalized spouse is made available to the community
21 spouse;

22 (5) a monthly allowance for children under age 18 which,
23 together with the net income of the children, would provide
24 income equal to the medical assistance standard for families and
25 children according to section 256B.056, subdivision 4, for a
26 family size that includes only the minor children. This
27 deduction applies only if the children do not live with the
28 community spouse and only to the extent that the deduction is
29 not included in the personal needs allowance under section
30 256B.35, subdivision 1, as child support garnished under a court
31 order;

32 (6) a monthly family allowance for other family members,
33 equal to one-third of the difference between 122 percent of the
34 federal poverty guidelines and the monthly income for that
35 family member;

36 (7) reparations payments made by the Federal Republic of

1 Germany and reparations payments made by the Netherlands for
2 victims of Nazi persecution between 1940 and 1945;

3 (8) all other exclusions from income for institutionalized
4 persons as mandated by federal law; and

5 (9) amounts for reasonable expenses incurred for necessary
6 medical or remedial care for the institutionalized person that
7 are not medical assistance covered expenses and that are not
8 subject to payment by a third party.

9 For purposes of clause (6), "other family member" means a
10 person who resides with the community spouse and who is a minor
11 or dependent child, dependent parent, or dependent sibling of
12 either spouse. "Dependent" means a person who could be claimed
13 as a dependent for federal income tax purposes under the
14 Internal Revenue Code.

15 (b) Income shall be allocated to an institutionalized
16 person for a period of up to three six calendar months, in an
17 amount equal to 100 percent of the medical-assistance-standard
18 federal poverty guidelines for a family size of one if:

19 (1) a physician certifies that the person is expected to
20 reside in the long-term care facility for three six calendar
21 months or less;

22 (2) if the person has expenses of maintaining a residence
23 in the community; and

24 (3) if one of the following circumstances apply:

25 (i) the person was not living together with a spouse or a
26 family member as defined in paragraph (a) when the person
27 entered a long-term care facility; or

28 (ii) the person and the person's spouse become
29 institutionalized on the same date, in which case the allocation
30 shall be applied to the income of one of the spouses.

31 For purposes of this paragraph, a person is determined to be
32 residing in a licensed nursing home, regional treatment center,
33 or medical institution if the person is expected to remain for a
34 period of one full calendar month or more.

35 Sec. 8. Minnesota Statutes 2004, section 256B.0621,
36 subdivision 4, is amended to read:

1 Subd. 4. [RELOCATION TARGETED CASE MANAGEMENT PROVIDER
2 QUALIFICATIONS.] (a) A relocation targeted case management
3 provider is an enrolled medical assistance provider who is
4 determined by the commissioner to have all of the following
5 characteristics:

6 (1) the legal authority to provide public welfare under
7 sections 393.01, subdivision 7; and 393.07; or a federally
8 recognized Indian tribe;

9 (2) the demonstrated capacity and experience to provide the
10 components of case management to coordinate and link community
11 resources needed by the eligible population;

12 (3) the administrative capacity and experience to serve the
13 target population for whom it will provide services and ensure
14 quality of services under state and federal requirements;

15 (4) the legal authority to provide complete investigative
16 and protective services under section 626.556, subdivision 10;
17 and child welfare and foster care services under section 393.07,
18 subdivisions 1 and 2; or a federally recognized Indian tribe;

19 (5) a financial management system that provides accurate
20 documentation of services and costs under state and federal
21 requirements; and

22 (6) the capacity to document and maintain individual case
23 records under state and federal requirements.

24 (b) The commissioner shall ensure that each eligible person
25 is given a choice of county and private agency relocation
26 targeted case management service providers.

27 (c) A provider of targeted case management under section
28 256B.0625, subdivision 20, may be deemed a certified provider of
29 relocation targeted case management.

30 ~~(c)~~ (d) A relocation targeted case management provider may
31 subcontract with another provider to deliver relocation targeted
32 case management services. Subcontracted providers must
33 demonstrate the ability to provide the services outlined in
34 subdivision 6, and have a procedure in place that notifies
35 provides full disclosure to the recipient and the recipient's
36 legal representative of any conflict of interest if the

1 contracted targeted case management provider also provides, or
 2 will provide, the recipient's housing, services and, or
 3 supports. Contracted providers must provide information on all
 4 conflicts of interest and obtain the recipient's informed
 5 consent or provide the recipient with alternatives.

6 [EFFECTIVE DATE.] This section is effective July 1, 2005,
 7 or, if a federal waiver is required, on the date the federal
 8 waiver is granted.

9 Sec. 9. Minnesota Statutes 2004, section 256B.0621,
 10 subdivision 6, is amended to read:

11 Subd. 6. [ELIGIBLE SERVICES.] (a) Services eligible for
 12 medical assistance reimbursement as targeted case management
 13 service coordination include:

14 ~~(1) assessment-of-the-recipient's-need-for-targeted-case~~
 15 ~~management-services;~~

16 ~~(2)~~ development, completion, and regular review of a
 17 written individual service plan, which is based upon the
 18 assessment of the recipient's needs and choices, and which will
 19 ensure access to medical, social, educational, and other related
 20 services and supports;

21 ~~(3)~~ (2) routine contact or communication with the
 22 recipient, recipient's family, primary caregiver, legal
 23 representative, substitute care provider, service providers, or
 24 other relevant persons identified as necessary to the
 25 development or implementation of the goals of the individual
 26 service plan;

27 ~~(4)~~ (3) coordinating referrals for, and the provision of,
 28 case management services for the recipient with appropriate
 29 service providers, consistent with section 1902(a)(23) of the
 30 Social Security Act;

31 ~~(5)~~ (4) coordinating and monitoring the overall service
 32 delivery to ensure quality of services, appropriateness, and
 33 continued need;

34 ~~(6)~~ (5) completing and maintaining necessary documentation
 35 that supports and verifies the activities in this subdivision;

36 ~~(7)~~ (6) traveling to conduct a visit with the recipient or

1 other relevant person necessary to develop or implement the
2 goals of the individual service plan; and

3 ~~(8)~~ (7) coordinating with the institution discharge planner
4 in the 180-day period before the recipient's discharge.

5 (b) Targeted relocation case management administrative
6 activities are the responsibility of the county or the agency
7 under contract. Targeted relocation case management
8 administrative activities include:

9 (1) assessment of the recipient's need for targeted case
10 management services;

11 (2) eligibility determination;

12 (3) providing information and assistance to the recipient
13 or their legal representative sufficient to allow the recipient
14 to choose a provider of targeted case management services;

15 (4) approval of service plans and necessary contracts; and

16 (5) monitoring spending and evaluating health, safety,
17 welfare, and service outcomes.

18 Sec. 10. Minnesota Statutes 2004, section 256B.0621, is
19 amended by adding a subdivision to read:

20 Subd. 11. [NOTICE OF RELOCATION TARGETED CASE MANAGEMENT
21 AVAILABILITY.] Upon admission and annually thereafter, the
22 commissioner shall provide notification to medical assistance
23 eligible persons who are residing in institutions of the
24 availability of relocation targeted case management services.

25 Sec. 11. Minnesota Statutes 2004, section 256B.0625,
26 subdivision 9, is amended to read:

27 Subd. 9. [DENTAL SERVICES.] ~~(a)~~ Medical assistance covers
28 dental services. Dental services include, with prior
29 authorization, fixed bridges that are cost-effective for persons
30 who cannot use removable dentures because of their medical
31 condition.

32 ~~(b)-Coverage-of-dental-services-for-adults-age-21-and-over~~
33 ~~who-are-not-pregnant-is-subject-to-a-\$500-annual-benefit-limit~~
34 ~~and-covered-services-are-limited-to:~~

35 ~~(1)-diagnostic-and-preventative-services;~~

36 ~~(2)-restorative-services;-and~~

1 ~~(3)-emergency-services-~~

2 ~~Emergency-services,-dentures,-and-extractions-related-to~~
3 ~~dentures-are-not-included-in-the-\$500-annual-benefit-limit-~~

4 Sec. 12. Minnesota Statutes 2004, section 256B.0916, is
5 amended by adding a subdivision to read:

6 Subd. 10. [TRANSITIONAL SUPPORTS ALLOWANCE.] A
7 transitional supports allowance shall be available to all
8 persons under a home and community-based waiver who are moving
9 from a licensed setting to a community setting. "Transitional
10 supports allowance" means a onetime payment of up to \$3,000, to
11 cover the costs, not covered by other sources, associated with
12 moving from a licensed setting to a community setting. Covered
13 costs include:

- 14 (1) lease or rent deposits;
15 (2) security deposits;
16 (3) utilities set-up costs, including telephone;
17 (4) essential furnishings and supplies; and
18 (5) personal supports and transports needed to locate and
19 transition to community settings.

20 [EFFECTIVE DATE.] This section is effective upon federal
21 approval and to the extent approved as a federal waiver
22 amendment.

23 Sec. 13. Minnesota Statutes 2004, section 256B.092,
24 subdivision 2a, is amended to read:

25 Subd. 2a. [MEDICAL ASSISTANCE FOR CASE MANAGEMENT
26 ACTIVITIES UNDER THE STATE PLAN MEDICAID OPTION.] (a) Upon
27 receipt of federal approval, the commissioner shall make
28 payments to approved vendors of case management services
29 participating in the medical assistance program to reimburse
30 costs for providing case management service activities to
31 medical assistance eligible persons with mental retardation or a
32 related condition, in accordance with the state Medicaid plan
33 and federal requirements and limitations.

34 (b) The commissioner shall ensure that each eligible person
35 is given a choice of county and private agency case management
36 service coordination vendors.

1 (c) The commissioner shall, with consumer input, develop
2 standards, notice requirements, and basic consumer rights so
3 that full disclosure is provided in cases in which a case
4 manager may be providing relocation services, housing, or other
5 support services to the same individual.

6 [EFFECTIVE DATE.] This section is effective July 1, 2005,
7 or, if a federal waiver is required, on the date the federal
8 waiver is granted.

9 Sec. 14. Minnesota Statutes 2004, section 256B.092,
10 subdivision 4b, is amended to read:

11 Subd. 4b. [CASE MANAGEMENT FOR PERSONS RECEIVING HOME AND
12 COMMUNITY-BASED SERVICES.] (a) Persons authorized for and
13 receiving home and community-based services may select from
14 public and private vendors of case management which have
15 provider agreements with the state to provide home and
16 community-based case management service activities. This
17 subdivision-becomes-effective-July-17-1992,-only-if-the-state
18 agency-is-unable-to-secure-federal-approval-for-limiting-choice
19 of-case-management-vendors-to-the-county-of-financial
20 responsibility.

21 (b) The commissioner shall ensure that each eligible person
22 is given a choice of county and private agency case management
23 service coordination vendors.

24 (c) The commissioner shall, with consumer input, develop
25 standards, notice requirements, and basic consumer rights so
26 that full disclosure is provided in cases in which a case
27 manager may be providing relocation services, housing, or other
28 support services to the same individual.

29 [EFFECTIVE DATE.] This section is effective July 1, 2005,
30 or, if a federal waiver is required, on the date the federal
31 waiver is granted.

32 Sec. 15. Minnesota Statutes 2004, section 256B.35,
33 subdivision 1, is amended to read:

34 Subdivision 1. [PERSONAL NEEDS ALLOWANCE.] (a)
35 Notwithstanding any law to the contrary, welfare allowances for
36 clothing and personal needs for individuals receiving medical

1 assistance while residing in any skilled nursing home,
 2 intermediate care facility, or medical institution including
 3 recipients of supplemental security income, in this state shall
 4 not be less than \$45 \$150 per month from all sources. When
 5 benefit amounts for Social Security or supplemental security
 6 income recipients are increased pursuant to United States Code,
 7 title 42, sections 415(i) and 1382f, the commissioner shall,
 8 effective in the month in which the increase takes effect,
 9 increase by the same percentage to the nearest whole dollar the
 10 clothing and personal needs allowance for individuals receiving
 11 medical assistance while residing in any skilled nursing home,
 12 medical institution, or intermediate care facility. The
 13 commissioner shall provide timely notice to local agencies,
 14 providers, and recipients of increases under this provision.

15 (b) The personal needs allowance may be paid as part of the
 16 Minnesota supplemental aid program, notwithstanding the
 17 provisions of section 256D.37, subdivision 2, and payments to
 18 recipients of Minnesota supplemental aid may be made once each
 19 three months covering liabilities that accrued during the
 20 preceding three months.

21 (c) The personal needs allowance shall be increased to
 22 include income garnished for child support under a court order,
 23 up to a maximum of \$250 per month but only to the extent that
 24 the amount garnished is not deducted as a monthly allowance for
 25 children under section 256B.0575, paragraph (a), clause (5).

26 Sec. 16. Minnesota Statutes 2004, section 256B.49,
 27 subdivision 13, is amended to read:

28 Subd. 13. [CASE MANAGEMENT SERVICE COORDINATION AND
 29 ADMINISTRATIVE ACTIVITIES.] (a) Each recipient of a home and
 30 community-based waiver shall ~~be provided~~ choose a vendor of case
 31 management services-by service coordination from among qualified
 32 public and private vendors as described in the federally
 33 approved waiver application. The case management
 34 service coordination activities provided will include:

35 (1) assessing the needs of the individual ~~within-20-working~~
 36 ~~days-of-a-recipient's-request~~ as changes occur, but at least

1 annually;

2 (2) developing the written individual service plan within
3 ten working days after the assessment is completed;

4 (3) informing the recipient or the recipient's legal
5 guardian or conservator of service options;

6 (4) assisting the recipient in the identification of
7 potential service providers;

8 (5) assisting the recipient to access services;

9 (6) coordinating, evaluating, and monitoring of the
10 services identified in the service plan;

11 (7) completing the annual reviews of the service plan; and

12 (8) informing the recipient or legal representative of the
13 right to have assessments completed and service plans developed
14 within specified time periods, and to appeal county action or
15 inaction under section 256.045, subdivision 3.

16 (b) Case management administrative activities are the
17 responsibility of the county or agency under contract. Case
18 management administrative functions include:

19 (1) screening;

20 (2) assistance with obtaining diagnoses and necessary
21 medical or health reports;

22 (3) eligibility determination;

23 (4) initial assessment within 20 days of a request for
24 waiver services;

25 (5) providing information and assistance to the person or
26 their legal representative sufficient to allow the person to
27 choose a vendor of case management service coordination;

28 (6) determination of resources needed to meet assessed
29 needs;

30 (7) approval of service plans and necessary contracts; and

31 (8) monitoring spending and evaluating health, safety,
32 welfare, and service outcomes.

33 (c) The case manager may delegate certain aspects of the
34 case management service activities to another individual
35 provided there is oversight by the case manager. The case
36 manager may not delegate those aspects which require

1 professional judgment including assessments, reassessments, and
2 care plan development.

3 [EFFECTIVE DATE.] This section is effective July 1, 2005,
4 or, if a federal waiver is required, on the date the federal
5 waiver is granted.

6 Sec. 17. Minnesota Statutes 2004, section 256B.49,
7 subdivision 16, is amended to read:

8 Subd. 16. [SERVICES AND SUPPORTS.] (a) Services and
9 supports included in the home and community-based waivers for
10 persons with disabilities shall meet the requirements set out in
11 United States Code, title 42, section 1396n. The services and
12 supports, which are offered as alternatives to institutional
13 care, shall promote consumer choice, community inclusion,
14 self-sufficiency, and self-determination.

15 (b) Beginning January 1, 2003, the commissioner shall
16 simplify and improve access to home and community-based waived
17 services, to the extent possible, through the establishment of a
18 common service menu that is available to eligible recipients
19 regardless of age, disability type, or waiver program.

20 (c) Consumer directed community support services shall be
21 offered as an option to all persons eligible for services under
22 subdivision 11, by January 1, 2002.

23 (d) Services and supports shall be arranged and provided
24 consistent with individualized written plans of care for
25 eligible waiver recipients.

26 (e) A transitional supports allowance shall be available to
27 all persons under a home and community-based waiver who are
28 moving from a licensed setting to a community setting.

29 "Transitional supports allowance" means a onetime payment of up
30 to \$3,000, to cover the costs, not covered by other sources,
31 associated with moving from a licensed setting to a community
32 setting. Covered costs include:

33 (1) lease or rent deposits;

34 (2) security deposits;

35 (3) utilities set-up costs, including telephone;

36 (4) essential furnishings and supplies; and

1 (5) personal supports and transports needed to locate and
2 transition to community settings.

3 (f) The state of Minnesota and county agencies that
4 administer home and community-based waived services for
5 persons with disabilities, shall not be liable for damages,
6 injuries, or liabilities sustained through the purchase of
7 supports by the individual, the individual's family, legal
8 representative, or the authorized representative with funds
9 received through the consumer-directed community support service
10 under this section. Liabilities include but are not limited
11 to: workers' compensation liability, the Federal Insurance
12 Contributions Act (FICA), or the Federal Unemployment Tax Act
13 (FUTA).

14 [EFFECTIVE DATE.] This section is effective upon federal
15 approval and to the extent approved as a federal waiver
16 amendment.

17 Sec. 18. Minnesota Statutes 2004, section 256B.5012, is
18 amended by adding a subdivision to read:

19 Subd. 6. [ICF/MR RATE INCREASES BEGINNING JANUARY 1, 2006,
20 AND JANUARY 1, 2007.] For the rate years beginning January 1,
21 2006, and January 1, 2007, the commissioner shall provide
22 facilities reimbursed under this section an adjustment to the
23 total operating payment rate of percent. At least
24 two-thirds of each year's adjustment must be used for increased
25 costs of employee salaries and benefits and associated costs for
26 FICA, the Medicare tax, workers' compensation premiums, and
27 federal and state unemployment insurance. Each facility
28 receiving an adjustment shall report to the commissioner, in the
29 form and manner specified by the commissioner, on how the
30 additional funding was used.

31 Sec. 19. Minnesota Statutes 2004, section 256B.69,
32 subdivision 23, is amended to read:

33 Subd. 23. [ALTERNATIVE INTEGRATED LONG-TERM CARE SERVICES;
34 ELDERLY AND DISABLED PERSONS.] (a) The commissioner may
35 implement demonstration projects to create alternative
36 integrated delivery systems for acute and long-term care

1 services to elderly persons and persons with disabilities as
2 defined in section 256B.77, subdivision 7a, that provide
3 increased coordination, improve access to quality services, and
4 mitigate future cost increases. The commissioner may seek
5 federal authority to combine Medicare and Medicaid capitation
6 payments for the purpose of such demonstrations. Medicare funds
7 and services shall be administered according to the terms and
8 conditions of the federal waiver and demonstration provisions.
9 For the purpose of administering medical assistance funds,
10 demonstrations under this subdivision are subject to
11 subdivisions 1 to 22. The provisions of Minnesota Rules, parts
12 9500.1450 to 9500.1464, apply to these demonstrations, with the
13 exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457,
14 subpart 1, items B and C, which do not apply to persons
15 enrolling in demonstrations under this section. An initial open
16 enrollment period may be provided. Persons who disenroll from
17 demonstrations under this subdivision remain subject to
18 Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is
19 enrolled in a health plan under these demonstrations and the
20 health plan's participation is subsequently terminated for any
21 reason, the person shall be provided an opportunity to select a
22 new health plan and shall have the right to change health plans
23 within the first 60 days of enrollment in the second health
24 plan. Persons required to participate in health plans under
25 this section who fail to make a choice of health plan shall not
26 be randomly assigned to health plans under these demonstrations.
27 Notwithstanding section 256L.12, subdivision 5, and Minnesota
28 Rules, part 9505.5220, subpart 1, item A, if adopted, for the
29 purpose of demonstrations under this subdivision, the
30 commissioner may contract with managed care organizations,
31 including counties, to serve only elderly persons eligible for
32 medical assistance, elderly and disabled persons, or disabled
33 persons only. For persons with primary diagnoses of mental
34 retardation or a related condition, serious and persistent
35 mental illness, or serious emotional disturbance, the
36 commissioner must ensure that the county authority has approved

1 the demonstration and contracting design. Enrollment in these
2 projects for persons with disabilities shall be voluntary. The
3 commissioner shall not implement any demonstration project under
4 this subdivision for persons with primary diagnoses of mental
5 retardation or a related condition, serious and persistent
6 mental illness, or serious emotional disturbance, without
7 approval of the county board of the county in which the
8 demonstration is being implemented.

9 (b) Notwithstanding chapter 245B, sections 252.40 to
10 252.46, 256B.092, 256B.501 to 256B.5015, and Minnesota Rules,
11 parts 9525.0004 to 9525.0036, 9525.1200 to 9525.1330, 9525.1580,
12 and 9525.1800 to 9525.1930, the commissioner may implement under
13 this section projects for persons with developmental
14 disabilities. The commissioner may capitate payments for ICF/MR
15 services, waived services for mental retardation or related
16 conditions, including case management services, day training and
17 habilitation and alternative active treatment services, and
18 other services as approved by the state and by the federal
19 government. Case management and active treatment must be
20 individualized and developed in accordance with a
21 person-centered plan. Costs under these projects may not exceed
22 costs that would have been incurred under fee-for-service.
23 Beginning July 1, 2003, and until two years after the pilot
24 project implementation date, subcontractor participation in the
25 long-term care developmental disability pilot is limited to a
26 nonprofit long-term care system providing ICF/MR services, home
27 and community-based waiver services, and in-home services to no
28 more than 120 consumers with developmental disabilities in
29 Carver, Hennepin, and Scott Counties. The commissioner shall
30 report to the legislature prior to expansion of the
31 developmental disability pilot project. This paragraph expires
32 two years after the implementation date of the pilot project.

33 (c) Before implementation of a demonstration project for
34 disabled persons, the commissioner must provide information to
35 appropriate committees of the house of representatives and
36 senate and must involve representatives of affected disability

1 groups in the design of the demonstration projects.

2 (d) A nursing facility reimbursed under the alternative
3 reimbursement methodology in section 256B.434 may, in
4 collaboration with a hospital, clinic, or other health care
5 entity provide services under paragraph (a). The commissioner
6 shall amend the state plan and seek any federal waivers
7 necessary to implement this paragraph.

8 (e) The commissioner shall seek federal approval to expand
9 the Minnesota disability health options (MnDHO) program
10 established under this subdivision in stages, first to regional
11 population centers outside the seven-county metro area and then
12 to all areas of the state.

13 Sec. 20. Minnesota Statutes 2004, section 256B.765, is
14 amended to read:

15 256B.765 [PROVIDER RATE INCREASES.]

16 Subdivision 1. [ANNUAL INFLATION ADJUSTMENTS.] (a)
17 Effective July 1, 2001, within the limits of appropriations
18 specifically for this purpose, the commissioner shall provide an
19 annual inflation adjustment for the providers listed
20 in ~~paragraph-(c)~~ subdivision 2. The index for the inflation
21 adjustment must be based on the change in the Employment Cost
22 Index for Private Industry Workers - Total Compensation
23 forecasted by Data Resources, Inc., as forecasted in the fourth
24 quarter of the calendar year preceding the fiscal year. The
25 commissioner shall increase reimbursement or allocation rates by
26 the percentage of this adjustment, and county boards shall
27 adjust provider contracts as needed.

28 (b) The commissioner of finance shall include an annual
29 inflationary adjustment in reimbursement rates for the providers
30 listed in ~~paragraph-(c)~~ subdivision 2 using the inflation factor
31 specified in paragraph (a) as a budget change request in each
32 biennial detailed expenditure budget submitted to the
33 legislature under section 16A.11.

34 ~~(c)~~ Subd. 2. [ELIGIBLE PROVIDERS.] The annual adjustment
35 under subdivision 1, paragraph (a), shall be provided for home
36 and community-based waiver services for persons with mental

1 retardation or related conditions under section 256B.501; home
2 and community-based waiver services for the elderly under
3 section 256B.0915; waived services under community
4 alternatives for disabled individuals under section 256B.49;
5 community alternative care waived services under section
6 256B.49; traumatic brain injury waived services under section
7 256B.49; nursing services and home health services under section
8 256B.0625, subdivision 6a; personal care services and nursing
9 supervision of personal care services under section 256B.0625,
10 subdivision 19a; private duty nursing services under section
11 256B.0625, subdivision 7; day training and habilitation services
12 for adults with mental retardation or related conditions under
13 sections 252.40 to 252.46; physical therapy services under
14 sections 256B.0625, subdivision 8, and 256D.03, subdivision 4;
15 occupational therapy services under sections 256B.0625,
16 subdivision 8a, and 256D.03, subdivision 4; speech-language
17 therapy services under section 256D.03, subdivision 4, and
18 Minnesota Rules, part 9505.0390; respiratory therapy services
19 under section 256D.03, subdivision 4, and Minnesota Rules, part
20 9505.0295; alternative care services under section 256B.0913;
21 adult residential program grants under Minnesota Rules, parts
22 9535.2000 to 9535.3000; adult and family community support
23 grants under Minnesota Rules, parts 9535.1700 to 9535.1760;
24 semi-independent living services under section 252.275 including
25 SILS funding under county social services grants formerly funded
26 under chapter 256I; and community support services for deaf and
27 hard-of-hearing adults with mental illness who use or wish to
28 use sign language as their primary means of communication.

29 Subd. 3. [RATE INCREASE FOR BIENNIUM BEGINNING JULY 1,
30 2005.] For the fiscal years beginning July 1, 2005, and July 1,
31 2006, the commissioner shall increase reimbursement rates for
32 the providers listed in subdivision 2 by percent. At
33 least two-thirds of each year's adjustment must be used for
34 increased costs of employee salaries and benefits and associated
35 costs for FICA, the Medicare tax, workers' compensation
36 premiums, and federal and state unemployment insurance. Each

1 provider receiving an adjustment shall report to the
2 commissioner, in the form and manner specified by the
3 commissioner, on how the additional funding was used.

4 Sec. 21. Minnesota Statutes 2004, section 256D.03,
5 subdivision 4, is amended to read:

6 Subd. 4. [GENERAL ASSISTANCE MEDICAL CARE; SERVICES.]

7 (a)(i) For a person who is eligible under subdivision 3,
8 paragraph (a), clause (2), item (i), general assistance medical
9 care covers, except as provided in paragraph (c):

10 (1) inpatient hospital services;

11 (2) outpatient hospital services;

12 (3) services provided by Medicare certified rehabilitation
13 agencies;

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

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

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

22 (7) hearing aids;

23 (8) prosthetic devices;

24 (9) laboratory and X-ray services;

25 (10) physician's services;

26 (11) medical transportation except special transportation;

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

29 (13) podiatric services;

30 (14) dental services ~~and dentures, subject to the~~
31 ~~limitations specified in section 256B.0625, subdivision 9~~ as
32 covered under the medical assistance program;

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

36 (16) day treatment services for mental illness provided

1 under contract with the county board;

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

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

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

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

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

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

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

1 deductible is required for each inpatient hospitalization.

2 (b) Gender reassignment surgery and related services are
3 not covered services under this subdivision unless the
4 individual began receiving gender reassignment services prior to
5 July 1, 1995.

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

32 (d) Recipients eligible under subdivision 3, paragraph (a),
33 clause (2), item (i), shall pay the following co-payments for
34 services provided on or after October 1, 2003:

35 (1) \$3 per nonpreventive visit. For purposes of this
36 subdivision, a visit means an episode of service which is

1 required because of a recipient's symptoms, diagnosis, or
2 established illness, and which is delivered in an ambulatory
3 setting by a physician or physician ancillary, chiropractor,
4 podiatrist, nurse midwife, advanced practice nurse, audiologist,
5 optician, or optometrist;

6 (2) \$25 for eyeglasses;

7 (3) \$25 for nonemergency visits to a hospital-based
8 emergency room; and

9 (4) \$3 per brand-name drug prescription and \$1 per generic
10 drug prescription, subject to a \$20 per month maximum for
11 prescription drug co-payments. No co-payments shall apply to
12 antipsychotic drugs when used for the treatment of mental
13 illness;--and

14 ~~(5) 50-percent-coinsurance-on-restorative-dental-services.~~

15 (e) Co-payments shall be limited to one per day per
16 provider for nonpreventive visits, eyeglasses, and nonemergency
17 visits to a hospital-based emergency room. Recipients of
18 general assistance medical care are responsible for all
19 co-payments in this subdivision. The general assistance medical
20 care reimbursement to the provider shall be reduced by the
21 amount of the co-payment, except that reimbursement for
22 prescription drugs shall not be reduced once a recipient has
23 reached the \$20 per month maximum for prescription drug
24 co-payments. The provider collects the co-payment from the
25 recipient. Providers may not deny services to recipients who
26 are unable to pay the co-payment, except as provided in
27 paragraph (f).

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

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

35 (h) Chemical dependency services that are reimbursed under
36 chapter 254B must not be reimbursed under general assistance

1 medical care.

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

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

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

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

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

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

22 Sec. 22. Minnesota Statutes 2004, section 256L.03,
23 subdivision 1, is amended to read:

24 Subdivision 1. [COVERED HEALTH SERVICES.] For individuals
25 under section 256L.04, subdivision 7, with income no greater
26 than 75 percent of the federal poverty guidelines or for
27 families with children under section 256L.04, subdivision 1, all
28 subdivisions of this section apply. "Covered health services"
29 means the health services reimbursed under chapter 256B, with
30 the exception of inpatient hospital services, special education
31 services, private duty nursing services, adult dental care
32 services other-than-services except as covered under section
33 ~~256B-06257~~ subdivision ~~97-paragraph-(b)7-orthodontic-services~~
34 3b, nonemergency medical transportation services, personal care
35 assistant and case management services, nursing home or
36 intermediate care facilities services, inpatient mental health

1 services, and chemical dependency services. Outpatient mental
 2 health services covered under the MinnesotaCare program are
 3 limited to diagnostic assessments, psychological testing,
 4 explanation of findings, medication management by a physician,
 5 day treatment, partial hospitalization, and individual, family,
 6 and group psychotherapy.

7 No public funds shall be used for coverage of abortion
 8 under MinnesotaCare except where the life of the female would be
 9 endangered or substantial and irreversible impairment of a major
 10 bodily function would result if the fetus were carried to term;
 11 or where the pregnancy is the result of rape or incest.

12 Covered health services shall be expanded as provided in
 13 this section.

14 Sec. 23. Minnesota Statutes 2004, section 256L.03, is
 15 amended by adding a subdivision to read:

16 Subd. 3b. [DENTAL SERVICES EFFECTIVE JULY 1, 2005.] (a)
 17 Effective July 1, 2005, the provisions in paragraphs (b) and (c)
 18 apply.

19 (b) For parents, grandparents, foster parents, relative
 20 caretakers, and legal guardians eligible under section 256L.04,
 21 subdivision 1, with incomes not exceeding 75 percent of the
 22 federal poverty guidelines, dental services are covered as
 23 provided under section 256B.0625, subdivision 9, except that no
 24 coverage is provided for orthodontic services.

25 (c) For pregnant women and children under age 21, dental
 26 services are covered as provided under section 256B.0625,
 27 subdivision 9.

28 Sec. 24. Minnesota Statutes 2004, section 256L.03,
 29 subdivision 5, is amended to read:

30 Subd. 5. [CO-PAYMENTS AND COINSURANCE.] (a) Except as
 31 provided in paragraphs (b) and (c), the MinnesotaCare benefit
 32 plan shall include the following co-payments and coinsurance
 33 requirements for all enrollees:

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

1 family;

2 (2) \$3 per prescription for adult enrollees;

3 (3) \$25 for eyeglasses for adult enrollees; and

4 (4) 50 percent of the fee-for-service rate for adult dental
5 care services other than preventive care services for persons
6 eligible under ~~section-256B.047-subdivisions-1-to-77-with-income~~
7 ~~equal-to-or-less-than-175-percent-of-the-federal-poverty~~
8 ~~guidelines~~ subdivision 3b, paragraph (b).

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

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

19 (d) Adult enrollees with family gross income that exceeds
20 175 percent of the federal poverty guidelines and who are not
21 pregnant shall be financially responsible for the coinsurance
22 amount, if applicable, and amounts which exceed the \$10,000
23 inpatient hospital benefit limit.

24 (e) When a MinnesotaCare enrollee becomes a member of a
25 prepaid health plan, or changes from one prepaid health plan to
26 another during a calendar year, any charges submitted towards
27 the \$10,000 annual inpatient benefit limit, and any
28 out-of-pocket expenses incurred by the enrollee for inpatient
29 services, that were submitted or incurred prior to enrollment,
30 or prior to the change in health plans, shall be disregarded.

31 Sec. 25. [FEDERAL APPROVAL.]

32 By August 1, 2005, the commissioner of human services shall
33 request any federal approval and plan amendments necessary to
34 implement (1) the transitional supports allowance under
35 Minnesota Statutes, sections 256B.0916, subdivision 10; and
36 256B.49, subdivision 16; and (2) the choice of case management

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[REVISOR] SGS/BT 05-2412

1 service coordination provisions under Minnesota Statutes,
2 sections 256B.0621, subdivision 4; 256B.092, subdivisions 2a and
3 4b; and 256B.49, subdivision 13.

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S.F. No. 984 - Services for Persons With Disabilities (The Delete-Everything Amendment)

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Date: March 10, 2005

S.F. No. 984 modifies a variety of programs affecting persons with disabilities. It increases MA asset limits for recipients who are aged, blind, or disabled. It modifies various case management provisions. It restores MA, GAMC, and MinnesotaCare dental benefits for adults. It authorizes a onetime payment of \$3,000 to assist waived services clients moving from a licensed facility to a community setting. It increases the MA personal needs allowance. It provides an unspecified rate increase for intermediate care facilities for persons with mental retardation and for a variety of community-based providers.

Section 1 (256B.04, subdivision 20) requires the Department of Human Services (DHS) to consult with private sector health plan companies and develop an incentive program to encourage MA recipients with disabilities to have regular wellness exams.

Section 2 (256B.056, subdivision 3) increases the asset limits for MA eligibility for the aged, blind, or disabled from \$3,000 to \$10,000 for an individual and from \$6,000 to \$18,000 for a family.

Section 3 (256B.056, subdivision 5c) sets the excess income standard for the aged, blind or disabled at 100 percent of the federal poverty guidelines (FPG).

Section 4 (256B.057, subdivision 9) states that in the MA employed persons with disabilities program for enrollees who are also enrolled in Medicare, the commissioner will reimburse the enrollee for Medicare part B premiums regardless of income. This section also states that increases

in benefits under Title II of the Social Security Act shall not be counted as income until July 1 of each year.

Section 5 (256B.0575) lengthens the period of time for allocating income to an MA recipient who is institutionalized but expected to return home eventually. Under current law, income is allocated to the person rather than to the cost of institutional care for up to three months. Under this bill, the allocation would be for up to six months. This section also changes terminology.

Sections 6 to 11 modify MA targeted case management services.

Section 6 (256B.0621, subdivision 2) broadens the definition of “relocation targeted case management” to include both targeted case management, which the bill renames county targeted case management, and service coordination services.

Section 7 (256B.0621, subdivision 3) postpones eligibility for home care targeted case management services for certain recipients of home care services from January 1, 2003, until July 1, 2005.

Section 8 (256B.0621, subdivision 4) assigns to counties the duty to require contracted providers of relocation targeted case management services to disclose to the recipient all conflicts of interest and obtain the recipient’s informed consent or provide the recipient with alternatives.

Section 9 (256B.0621, subdivision 5) modifies provider qualifications for the broadened relocation targeted case management service. Providers must meet the standards in subdivision 4 or the qualifications in this subdivision. Qualifications are added regarding financial conflicts of interest.

Section 10 (256B.0621, subdivision 6) requires the county to provide service coordinator provider options to persons choosing to relocate at the first contact and upon request. It also lists the services included in relocation targeted county case management and in relocation service coordination.

Section 11 (256B.0621, subdivision 7) requires relocation targeted case management recipients to be assigned a county case manager. Current law refers only to case manager. If the county, its contractor, or a tribe does not provide case management services as required, the recipient may obtain relocation service coordination from a qualified provider. The option to receive targeted case management services from an alternative qualified provider is stricken.

Section 12 (256B.0621, subdivision 11) adds a new subdivision, which requires the commissioner to execute an agreement with the federal government to obtain the minimum data set in order to assist residents who want to leave nursing homes. The commissioner must enter into agreements with community organizations to help persons move into the community. Upon admission and annually thereafter, the commissioner must provide notification to MA-eligible persons who are residing in institutions of the availability of relocation targeted case management services.

Section 13 (256B.0622, subdivision 2) modifies several definitions.

Section 14 (256B.0625, subdivision 9) removes the \$500 annual benefit limit on dental services for adults in the MA program and restores the benefits to what they were prior to 2003.

Section 15 (256B.0916, subdivision 10) authorizes a transitional supports allowance for persons receiving waiver services for persons with mental retardation and related conditions who are moving from a licensed setting to a community setting. The allowance is a one-time payment of up to \$3,000 to pay for items not covered by other sources, including rent and security deposits, utility set-up costs, essential furnishings and supplies, and personal supports and transportation needed to locate and transition to community settings.

Section 16 (256B.092, subdivision 4b) requires recipients of waiver services for persons with developmental disabilities to select from public vendors of county case management services but requires DHS to ensure them a choice between county and private service coordination vendors. This section is effective July 1, 2005, or upon federal approval if required.

Section 17 (256B.35, subdivision 1) increases the MA personal needs allowance to \$150.

Section 18 (256B.49, subdivision 13) amends the home and community-based waiver for chronically ill children and disabled persons (CADI, CAC, and TBI waivers) by requiring the recipient of services to be provided county case management and service coordination. The client must be allowed to choose a county or private services coordination provider. This section also modifies the description of case management services and adds a description of service coordination activities. This section is effective July 1, 2005, or, if a federal waiver is required, on the date the federal waiver is granted.

Section 19 (256B.49, subdivision 14) specifies that recipient assessments and reassessments are the duty of the county case manager.

Section 20 (256B.49, subdivision 16) authorizes a transitional supports allowance for persons receiving waiver services under one of three waiver programs (Community Alternatives for Disabled Individuals (CADI); Community Alternative Care (CAC); and the Traumatic Brain Injury (TBI) waiver), who are moving from a licensed setting to a community setting. The allowance is a onetime payment of up to \$3,000 to pay for items not covered by other sources, including rent and security deposits, utility set-up costs, essential furnishings and supplies, and personal supports and transportation needed to locate and transition to community settings.

Section 21 (256B.5012, subdivision 6) provides an unspecified rate increase for intermediate care facilities for persons with mental retardation (ICFs/MR) effective January 1, 2006, and January 1, 2007. At least two-thirds of the increase must be used to increase employee salaries and benefits and pay related costs. Facilities must report to DHS on how the additional funding was used.

Section 22 (256B.69, subdivision 23) requires DHS to seek federal approval to expand the Minnesota Disability Health Options (MnDHO) Program in stages, beginning with population centers outside the seven-county metro area and then expanding to all areas of the state.

Section 23 (256B.765) provides an unspecified rate increase each year of the upcoming biennium for a variety of community-based providers. At least two-thirds of the increase must be used to increase employee salaries and benefits and pay related costs. Providers must report to DHS on how the additional funding was used.

Section 24 (256D.03, subdivision 4) removes the \$500 annual benefit limit on dental services and the 50 percent co-payment on restorative dental services for individuals in the general assistance medical care program, restoring the benefits to what they were prior to 2003.

Sections 25 and 26 (256L.03) restore the adult dental benefits in MinnesotaCare as follows: for adult enrollees who are parents or single adults with income under 75 percent of FPG, dental coverage is the same as in the MA program. For pregnant women and children, dental services are the same as in the MA program.

Section 27 requires DHS to request any federal approvals and plan amendments necessary to implement the transitional supports allowance and the case management service coordination choices authorized under this bill.

Section 28 requires DHS to study access to dental services for persons with disabilities and present recommendations to the legislature by January 15, 2006.

Section 29 requires the establishment of an interagency work group to study issues surrounding efforts by persons with disabilities to relocate from or avoid placement in an institution. A report is due by October 15, 2006.

JW/KC/DG:rdr

1 Senator ^{Lourey}..... moves to amend S.F. No. 984 as follows:

2 Delete everything after the enacting clause and insert:

3 "Section 1. Minnesota Statutes 2004, section 256B.04, is
4 amended by adding a subdivision to read:

5 Subd. 20. [INCENTIVE FOR WELLNESS VISITS.] The
6 commissioner of human services shall consult with private sector
7 health plan companies and shall develop an incentive program to
8 encourage medical assistance enrollees with disabilities to have
9 regular wellness exams conducted by a primary care physician.
10 The commissioner shall implement the incentive program beginning
11 January 1, 2006.

12 Sec. 2. Minnesota Statutes 2004, section 256B.056,
13 subdivision 3, is amended to read:

14 Subd. 3. [~~ASSET LIMITATIONS FOR INDIVIDUALS-AND~~
15 ~~FAMILIES~~ THE AGED, BLIND, OR DISABLED.] To be eligible for
16 medical assistance, a person whose eligibility category is based
17 on blindness, disability, or age of 65 or more years must not
18 individually own more than ~~\$3,000~~ \$10,000 in assets, or if a
19 member of a household with two ~~family-members, husband-and-wife,~~
20 ~~or-parent-and-child~~ or more persons, the household must not own
21 more than ~~\$6,000~~ \$18,000 in assets, ~~plus-\$200-for-each~~
22 ~~additional-legal-dependent.~~ In addition to these maximum
23 amounts, an eligible individual or family may accrue interest on
24 these amounts, but they must be reduced to the maximum at the
25 time of an eligibility redetermination. The accumulation of the
26 clothing and personal needs allowance according to section
27 256B.35 must also be reduced to the maximum at the time of the
28 eligibility redetermination. The value of assets that are not
29 considered in determining eligibility for medical assistance is
30 the value of those assets excluded under the supplemental
31 security income program for aged, blind, and disabled persons,
32 with the following exceptions:

33 (a) Household goods and personal effects are not considered.

34 (b) Capital and operating assets of a trade or business
35 that the local agency determines are necessary to the person's
36 ability to earn an income are not considered.

1 (c) Motor vehicles are excluded to the same extent excluded
2 by the supplemental security income program.

3 (d) Assets designated as burial expenses are excluded to
4 the same extent excluded by the supplemental security income
5 program. Burial expenses funded by annuity contracts or life
6 insurance policies must irrevocably designate the individual's
7 estate as contingent beneficiary to the extent proceeds are not
8 used for payment of selected burial expenses.

9 (e) Effective upon federal approval, for a person who no
10 longer qualifies as an employed person with a disability due to
11 loss of earnings, assets allowed while eligible for medical
12 assistance under section 256B.057, subdivision 9, are not
13 considered for 12 months, beginning with the first month of
14 ineligibility as an employed person with a disability, to the
15 extent that the person's total assets remain within the allowed
16 limits of section 256B.057, subdivision 9, paragraph (b).

17 (f) Assets owned by children are not considered.

18 Sec. 3. Minnesota Statutes 2004, section 256B.056,
19 subdivision 5c, is amended to read:

20 Subd. 5c. [EXCESS INCOME STANDARD.] (a) The excess income
21 standard for families with children is the standard specified in
22 subdivision 4.

23 (b) The excess income standard for a person whose
24 eligibility is based on blindness, disability, or age of 65 or
25 more years is 70 100 percent of the federal poverty guidelines
26 for the family size. ~~Effective-July-17-2002,-the-excess-income~~
27 ~~standard-for-this-paragraph-shall-equal-75-percent-of-the~~
28 ~~federal-poverty-guidelines-~~

29 Sec. 4. Minnesota Statutes 2004, section 256B.057,
30 subdivision 9, is amended to read:

31 Subd. 9. [EMPLOYED PERSONS WITH DISABILITIES.] (a) Medical
32 assistance may be paid for a person who is employed and who:

33 (1) meets the definition of disabled under the supplemental
34 security income program;

35 (2) is at least 16 but less than 65 years of age;

36 (3) meets the asset limits in paragraph (b); and

1 (4) effective November 1, 2003, pays a premium and other
2 obligations under paragraph (d).

3 Any spousal income or assets shall be disregarded for purposes
4 of eligibility and premium determinations.

5 After the month of enrollment, a person enrolled in medical
6 assistance under this subdivision who:

7 (1) is temporarily unable to work and without receipt of
8 earned income due to a medical condition, as verified by a
9 physician, may retain eligibility for up to four calendar
10 months; or

11 (2) effective January 1, 2004, loses employment for reasons
12 not attributable to the enrollee, may retain eligibility for up
13 to four consecutive months after the month of job loss. To
14 receive a four-month extension, enrollees must verify the
15 medical condition or provide notification of job loss. All
16 other eligibility requirements must be met and the enrollee must
17 pay all calculated premium costs for continued eligibility.

18 (b) For purposes of determining eligibility under this
19 subdivision, a person's assets must not exceed \$20,000,
20 excluding:

21 (1) all assets excluded under section 256B.056;

22 (2) retirement accounts, including individual accounts,
23 401(k) plans, 403(b) plans, Keogh plans, and pension plans; and

24 (3) medical expense accounts set up through the person's
25 employer.

26 (c) (1) Effective January 1, 2004, for purposes of
27 eligibility, there will be a \$65 earned income disregard. To be
28 eligible, a person applying for medical assistance under this
29 subdivision must have earned income above the disregard level.

30 (2) Effective January 1, 2004, to be considered earned
31 income, Medicare, Social Security, and applicable state and
32 federal income taxes must be withheld. To be eligible, a person
33 must document earned income tax withholding.

34 (d) (1) A person whose earned and unearned income is equal
35 to or greater than 100 percent of federal poverty guidelines for
36 the applicable family size must pay a premium to be eligible for

1 medical assistance under this subdivision. The premium shall be
2 based on the person's gross earned and unearned income and the
3 applicable family size using a sliding fee scale established by
4 the commissioner, which begins at one percent of income at 100
5 percent of the federal poverty guidelines and increases to 7.5
6 percent of income for those with incomes at or above 300 percent
7 of the federal poverty guidelines. Annual adjustments in the
8 premium schedule based upon changes in the federal poverty
9 guidelines shall be effective for premiums due in July of each
10 year.

11 (2) Effective January 1, 2004, all enrollees must pay a
12 premium to be eligible for medical assistance under this
13 subdivision. An enrollee shall pay the greater of a \$35 premium
14 or the premium calculated in clause (1).

15 (3) Effective November 1, 2003, all enrollees who receive
16 unearned income must pay one-half of one percent of unearned
17 income in addition to the premium amount.

18 (4) Effective ~~November 1, 2003~~ July 1, 2005, for
19 enrollees ~~whose income does not exceed 200 percent of the~~
20 ~~federal poverty guidelines and~~ who are also enrolled in
21 Medicare, the commissioner must reimburse the enrollee for
22 Medicare Part B premiums under section 256B.0625, subdivision
23 15, paragraph (a).

24 (5) Increases in benefits under title II of the Social
25 Security Act shall not be counted as income for purposes of this
26 subdivision until July 1 of each year.

27 (e) A person's eligibility and premium shall be determined
28 by the local county agency. Premiums must be paid to the
29 commissioner. All premiums are dedicated to the commissioner.

30 (f) Any required premium shall be determined at application
31 and redetermined at the enrollee's six-month income review or
32 when a change in income or household size is reported.

33 Enrollees must report any change in income or household size
34 within ten days of when the change occurs. A decreased premium
35 resulting from a reported change in income or household size
36 shall be effective the first day of the next available billing

1 month after the change is reported. Except for changes
2 occurring from annual cost-of-living increases, a change
3 resulting in an increased premium shall not affect the premium
4 amount until the next six-month review.

5 (g) Premium payment is due upon notification from the
6 commissioner of the premium amount required. Premiums may be
7 paid in installments at the discretion of the commissioner.

8 (h) Nonpayment of the premium shall result in denial or
9 termination of medical assistance unless the person demonstrates
10 good cause for nonpayment. Good cause exists if the
11 requirements specified in Minnesota Rules, part 9506.0040,
12 subpart 7, items B to D, are met. Except when an installment
13 agreement is accepted by the commissioner, all persons
14 disenrolled for nonpayment of a premium must pay any past due
15 premiums as well as current premiums due prior to being
16 reenrolled. Nonpayment shall include payment with a returned,
17 refused, or dishonored instrument. The commissioner may require
18 a guaranteed form of payment as the only means to replace a
19 returned, refused, or dishonored instrument.

20 Sec. 5. Minnesota Statutes 2004, section 256B.0575, is
21 amended to read:

22 256B.0575 [AVAILABILITY OF INCOME FOR INSTITUTIONALIZED
23 PERSONS.]

24 When an institutionalized person is determined eligible for
25 medical assistance, the income that exceeds the deductions in
26 paragraphs (a) and (b) must be applied to the cost of
27 institutional care.

28 (a) The following amounts must be deducted from the
29 institutionalized person's income in the following order:

30 (1) the personal needs allowance under section 256B.35 or,
31 for a veteran who does not have a spouse or child, or a
32 surviving spouse of a veteran having no child, the amount of an
33 improved pension received from the veteran's administration not
34 exceeding \$90 per month;

35 (2) the personal allowance for disabled individuals under
36 section 256B.36;

1 (3) if the institutionalized person has a legally appointed
2 guardian or conservator, five percent of the recipient's gross
3 monthly income up to \$100 as reimbursement for guardianship or
4 conservatorship services;

5 (4) a monthly income allowance determined under section
6 256B.058, subdivision 2, but only to the extent income of the
7 institutionalized spouse is made available to the community
8 spouse;

9 (5) a monthly allowance for children under age 18 which,
10 together with the net income of the children, would provide
11 income equal to the medical assistance standard for families and
12 children according to section 256B.056, subdivision 4, for a
13 family size that includes only the minor children. This
14 deduction applies only if the children do not live with the
15 community spouse and only to the extent that the deduction is
16 not included in the personal needs allowance under section
17 256B.35, subdivision 1, as child support garnished under a court
18 order;

19 (6) a monthly family allowance for other family members,
20 equal to one-third of the difference between 122 percent of the
21 federal poverty guidelines and the monthly income for that
22 family member;

23 (7) reparations payments made by the Federal Republic of
24 Germany and reparations payments made by the Netherlands for
25 victims of Nazi persecution between 1940 and 1945;

26 (8) all other exclusions from income for institutionalized
27 persons as mandated by federal law; and

28 (9) amounts for reasonable expenses incurred for necessary
29 medical or remedial care for the institutionalized person that
30 are not medical assistance covered expenses and that are not
31 subject to payment by a third party.

32 For purposes of clause (6), "other family member" means a
33 person who resides with the community spouse and who is a minor
34 or dependent child, dependent parent, or dependent sibling of
35 either spouse. "Dependent" means a person who could be claimed
36 as a dependent for federal income tax purposes under the

1 Internal Revenue Code.

2 (b) Income shall be allocated to an institutionalized
3 person for a period of up to ~~three~~ six calendar months, in an
4 amount equal to 100 percent of the medical-assistance-standard
5 federal poverty guidelines for a family size of one if:

6 (1) a physician certifies that the person is expected to
7 reside in the long-term care facility for ~~three~~ six calendar
8 months or less;

9 (2) if the person has expenses of maintaining a residence
10 in the community; and

11 (3) if one of the following circumstances apply:

12 (i) the person was not living together with a spouse or a
13 family member as defined in paragraph (a) when the person
14 entered a long-term care facility; or

15 (ii) the person and the person's spouse become
16 institutionalized on the same date, in which case the allocation
17 shall be applied to the income of one of the spouses.

18 For purposes of this paragraph, a person is determined to be
19 residing in a licensed nursing home, regional treatment center,
20 or medical institution if the person is expected to remain for a
21 period of one full calendar month or more.

22 Sec. 6. Minnesota Statutes 2004, section 256B.0621,
23 subdivision 2, is amended to read:

24 Subd. 2. [TARGETED CASE MANAGEMENT; DEFINITIONS.] For
25 purposes of subdivisions 3 to 10, the following terms have the
26 meanings given them:

27 (1) "home care service recipients" means those individuals
28 receiving the following services under section 256B.0627:
29 skilled nursing visits, home health aide visits, private duty
30 nursing, personal care assistants, or therapies provided through
31 a home health agency;

32 (2) "home care targeted case management" means the
33 provision of targeted case management services for the purpose
34 of assisting home care service recipients to gain access to
35 needed services and supports so that they may remain in the
36 community;

1 (3) "institutions" means hospitals, consistent with Code of
2 Federal Regulations, title 42, section 440.10; regional
3 treatment center inpatient services, consistent with section
4 245.474; nursing facilities; and intermediate care facilities
5 for persons with mental retardation;

6 (4) "relocation targeted case management" means includes
7 the provision of both county targeted case management and
8 service coordination services for the purpose of assisting
9 recipients to gain access to needed services and supports if
10 they choose to move from an institution to the community.
11 Relocation targeted case management may be provided during the
12 last 180 consecutive days of an eligible recipient's
13 institutional stay; and

14 (5) "targeted case management" means case management
15 services provided to help recipients gain access to needed
16 medical, social, educational, and other services and supports.

17 Sec. 7. Minnesota Statutes 2004, section 256B.0621,
18 subdivision 3, is amended to read:

19 Subd. 3. [ELIGIBILITY.] The following persons are eligible
20 for relocation targeted case management or home care-targeted
21 care targeted case management:

22 (1) medical assistance eligible persons residing in
23 institutions who choose to move into the community are eligible
24 for relocation targeted case management services; and

25 (2) medical assistance eligible persons receiving home care
26 services, who are not eligible for any other medical assistance
27 reimbursable case management service, are eligible for home
28 ~~care-targeted~~ care targeted case management services beginning
29 ~~January-17-2003~~ July 1, 2005.

30 Sec. 8. Minnesota Statutes 2004, section 256B.0621,
31 subdivision 4, is amended to read:

32 Subd. 4. [RELOCATION COUNTY TARGETED CASE MANAGEMENT
33 PROVIDER QUALIFICATIONS.] (a) A relocation targeted county case
34 management provider is an enrolled medical assistance provider
35 who is determined by the commissioner to have all of the
36 following characteristics:

1 (1) the legal authority to provide public welfare under
2 sections 393.01, subdivision 7; and 393.07; or a federally
3 recognized Indian tribe;

4 (2) the demonstrated capacity and experience to provide the
5 components of case management to coordinate and link community
6 resources needed by the eligible population;

7 (3) the administrative capacity and experience to serve the
8 target population for whom it will provide services and ensure
9 quality of services under state and federal requirements;

10 (4) the legal authority to provide complete investigative
11 and protective services under section 626.556, subdivision 10;
12 and child welfare and foster care services under section 393.07,
13 subdivisions 1 and 2; or a federally recognized Indian tribe;

14 (5) a financial management system that provides accurate
15 documentation of services and costs under state and federal
16 requirements; and

17 (6) the capacity to document and maintain individual case
18 records under state and federal requirements.

19 (b) A provider of targeted case management under section
20 256B.0625, subdivision 20, may be deemed a certified provider of
21 relocation targeted case management.

22 (c) A relocation targeted county case management provider
23 may subcontract with another provider to deliver relocation
24 targeted case management services. Subcontracted providers must
25 demonstrate the ability to provide the services outlined in
26 subdivision 6, and have a procedure in place that notifies the
27 recipient and the recipient's legal representative of any
28 conflict of interest if the contracted targeted case management
29 provider also provides, or will provide, the recipient's
30 services and supports. Counties must require that contracted
31 providers must provide information on all conflicts of interest
32 and obtain the recipient's informed consent or provide the
33 recipient with alternatives.

34 Sec. 9. Minnesota Statutes 2004, section 256B.0621,
35 subdivision 5, is amended to read:

36 Subd. 5. [HOME CARE TARGETED CASE MANAGEMENT AND

1 RELOCATION SERVICE COORDINATION PROVIDER QUALIFICATIONS.] The
 2 following-qualifications-and-certification-standards-must-be-met
 3 by Providers of home care targeted case management and
 4 relocation service coordination must meet the qualifications
 5 under subdivision 4 or the following qualifications and
 6 certification standards.

7 (a) The commissioner must certify each provider of home
 8 care targeted case management and relocation service
 9 coordination before enrollment. The certification process shall
 10 examine the provider's ability to meet the requirements in this
 11 subdivision and other state and federal requirements of this
 12 service.

13 (b) ~~A~~ Both home care targeted case management ~~provider-is~~
 14 ~~an~~ providers and relocation service coordination providers are
 15 enrolled medical assistance ~~provider~~ providers who has have a
 16 minimum of a bachelor's degree or a license in a health or human
 17 services field, or comparable training and two years of
 18 experience in human services, and ~~is~~ have been determined by the
 19 commissioner to have all of the following characteristics:

20 (1) the demonstrated capacity and experience to provide the
 21 components of case management to coordinate and link community
 22 resources needed by the eligible population;

23 (2) the administrative capacity and experience to serve the
 24 target population for whom it will provide services and ensure
 25 quality of services under state and federal requirements;

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

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

31 (5) the capacity to coordinate with county administrative
 32 functions;

33 (6) have no financial interest in the provision of
 34 out-of-home residential services to persons for whom targeted
 35 case management or relocation service coordination is provided;
 36 and

1 (7) if a provider has a financial interest in services
2 other than out-of-home residential services provided to persons
3 for whom targeted case management or relocation service
4 coordination is also provided, the county must determine each
5 year that:

6 (i) any possible conflict of interest is explained annually
7 at a face-to-face meeting and in writing and the person provides
8 written informed consent consistent with section 256B.77,
9 subdivision 2, paragraph (p); and

10 (ii) information on a range of other feasible service
11 provider options has been provided.

12 Sec. 10. Minnesota Statutes 2004, section 256B.0621,
13 subdivision 6, is amended to read:

14 Subd. 6. [ELIGIBLE SERVICES.] (a) Services eligible for
15 medical assistance reimbursement as targeted case management
16 include:

17 (1) assessment of the recipient's need for targeted case
18 management services;

19 (2) development, completion, and regular review of a
20 written individual service plan, which is based upon the
21 assessment of the recipient's needs and choices, and which will
22 ensure access to medical, social, educational, and other related
23 services and supports;

24 (3) routine contact or communication with the recipient,
25 recipient's family, primary caregiver, legal representative,
26 substitute care provider, service providers, or other relevant
27 persons identified as necessary to the development or
28 implementation of the goals of the individual service plan;

29 (4) coordinating referrals for, and the provision of, case
30 management services for the recipient with appropriate service
31 providers, consistent with section 1902(a)(23) of the Social
32 Security Act;

33 (5) coordinating and monitoring the overall service
34 delivery and engaging in advocacy as needed to ensure quality of
35 services, appropriateness, and continued need;

36 (6) completing and maintaining necessary documentation that

1 supports and verifies the activities in this subdivision;

2 (7) traveling assisting individuals in order to access
3 needed services, including travel to conduct a visit with the
4 recipient or other relevant person necessary to develop or
5 implement the goals of the individual service plan; and

6 (8) coordinating with the institution discharge planner in
7 the 180-day period before the recipient's discharge.

8 (b) Relocation targeted county case management includes
9 services under paragraph (a), clauses (2) and (4). Relocation
10 service coordination includes services under paragraph (a),
11 clauses (1), (3), and (5) to (8). Home care targeted case
12 management includes services under paragraph (a), clauses (1) to
13 (8).

14 Sec. 11. Minnesota Statutes 2004, section 256B.0621,
15 subdivision 7, is amended to read:

16 Subd. 7. [TIME LINES.] The following time lines must be
17 met for assigning a case manager:

18 (a) For relocation targeted case management, an eligible
19 recipient must be assigned a county case manager who visits the
20 person within 20 working days of requesting a case manager from
21 their county of financial responsibility as determined under
22 chapter 256G.

23 (1) If a county agency, its contractor, or federally
24 recognized tribe does not provide case management services as
25 required, the recipient may obtain ~~targeted-relocation-case~~
26 ~~management-services~~ relocation service coordination from an
27 ~~alternative a provider of-targeted-case-management-services~~
28 ~~enrolled-by-the-commissioner~~ qualified under subdivision 5.

29 (2) The commissioner may waive the provider requirements in
30 subdivision 4, paragraph (a), clauses (1) and (4), to ensure
31 recipient access to the assistance necessary to move from an
32 institution to the community. The recipient or the recipient's
33 legal guardian shall provide written notice to the county or
34 tribe of the decision to obtain services from an alternative
35 provider.

36 (3) Providers of relocation targeted case management

1 enrolled under this subdivision shall:

2 (i) meet the provider requirements under subdivision 4 that
3 are not waived by the commissioner;

4 (ii) be qualified to provide the services specified in
5 subdivision 6;

6 (iii) coordinate efforts with local social service agencies
7 and tribes; and

8 (iv) comply with the conflict of interest provisions
9 established under subdivision 4, paragraph (c).

10 (4) Local social service agencies and federally recognized
11 tribes shall cooperate with providers certified by the
12 commissioner under this subdivision to facilitate the
13 recipient's successful relocation from an institution to the
14 community.

15 (b) For home care targeted case management, an eligible
16 recipient must be assigned a case manager within 20 working days
17 of requesting a case manager from a home care targeted case
18 management provider, as defined in subdivision 5.

19 Sec. 12. Minnesota Statutes 2004, section 256B.0621, is
20 amended by adding a subdivision to read:

21 Subd. 11. [DATA USE AGREEMENT AND NOTICE OF RELOCATION
22 TARGETED CASE MANAGEMENT AVAILABILITY.] (a) The commissioner
23 shall execute a data use agreement with the Center for Medicare
24 and Medicaid Services to obtain the long-term care minimum data
25 set data to assist residents of nursing facilities who have
26 indicated a desire to live in the community. The commissioner
27 shall in turn enter into agreements with the Centers for
28 Independent Living and other disability advocacy organizations
29 to assist persons who want help to move to the community.

30 (b) Upon admission and annually thereafter, the
31 commissioner shall provide notification to medical assistance
32 eligible persons who are residing in institutions of the
33 availability of relocation targeted case management services,
34 including contact information for the responsible county and
35 senior and disability organizations that provide assistance to
36 persons with disabilities.

1 Sec. 13. Minnesota Statutes 2004, section 256B.0625,
2 subdivision 9, is amended to read:

3 Subd. 9. [DENTAL SERVICES.] ~~{a}~~ Medical assistance covers
4 dental services. Dental services include, with prior
5 authorization, fixed bridges that are cost-effective for persons
6 who cannot use removable dentures because of their medical
7 condition.

8 ~~{b}-Coverage-of-dental-services-for-adults-age-21-and-over~~
9 ~~who-are-not-pregnant-is-subject-to-a-\$500-annual-benefit-limit~~
10 ~~and-covered-services-are-limited-to:~~

11 ~~{1}-diagnostic-and-preventative-services;~~

12 ~~{2}-restorative-services;-and~~

13 ~~{3}-emergency-services-~~

14 ~~Emergency-services,-dentures,-and-extractions-related-to~~
15 ~~dentures-are-not-included-in-the-\$500-annual-benefit-limit-~~

16 Sec. 14. Minnesota Statutes 2004, section 256B.0916, is
17 amended by adding a subdivision to read:

18 Subd. 10. [TRANSITIONAL SUPPORTS ALLOWANCE.] A
19 transitional supports allowance shall be available to all
20 persons under a home and community-based waiver who are moving
21 from a licensed setting to a community setting. "Transitional
22 supports allowance" means a onetime payment of up to \$3,000, to
23 cover the costs, not covered by other sources, associated with
24 moving from a licensed setting to a community setting. Covered
25 costs include:

26 (1) lease or rent deposits;

27 (2) security deposits;

28 (3) utilities set-up costs, including telephone;

29 (4) essential furnishings and supplies; and

30 (5) personal supports and transports needed to locate and
31 transition to community settings.

32 [EFFECTIVE DATE.] This section is effective upon federal
33 approval and to the extent approved as a federal waiver
34 amendment.

35 Sec. 15. Minnesota Statutes 2004, section 256B.092,
36 subdivision 4b, is amended to read:

1 Subd. 4b. [COUNTY CASE MANAGEMENT AND SERVICE COORDINATION
2 FOR PERSONS RECEIVING HOME AND COMMUNITY-BASED SERVICES.] (a)
3 Persons authorized for and receiving home and community-based
4 services may select from public vendors of county case
5 management which have provider agreements with the state to
6 provide home and community-based case management service
7 activities. ~~This subdivision becomes effective July 17, 1992,~~
8 ~~only if the state agency is unable to secure federal approval~~
9 ~~for limiting choice of case management vendors to the county of~~
10 ~~financial responsibility.~~

11 (b) The commissioner shall ensure that each eligible person
12 is given a choice between county and private agency service
13 coordination vendors consistent with the provisions of section
14 256B.49, subdivision 13.

15 [EFFECTIVE DATE.] This section is effective July 1, 2005,
16 or, if a federal waiver is required, on the date the federal
17 waiver is granted.

18 Sec. 16. Minnesota Statutes 2004, section 256B.35,
19 subdivision 1, is amended to read:

20 Subdivision 1. [PERSONAL NEEDS ALLOWANCE.] (a)
21 Notwithstanding any law to the contrary, welfare allowances for
22 clothing and personal needs for individuals receiving medical
23 assistance while residing in any skilled nursing home,
24 intermediate care facility, or medical institution including
25 recipients of supplemental security income, in this state shall
26 not be less than \$45 \$150 per month from all sources. When
27 benefit amounts for Social Security or supplemental security
28 income recipients are increased pursuant to United States Code,
29 title 42, sections 415(i) and 1382f, the commissioner shall,
30 effective in the month in which the increase takes effect,
31 increase by the same percentage to the nearest whole dollar the
32 clothing and personal needs allowance for individuals receiving
33 medical assistance while residing in any skilled nursing home,
34 medical institution, or intermediate care facility. The
35 commissioner shall provide timely notice to local agencies,
36 providers, and recipients of increases under this provision.

1 (b) The personal needs allowance may be paid as part of the
2 Minnesota supplemental aid program, notwithstanding the
3 provisions of section 256D.37, subdivision 2, and payments to
4 recipients of Minnesota supplemental aid may be made once each
5 three months covering liabilities that accrued during the
6 preceding three months.

7 (c) The personal needs allowance shall be increased to
8 include income garnished for child support under a court order,
9 up to a maximum of \$250 per month but only to the extent that
10 the amount garnished is not deducted as a monthly allowance for
11 children under section 256B.0575, paragraph (a), clause (5).

12 Sec. 17. Minnesota Statutes 2004, section 256B.49,
13 subdivision 13, is amended to read:

14 Subd. 13. [COUNTY CASE MANAGEMENT AND SERVICE COORDINATION
15 SERVICES.] (a) Each recipient of a home and community-based
16 waiver shall be provided county case management and service
17 coordination services by qualified vendors as described in the
18 federally approved waiver application and offered a choice
19 between county and private vendors for service coordination
20 services. The county case management service
21 activities services to be provided will include:

22 (1) assessing the needs of the individual within 20 working
23 days of a recipient's request;

24 (2) developing the written individual service plan within
25 ten working days after the assessment is completed, including a
26 determination of resources needed to meet assessed needs;

27 (3) informing the recipient or the recipient's legal
28 guardian or conservator of service options; and

29 (4) monitoring and evaluating the overall service plan
30 implementation to assure the recipient's health, safety,
31 welfare, and service outcomes.

32 (b) Each recipient shall be offered a choice of a service
33 coordination vendor among qualified public and private vendors
34 as described in the federally approved waiver application. The
35 service coordination activities include:

36 (1) assisting the recipient to provide medical and other

1 information to determine services needs;

2 (2) assisting the recipient in the identification of
3 potential service providers;

4 ~~(5)~~ (3) assisting the recipient to access services;

5 ~~(6)~~ (4) coordinating, evaluating, and monitoring of the
6 recipient and the services identified in the service plan to
7 assure that the ongoing needs of the recipient are met or
8 changes are made, if needed;

9 ~~(7)~~ (5) assisting the recipient to obtain all information
10 for completing the annual or other reviews described in
11 subdivision 14 of the service plan with the case manager; and

12 (6) participating in meetings and consultations and
13 advocating for the recipient with recipient's service providers,
14 medical providers, and county staff as needed;

15 (7) having no financial interest in out-of-home residential
16 services for persons for whom service coordination is provided;
17 and

18 (8) ~~informing-the-recipient-or-legal-representative-of-the~~
19 ~~right-to-have-assessments-completed-and-service-plans-developed~~
20 ~~within-specified-time-periods,-and-to-appeal-county-action-or~~
21 ~~inaction-under-section-256-045,-subdivision-3~~ if a provider has
22 a financial interest in services other than out-of-home
23 residential services provided to persons for whom targeted case
24 management or relocation service coordination is also provided,
25 the county must determine each year that:

26 (i) any possible conflict of interest is explained annually
27 at a face-to-face meeting and in writing and the person provides
28 written informed consent consistent with section 256B.77,
29 subdivision 2, paragraph (p); and

30 (ii) information on a range of other feasible service
31 provider options has been provided.

32 ~~(b)~~ (c) The case-manager county may delegate certain
33 aspects of the county case management or service coordination
34 activities to another individual provided there is oversight by
35 the case manager. The case manager may not delegate those
36 aspects which require professional judgment including

1 assessments, reassessments, and care plan development.

2 [EFFECTIVE DATE.] This section is effective July 1, 2005,
3 or, if a federal waiver is required, on the date the federal
4 waiver is granted.

5 Sec. 18. Minnesota Statutes 2004, section 256B.49,
6 subdivision 14, is amended to read:

7 Subd. 14. [ASSESSMENT AND REASSESSMENT.] (a) Assessments
8 of each recipient's strengths, informal support systems, and
9 need for services shall be completed by the county case manager
10 within 20 working days of the recipient's request. Reassessment
11 of each recipient's strengths, support systems, and need for
12 services shall be conducted by the county case manager at least
13 every 12 months and at other times when there has been a
14 significant change in the recipient's functioning.

15 (b) Persons with mental retardation or a related condition
16 who apply for services under the nursing facility level waiver
17 programs shall be screened for the appropriate level of care
18 according to section 256B.092.

19 (c) Recipients who are found eligible for home and
20 community-based services under this section before their 65th
21 birthday may remain eligible for these services after their 65th
22 birthday if they continue to meet all other eligibility factors.

23 Sec. 19. Minnesota Statutes 2004, section 256B.49,
24 subdivision 16, is amended to read:

25 Subd. 16. [SERVICES AND SUPPORTS.] (a) Services and
26 supports included in the home and community-based waivers for
27 persons with disabilities shall meet the requirements set out in
28 United States Code, title 42, section 1396n. The services and
29 supports, which are offered as alternatives to institutional
30 care, shall promote consumer choice, community inclusion,
31 self-sufficiency, and self-determination.

32 (b) Beginning January 1, 2003, the commissioner shall
33 simplify and improve access to home and community-based waived
34 services, to the extent possible, through the establishment of a
35 common service menu that is available to eligible recipients
36 regardless of age, disability type, or waiver program.

1 (c) Consumer directed community support services shall be
2 offered as an option to all persons eligible for services under
3 subdivision 11, by January 1, 2002.

4 (d) Services and supports shall be arranged and provided
5 consistent with individualized written plans of care for
6 eligible waiver recipients.

7 (e) A transitional supports allowance shall be available to
8 all persons under a home and community-based waiver who are
9 moving from a licensed setting to a community setting.
10 "Transitional supports allowance" means a onetime payment of up
11 to \$3,000, to cover the costs, not covered by other sources,
12 associated with moving from a licensed setting to a community
13 setting. Covered costs include:

14 (1) lease or rent deposits;

15 (2) security deposits;

16 (3) utilities set-up costs, including telephone;

17 (4) essential furnishings and supplies; and

18 (5) personal supports and transports needed to locate and
19 transition to community settings.

20 (f) The state of Minnesota and county agencies that
21 administer home and community-based waived services for
22 persons with disabilities, shall not be liable for damages,
23 injuries, or liabilities sustained through the purchase of
24 supports by the individual, the individual's family, legal
25 representative, or the authorized representative with funds
26 received through the consumer-directed community support service
27 under this section. Liabilities include but are not limited
28 to: workers' compensation liability, the Federal Insurance
29 Contributions Act (FICA), or the Federal Unemployment Tax Act
30 (FUTA).

31 [EFFECTIVE DATE.] This section is effective upon federal
32 approval and to the extent approved as a federal waiver
33 amendment.

34 Sec. 20. Minnesota Statutes 2004, section 256B.5012, is
35 amended by adding a subdivision to read:

36 Subd. 6. [ICF/MR RATE INCREASES BEGINNING JANUARY 1, 2006,

1 AND JANUARY 1, 2007.] For the rate years beginning January 1,
2 2006, and January 1, 2007, the commissioner shall provide
3 facilities reimbursed under this section an adjustment to the
4 total operating payment rate of percent. At least
5 two-thirds of each year's adjustment must be used for increased
6 costs of employee salaries and benefits and associated costs for
7 FICA, the Medicare tax, workers' compensation premiums, and
8 federal and state unemployment insurance. Each facility
9 receiving an adjustment shall report to the commissioner, in the
10 form and manner specified by the commissioner, on how the
11 additional funding was used.

12 Sec. 21. Minnesota Statutes 2004, section 256B.69,
13 subdivision 23, is amended to read:

14 Subd. 23. [ALTERNATIVE INTEGRATED LONG-TERM CARE SERVICES;
15 ELDERLY AND DISABLED PERSONS.] (a) The commissioner may
16 implement demonstration projects to create alternative
17 integrated delivery systems for acute and long-term care
18 services to elderly persons and persons with disabilities as
19 defined in section 256B.77, subdivision 7a, that provide
20 increased coordination, improve access to quality services, and
21 mitigate future cost increases. The commissioner may seek
22 federal authority to combine Medicare and Medicaid capitation
23 payments for the purpose of such demonstrations. Medicare funds
24 and services shall be administered according to the terms and
25 conditions of the federal waiver and demonstration provisions.
26 For the purpose of administering medical assistance funds,
27 demonstrations under this subdivision are subject to
28 subdivisions 1 to 22. The provisions of Minnesota Rules, parts
29 9500.1450 to 9500.1464, apply to these demonstrations, with the
30 exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457,
31 subpart 1, items B and C, which do not apply to persons
32 enrolling in demonstrations under this section. An initial open
33 enrollment period may be provided. Persons who disenroll from
34 demonstrations under this subdivision remain subject to
35 Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is
36 enrolled in a health plan under these demonstrations and the

1 health plan's participation is subsequently terminated for any
2 reason, the person shall be provided an opportunity to select a
3 new health plan and shall have the right to change health plans
4 within the first 60 days of enrollment in the second health
5 plan. Persons required to participate in health plans under
6 this section who fail to make a choice of health plan shall not
7 be randomly assigned to health plans under these demonstrations.
8 Notwithstanding section 256L.12, subdivision 5, and Minnesota
9 Rules, part 9505.5220, subpart 1, item A, if adopted, for the
10 purpose of demonstrations under this subdivision, the
11 commissioner may contract with managed care organizations,
12 including counties, to serve only elderly persons eligible for
13 medical assistance, elderly and disabled persons, or disabled
14 persons only. For persons with primary diagnoses of mental
15 retardation or a related condition, serious and persistent
16 mental illness, or serious emotional disturbance, the
17 commissioner must ensure that the county authority has approved
18 the demonstration and contracting design. Enrollment in these
19 projects for persons with disabilities shall be voluntary. The
20 commissioner shall not implement any demonstration project under
21 this subdivision for persons with primary diagnoses of mental
22 retardation or a related condition, serious and persistent
23 mental illness, or serious emotional disturbance, without
24 approval of the county board of the county in which the
25 demonstration is being implemented.

26 (b) Notwithstanding chapter 245B, sections 252.40 to
27 252.46, 256B.092, 256B.501 to 256B.5015, and Minnesota Rules,
28 parts 9525.0004 to 9525.0036, 9525.1200 to 9525.1330, 9525.1580,
29 and 9525.1800 to 9525.1930, the commissioner may implement under
30 this section projects for persons with developmental
31 disabilities. The commissioner may capitate payments for ICF/MR
32 services, waived services for mental retardation or related
33 conditions, including case management services, day training and
34 habilitation and alternative active treatment services, and
35 other services as approved by the state and by the federal
36 government. Case management and active treatment must be

1 individualized and developed in accordance with a
2 person-centered plan. Costs under these projects may not exceed
3 costs that would have been incurred under fee-for-service.
4 Beginning July 1, 2003, and until two years after the pilot
5 project implementation date, subcontractor participation in the
6 long-term care developmental disability pilot is limited to a
7 nonprofit long-term care system providing ICF/MR services, home
8 and community-based waiver services, and in-home services to no
9 more than 120 consumers with developmental disabilities in
10 Carver, Hennepin, and Scott Counties. The commissioner shall
11 report to the legislature prior to expansion of the
12 developmental disability pilot project. This paragraph expires
13 two years after the implementation date of the pilot project.

14 (c) Before implementation of a demonstration project for
15 disabled persons, the commissioner must provide information to
16 appropriate committees of the house of representatives and
17 senate and must involve representatives of affected disability
18 groups in the design of the demonstration projects.

19 (d) A nursing facility reimbursed under the alternative
20 reimbursement methodology in section 256B.434 may, in
21 collaboration with a hospital, clinic, or other health care
22 entity provide services under paragraph (a). The commissioner
23 shall amend the state plan and seek any federal waivers
24 necessary to implement this paragraph.

25 (e) The commissioner shall seek federal approval to expand
26 the Minnesota disability health options (MnDHO) program
27 established under this subdivision in stages, first to regional
28 population centers outside the seven-county metro area and then
29 to all areas of the state.

30 Sec. 22. Minnesota Statutes 2004, section 256B.765, is
31 amended to read:

32 256B.765 [PROVIDER RATE INCREASES.]

33 Subdivision 1. [ANNUAL INFLATION ADJUSTMENTS.] (a)

34 Effective July 1, 2001, within the limits of appropriations
35 specifically for this purpose, the commissioner shall provide an
36 annual inflation adjustment for the providers listed

1 in ~~paragraph-(e)~~ subdivision 2. The index for the inflation
2 adjustment must be based on the change in the Employment Cost
3 Index for Private Industry Workers - Total Compensation
4 forecasted by Data Resources, Inc., as forecasted in the fourth
5 quarter of the calendar year preceding the fiscal year. The
6 commissioner shall increase reimbursement or allocation rates by
7 the percentage of this adjustment, and county boards shall
8 adjust provider contracts as needed.

9 (b) The commissioner of finance shall include an annual
10 inflationary adjustment in reimbursement rates for the providers
11 listed in ~~paragraph-(e)~~ subdivision 2 using the inflation factor
12 specified in paragraph (a) as a budget change request in each
13 biennial detailed expenditure budget submitted to the
14 legislature under section 16A.11.

15 ~~(e)~~ Subd. 2. [ELIGIBLE PROVIDERS.] The annual adjustment
16 under subdivision 1, paragraph (a), shall be provided for home
17 and community-based waiver services for persons with mental
18 retardation or related conditions under section 256B.501; home
19 and community-based waiver services for the elderly under
20 section 256B.0915; waived services under community
21 alternatives for disabled individuals under section 256B.49;
22 community alternative care waived services under section
23 256B.49; traumatic brain injury waived services under section
24 256B.49; nursing services and home health services under section
25 256B.0625, subdivision 6a; personal care services and nursing
26 supervision of personal care services under section 256B.0625,
27 subdivision 19a; private duty nursing services under section
28 256B.0625, subdivision 7; day training and habilitation services
29 for adults with mental retardation or related conditions under
30 sections 252.40 to 252.46; physical therapy services under
31 sections 256B.0625, subdivision 8, and 256D.03, subdivision 4;
32 occupational therapy services under sections 256B.0625,
33 subdivision 8a, and 256D.03, subdivision 4; speech-language
34 therapy services under section 256D.03, subdivision 4, and
35 Minnesota Rules, part 9505.0390; respiratory therapy services
36 under section 256D.03, subdivision 4, and Minnesota Rules, part

1 9505.0295; alternative care services under section 256B.0913;
2 adult residential program grants under Minnesota Rules, parts
3 9535.2000 to 9535.3000; adult and family community support
4 grants under Minnesota Rules, parts 9535.1700 to 9535.1760;
5 semi-independent living services under section 252.275 including
6 SILS funding under county social services grants formerly funded
7 under chapter 256I; and community support services for deaf and
8 hard-of-hearing adults with mental illness who use or wish to
9 use sign language as their primary means of communication.

10 Subd. 3. [RATE INCREASE FOR BIENNIUM BEGINNING JULY 1,
11 2005.] For the fiscal years beginning July 1, 2005, and July 1,
12 2006, the commissioner shall increase reimbursement rates for
13 the providers listed in subdivision 2 by percent. At
14 least two-thirds of each year's adjustment must be used for
15 increased costs of employee salaries and benefits and associated
16 costs for FICA, the Medicare tax, workers' compensation
17 premiums, and federal and state unemployment insurance. Each
18 provider receiving an adjustment shall report to the
19 commissioner, in the form and manner specified by the
20 commissioner, on how the additional funding was used.

21 Sec. 23. Minnesota Statutes 2004, section 256D.03,
22 subdivision 4, is amended to read:

23 Subd. 4. [GENERAL ASSISTANCE MEDICAL CARE; SERVICES.]

24 (a)(i) For a person who is eligible under subdivision 3,
25 paragraph (a), clause (2), item (i), general assistance medical
26 care covers, except as provided in paragraph (c):

27 (1) inpatient hospital services;

28 (2) outpatient hospital services;

29 (3) services provided by Medicare certified rehabilitation
30 agencies;

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

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

- 1 (6) eyeglasses and eye examinations provided by a physician
2 or optometrist;
- 3 (7) hearing aids;
- 4 (8) prosthetic devices;
- 5 (9) laboratory and X-ray services;
- 6 (10) physician's services;
- 7 (11) medical transportation except special transportation;
- 8 (12) chiropractic services as covered under the medical
9 assistance program;
- 10 (13) podiatric services;
- 11 (14) dental services and dentures, subject to the
12 limitations specified in section 256B-0625, subdivision 9 as
13 covered under the medical assistance program;
- 14 (15) outpatient services provided by a mental health center
15 or clinic that is under contract with the county board and is
16 established under section 245.62;
- 17 (16) day treatment services for mental illness provided
18 under contract with the county board;
- 19 (17) prescribed medications for persons who have been
20 diagnosed as mentally ill as necessary to prevent more
21 restrictive institutionalization;
- 22 (18) psychological services, medical supplies and
23 equipment, and Medicare premiums, coinsurance and deductible
24 payments;
- 25 (19) medical equipment not specifically listed in this
26 paragraph when the use of the equipment will prevent the need
27 for costlier services that are reimbursable under this
28 subdivision;
- 29 (20) services performed by a certified pediatric nurse
30 practitioner, a certified family nurse practitioner, a certified
31 adult nurse practitioner, a certified obstetric/gynecological
32 nurse practitioner, a certified neonatal nurse practitioner, or
33 a certified geriatric nurse practitioner in independent
34 practice, if (1) the service is otherwise covered under this
35 chapter as a physician service, (2) the service provided on an
36 inpatient basis is not included as part of the cost for

1 inpatient services included in the operating payment rate, and
2 (3) the service is within the scope of practice of the nurse
3 practitioner's license as a registered nurse, as defined in
4 section 148.171;

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

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

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

19 (b) Gender reassignment surgery and related services are
20 not covered services under this subdivision unless the
21 individual began receiving gender reassignment services prior to
22 July 1, 1995.

23 (c) In order to contain costs, the commissioner of human
24 services shall select vendors of medical care who can provide
25 the most economical care consistent with high medical standards
26 and shall where possible contract with organizations on a
27 prepaid capitation basis to provide these services. The
28 commissioner shall consider proposals by counties and vendors
29 for prepaid health plans, competitive bidding programs, block
30 grants, or other vendor payment mechanisms designed to provide
31 services in an economical manner or to control utilization, with
32 safeguards to ensure that necessary services are provided.
33 Before implementing prepaid programs in counties with a county
34 operated or affiliated public teaching hospital or a hospital or
35 clinic operated by the University of Minnesota, the commissioner
36 shall consider the risks the prepaid program creates for the

1 hospital and allow the county or hospital the opportunity to
2 participate in the program in a manner that reflects the risk of
3 adverse selection and the nature of the patients served by the
4 hospital, provided the terms of participation in the program are
5 competitive with the terms of other participants considering the
6 nature of the population served. Payment for services provided
7 pursuant to this subdivision shall be as provided to medical
8 assistance vendors of these services under sections 256B.02,
9 subdivision 8, and 256B.0625. For payments made during fiscal
10 year 1990 and later years, the commissioner shall consult with
11 an independent actuary in establishing prepayment rates, but
12 shall retain final control over the rate methodology.

13 (d) Recipients eligible under subdivision 3, paragraph (a),
14 clause (2), item (i), shall pay the following co-payments for
15 services provided on or after October 1, 2003:

16 (1) \$3 per nonpreventive visit. For purposes of this
17 subdivision, a visit means an episode of service which is
18 required because of a recipient's symptoms, diagnosis, or
19 established illness, and which is delivered in an ambulatory
20 setting by a physician or physician ancillary, chiropractor,
21 podiatrist, nurse midwife, advanced practice nurse, audiologist,
22 optician, or optometrist;

23 (2) \$25 for eyeglasses;

24 (3) \$25 for nonemergency visits to a hospital-based
25 emergency room; and

26 (4) \$3 per brand-name drug prescription and \$1 per generic
27 drug prescription, subject to a \$20 per month maximum for
28 prescription drug co-payments. No co-payments shall apply to
29 antipsychotic drugs when used for the treatment of mental
30 illness; ~~and~~

31 ~~{5}-50-percent-coinsurance-on-restorative-dental-services.~~

32 (e) Co-payments shall be limited to one per day per
33 provider for nonpreventive visits, eyeglasses, and nonemergency
34 visits to a hospital-based emergency room. Recipients of
35 general assistance medical care are responsible for all
36 co-payments in this subdivision. The general assistance medical

1 care reimbursement to the provider shall be reduced by the
2 amount of the co-payment, except that reimbursement for
3 prescription drugs shall not be reduced once a recipient has
4 reached the \$20 per month maximum for prescription drug
5 co-payments. The provider collects the co-payment from the
6 recipient. Providers may not deny services to recipients who
7 are unable to pay the co-payment, except as provided in
8 paragraph (f).

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

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

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

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

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

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

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

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

36 (n) A hospital receiving a reduced payment as a result of

1 this section may apply the unpaid balance toward satisfaction of
2 the hospital's bad debts.

3 Sec. 24. Minnesota Statutes 2004, section 256L.03,
4 subdivision 1, is amended to read:

5 Subdivision 1. [COVERED HEALTH SERVICES.] For individuals
6 under section 256L.04, subdivision 7, with income no greater
7 than 75 percent of the federal poverty guidelines or for
8 families with children under section 256L.04, subdivision 1, all
9 subdivisions of this section apply. "Covered health services"
10 means the health services reimbursed under chapter 256B, with
11 the exception of inpatient hospital services, special education
12 services, private duty nursing services, adult dental care
13 services ~~other-than-services~~ except as covered under section
14 256B.0625, subdivision 9, ~~paragraph-(b),-orthodontic-services,~~
15 nonemergency medical transportation services, personal care
16 assistant and case management services, nursing home or
17 intermediate care facilities services, inpatient mental health
18 services, and chemical dependency services. Outpatient mental
19 health services covered under the MinnesotaCare program are
20 limited to diagnostic assessments, psychological testing,
21 explanation of findings, medication management by a physician,
22 day treatment, partial hospitalization, and individual, family,
23 and group psychotherapy.

24 No public funds shall be used for coverage of abortion
25 under MinnesotaCare except where the life of the female would be
26 endangered or substantial and irreversible impairment of a major
27 bodily function would result if the fetus were carried to term;
28 or where the pregnancy is the result of rape or incest.

29 Covered health services shall be expanded as provided in
30 this section.

31 Sec. 25. Minnesota Statutes 2004, section 256L.03,
32 subdivision 5, is amended to read:

33 Subd. 5. [CO-PAYMENTS AND COINSURANCE.] (a) Except as
34 provided in paragraphs (b) and (c), the MinnesotaCare benefit
35 plan shall include the following co-payments and coinsurance
36 requirements for all enrollees:

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

5 (2) \$3 per prescription for adult enrollees; and

6 (3) \$25 for eyeglasses for adult enrollees; ~~and~~

7 ~~(4) 50 percent of the fee-for-service rate for adult dental~~
 8 ~~care services other than preventive care services for persons~~
 9 ~~eligible under section 256B.047, subdivisions 1 to 7, with income~~
 10 ~~equal to or less than 175 percent of the federal poverty~~
 11 ~~guidelines.~~

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

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

22 (d) Adult enrollees with family gross income that exceeds
 23 175 percent of the federal poverty guidelines and who are not
 24 pregnant shall be financially responsible for the coinsurance
 25 amount, if applicable, and amounts which exceed the \$10,000
 26 inpatient hospital benefit limit.

27 (e) When a MinnesotaCare enrollee becomes a member of a
 28 prepaid health plan, or changes from one prepaid health plan to
 29 another during a calendar year, any charges submitted towards
 30 the \$10,000 annual inpatient benefit limit, and any
 31 out-of-pocket expenses incurred by the enrollee for inpatient
 32 services, that were submitted or incurred prior to enrollment,
 33 or prior to the change in health plans, shall be disregarded.

34 Sec. 26. [FEDERAL APPROVAL.]

35 By August 1, 2005, the commissioner of human services shall
 36 request any federal approval and plan amendments necessary to

1 implement (1) the transitional supports allowance under
2 Minnesota Statutes, sections 256B.0916, subdivision 10; and
3 256B.49, subdivision 16; and (2) the choice of case management
4 service coordination provisions under Minnesota Statutes,
5 sections 256B.0621, subdivision 4; 256B.092, subdivisions 2a and
6 4b; and 256B.49, subdivision 13.

7 Sec. 27. [DENTAL ACCESS FOR PERSONS WITH DISABILITIES.]

8 The commissioner of human services shall study access to
9 dental services for persons with disabilities, and shall present
10 recommendations for improving access to dental services to the
11 legislature by January 15, 2006. The study must examine
12 physical and geographic access, the willingness of dentists to
13 serve persons with disabilities enrolled in state health care
14 programs, reimbursement rates for dental service providers, and
15 other factors identified by the commissioner as potential
16 barriers to accessing dental services.

17 Sec. 28. [DISABILITY SERVICES INTERAGENCY WORK GROUP.]

18 Subdivision 1. [ESTABLISHMENT.] The commissioners of human
19 services and housing finance and the Minnesota Council on
20 Disabilities shall convene an interagency work group of
21 interested stakeholders, including other state agencies,
22 counties, public housing authorities, the Metropolitan Council,
23 disability service providers, and representatives from
24 disability advocacy organizations to identify barriers,
25 strengthen coordination, recommend policy and funding changes,
26 and pursue federal financing that will assist Minnesotans with
27 disabilities who are attempting to relocate from or avoid
28 placement in institutional settings.

29 Subd. 2. [WORK GROUP ACTIVITIES.] The work group shall

30 make recommendations to the state agencies and the legislature
31 related to:

32 (1) coordinating the availability of housing,
33 transportation, and support services needed to discharge persons
34 with disabilities from institutions;

35 (2) improving information and assistance needed to make an
36 informed choice about relocating from an institutional placement

1 to community-based services;

2 (3) identifying gaps in human services, transportation, and
3 housing access that are barriers to moving to community
4 services;

5 (4) identifying strategies that would result in earlier
6 identification of persons most at risk of institutional
7 placement in order to promote diversion to community services or
8 reduce lengths of stay in an institutional facility;

9 (5) identifying funding mechanisms and financial strategies
10 to assure a financially sustainable community support system
11 that diverts and relocates individuals from institutional
12 placement; and

13 (6) identifying state actions needed to address any federal
14 changes affecting policies, benefits, or funding used to support
15 persons with disabilities in avoiding institutional placement.

16 Subd. 3. [RECOMMENDATIONS.] Recommendations of the work
17 group must be submitted to each state agency and to the chairs
18 of the health and human services policy and finance committees
19 of the senate and house of representatives by October 15, 2006."

20 Delete the title and insert:

21 "A bill for an act relating to human services; modifying
22 programs and services for persons with disabilities; amending
23 Minnesota Statutes 2004, sections 256B.04, by adding a
24 subdivision; 256B.056, subdivisions 3, 5c; 256B.057, subdivision
25 9; 256B.0575; 256B.0621, subdivisions 2, 3, 4, 5, 6, 7, by
26 adding a subdivision; 256B.0625, subdivision 9; 256B.0916, by
27 adding a subdivision; 256B.092, subdivision 4b; 256B.35,
28 subdivision 1; 256B.49, subdivisions 13, 14, 16; 256B.5012, by
29 adding a subdivision; 256B.69, subdivision 23; 256B.765;
30 256D.03, subdivision 4; 256L.03, subdivisions 1, 5."

1 Senator *Berfin* moves to amend the delete-everything
2 amendment (SCS0984A-3) to S.F. No. 984 as follows:

3 Page 13, after line 36, insert:

4 "Sec. 13. Minnesota Statutes 2004, section 256B.0622,
5 subdivision 2, is amended to read:

6 Subd. 2. [DEFINITIONS.] For purposes of this section, the
7 following terms have the meanings given them.

8 (a) "Intensive nonresidential rehabilitative mental health
9 services" means adult rehabilitative mental health services as
10 defined in section 256B.0623, subdivision 2, paragraph (a),
11 except that these services are provided by a multidisciplinary
12 staff using a total team approach consistent with assertive
13 community treatment, the Fairweather Lodge treatment model, as
14 defined by the standards established by the National Coalition
15 for Community Living, and other evidence-based practices, and
16 directed to recipients with a serious mental illness who require
17 intensive services.

18 (b) "Intensive residential rehabilitative mental health
19 services" means short-term, time-limited services provided in a
20 residential setting to recipients who are in need of more
21 restrictive settings and are at risk of significant functional
22 deterioration if they do not receive these services. Services
23 are designed to develop and enhance psychiatric stability,
24 personal and emotional adjustment, self-sufficiency, and skills
25 to live in a more independent setting. Services must be
26 directed toward a targeted discharge date with specified client
27 outcomes and must be consistent with the Fairweather Lodge
28 treatment model as defined in paragraph (a), and other
29 evidence-based practices.

30 (c) "Evidence-based practices" are nationally recognized
31 mental health services that are proven by substantial research
32 to be effective in helping individuals with serious mental
33 illness obtain specific treatment goals.

34 (d) "Overnight staff" means a member of the intensive
35 residential rehabilitative mental health treatment team who is
36 responsible during hours when recipients are typically asleep.

1 (e) "Treatment team" means all staff who provide services
2 under this section to recipients. At a minimum, this includes
3 the clinical supervisor, mental health professionals, mental
4 health practitioners, and mental health rehabilitation workers."

5 Renumber the sections in sequence and correct the internal
6 references

7 Amend the title accordingly

Ron Franke Testimony

**Senate Health and Family Security Committee
March 10, 2005**

My name is Ron Franke and I am here to testify in support of Senate File 984. I was diagnosed with Multiple Sclerosis in 1983. After I was diagnosed I continued to work as a geologist until 1986. Then I became a financial planner, a job I kept until the early 1990's when I was forced to quit because of MS.

My MS put me in one medical crisis after another. Late in 2000, I was put into a nursing home for a year because of problems with bedsores. The situation was frustrating.

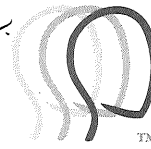
After three surgeries, four infections and five trips to the hospital, I desperately sought an alternative. That alternative came in the way of the Minnesota Disability Health Options program.

This program has allowed me to move home, stay out of the hospital, stay out of the nursing home and get the care I need when I need it. I have also been able to continue my work as a financial planner because of the MA-EPD program since I left the nursing home.

Now when health care issues arise, I just make one phone call and someone helps me to assess and treat whatever symptoms have developed. I know this approach is saving the state money. I would guess that my nursing home stay cost the state almost \$100,000 in health care costs that could have been avoided. Thanks to the Minnesota Disability Health Options program, I no longer amass avoidable hospital bills and nursing home stays.

I currently have an open bedsore that is efficiently being treated at home by nurses and personal care attendants. This does not involve expensive hospitals or doctors. Unfortunately, this program is only available in a few counties in the Metro area, so I support this bill's goal to expand the program to people with disabilities throughout the state.

Tom Gode, Exec. Dir.



Brain Injury
Association
of Minnesota

Brain Injury Association of Minnesota Testimony

Minnesota Senate, Health & Family Security Committee, March 8, 2005

Mr. Chairman, members of the committee, good morning. My name is Tom Gode; I am the Executive Director of the Brain Injury Association of Minnesota. Thank you for the opportunity to speak to you today in support of SF 984. The Brain Injury Association is a statewide nonprofit organization that supports the more than 94,000 Minnesotans who have a disability as a result of traumatic brain injury (TBI).

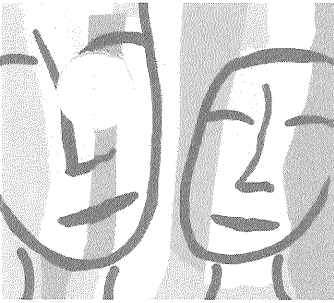
As you are well aware, the Medical Assistance Home and Community Based Waivers, like the Community Alternatives for Disabled Individuals, or CADI, and Traumatic Brain Injury, or TBI Waiver, are for many people the only way out of an institution. For others, it is the tool that enables them to remain living in their home and community when the alternative is to be institutionalized. Individuals with brain injury appear in all of the waivers, they may have co-occurring disabilities or may be misdiagnosed, and they make up a significant portion of individuals with mental illness, chemical dependency, developmental disabilities and the elderly. About 60% of the people currently in nursing facilities in Minnesota under the age of 65 have been diagnosed with a brain injury.

SF 984 goes a long way in addressing a variety of barriers for people with disabilities. Although our organization supports the bill in its entirety, I want to talk with you specifically about the benefits of the relocation service coordination and case management provisions in the bill.

SF 984 strengthens the ability of individuals on Home and Community based waivers, as well as individuals in nursing facilities, to have real choice in relocation service coordination and case management. The Brain Injury Association of Minnesota, along with a small group of other private case management vendors, currently contract out to several counties to provide these services and we know that it can be a success.

These contracts were put into place as a convenience for the counties as case load sizes continue to increase and the county's abilities to meet these demands has become more and more challenging. Private vendors provide counties the flexibility to handle changing case loads, expertise on particular disabilities, cultural or language that compliment and expands that of their own staff and effectively meet the needs of Minnesotans with disabilities. The addition of consumer choice in case management and relocation service coordination empowers consumers, eliminates some current inequities, enhances the overall performance of the waivers and results in increased consumer satisfaction.

We recognize that language allowing counties to contract relocation service coordination and case management services with private vendors needs to be strengthened to allow for real consumer choice. The Consortium of Citizens with Disabilities is continuing conversations with representatives from the counties as well as with DHS on language to



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ensure that the potential for conflict of interest and the separation of the roles of service coordination and eligibility determination are clearly addressed. The potential for conflict of interest is a real concern, and one that we take very seriously. The Brain Injury Association's experience is that counties want to contract with vendors who do not have a potential conflict of interest, but the pool of vendors needs to be large enough to provide real choice.

SF 984 will increase the ability of consumers and counties to access and provide high quality relocation service coordination and case management in a more timely manner by increasing the pool of available providers, allowing access to providers who have expertise in a variety of disabilities, and empowering consumers through real choice. These provisions also facilitate a strong working relationship between private case management providers and counties through collaboration and common vision. Successful relocation service coordination and case management is essential to people with brain injury and other disabilities having the ability to live, work, and play in their own homes, in their own communities. Keeping people out of and from returning to institutions, not only ultimately saves the state money, but speaks to Minnesota's quality of life and reputation as a leader in the healthcare arena

In closing, I want to thank Chairperson Lourey and committee members for listening to my testimony today and I hope that you will support SF 984.

Thank you.

**Senate Counsel, Research,
and Fiscal Analysis**

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Senate

State of Minnesota

S.F. No. 1266 - Modifying Certain Critical Access Hospital Provisions

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Date: March 7, 2005



S.F. No. 1266 modifies the definition of “eligible rural hospital” for the purposes of several grant programs; grants a hospital construction moratorium exception for Critical Access Hospitals (CAHs) that delicensed beds in response to a 1997 federal law; and exempts CAHs from the limits in state law on the amount of swing bed care that can be provided in a hospital.

Section 1 (144.147, subdivision 1) modifies the definition of “eligible rural hospital” in the Rural Hospital Planning and Transition Grant Program to include hospitals located in communities with a population of less than 15,000 persons. The current limit is 10,000.

Section 2 (144.148, subdivision 1) makes the same change for the Rural Hospital Capital Improvement Grant Program.

Section 3 (144.551, subdivision 1) grants an exception to the hospital construction moratorium for any CAH that delicensed beds since the enactment of the federal Balanced Budget Act of 1997, as long as CAHs that add beds do not exceed the CAH bed limit set in federal law.

Section 4 (144.562, subdivision 2) exempts CAHs from the state law that limits hospitals to 1,460 days of swing bed use per year and allows no more than ten beds to be used as swing beds at any one time. The bill allows CAHs to provide swing bed services as provided in federal law.

DG:rdr

Senators Rosen, Wergin, Fischbach and Lourey introduced--
S.F. No. 1266: Referred to the Committee on Health and Family Security.

1 A bill for an act

2 relating to health; modifying certain critical access
3 hospital provisions; amending Minnesota Statutes 2004,
4 sections 144.147, subdivision 1; 144.148, subdivision
5 1; 144.551, subdivision 1; 144.562, subdivision 2.

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

7 Section 1. Minnesota Statutes 2004, section 144.147,
8 subdivision 1, is amended to read:

9 Subdivision 1. [DEFINITION.] "Eligible rural hospital"
10 means any nonfederal, general acute care hospital that:

11 (1) is either located in a rural area, as defined in the
12 federal Medicare regulations, Code of Federal Regulations, title
13 42, section 405.1041, or located in a community with a
14 population of less than ~~±0,000~~ 15,000, according to United
15 States Census Bureau statistics, outside the seven-county
16 metropolitan area;

17 (2) has 50 or fewer beds; and

18 (3) is not for profit.

19 Sec. 2. Minnesota Statutes 2004, section 144.148,
20 subdivision 1, is amended to read:

21 Subdivision 1. [DEFINITION.] (a) For purposes of this
22 section, the following definitions apply.

23 (b) "Eligible rural hospital" means any nonfederal, general
24 acute care hospital that:

25 (1) is either located in a rural area, as defined in the

1 federal Medicare regulations, Code of Federal Regulations, title
2 42, section 405.1041, or located in a community with a
3 population of less than ~~10,000~~ 15,000, according to United
4 States Census Bureau statistics, outside the seven-county
5 metropolitan area;

6 (2) has 50 or fewer beds; and

7 (3) is not for profit.

8 (c) "Eligible project" means a modernization project to
9 update, remodel, or replace aging hospital facilities and
10 equipment necessary to maintain the operations of a hospital.

11 Sec. 3. Minnesota Statutes 2004, section 144.551,
12 subdivision 1, is amended to read:

13 Subdivision 1. [RESTRICTED CONSTRUCTION OR MODIFICATION.]

14 (a) The following construction or modification may not be
15 commenced:

16 (1) any erection, building, alteration, reconstruction,
17 modernization, improvement, extension, lease, or other
18 acquisition by or on behalf of a hospital that increases the bed
19 capacity of a hospital, relocates hospital beds from one
20 physical facility, complex, or site to another, or otherwise
21 results in an increase or redistribution of hospital beds within
22 the state; and

23 (2) the establishment of a new hospital.

24 (b) This section does not apply to:

25 (1) construction or relocation within a county by a
26 hospital, clinic, or other health care facility that is a
27 national referral center engaged in substantial programs of
28 patient care, medical research, and medical education meeting
29 state and national needs that receives more than 40 percent of
30 its patients from outside the state of Minnesota;

31 (2) a project for construction or modification for which a
32 health care facility held an approved certificate of need on May
33 1, 1984, regardless of the date of expiration of the
34 certificate;

35 (3) a project for which a certificate of need was denied
36 before July 1, 1990, if a timely appeal results in an order

1 reversing the denial;

2 (4) a project exempted from certificate of need
3 requirements by Laws 1981, chapter 200, section 2;

4 (5) a project involving consolidation of pediatric
5 specialty hospital services within the Minneapolis-St. Paul
6 metropolitan area that would not result in a net increase in the
7 number of pediatric specialty hospital beds among the hospitals
8 being consolidated;

9 (6) a project involving the temporary relocation of
10 pediatric-orthopedic hospital beds to an existing licensed
11 hospital that will allow for the reconstruction of a new
12 philanthropic, pediatric-orthopedic hospital on an existing site
13 and that will not result in a net increase in the number of
14 hospital beds. Upon completion of the reconstruction, the
15 licenses of both hospitals must be reinstated at the capacity
16 that existed on each site before the relocation;

17 (7) the relocation or redistribution of hospital beds
18 within a hospital building or identifiable complex of buildings
19 provided the relocation or redistribution does not result in:
20 (i) an increase in the overall bed capacity at that site; (ii)
21 relocation of hospital beds from one physical site or complex to
22 another; or (iii) redistribution of hospital beds within the
23 state or a region of the state;

24 (8) relocation or redistribution of hospital beds within a
25 hospital corporate system that involves the transfer of beds
26 from a closed facility site or complex to an existing site or
27 complex provided that: (i) no more than 50 percent of the
28 capacity of the closed facility is transferred; (ii) the
29 capacity of the site or complex to which the beds are
30 transferred does not increase by more than 50 percent; (iii) the
31 beds are not transferred outside of a federal health systems
32 agency boundary in place on July 1, 1983; and (iv) the
33 relocation or redistribution does not involve the construction
34 of a new hospital building;

35 (9) a construction project involving up to 35 new beds in a
36 psychiatric hospital in Rice County that primarily serves

1 adolescents and that receives more than 70 percent of its
2 patients from outside the state of Minnesota;

3 (10) a project to replace a hospital or hospitals with a
4 combined licensed capacity of 130 beds or less if: (i) the new
5 hospital site is located within five miles of the current site;
6 and (ii) the total licensed capacity of the replacement
7 hospital, either at the time of construction of the initial
8 building or as the result of future expansion, will not exceed
9 70 licensed hospital beds, or the combined licensed capacity of
10 the hospitals, whichever is less;

11 (11) the relocation of licensed hospital beds from an
12 existing state facility operated by the commissioner of human
13 services to a new or existing facility, building, or complex
14 operated by the commissioner of human services; from one
15 regional treatment center site to another; or from one building
16 or site to a new or existing building or site on the same
17 campus;

18 (12) the construction or relocation of hospital beds
19 operated by a hospital having a statutory obligation to provide
20 hospital and medical services for the indigent that does not
21 result in a net increase in the number of hospital beds;

22 (13) a construction project involving the addition of up to
23 31 new beds in an existing nonfederal hospital in Beltrami
24 County;

25 (14) a construction project involving the addition of up to
26 eight new beds in an existing nonfederal hospital in Otter Tail
27 County with 100 licensed acute care beds;

28 (15) a construction project involving the addition of 20
29 new hospital beds used for rehabilitation services in an
30 existing hospital in Carver County serving the southwest
31 suburban metropolitan area. Beds constructed under this clause
32 shall not be eligible for reimbursement under medical
33 assistance, general assistance medical care, or MinnesotaCare;

34 (16) a project for the construction or relocation of up to
35 20 hospital beds for the operation of up to two psychiatric
36 facilities or units for children provided that the operation of

1 the facilities or units have received the approval of the
2 commissioner of human services;

3 (17) a project involving the addition of 14 new hospital
4 beds to be used for rehabilitation services in an existing
5 hospital in Itasca County; or

6 (18) a project to add 20 licensed beds in existing space at
7 a hospital in Hennepin County that closed 20 rehabilitation beds
8 in 2002, provided that the beds are used only for rehabilitation
9 in the hospital's current rehabilitation building. If the beds
10 are used for another purpose or moved to another location, the
11 hospital's licensed capacity is reduced by 20 beds; or

12 (19) a critical access hospital established under section
13 144.1483, clause (10), and section 1820 of the federal Social
14 Security Act, United States Code, title 42, section 1395i-4,
15 that delicensed beds since enactment of the Balanced Budget Act
16 of 1997, Public Law 105-33, to the extent that the critical
17 access hospital does not seek to exceed the maximum number of
18 beds permitted such hospital under federal law.

19 Sec. 4. Minnesota Statutes 2004, section 144.562,
20 subdivision 2, is amended to read:

21 Subd. 2. [ELIGIBILITY FOR LICENSE CONDITION.] A hospital
22 is not eligible to receive a license condition for swing beds
23 unless (1) it either has a licensed bed capacity of less than 50
24 beds defined in the federal Medicare regulations, Code of
25 Federal Regulations, title 42, section 482.66, or it has a
26 licensed bed capacity of 50 beds or more and has swing beds that
27 were approved for Medicare reimbursement before May 1, 1985, or
28 it has a licensed bed capacity of less than 65 beds and the
29 available nursing homes within 50 miles have had, in the
30 aggregate, an average occupancy rate of 96 percent or higher in
31 the most recent two years as documented on the statistical
32 reports to the Department of Health; and (2) it is located in a
33 rural area as defined in the federal Medicare regulations, Code
34 of Federal Regulations, title 42, section 482.66. Except for
35 critical access hospitals established under section 144.1483,
36 clause (10), and section 1820 of the federal Social Security

1 Act, United States Code, title 42, section 1395i-4, eligible
2 hospitals are allowed a total of 1,460 days of swing bed use per
3 year, provided that no more than ten hospital beds are used as
4 swing beds at any one time. Except for critical access
5 hospitals, the commissioner of health must approve swing bed use
6 beyond 1,460 days as long as there are no Medicare certified
7 skilled nursing facility beds available within 25 miles of that
8 hospital. Critical access hospitals are allowed swing bed use
9 as provided in federal law.

Create Conformity with Federal Law for Critical Access Hospitals

M.S. 144.562, M.S. 144.147, M.S. 144.148, M.S. 144.551

Problem statement

Recent changes were made to federal law and the regulations applicable to rural Minnesota's 65 Critical Access Hospitals. These changes resulted in two major inconsistencies with state statutes; the definitions of a rural hospital and the limit on swing beds. Hospital swing beds provide patients brief transitional care at the hospital following their acute care stay. The 2003 federal legislation also changed these bed limits upward. However, Minnesota law retains the earlier 10 bed limit, instead of the federal 25 bed limit.

In addition, several Critical Access Hospitals reduced their number of licensed beds between 1998 and 2003 to comply with the limit of 15 beds provided in the 1997 federal law creating the Critical Access Hospital option. In 2003, federal legislation raised the bed limit for Critical Access Hospitals to 25. However, Minnesota's hospital construction moratorium prohibits these hospitals from adjusting to this federal change.

How does this legislation address the problem?

The following amendments will bring state law into conformity with new federal regulations. This will allow Critical Access Hospitals to provide all the services established under federal law for rural communities:

- Amend M.S. 144.562 to exempt Critical Access Hospitals from the daily limit of 10 swing beds and the annual limit of 1,460 swing bed days. Critical Access Hospitals

could then use any of their 25 beds for swing bed patients.

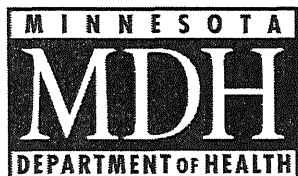
- Amend the definition of rural hospitals in M.S. 144.147 and 144.148 to retain eligibility for current and prospective Critical Access Hospitals.
- Amend M.S. 144.551 to allow Critical Access Hospitals a moratorium exception to increase up to the 25 beds allowed under federal law.

Move backed by stakeholders

The Minnesota Hospital Association already supports the initiative. The support of the Minnesota Rural Health Association is expected. There are no known opponents.

Consequences if this legislation does not pass:

- If the more restrictive state limit on swing bed use is not revised, recovering patients could be unnecessarily transferred from the hospital even though Critical Access Hospitals could provide the needed care.
- One hospital would lose its status as a Critical Access Hospital, if the state definition of a rural hospital is not revised to include it. Yet other hospitals—in similar circumstances—would continue operating as Critical Access Hospitals.
- Patients could be forced to travel farther for hospital services than necessary, if Critical Access Hospitals are not allowed to regain the beds they gave up to comply with the 1997 federal requirements.



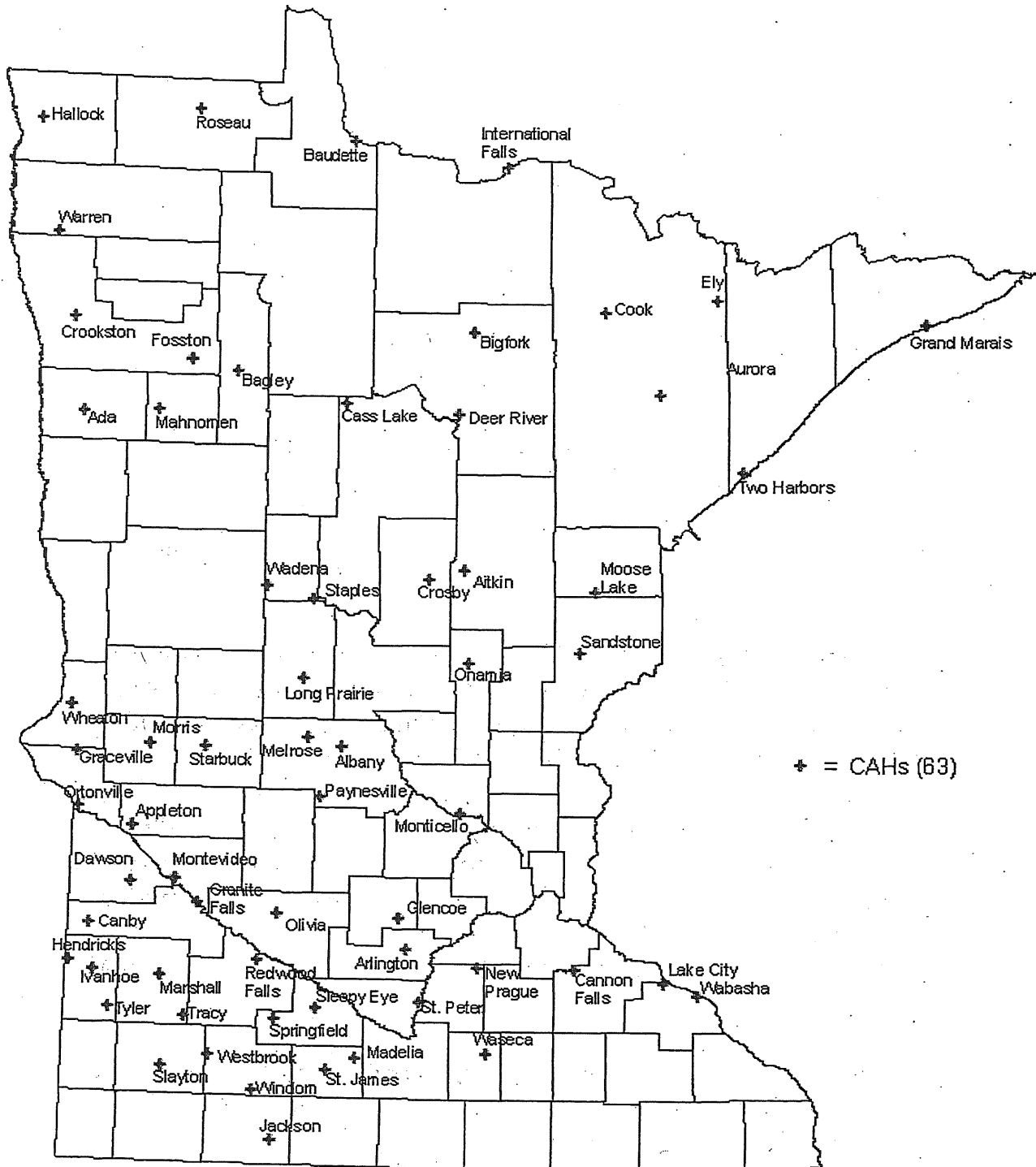
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What is a Critical Access Hospital (CAH)?

- A CAH is a small, rural, acute care facility that provides outpatient, emergency, and limited inpatient services.
- Is located outside of a Metropolitan Statistical Area, and not classified as “urban” for Medicare standardized payment or by the Medicare Geographic Review Board; be in a rural urban commuting area in an MSA or be designated by the State as a necessary provider.
- Receives enhanced Medicare reimbursement of 101 percent of reasonable costs.
- May have up to 25 beds with any combination of acute or swing (semi-skilled beds for patients meeting certain criteria).
- Provides inpatient care for no more than a 96 hour average length of stay.
- Must be more than a 35-mile drive or 15 miles in mountainous terrain or areas with only secondary roads, from another hospital or CAH. The State may also certify a hospital as being a “necessary provider” according to State guidelines (will end January 1, 2006)
- Must make available 24-hour emergency care but doesn’t need to meet all the staffing and service requirements that apply to full service hospitals (e.g. some ancillary and support services may be provided on a part-time off-site basis). Inpatient care in a CAH may be provided by a mid-level practitioner under the remote supervision of a physician.
- Can have 10 bed distinct part units (rehab and/or psych, but only one of each) that does not count against the bed limit and is paid under PPS. (goes into effect 10/1/2004)

Critical Access Hospitals - Minnesota



+ = CAHs (63)

1 Senator moves to amend the SCS1266A-1 amendment to
2 S.F. No. 1266 as follows:

3 Page 2, after line 8, insert;

4 "(e) A health care system that is in full compliance with
5 this subdivision may allocate its total limit of swing bed days
6 among the hospitals within the system, provided that no hospital
7 in the system without an attached nursing home may exceed 4,000
8 swing bed days per year."

1 Senator moves to amend S.F. No. 1266 as follows:

2 Pages 5 and 6, delete section 4 and insert:

3 "Sec. 4. Minnesota Statutes 2004, section 144.562,
4 subdivision 2, is amended to read:

5 Subd. 2. [ELIGIBILITY FOR LICENSE CONDITION.] (a) A
6 hospital is not eligible to receive a license condition for
7 swing beds unless (1) it either has a licensed bed capacity of
8 less than 50 beds defined in the federal Medicare regulations,
9 Code of Federal Regulations, title 42, section 482.66, or it has
10 a licensed bed capacity of 50 beds or more and has swing beds
11 that were approved for Medicare reimbursement before May 1,
12 1985, or it has a licensed bed capacity of less than 65 beds and
13 the available nursing homes within 50 miles have had, in the
14 aggregate, an average occupancy rate of 96 percent or higher in
15 the most recent two years as documented on the statistical
16 reports to the Department of Health; and (2) it is located in a
17 rural area as defined in the federal Medicare regulations, Code
18 of Federal Regulations, title 42, section 482.66.

19 (b) Except for those critical access hospitals established
20 under section 144.1483, clause (10), and section 1820 of the
21 federal Social Security Act, United States Code, title 42,
22 section 1395i-4, that have an attached nursing home, eligible
23 hospitals are allowed a total of ~~17,460~~ 2,000 days of swing bed
24 use per year, ~~provided that no more than ten hospital beds are~~
25 ~~used as swing beds at any one time.~~ Critical access hospitals
26 that have an attached nursing home are allowed swing bed use as
27 provided in federal law. Except for critical access hospitals
28 that have an attached nursing home, the commissioner of health
29 ~~must~~ may approve swing bed use beyond ~~17,460~~ 2,000 days as long
30 as there are no Medicare certified skilled nursing facility beds
31 available within 25 miles of that hospital that are willing to
32 admit the patient.

33 (c) Critical access hospitals exceeding 2,000 swing bed
34 days must maintain documentation that they have contacted
35 skilled nursing facilities within 25 miles to determine if any
36 skilled nursing facility beds are available. The commissioner

1 is authorized to request copies of this documentation.

2 (d) After reaching 2,000 days of swing bed use in a year,
3 an eligible hospital to which this limit applies may admit six
4 additional patients to swing beds each year without seeking
5 approval from the commissioner or being in violation of this
6 subdivision. These six swing bed admissions are exempt from the
7 limit of 2,000 annual swing bed days for hospitals subject to
8 this limit.

9 Sec. 5. [REPORT TO THE LEGISLATURE ON SWING BED USAGE.]

10 The commissioner of health shall review swing bed and
11 related data reported under Minnesota Statutes, sections
12 144.562, subdivision 3, paragraph (f); 144.564; and 144.698.
13 The commissioner shall report to the legislature by January 31,
14 2007, on:

15 (1) the use of swing bed days by all hospitals and by
16 critical access hospitals;

17 (2) occupancy rates in skilled nursing facilities within 25
18 miles of hospitals with swing beds; and

19 (3) information provided by rural providers on the use of
20 swing beds and the impact of that use on the rural health care
21 infrastructure."