A bill for an act

relating to health; establishing requirements for assisted living services; limiting use of the term assisted living; specifying procedures for terminating services for assisted living clients; modifying the home care bill of rights for purposes of assisted living; establishing the Class F home care provider category; eliminating the Class E assisted living programs license; requiring the provision of information on assisted living and the legal rights of assisted living clients; amending Minnesota Statutes 2004, sections 144A.4605; 144D.01, by adding a subdivision; 144D.015; 144D.02; 144D.03, subdivision 2; 144D.04; 144D.05; 144D.065; proposing coding for new law in Minnesota Statutes, chapters 144A; 144D; proposing coding for new law as Minnesota Statutes, chapter 144G; repealing Minnesota Rules, part 4668.0215.

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

Section 1. **[144A.441] ASSISTED LIVING BILL OF RIGHTS ADDENDUM.**

Assisted living clients, as defined in section 144G.01, subdivision 3, shall be provided with the home care bill of rights required by section 144A.44, except that the home care bill of rights provided to these clients must include the following provision in place of the provision in section 144A.44, subdivision 1, clause (16):

"(16) the right to reasonable, advance notice of changes in services or charges, including at least 30 days' advance notice of the termination of a service by a provider, except in cases where:

(i) the recipient of services engages in conduct that alters the conditions of employment as specified in the employment contract between the home care provider and the individual providing home care services, or creates an abusive or unsafe work environment for the individual providing home care services;

(ii) an emergency for the informal caregiver or a significant change in the recipient's condition has resulted in service needs that exceed the current service provider agreement and that cannot be safely met by the home care provider; or

(iii) the provider has not received payment for services, for which at least ten days' advance notice of the termination of a service shall be provided."

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 2. **[144A.442] TERMINATION OF HOME CARE SERVICES FOR ASSISTED LIVING CLIENTS.**

If an arranged home care provider, as defined in section 144D.01, subdivision 2a, who is not also Medicare certified terminates a service agreement or service plan with an assisted living client, as defined in section 144G.01, subdivision 3, the home care provider shall provide the assisted living client and the legal or designated representatives of the client, if any, with a written notice of termination which includes the following information:

(1) the effective date of termination;

(2) the reason for termination;

(3) without extending the termination notice period, an affirmative offer to meet with the assisted living client or client representatives within no more than five business days of the date of the termination notice to discuss the termination;

(4) contact information for a reasonable number of other home care providers in the geographic area of the assisted living client, as required by Minnesota Rules, part 4668.0050;

(5) a statement that the provider will participate in a coordinated transfer of the care of the client to another provider or caregiver, as required by section 144A.44, subdivision 1, clause (17);

(6) the name and contact information of a representative of the home care provider with whom the client may discuss the notice of termination;

(7) a copy of the home care bill of rights; and

(8) a statement that the notice of termination of home care services by the home care provider does not constitute notice of termination of the housing with services contract with a housing with services establishment.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 3. Minnesota Statutes 2004, section 144A.4605, is amended to read:

144A.4605 ~~ASSISTED LIVING HOME CARE~~ CLASS F PROVIDER.

Subdivision 1. **Definitions.** For purposes of this section, the term "~~assisted living~~ class F home care provider" means a home care provider who provides nursing services, delegated nursing services, other services performed by unlicensed personnel, or central storage of medications solely for residents of one or more housing with services establishments registered under chapter 144D.

Subd. 2. ~~**Assisted living**~~ **Class F home care license established.** A home care provider license category entitled ~~assisted living~~ class F home care provider is hereby established. A home care provider may obtain ~~an assisted living~~ a class F license if the program meets the following requirements:

(a) nursing services, delegated nursing services, other services performed by unlicensed personnel, or central storage of medications under the ~~assisted living~~ class F license are provided solely for residents of one or more housing with services establishments registered under chapter 144D;

(b) unlicensed personnel perform home health aide and home care aide tasks identified in Minnesota Rules, parts 4668.0100, subparts 1 and 2, and 4668.0110, subpart 1. Qualifications to perform these tasks shall be established in accordance with subdivision 3;

(c) periodic supervision of unlicensed personnel is provided as required by rule;

(d) notwithstanding Minnesota Rules, part 4668.0160, subpart 6, item D, client records shall include:

(1) daily records or a weekly summary of home care services provided;

(2) documentation each time medications are administered to a client; and

(3) documentation on the day of occurrence of any significant change in the client's status or any significant incident, such as a fall or refusal to take medications.

All entries must be signed by the staff providing the services and entered into the record no later than two weeks after the end of the service day, except as specified in clauses (2) and (3);

(e) medication and treatment orders, if any, are included in the client record and are renewed at least every 12 months, or more frequently when indicated by a clinical assessment;

(f) the central storage of medications in a housing with services establishment registered under chapter 144D is managed under a system that is established by a registered nurse and addresses the control of medications, handling of medications, medication containers, medication records, and disposition of medications; and

(g) in other respects meets the requirements established by rules adopted under sections 144A.45 to 144A.47.

Subd. 3. **Training or competency evaluations required.** (a) Unlicensed personnel must:

(1) satisfy the training or competency requirements established by rule under sections 144A.45 to 144A.47; or

(2) be trained or determined competent by a registered nurse in each task identified under Minnesota Rules, part 4668.0100, subparts 1 and 2, when offered to clients in a housing with services establishment as described in paragraphs (b) to (e).

(b) Training for tasks identified under Minnesota Rules, part 4668.0100, subparts 1 and 2, shall use a curriculum which meets the requirements in Minnesota Rules, part 4668.0130.

(c) Competency evaluations for tasks identified under Minnesota Rules, part 4668.0100, subparts 1 and 2, must be completed and documented by a registered nurse.

(d) Unlicensed personnel performing tasks identified under Minnesota Rules, part 4668.0100, subparts 1 and 2, shall be trained or demonstrate competency in the following topics:

(1) an overview of sections 144A.43 to 144A.47 and rules adopted thereunder;

(2) recognition and handling of emergencies and use of emergency services;

(3) reporting the maltreatment of vulnerable minors or adults under sections 626.556 and 626.557;

(4) home care bill of rights;

(5) handling of clients' complaints and reporting of complaints to the Office of Health Facility Complaints;

(6) services of the ombudsman for older Minnesotans;

(7) observation, reporting, and documentation of client status and of the care or services provided;

(8) basic infection control;

(9) maintenance of a clean, safe, and healthy environment;

(10) communication skills;

(11) basic elements of body functioning and changes in body function that must be reported to an appropriate health care professional; and

(12) physical, emotional, and developmental needs of clients, and ways to work with clients who have problems in these areas, including respect for the client, the client's property, and the client's family.

(e) Unlicensed personnel who administer medications must comply with rules relating to the administration of medications in Minnesota Rules, part 4668.0100, subpart 2, except that unlicensed personnel need not comply with the requirements of Minnesota Rules, part 4668.0100, subpart 5.

Subd. 4. **License required.** (a) A housing with services establishment registered under chapter 144D that is required to obtain a home care license must obtain ~~an assisted living~~ a class F home care license according to this section or a class A or class ~~E~~ B license according to rule. A housing with services establishment that obtains a class ~~E~~ B license under this subdivision remains subject to the payment limitations in sections 256B.0913, subdivision 5f, paragraph (b), and 256B.0915, subdivision 3d.

(b) A board and lodging establishment registered for special services as of December 31, 1996, and also registered as a housing with services establishment under chapter 144D, must deliver home care services according to sections 144A.43 to 144A.47, and may apply for a waiver from requirements under Minnesota Rules, parts 4668.0002 to 4668.0240, to operate a licensed agency under the standards of section 157.17. Such waivers as may be granted by the department will expire upon promulgation of home care rules implementing section 144A.4605.

~~(c) An adult foster care provider licensed by the Department of Human Services and registered under chapter 144D may continue to provide health-related services under its foster care license until the promulgation of home care rules implementing this section.~~

~~(d) An assisted living~~ (c) A class F home care provider licensed under this section must comply with the disclosure provisions of section 325F.72 to the extent they are applicable.

Subd. 5. **License fees.** The license fees for ~~assisted living~~ class F home care providers shall be as follows:

(1) $125 annually for those providers serving a monthly average of 15 or fewer clients, and for ~~assisted living~~ class F providers of all sizes during the first year of operation;

(2) $200 annually for those providers serving a monthly average of 16 to 30 clients;

(3) $375 annually for those providers serving a monthly average of 31 to 50 clients; and

(4) $625 annually for those providers serving a monthly average of 51 or more clients.

Subd. 6. **Waiver.** Upon request of the home care provider, the commissioner may waive the provisions of this section relating to registered nurse duties.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 4. Minnesota Statutes 2004, section 144D.01, is amended by adding a subdivision to read:

Subd. 2a. **Arranged home care provider.** "Arranged home care provider" means a home care provider licensed under Minnesota Rules, chapter 4668, that provides services to some or all of the residents of a housing with services establishment and that is either the establishment itself or another entity with which the establishment has an arrangement.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 5. Minnesota Statutes 2004, section 144D.015, is amended to read:

144D.015 ASSISTED LIVING FACILITY OR ASSISTED LIVING RESIDENCE DEFINITION FOR PURPOSES OF LONG-TERM CARE INSURANCE.

For purposes of consistency with terminology commonly used in long-term care insurance policies and notwithstanding chapter 144G, a housing with services establishment that is registered under section 144D.03 and that holds, or ~~contracts~~ makes arrangements with an individual or entity that holds~~, a~~ any type of home care license and all other licenses, permits, registrations, or other governmental approvals legally required for delivery of the services the establishment offers or provides to its residents, constitutes an "assisted living facility" or "assisted living residence."

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 6. Minnesota Statutes 2004, section 144D.02, is amended to read:

144D.02 REGISTRATION REQUIRED.

No entity may establish, operate, conduct, or maintain ~~an elderly~~ a housing with services establishment in this state without registering and operating as required in sections 144D.01 to 144D.06.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 7. Minnesota Statutes 2004, section 144D.03, subdivision 2, is amended to read:

Subd. 2. **Registration information.** The establishment shall provide the following information to the commissioner in order to be registered:

(1) the business name, street address, and mailing address of the establishment;

(2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners are not natural persons, identification of the type of business entity

of the owner or owners, and the names and addresses of the officers and members of the governing body, or comparable persons for partnerships, limited liability corporations, or other types of business organizations of the owner or owners;

(3) the name and mailing address of the managing agent, whether through management agreement or lease agreement, of the establishment, if different from the owner or owners, and the name of the on-site manager, if any;

(4) verification that the establishment has entered into ~~an elderly~~ a housing with services contract, as required in section 144D.04, with each resident or resident's representative;

(5) verification that the establishment is complying with the requirements of section 325F.72, if applicable;

(6) the name and address of at least one natural person who shall be responsible for dealing with the commissioner on all matters provided for in sections 144D.01 to 144D.06, and on whom personal service of all notices and orders shall be made, and who shall be authorized to accept service on behalf of the owner or owners and the managing agent, if any; and

(7) the signature of the authorized representative of the owner or owners or, if the owner or owners are not natural persons, signatures of at least two authorized representatives of each owner, one of which shall be an officer of the owner.

Personal service on the person identified under clause (6) by the owner or owners in the registration shall be considered service on the owner or owners, and it shall not be a defense to any action that personal service was not made on each individual or entity. The designation of one or more individuals under this subdivision shall not affect the legal responsibility of the owner or owners under sections 144D.01 to 144D.06.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 8. Minnesota Statutes 2004, section 144D.04, is amended to read:

144D.04 ~~ELDERLY~~ HOUSING WITH SERVICES CONTRACTS.

Subdivision 1. **Contract required.** No ~~elderly~~ housing with services establishment may operate in this state unless a written ~~elderly~~ housing with services contract, as defined in subdivision 2, is executed between the establishment and each resident or resident's representative and unless the establishment operates in accordance with the terms of the contract. The resident or the resident's representative shall be given a complete copy of the contract and all supporting documents and attachments and any changes whenever changes are made.

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

(1) the name, street address, and mailing address of the establishment;

(2) the name and mailing address of the owner or owners of the establishment and, if the owner or owners is not a natural person, identification of the type of business entity of the owner or owners;

(3) the name and mailing address of the managing agent, through management agreement or lease agreement, of the establishment, if different from the owner or owners;

(4) the name and address of at least one natural person who is authorized to accept service of process on behalf of the owner or owners and managing agent;

(5) a statement describing the registration and licensure status of the establishment and any provider providing health-related or supportive services under an arrangement with the establishment;

(6) the term of the contract;

(7) a description of the services to be provided to the resident in the base rate to be paid by resident;

(8) a description of any additional services, including home care services, available for an additional fee from the establishment directly or through arrangements with the establishment, and a schedule of fees charged for these services;

~~(9) fee schedules outlining the cost of any additional services;~~

~~(10)~~ (9) a description of the process through which the contract may be modified, amended, or terminated;

~~(11)~~ (10) a description of the establishment's complaint resolution process available to residents including the toll-free complaint line for the Office of Ombudsman for Older Minnesotans;

~~(12)~~ (11) the resident's designated representative, if any;

~~(13)~~ (12) the establishment's referral procedures if the contract is terminated;

~~(14) criteria~~ (13) requirements of residency used by the establishment to determine who may reside or continue to reside in the ~~elderly~~ housing with services establishment;

~~(15)~~ (14) billing and payment procedures and requirements;

~~(16)~~ (15) a statement regarding the ability of residents to receive services from service providers with whom the establishment does not have an arrangement; ~~and~~

~~(17)~~ (16) a statement regarding the availability of public funds for payment for residence or services in the establishment; and

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

Subd. 3. **Contracts in permanent files.** ~~Elderly~~ Housing with services contracts and related documents executed by each resident or resident's representative shall be maintained by the establishment in files from the date of execution until three years after the contract is terminated. The contracts and the written disclosures required under section 325F.72, if applicable, shall be made available for on-site inspection by the commissioner upon request at any time.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 9. **[144D.045] INFORMATION CONCERNING ARRANGED HOME CARE PROVIDERS.**

If a housing with services establishment has one or more arranged home care providers, the establishment shall arrange to have that arranged home care provider deliver the following information in writing to a prospective resident, prior to the date on which the prospective resident executes a contract with the establishment or the prospective resident's move-in date, whichever is earlier:

(1) the name, mailing address, and telephone number of the arranged home care provider;

(2) the name and mailing address of at least one natural person who is authorized to accept service of process on behalf of the entity described in clause (1) ;

(3) a description of the process through which a home care service agreement or service plan between a resident and the arranged home care provider, if any, may be modified, amended, or terminated;

(4) the arranged home care provider's billing and payment procedures and requirements; and

(5) any limits to the services available from the arranged provider.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 10. Minnesota Statutes 2004, section 144D.05, is amended to read:

144D.05 AUTHORITY OF COMMISSIONER.

The commissioner shall, upon receipt of information which may indicate the failure of the ~~elderly~~ housing with services establishment, a resident, a resident's representative, or a service provider to comply with a legal requirement to which one or more of them

may be subject, make appropriate referrals to other governmental agencies and entities having jurisdiction over the subject matter. The commissioner may also make referrals to any public or private agency the commissioner considers available for appropriate assistance to those involved.

The commissioner shall have standing to bring an action for injunctive relief in the district court in the district in which an establishment is located to compel the ~~elderly~~ housing with services establishment to meet the requirements of this chapter or other requirements of the state or of any county or local governmental unit to which the establishment is otherwise subject. Proceedings for securing an injunction may be brought by the commissioner through the attorney general or through the appropriate county attorney. The sanctions in this section do not restrict the availability of other sanctions.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 11. Minnesota Statutes 2004, section 144D.065, is amended to read:

144D.065 ESTABLISHMENTS THAT SERVE PERSONS WITH ALZHEIMER'S DISEASE OR RELATED DISORDERS.

(a) If a housing with services establishment registered under this chapter markets or otherwise promotes services for persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the ~~facility's~~ establishment's direct care staff and their supervisors must be trained in dementia care.

(b) Areas of required training include:

(1) an explanation of Alzheimer's disease and related disorders;

(2) assistance with activities of daily living;

(3) problem solving with challenging behaviors; and

(4) communication skills.

(c) The establishment shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This information satisfies the disclosure requirements of section 325F.72, subdivision 2, clause (4).

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 12. **[144G.01] DEFINITIONS.**

Subdivision 1. **Scope; other definitions.** For purposes of sections 144G.01 to 144G.05, the following definitions apply. In addition, the definitions provided in section 144D.01 also apply to sections 144G.01 to 144G.05.

Subd. 2. **Assisted living.** "Assisted living" means a service or package of services advertised, marketed, or otherwise described, offered, or promoted using the phrase "assisted living" either alone or in combination with other words, whether orally or in writing, and which is subject to the requirements of this chapter.

Subd. 3. **Assisted living client.** "Assisted living client" or "client" means a housing with services resident who receives assisted living that is subject to the requirements of this chapter.

Subd. 4. **Commissioner.** "Commissioner" means the commissioner of health.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 13. **[144G.02] ASSISTED LIVING; PROTECTED TITLE; RESTRICTION ON USE; REGULATORY FUNCTIONS.**

Subdivision 1. **Protected title; restriction on use.** No person or entity may use the phrase "assisted living," whether alone or in combination with other words and whether orally or in writing, to advertise, market, or otherwise describe, offer, or promote itself, or any housing, service, service package, or program that it provides within this state, unless the person or entity is a housing with services establishment that meets the requirements of this chapter, or is a person or entity that provides some or all components of assisted living that meet the requirements of this chapter. A person or entity entitled to use the phrase "assisted living" shall use the phrase only in the context of its participation in assisted living that meets the requirements of this chapter. A housing with services establishment offering or providing assisted living that is not made available to residents in all of its housing units shall identify the number or location of the units in which assisted living is available, and may not use the term "assisted living" in the name of the establishment registered with the commissioner under chapter 144D, or in the name the establishment uses to identify itself to residents or the public.

Subd. 2. **Authority of commissioner.** (a) The commissioner, upon receipt of information that may indicate the failure of a housing with services establishment, the arranged home care provider, an assisted living client, or an assisted living client's representative to comply with a legal requirement to which one or more of the entities may be subject, shall make appropriate referrals to other governmental agencies and entities having jurisdiction over the subject matter. The commissioner may also make referrals to any public or private agency the commissioner considers available for appropriate assistance to those involved.

(b) In addition to the authority with respect to licensed home care providers under sections 144A.45 and 144A.46 and with respect to housing with services establishments

under chapter 144D, the commissioner shall have standing to bring an action for injunctive relief in the district court in the district in which a housing with services establishment is located to compel the housing with services establishment or the arranged home care provider to meet the requirements of this chapter or other requirements of the state or of any county or local governmental unit to which the establishment or arranged home care provider is otherwise subject. Proceedings for securing an injunction may be brought by the commissioner through the attorney general or through the appropriate county attorney. The sanctions in this section do not restrict the availability of other sanctions.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 14. **[144G.03] ASSISTED LIVING REQUIREMENTS.**

Subdivision 1. **Verification in annual registration.** A registered housing with services establishment using the phrase "assisted living," pursuant to section 144G.02, subdivision 1, shall verify to the commissioner in its annual registration pursuant to chapter 144D that the establishment is complying with sections 144G.01 to 144G.05, as applicable.

Subd. 2. **Minimum requirements for assisted living.** (a) Assisted living shall be provided or made available only to individuals residing in a registered housing with services establishment. Except as expressly stated in this chapter, a person or entity offering assisted living may define the available services and may offer assisted living to all or some of the residents of a housing with services establishment. The services that comprise assisted living may be provided or made available directly by a housing with services establishment or by persons or entities with which the housing with services establishment has made arrangements.

(b) A person or entity entitled to use the phrase "assisted living," according to section 144G.02, subdivision 1, shall do so only with respect to a housing with services establishment, or a service, service package, or program available within a housing with services establishment that, at a minimum:

(1) provides or makes available health related services under a class A or class F home care license. At a minimum, health related services must include:

(i) assistance with self-administration of medication as defined in Minnesota Rules, part 4668.0003, subpart 2a, or medication administration as defined in Minnesota Rules, part 4668.0003, subpart 21a; and

(ii) assistance with at least three of the following seven activities of daily living: bathing, dressing, grooming, eating, transferring, continence care, and toileting.

All health related services shall be provided in a manner that complies with applicable home care licensure requirements in chapter 144A and Minnesota Rules, chapter 4668, and with sections 148.171 to 148.285;

(2) provides necessary assessments of the physical and cognitive needs of assisted living clients by a registered nurse, as required by applicable home care licensure requirements in chapter 144A and Minnesota Rules, chapter 4668, and by sections 148.171 to 148.285;

(3) has and maintains a system for delegation of health care activities to unlicensed assistive health care personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by applicable home care licensure requirements in chapter 144A and Minnesota Rules, chapter 4668, and by sections 148.171 to 148.285;

(4) provides staff access to an on-call registered nurse 24 hours per day, seven days per week;

(5) has and maintains a system to check on each assisted living client at least daily;

(6) provides a means for assisted living clients to request assistance for health and safety needs 24 hours per day, seven days per week, from the establishment or a person or entity with which the establishment has made arrangements;

(7) has a person or persons available 24 hours per day, seven days per week, to respond to the requests of assisted living clients for assistance with health or safety needs, who shall be:

(i) awake;

(ii) located in the same building, in an attached building, or on a contiguous campus with the housing with services establishment in order to respond within a reasonable amount of time;

(iii) capable of communicating with assisted living clients;

(iv) capable of recognizing the need for assistance;

(v) capable of providing either the assistance required or summoning the appropriate assistance; and

(vi) capable of following directions;

(8) offers to provide or make available at least the following supportive services to assisted living clients:

(i) two meals per day;

(ii) weekly housekeeping;

(iii) weekly laundry service;

(iv) upon the request of the client, reasonable assistance with arranging for transportation to medical and social services appointments, and the name of or other

identifying information about the person or persons responsible for providing this assistance;

(v) upon the request of the client, reasonable assistance with accessing community resources and social services available in the community, and the name of or other identifying information about the person or persons responsible for providing this assistance; and

(vi) periodic opportunities for socialization; and

(9) makes available to all prospective and current assisted living clients information consistent with the uniform format and the required components adopted by the commissioner under section 144G.06. This information must be made available beginning no later than six months after the commissioner makes the uniform format and required components available to providers according to section 144G.06.

Subd. 3. **Nursing assessment.** (a) A housing with services establishment offering or providing assisted living shall:

(1) offer to have the arranged home care provider conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a service agreement or service plan prior to the date on which a prospective resident executes a contract with a housing with services establishment or the date on which a prospective resident moves in, whichever is earlier; and

(2) inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a housing with services establishment or the date on which a prospective resident moves in, whichever is earlier.

(b) An arranged home care provider is not obligated to conduct a nursing assessment by a registered nurse when requested by a prospective resident if either the geographic distance between the prospective resident and the provider, or urgent or unexpected circumstances, do not permit the assessment to be conducted prior to the date on which the prospective resident executes a contract or moves in, whichever is earlier. When such circumstances occur, the arranged home care provider shall offer to conduct a telephone conference whenever reasonably possible.

(c) The arranged home care provider shall comply with applicable home care licensure requirements in chapter 144A and Minnesota Rules, chapter 4668, and with sections 148.171 to 148.285 with respect to the provision of a nursing assessment prior to the delivery of nursing services and the execution of a home care service plan or service agreement.

Subd. 4. **Assistance with arranged home care provider.** The housing with services establishment shall provide each assisted living client with identifying information about a person or persons reasonably available to assist the client with concerns the client may have with respect to the services provided by the arranged home care provider. The establishment shall keep each assisted living client reasonably informed of any changes in the personnel referenced in this subdivision. Upon request of the assisted living client, such personnel or designee shall provide reasonable assistance to the assisted living client in addressing concerns regarding services provided by the arranged home care provider.

Subd. 5. **Termination of housing with services contract.** If a housing with services establishment terminates a housing with services contract with an assisted living client, the establishment shall provide the assisted living client, and the legal or designated representative of the assisted living client, if any, with a written notice of termination which includes the following information:

(1) the effective date of termination;

(2) the section of the contract that authorizes the termination;

(3) without extending the termination notice period, an affirmative offer to meet with the assisted living client and, if applicable, client representatives, within no more than five business days of the date of the termination notice to discuss the termination;

(4) an explanation that:

(i) the assisted living client must vacate the apartment, along with all personal possessions, on or before the effective date of termination;

(ii) failure to vacate the apartment by the date of termination may result in the filing of an eviction action in court by the establishment, and that the assisted living client may present a defense, if any, to the court at that time; and

(iii) the assisted living client may seek legal counsel in connection with the notice of termination;

(5) a statement that, with respect to the notice of termination, reasonable accommodation is available for the disability of the assisted living client, if any; and

(6) the name and contact information of the representative of the establishment with whom the assisted living client or client representatives may discuss the notice of termination.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 15. **[144G.04] RESERVATION OF RIGHTS.**

Subdivision 1. **Use of services.** Nothing in this chapter requires an assisted living client to utilize any service provided or made available in assisted living.

Subd. 2. **Housing with services contracts.** Nothing in this chapter requires a housing with services establishment to execute or refrain from terminating a housing with services contract with a prospective or current resident who is unable or unwilling to meet the requirements of residency, with or without assistance.

Subd. 3. **Provision of services.** Nothing in this chapter requires the arranged home care provider to offer or continue to provide services under a service agreement or service plan to a prospective or current resident of the establishment whose needs cannot be met by the arranged home care provider.

Subd. 4. **Altering operations; service packages.** Nothing in this chapter requires a housing with services establishment or arranged home care provider offering assisted living to fundamentally alter the nature of the operations of the establishment or the provider in order to accommodate the request or need for facilities or services by any assisted living client, or to refrain from requiring, as a condition of residency, that an assisted living client pay for a package of assisted living services even if the client does not choose to utilize all or some of the services in the package.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 16. **[144G.05] REIMBURSEMENT UNDER ASSISTED LIVING SERVICE PACKAGES.**

Notwithstanding the provisions of this chapter, the requirements for the Elderly Waiver program's assisted living payment rates under section 256B.0915, subdivision 3e, shall continue to be effective and providers who do not meet the requirements of this chapter may continue to receive payment under section 256B.0915, subdivision 3e, as long as they continue to meet the definitions and standards for assisted living and assisted living plus set forth in the federally approved Elderly Home and Community Based Services Waiver Program (Control Number 0025.91).

Providers of assisted living for the Community Alternatives for Disabled Individuals (CADI) and Traumatic Brain Injury (TBI) waivers shall continue to receive payment as long as they continue to meet the definitions and standards for assisted living and assisted living plus set forth in the federally approved CADI and TBI waiver plans.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 17. **[144G.06] UNIFORM CONSUMER INFORMATION GUIDE.**

(a) The commissioner of health shall establish an advisory committee consisting of representatives of consumers, providers, county and state officials, and other

groups the commissioner considers appropriate. The advisory committee shall present recommendations to the commissioner on:

(1) a format for a guide to be used by individual providers of assisted living, as defined in Minnesota Statutes, section 144G.01, that includes information about services offered by that provider, service costs, and other relevant provider-specific information, as well as a statement of philosophy and values associated with assisted living, presented in uniform categories that facilitate comparison with guides issued by other providers; and

(2) requirements for informing assisted living clients, as defined in Minnesota Statutes, section 144G.01, of their applicable legal rights.

(b) The commissioner, after reviewing the recommendations of the advisory committee, shall adopt a uniform format for the guide to be used by individual providers, and the required components of materials to be used by providers to inform assisted living clients of their legal rights, and shall make the uniform format and the required components available to assisted living providers.

Sec. 18. **REVISOR'S INSTRUCTION.**

(a) The revisor of statutes shall strike all references to the "Class E assisted living home care programs license, "Class E license," and similar terms in Minnesota Rules, chapters 4668 and 4669. In sections affected by this instruction, the revisor may make changes necessary to correct the punctuation, grammar, or structure of the remaining text and preserve its meaning.

(b) The revisor of statutes shall change the term "assisted living home care provider," "assisted living license," and similar terms to "Class F home care provider," "Class F license," and similar terms to "Class F home care provider," "Class F license," and similar terms, in Minnesota Rules, chapter 4668. In sections affected by this instruction, the revisor may make changes necessary to correct the punctuation, grammar, or structure of the remaining text and preserve its meaning.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 19. **REPEALER.**

Minnesota Rules, part 4668.0215, is repealed, effective January 1, 2007.

Senate Counsel, Research, and Fiscal Analysis

G-17 STATE CAPITOL
75 REV. DR. MARTIN LUTHER KING, JR. BLVD.
ST. PAUL, MN 55155-1606
(651) 296-4791
FAX: (651) 296-7747
JO ANNE ZOFF SELLNER
DIRECTOR

Senate
State of Minnesota

S.F. No. 2888 - Establishing Requirements for Assisted Living Services (The First Engrossment)

Author: Senator Linda Berglin

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

Date: March 29, 2006

S.F. No. 2888 establishes minimum requirements for assisted living services in a new chapter of state law, Chapter 144G. It allows assisted living services to be provided only in a registered housing with services establishment. It modifies the home care bill of rights for assisted living clients with respect to certain advance notice requirements. It establishes a Class F home care provider category and eliminates the Class E assisted living program license. These provisions are effective January 1, 2007.

Section 1 (144A.441) modifies the home care bill of rights to require that assisted living clients receive 30 days of advance notice, rather than ten days, regarding the termination of a service by a provider, except in certain unusual circumstances.

Section 2 (144A.442) requires that when a non-Medicare-certified provider of home care services terminates services to an assisted living client, the provider must give the client a written notice that includes certain required information, including the date of termination, reason for termination, contact information for other service providers, and an offer to coordinate the transfer of care.

Section 3 (144A.4605) changes the title of licensed providers that offer home care services to residents of housing with services establishments. These providers are referred to as "class F home care providers" rather than "assisted living home care providers."

Section 4 (144D.01, subdivision 2a) adds a definition of "arranged home care provider" to the statute regulating housing with services establishments.

Section 5 (144D.015) clarifies the definition of "assisted living facility" and "assisted living residence" for purposes of consistency with long-term care insurance terminology.

Section 6 (144D.02) deletes outdated language.

Section 7 (144D.03, subdivision 2) deletes outdated language.

Section 8 (144D.04) modifies the contents of a housing with services contract. It clarifies language and requires the contract to include contact information for long-term care consultation services.

Section 9 (144D.045) outlines the information a housing with services establishment must provide to prospective residents regarding assisted living service providers that offer services in the establishment.

Section 10 (144D.05) deletes outdated language.

Section 11 (144D.065) corrects terminology.

Sections 12 to 17 establish a new Chapter 144G regulating assisted living services.

Section 12 (144G.01) defines terms.

Section 13 (144G.02) prohibits a person or entity from using the phrase "assisted living" to advertise or describe itself unless the entity is a housing with services establishment that meets the requirements of Chapter 144G or the person or entity provides some or all components of assisted living that meet these requirements. An establishment that only offers assisted living services in a portion of its housing units must identify the number or location of those units and may not use the term "assisted living" in its name. This section also authorizes the Commissioner of the Minnesota Department of Health (MDH) to enforce this chapter.

Section 14 (144G.03) requires that assisted living services be provided only to individuals living in a registered housing with services establishment. This section also establishes minimum requirements for assisted living services. A housing with services establishment using the phrase "assisted living" to identify or market itself must register annually with MDH to verify compliance with this chapter. Minimum assisted living service requirements include:

- the provision of health-related services, including medication administration or assistance with self-administration and assistance with at least three of seven listed activities of daily living;
- provision of necessary client assessments by a registered nurse;
- a system to supervise and evaluate the delegation of health care activities to unlicensed health care personnel;

- staff access to an on-call registered nurse at all times;
- a system to check at least daily on each client;
- a person available at all times to respond to client requests who is awake, located in the same building or nearby, and capable of understanding and responding to requests for assistance;
- the provision of, or offer to provide, two meals each day, weekly housekeeping and laundry service, and assistance in accessing other services; and
- provision of a consumer information guide as required under section 17.

This section also regulates the provision of nurse assessments prior to move in, the provision of information to help a resident who has concerns about assisted living services being provided, and the provision of notice to a resident when the establishment terminates the client's housing contract.

Section 15 (144G.04) protects a client from having to utilize any assisted living services made available in the establishment and protects the rights of the establishment to terminate contracts under certain circumstances; to decline to serve a client whose needs cannot be met; to refuse to fundamentally alter the operation of the establishment to accommodate a resident; and to require a resident, as a condition of residency, to pay for a package of assisted living services even if the client chooses not to utilize every service.

Section 16 (144G.05) allows providers who do not meet the requirements of this chapter to continue to receive payment for assisted living services under several waiver programs if they continue to satisfy federal standards.

Section 17 (144G.06) requires MDH, after receiving the recommendations of an advisory committee, to adopt a uniform format and required components for a consumer information guide and make them available to assisted living providers.

Section 18 is a Revisor's instruction.

Section 19 is a repealer.

DG:rdr

Consolidated Fiscal Note – 2005-06 Session

Bill #: S2888-1A **Complete Date:** 03/30/06

Chief Author: BERGLIN, LINDA

Title: ASSISTED LIVING RQRMNT; LIC & REG

Fiscal Impact	Yes	No
State	X	
Local		X
Fee/Departmental Earnings	X	
Tax Revenue		X

Agencies: Health Dept (03/29/06) Human Services Dept (03/30/06)

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Net Expenditures					
State Govt Special Revenue Fund			140	280	280
Health Dept			140	280	280
Revenues					
-- No Impact --					
Net Cost <Savings>					
State Govt Special Revenue Fund			140	280	280
Health Dept			140	280	280
Total Cost <Savings> to the State			140	280	280

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

Consolidated EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 03/30/06 Phone: 286-5618

Fiscal Note – 2005-06 Session

Bill #: S2888-1A **Complete Date:** 03/29/06

Chief Author: BERGLIN, LINDA

Title: ASSISTED LIVING RQRMNT; LIC & REG

Agency Name: Health Dept

Fiscal Impact	Yes	No
State	X	
Local		X
Fee/Departmental Earnings	X	
Tax Revenue		X

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
State Govt Special Revenue Fund			140	280	280
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
State Govt Special Revenue Fund			140	280	280
Revenues					
-- No Impact --					
Net Cost <Savings>					
State Govt Special Revenue Fund			140	280	280
Total Cost <Savings> to the State			140	280	280

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

Bill Description

Limits the use of the term assisted living; specifies procedures for terminating services for assisted living clients; modifies the home care bill of rights for purposes of assisted living; establishes the Class F home care provider category; eliminates the Class E assisted living programs license; and requires the use of a uniform format for presenting information on assisted living and informing assisted living clients of legal rights.

Assumptions

Section 1. through Section 12: No Fiscal Impact

Section 13. Assisted Living; Protected Title; Restriction on Use; Regulatory Functions:

Subd1. Protected Title:

Training workshops will be conducted for Registered Housing With Services Establishments (1058 registered), Assisted Living Home Care Providers (478 licensed), Class A Home Care Providers (322 licensed), Advocates and Ombudsman concerning the provisions of the new requirements to use the term assisted living. It is estimated that approximately 1,500 interested individuals will attend. The workshops will be conducted statewide with 4 out-state and 2 metro sites identified. A registration fee of $20 will be charged, to cover the costs of the workshop facilities, development and printing of materials, and staff development time. These dedicated receipts will be deposited to the Miscellaneous Special Revenue Fund. Workshop materials will be placed on the MDH website. No additional funding will be requested for these training workshops.

Subd2. Authority of Commissioner:

There are approximately 1,050 entities registered as "housing with services". It is estimated that at least 500 of these will be subject to the new requirements. The enforcement mechanism provided in the bill is that MDH may seek injunctive relief in District Court. MDH will need to establish criteria for possible violations and determine when to proceed. It is estimated that during the time period from January 1, 2007 through June 30, 2007 that approximately 10 actions will proceed forward with injunctive relief.

MDH estimates that approximately 5 cases will be identified during the survey process and that an additional 5 will be the result of complaints received by the Office of Health Facility Complaints. The estimated average cost for attorney general involvement is $14,000 for a total of $140,000. The SGSR appropriation will need to be increased by $140,000.

There is currently sufficient fee revenue in the Home Care SGSR account to support the increased appropriation of $140,000. MDH would have the funds available to proceed with the necessary enforcement actions for the current biennium. Home Care licensure and/or Housing With Services registration fees would need to be adjusted to cover these costs in the 2008-2009 biennium.

Section 14. Assisted Living Requirements: No Fiscal Impact

Subd. 1. The application will be modified to incorporate the new verification requirements. Data system modifications will be scheduled to allow for development, testing and implementation in ample time for the licensure and renewal cycle.

Subd. 2,3,4 and 5. The new survey requirements can be implemented by updating the assisted living licensure forms and when providers are renewing or applying for a new license there will be a check off list of the new requirements that will be verified during the survey. These requirements will be incorporated into the survey process by slightly increasing survey time by approximately 1 hour. The current average survey and follow-up time will be monitored closely to ensure that the number of surveys performed can be maintained within the number of available hours. No additional funding will be requested for these requirements.

Section 15 through 19: No Fiscal Impact

Expenditure and/or Revenue Formula

MDH estimates that approximately 5 cases will be identified during the survey process and that an additional 5 will be the result of complaints received by the Office of Health Facility Complaints. The estimated average cost for attorney general involvement is $14,000 for a total of $140,000 for 6 months during SFY 2007.

Beginning in SFY 2008, the annual anticipated cost is $280,000.

Long-Term Fiscal Considerations

Annual costs of $280,000 will be ongoing.

References/Sources

David Giese, Division Director
Compliance Monitoring Division
651-201-3700

Agency Contact Name: David Giese (651-201-3700)
FN Coord Signature: MARGARET KELLY
Date: 03/22/06 Phone: 201-5812

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: CRAIG WIEBER
Date: 03/29/06 Phone: 282-5065

Fiscal Note – 2005-06 Session

Bill #: S2888-1A **Complete Date:** 03/30/06

Chief Author: BERGLIN, LINDA

Title: ASSISTED LIVING RQRMNT; LIC & REG

Fiscal Impact	Yes	No
State		X
Local		X
Fee/Departmental Earnings		X
Tax Revenue		X

Agency Name: Human Services Dept

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
-- No Impact --					
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
-- No Impact --					
Revenues					
-- No Impact --					
Net Cost <Savings>					
-- No Impact --					
Total Cost <Savings> to the State					

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

NARRATIVE: SF 2888-1A

Bill Description

The provisions in the previous version of this bill that had fiscal implications have been removed or changed. The amendment eliminated the additional duties of the Office of the Ombudsman for older Minnesotans, and the absence of "grandfathering" of existing assisted living providers paid by home and community based waiver programs. As a result, the amended bill does not have a fiscal impact.

Assumptions
1. The amended version of the bill addresses the areas which previously had fiscal implications.

Expenditure and/or Revenue Formula
Not Applicable

Long-Term Fiscal Considerations

None

Local Government Costs
None

References/Sources
Continuing Care Research and Analysis
Office of the Ombudsman for Older Minnesotans

Agency Contact Name: Bob Meyer 431-2383
FN Coord Signature: STEVE BARTA
Date: 03/20/06 Phone: 431-2916

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 03/30/06 Phone: 286-5618

2006 Legislative Proposal for Assisted Living

The following proposal is a result of the work of many stakeholder groups over nearly two years, including AARP, the Alzheimer's Association, Care Providers of Minnesota, ElderCare Rights Alliance, the Minnesota Health & Housing Alliance, the Minnesota Home Care Association, and the Minnesota Nurses Association. This bill accomplishes two goals: title protection for providers and clearer expectations for consumers.

1. **Requirements for Use of the Term "Assisted Living".** The bill establishes requirements that must be met by any building or program that markets itself as "Assisted Living". In addition to the other requirements in this summary:
    - Assisted Living must be provided in a registered housing-with-services establishment.
    - A housing-with-services establishment that does not make assisted living available to residents in all of its housing units shall identify the number or location of the units in which assisted living is available, and may not use the term "assisted living" in the name of the establishment registered with the commissioner under chapter 144D, or in the name the establishment uses to identify itself to residents or the public.

2. **Required Health Related Services** to be made available to all clients include:
    - RN assessment to be offered to all assisted living clients
    - Supervision of unlicensed staff by licensed nurses
    - Assistance with self-administration of medications or administration of medications

3. **Activities of Daily Living (ADL's)** – Assisted Living must offer to provide or make available assistance with at least three of the following ADL's:
    - Bathing
    - Dressing
    - Grooming
    - Eating
    - Toileting
    - Transferring
    - Continence care

4. **Response System:** Assisted Living must have:
    - An RN on-call 24 hours per day, 7 days per week for staff
    - A means for clients to request assistance for health and safety needs 24 hours per day, 7 days per week.
    - A staff person available to respond to health and safety requests 24 hours per day, 7 days per week, who is awake; located in the same building, in an attached building, or on a contiguous campus; capable of communicating with clients, capable of recognizing the need for assistance; capable of providing the assistance required, or summoning the appropriate assistance, and capable of following directions.

5. **Supportive Services** – Assisted Living must offer to provide or make available:
    - At least two meals per day
    - At least weekly housekeeping
    - At least weekly laundry service
    - Reasonable assistance with arranging transportation to medical and social services appointments and a designated person or title for providing this assistance
    - Reasonable assistance with accessing community resources and social services available in the community and a designated person or title for providing this assistance
    - Periodic opportunities for socialization

6. **Consumer Information** - A Uniform Consumer Information Guide will be developed to provide consumers with consistent information to compare Assisted Living providers.

7. **Accountability for Services**
    - All Assisted Living must provide a contact person within the housing establishment that clients may look to for resolving concerns about their home care provider.
    - Minnesota Department of Health has authority to survey home care providers in Assisted Living and seek injunctive relief against housing providers in the event of violations, consistent with current law.

8. **Notice of Termination of Services.** If a provider terminates either a housing or home care services agreement with an assisted living client, the provider will provide a termination notice that contains specified explanations and information.

AARP Minnesota

March 15, 2006

Senator Berglin
309 State Capitol
St. Paul, MN 55155

Dear Senator Berglin:

On behalf of more than 650,000 Minnesotan's over the age of 50, thank you for authoring the Assisted Living Legislative Proposal, Senate File 2888. This is an important topic not only to our members, but also for their families.

As we plan our future long-term care needs, more Minnesotans are turning to assisted living in order to retain independence and a high quality of life. While often a good choice for consumers, the quality and services offered by those that call themselves assisted living varies, and consumers sometimes enter into living arrangements without a clear idea of the exact level of services offered.

This legislation creates a standard definition of assisted living and adds basic consumer protections to Minnesota law. For example, any building or program that calls itself assisted living must provide for twenty-four hour awake staff. They must also offer to provide assistance with things such as laundry, meals, transportation services, and activities of daily living.

Additionally, AARP believes that this legislation will help protect Minnesota's consumers by giving consumers a clear understanding of what is and isn't offered in facilities through the development of the Uniform Consumer Information Guide.

This legislation is a good example of the work that can be done on behalf of consumers and providers when we come together around a common goal. Our intent as a consumer advocate was to give consumers that reside in assisted living some very basic, common sense protections – and to provide their families necessary assurance and clear communication that will help them help their loved ones find the right living situation. We believe that this legislation will help provide those assurances.

Thank you again for authoring this important legislation. If you have any questions or concerns, please feel free to contact our Advocacy Director, Heidi Holste at 651-726-5645.

Sincerely,

Michele H. Kimball

Michele H. Kimball
State Director

30 E. 7th Street, Suite 1200 | St. Paul, MN 55101 | toll-free 866-554-5381 | 651-221-2636 fax | toll-free 877-434-7598 TTY
Marie F. Smith, President | William D. Novelli, Chief Executive Officer | www.aarp.org/mn

Minnesota – North Dakota
www.alzmndak.org
1-800-232-0851 24/7

alzheimer's association

March 14, 2006

Metro Regional Center
4550 W 77th Street
Suite 200
Minneapolis, MN 55435

1-800-232-0851
952-830-0512
952-830-0513 fax

The Honorable Linda Berglin
Chair, Health, Human Services and Corrections
Budget Division
309 State Capitol
St. Paul, MN 55155

Dear Senator Berglin:

The Alzheimer's Association thanks you for being the Chief Author of SF2888, a bill to define and set basic standards for Assisted Living.

Assisted Living settings are quickly becoming the first choice in residential care for people with Alzheimer's and related dementias. Yet, families who call our Information Helpline run into problems as they try to navigate the system and make the best choices for their loved ones.

Families are under pressure to reach a decision when home care is no longer possible. Although, there is an array of choices, neither the term "assisted living" nor descriptors like "memory care" have a standard meaning.

Safety is always an issue, as dementia typically attacks memory and judgment long before it saps physical strength. But there is no bottom line requirement for security in Assisted Living in Minnesota.

Families are often faced with making repeated changes as the promise of "aging in place" turns out not to be realistic.

The Association has been actively committed to the work of the Assisted Living Stakeholder Group and commends the product of its extensive work.

Sincerely,

Jane Ochrymowycz
Secretary, Board of Directors
Chair, Public Policy Committee

Northern Minnesota Office
202 Ordean Building
424 W Superior Street
Duluth, MN 55802
218-726-4819
218-726-4849 fax

Southern Minnesota Office
1001 14th Street NW
Suite 800
Rochester, MN 55901
507-289-3950
507-289-4666 fax

Western Minnesota Office
Whitney Senior Center
1527 Northway Drive
St. Cloud, MN 56303
320-650-3070

Eastern North Dakota Office
4357 13th Avenue SW
Suite 203
Fargo, ND 58103
701-277-9757
701-277-9785 fax

Western North Dakota Office
1223 South 12th Street
Suite 7
Bismarck, ND 58504
701-258-4933
701-258-4914 fax

The
Long-Term Care
IMPERATIVE

A Minnesota Collaboration for Changes in Older Adult Services

March 15, 2006

The Honorable Linda Berglin
Minnesota Senate
309 Capitol
St. Paul, MN 55155

Dear Senator Berglin:

This letter expresses our strong support for Senate File 2888, a bill that will provide protections and increase clarity for providers and consumers with respect to the services offered in assisted living housing.

Since August 2004, Minnesota Health & Housing Alliance, Care Providers of Minnesota, and a group of nearly 20 stakeholders have worked together to develop legislation that will clarify "assisted living" services. The Assisted Living Stakeholders Group included state agencies, consumer advocacy groups, county representatives and other interested organizations. The result of their hard work is SF 2188.

Care Providers of Minnesota and Minnesota Health & Housing Alliance , in a coalition called the Long-Term Care Imperative, strive to transform older adult services in Minnesota to meet the needs of an aging population while preserving choice for consumers. The associations convened the Assisted Living Stakeholders Group to identify and address the issues and concerns of both providers and consumers. The group sought to place some parameters around assisted living, while preserving provider flexibility and consumer choice. The proposed legislation builds on Minnesota's unique and consumer-centered framework of the Housing with Services Contract Act, with a continued focus on disclosure of important information that consumers need to make good decisions and to enforce their rights.

This existing framework, along with the Minnesota Department of Health's enforcement of licensure requirements for the health related/home care services delivered by assisted living providers, will be strengthened by the additional clarifications and protections included in Senate File 2888. We are confident that consumers, providers and regulatory agencies will all benefit

by setting standards that providers must meet in order to market themselves as "assisted living" providers, by addressing the need for more consumer information related to assisted living, and by clarifying consumer rights in this area.

Thank you for supporting SF 2888 on behalf of your constituents.

Sincerely,

Lori Meyer
Acting Vice President of Public Affairs
Minnesota Health & Housing Alliance

Patti Cullen
Vice President
Care Providers of Minnesota

Minnesota Nurses Association

Uniting nurses in vision and voice

March 13, 2006

Senator Becky Lourey, Chair
Senate Health and Family Security Committee
Minnesota Senate
75 Dr Martin Luther King Jr Blvd
St. Paul, MN 55155

Dear Senator Lourey
and Members of the Senate Health and Family Security Committee:

The Minnesota Nurses Association is writing to urge your support of Senate File 2888, authored by Senator Berglin. This legislation both defines Assisted Living and establishes standards for Assisted Living. It is the product of two years' work with a variety of stakeholders including our association, the industry and consumer advocacy groups. We are pleased with the outcome.

We believe this legislation addresses the concerns our members expressed regarding both quality of care and clarity around the role and responsibilities of the Registered Nurse in Assisted Living. It does this by requiring the following provisions:

- An RN assessment must be offered to all assisted living clients.
- An RN on-call 24 hours a day & 24 hour-a-day/7days a week awake staff
- Clarity around the role of the RN
- Definition of a minimum health benefit

An RN assessment must be offered to all assisted living clients.
Under current law an RN assessment is only required prior to initiation of services. We believe with this change, both residents and families will be in a better position to choose the Assisted Living Facility or program that best meets their needs. Also, RN's and other care providers will have a better understanding upfront of the resident's care needs.

An RN is on-call 24 hours a day & 24 hour-a-day/7days a week awake staff
By requiring a Registered Nurse to be on call 24-hours-a- day to unlicensed staff, RNs will be able to better direct staff in the care of residents for both patient safety purposes and to prevent unnecessary hospitalization or nursing home placement. Also, the awake-staff will assist residents with health and safety needs.

Professional Distinction

Personal Dignity

Patient Advocacy

Minnesota Nurses Association 100 Years A Legacy of Caring 1905 2005

16. Energy Park Drive
Suite 200
St. Paul, MN 55108
Tel: 651-646-4807
800-536-4662
Fax: 651-647-5301
Email: mnnurses@mnnurses.org

Web: www.mnnurses.org

ANA American Nurses Association

UAN United American Nurses, AFL-CIO

Clarity around the role of the RN
This bill clarifies that the Registered Nurse is the only person authorized to supervise and delegate services to unlicensed personnel as defined in the Nur Practice Act. We often find that nurses and employers are unclear as to their responsibilities in assessment of the care needs of the client and delegation to and supervision of the unlicensed assistive personnel who are providing that care.

Definition of a minimum health benefit
The bill also requires Assisted Living to offer a minimum package of health related services that include at least three activities of daily living as well as help with medication administration. Studies show, the average resident uses1-3 Aides to Daily Living and need assistance with medication. By setting forth a minimum package of services consumers will have clearer role of what additional services they may have to purchase beyond the minimum.

Thank you in advance for your support this legislation. Please feel free to contact us if you have any questions.

Sincerely,

Erin Murphy

Erin Murphy, RN, MA
Executive Director
Minnesota Nurses Association

CC: Mary Jo George and Carrie Mortrud, Staff Specialists, Governmental Affairs

Minnesota – North Dakota
ww.alzmndak.org
1-800-232-0851 24/7

alzheimer's association

March 14, 2006

Metro Regional Center
4550 W 77th Street
Suite 200
Minneapolis, MN 55435

1-800-232-0851
952-830-0512
952-830-0513 fax

rthern Minnesota Office
..2 Ordean Building
424 W Superior Street
Duluth, MN 55802
218-726-4819
218-726-4849 fax

Southern Minnesota Office
1001 14th Street NW
Suite 800
Rochester, MN 55901
507-289-3950
507-289-4666 fax

Western Minnesota Office
Whitney Senior Center
1527 Northway Drive
St. Cloud, MN 56303
320-650-3070

Eastern North Dakota Office
4357 13th Avenue SW
te 203
rargo, ND 58103
701-277-9757
701-277-9785 fax

Western North Dakota Office
1223 South 12th Street
Suite 7
Bismarck, ND 58504
701-258-4933
701-258-4914 fax

The Honorable Linda Berglin
Chair, Health, Human Services and Corrections
Budget Division
309 State Capitol
St. Paul, MN 55155

Dear Senator Berglin:

The Alzheimer's Association thanks you for being the Chief Author of SF2888, a bill to define and set basic standards for Assisted Living.

Assisted Living settings are quickly becoming the first choice in residential care for people with Alzheimer's and related dementias. Yet, families who call our Information Helpline run into problems as they try to navigate the system and make the best choices for their loved ones.

Families are under pressure to reach a decision when home care is no longer possible. Although, there is an array of choices, neither the term "assisted living" nor descriptors like "memory care" have a standard meaning.

Safety is always an issue, as dementia typically attacks memory and judgment long before it saps physical strength. But there is no bottom line requirement for security in Assisted Living in Minnesota.

Families are often faced with making repeated changes as the promise of "aging in place" turns out not to be realistic.

The Association has been actively committed to the work of the Assisted Living Stakeholder Group and commends the product of its extensive work.

Sincerely,

Jane Ochrymowycz
Secretary, Board of Directors
Chair, Public Policy Committee

MINNESOTA
HOMECARE
ASSOCIATION

1711 West County Road B, Suite 211 S, St. Paul, MN 55113
651/635-0607 • Fax 651/635-0043 • Toll-Free 866/607-0607
www.mnhomecare.org

March 15, 2006

To Whom It May Concern:

The Minnesota HomeCare Association urges you to support House File 3144 and Senate File 2888, the Assisted Living Legislative Proposal for 2006. This proposal has been generated by a coalition of advocacy groups and provider organizations over the last two and a half years. The legislation is intended to develop parameters around the term "assisted living" and provide a clearer understanding of what is "assisted living".

This new legislation is not intended to prohibit any existing provider from delivering services in a "housing with services" establishment. It will require the agency to declare whether or not the facility has staff awake 24-hours, 7 days a week in order to call itself "assisted living". If they do not have awake staff, providers may continue to deliver services under this new class of licensure; however, they may not call themselves "assisted living".

It is our understanding that public programs (i.e., MA home and community-based waivers) will continue to allow both "housing with services" and "assisted living". This will assure no interruption for current clients on MA who live in facilities throughout the State.

We are pleased that all parties have been able to come together and reach a viable compromise.

Sincerely,

T. Jeff Bangsberg
Director of Government Relations

ElderCare Rights Alliance

advocacy & education since 1972

March 10, 2006

Senator Linda Berglin
309 State Capitol
75 Rev. Dr. Martin Luther King Jr. Blvd.
St. Paul, MN 55155-1606

RE: Support for Senate File 2888 – Assisted Living legislation

Dear Senator Berglin:

The ElderCare Rights Alliance is a non-profit advocacy and education organization with a thirty year history of advocating for elders and persons with disabilities in the long-term care system. Our agency mission is to advance the principles of justice and dignity in long-term care through education, advocacy and action.

Our agency supports Senate File 2888, Assisted Living legislation, and encourages the legislature to enact it into law this session. A stakeholders group, consisting of advocates, providers, and state agency personnel met regularly for over a year to develop the proposal. We believe the proposed legislation offers adequate safeguards, protections, and services for the elderly and persons with disabilities who desire to live and receive services in assisted living facilities. Further, the proposed legislation clearly delineates the requirements to be met for any facility in Minnesota that chooses to market itself as providing assisted living services.

We strongly support the passage of Senate File 2888, Assisted Living.

Sincerely,

Mary Ellen Kennedy,
Board Chair

2626 East 82nd Street · The Atrium · Suite 230 · Bloomington, MN · 55425-1381
(952) 854-7304 · (800) 893-4055 · Fax (952) 854-8535 · info@eldercarerights.org

ATTACHMENT "A"

Senator ..... moves to amend S.F. No. 2888 as follows:

Page 13, line 18, delete "to"

Page 13, line 19, delete "respond" and insert "who is responsible for responding"

Page 14, after line 12, insert:

"Subd. 3. **Exemption from awake-staff requirement.** (a) A housing with services establishment that offers or provides assisted living is exempt from the requirement in subdivision 2, paragraph (b), clause (7), item (i), that the person or persons available and responsible for responding to requests for assistance must be awake, if the establishment meets the following requirements:

(1) the establishment has a maximum capacity to serve 12 or fewer assisted living clients;

(2) the person or persons available and responsible for responding to requests for assistance are physically present within the housing with services establishment in which the assisted living clients reside;

(3) the establishment has a system in place that is compatible with the health, safety, and welfare of the establishment's assisted living clients;

(4) the establishment's housing with services contract, as required by section 144D.04, includes a statement disclosing the establishment's qualification for, and intention to rely upon, this exemption;

(5) the establishment files with the commissioner, for purposes of public information but not review or approval by the commissioner, a statement describing how the establishment meets the conditions in clauses (1) to (5), and makes a copy of this statement available to actual and prospective assisted living clients; and

(6) the establishment indicates on its housing with services registration, under section 144D.02 or 144D.03, as applicable, that is qualifies for and intends to rely upon the exemption under this subdivision."

Page 14, line 13, delete "3" and insert "4"

Page 15, line 1, delete "4" and insert "5"

Page 15, line 9, delete "5" and insert "6"

Page 17, after line 14, insert:

"Sec. 18. **APPROPRIATION.**

$140,000 is appropriated from the state government special revenue fund to the commissioner of health for the biennium ending June 30, 2007, to enforce the standards

established in sections 1 to 17. This appropriation shall not become part of base level funding for the biennium beginning July 1, 2007."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

To: Senator Cohen, Chair

Committee on Finance

Senator Berglin,

Chair of the Health and Human Services Budget Division, to which was referred

S.F. No. 2888: A bill for an act relating to health; establishing requirements for assisted living services; limiting use of the term assisted living; specifying procedures for terminating services for assisted living clients; modifying the home care bill of rights for purposes of assisted living; establishing the Class F home care provider category; eliminating the Class E assisted living programs license; requiring the provision of information on assisted living and the legal rights of assisted living clients; amending Minnesota Statutes 2004, sections 144A.4605; 144D.01, by adding a subdivision; 144D.015; 144D.02; 144D.03, subdivision 2; 144D.04; 144D.05; 144D.065; proposing coding for new law in Minnesota Statutes, chapters 144A; 144D; proposing coding for new law as Minnesota Statutes, chapter 144G; repealing Minnesota Rules, part 4668.0215.

Reports the same back with the recommendation that the bill be amended as follows:

Page 13, line 18, delete "to"

Page 13, line 19, delete "respond" and insert "who is responsible for responding"

Page 14, after line 12, insert:

"Subd. 3. **Exemption from awake-staff requirement.** A housing with services establishment that offers or provides assisted living is exempt from the requirement in subdivision 2, paragraph (b), clause (7), item (i), that the person or persons available and responsible for responding to requests for assistance must be awake, if the establishment meets the following requirements:

(1) the establishment has a maximum capacity to serve 12 or fewer assisted living clients;

(2) the person or persons available and responsible for responding to requests for assistance are physically present within the housing with services establishment in which the assisted living clients reside;

(3) the establishment has a system in place that is compatible with the health, safety, and welfare of the establishment's assisted living clients;

(4) the establishment's housing with services contract, as required by section 144D.04, includes a statement disclosing the establishment's qualification for, and intention to rely upon, this exemption;

(5) the establishment files with the commissioner, for purposes of public information but not review or approval by the commissioner, a statement describing how the establishment meets the conditions in clauses (1) to (4), and makes a copy of this statement available to actual and prospective assisted living clients; and

(6) the establishment indicates on its housing with services registration, under section 144D.02 or 144D.03, as applicable, that it qualifies for and intends to rely upon the exemption under this subdivision."

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Renumber the sections in sequence

Amend the title accordingly

And when so amended that the bill be recommended to pass and be referred to the full committee.

Linda Berglin
(Division Chair)

March 30, 2006
(Date of Division action)

A bill for an act

relating to human services; providing children's mental health grants; establishing mental health service delivery and finance reform; modifying mental health case management and rates; modifying general assistance medical care coverages; adding services provided by clinical nurse specialist in mental health and certified psychiatric nurse practitioner covered under medical assistance; adding crisis assistance as a covered service; amending Minnesota Statutes 2004, sections 245.465, by adding a subdivision; 246.54, subdivision 1, by adding a subdivision; 256B.0625, subdivisions 20, 28; 256B.0945, subdivisions 1, 4; 256B.69, subdivisions 5g, 5h; 256L.12, subdivision 9a; Minnesota Statutes 2005 Supplement, sections 245.4874; 256B.0946, subdivision 1; 256D.03, subdivision 4; 256L.03, subdivision 1; 256L.035; proposing coding for new law in Minnesota Statutes, chapters 245; 256B; repealing Minnesota Statutes 2004, sections 245.465, subdivision 2; 256B.0945, subdivisions 5, 6, 7, 8, 9; 256B.83.

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

Section 1. Minnesota Statutes 2004, section 245.465, is amended by adding a subdivision to read:

Subd. 3. **Responsibility not duplicated.** For individuals who have health care coverage, the county board is not responsible for providing mental health services which are covered by the entity that administers the health care coverage.

Sec. 2. **[245.4682] MENTAL HEALTH SERVICE DELIVERY AND FINANCE REFORM.**

Subdivision 1. **Policy.** The commissioner of human services shall undertake a series of reforms to improve the underlying structural, financing, and organizational problems in Minnesota's mental health system with the goal of improving the availability, quality, and accountability of mental health care within the state.

Subd. 2. **General provisions.** In the design and implementation of reforms to the mental health system, the commissioner shall:

(1) consult with consumers, families, counties, tribes, advocates, providers, and other stakeholders;

(2) report to the legislature and the state Mental Health Advisory Council by January 15, 2007, with any recommendations for amending statutes, including to update the role of counties and health plans in mental health services, including case management;

(3) ensure continuity of care for persons affected by these reforms including:

(i) ensuring client choice of provider by requiring broad provider networks;

(ii) allowing clients options to maintain previously established therapeutic relationships; and

(iii) developing mechanisms to facilitate a smooth transition of service responsibilities;

(4) provide accountability for the efficient and effective use of public and private resources in achieving positive outcomes for consumers;

(5) ensure client access to applicable protections and appeals; and

(6) make budget transfers that do not increase the state and county costs to effectively implement improvements to the mental health system and efficiently allocate state funds. When making transfers necessary to implement movement of responsibility for clients and services between counties and health care programs, the commissioner, in consultation with counties, shall ensure that any transfer of state grants to health care programs, including the value of case management transfer grants under section 256B.0625, subdivision 20, does not exceed the value of the services being transferred for the latest 12-month period for which data is available. The commissioner may make quarterly adjustments based on the availability of additional data during the first four quarters after the transfers first occur.

Subd. 3. **Regional projects for coordination of care.** (a) Consistent with section 256B.69 and chapters 256D and 256L, the commissioner is authorized to solicit, approve, and implement regional projects to demonstrate the integration of physical and mental health services within prepaid health plans and their coordination with social services. The commissioner, in consultation with consumers, families, and their representatives, shall:

(1) determine criteria for approving the regional projects and use those criteria to solicit regional proposals for integrated service networks;

(2) require that each project be based on locally defined partnerships that include at least one health maintenance organization, community integrated service network, or accountable provider network authorized and operating under chapter 62D, 62N, or 62T,

or county-based purchasing entity under section 256B.692 that is eligible to contract with the commissioner as a prepaid health plan, and the county or counties within the region;

(3) allow potential bidders at least 90 days to respond to the request for proposals;

(4) waive any administrative rule not consistent with the implementation of the regional projects; and

(5) begin implementation of the regional projects no earlier than January 1, 2008, with not more than 20 percent of the statewide population described in paragraph (b) included during calendar year 2008 and additional individuals included in subsequent years.

(b) Notwithstanding any statute or administrative rule to the contrary, the commissioner shall enroll all medical assistance eligible persons with serious and persistent mental illness or severe emotional disturbance in the prepaid plan of their choice within the project region unless:

(1) an individual has another basis for exclusion from the prepaid plan under section 256B.69, subdivision 4; or

(2) an individual has a previously established therapeutic relationship with a provider who is not included in the available prepaid plans.

(c) If the person with serious and persistent mental illness or severe emotional disturbance declines to choose a plan, the commissioner may preferentially assign that person to the prepaid plan participating in the integrated service network. The commissioner shall implement the enrollment changes within a regional project on the timeline specified in that region's approved application.

(d) The commissioner, in consultation with consumers, families, and their representatives, shall refine the design of the regional service integration projects and expand the number of regions engaged in the demonstration projects as additional qualified applicant partnerships present themselves.

(e) The commissioner shall apply for any federal waivers necessary to implement these changes.

Sec. 3. **[245.4835] COUNTY MAINTENANCE OF EFFORT.**

Subdivision 1. **Required expenditures.** Counties must maintain a level of expenditures for mental health services under sections 245.461 to 245.484 and 245.487 to 245.4887 so that each year's county expenditures are at least equal to that county's average expenditures for those services for calendar years 2004 and 2005. The commissioner will adjust each county's base level for minimum expenditures in each year by the amount of

any increase or decrease in that county's state grants or other noncounty revenues for mental health services under sections 245.461 to 245.484 and 245.487 to 245.4887.

Subd. 2. **Failure to maintain expenditures.** If a county does not comply with subdivision 1, the commissioner shall require the county to develop a corrective action plan according to a format and timeline established by the commissioner. If the commissioner determines that a county has not developed an acceptable corrective action plan within the required timeline, or that the county is not in compliance with an approved corrective action plan, the protections provided to that county under section 245.485 do not apply.

Sec. 4. Minnesota Statutes 2005 Supplement, section 245.4874, is amended to read:

245.4874 DUTIES OF COUNTY BOARD.

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

(1) develop a system of affordable and locally available children's mental health services according to sections 245.487 to 245.4887;

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

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

(4) assure that parents and providers in the county receive information about how to gain access to services provided according to sections 245.487 to 245.4887;

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

(6) assure that mental health services delivered according to sections 245.487 to 245.4887 are delivered expeditiously and are appropriate to the child's diagnostic assessment and individual treatment plan;

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

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

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

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

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

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

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

(14) consistent with section 245.486, arrange for or provide a children's mental health screening to a child receiving child protective services or a child in out-of-home placement, a child for whom parental rights have been terminated, a child found to be delinquent, and a child found to have committed a juvenile petty offense for the third or subsequent time, unless a screening has been performed within the previous 180 days, or the child is currently under the care of a mental health professional. The court or county agency must notify a parent or guardian whose parental rights have not been terminated of the potential mental health screening and the option to prevent the screening by notifying the court or county agency in writing. The screening shall be conducted with a screening instrument approved by the commissioner of human services according to criteria that are updated and issued annually to ensure that approved screening instruments are valid and useful for child welfare and juvenile justice populations, and shall be conducted by a mental health practitioner as defined in section 245.4871, subdivision 26, or a probation officer or local social services agency staff person who is trained in the use of the screening instrument. Training in the use of the instrument shall include training in the administration of the instrument, the interpretation of its validity given the child's current circumstances, the state and federal data practices laws and confidentiality standards, the parental consent requirement, and providing respect for families and cultural values. If the screen indicates a need for assessment, the child's family, or if the family lacks mental health insurance, the local social services agency, in consultation with the child's

family, shall have conducted a diagnostic assessment, including a functional assessment, as defined in section 245.4871. The administration of the screening shall safeguard the privacy of children receiving the screening and their families and shall comply with the Minnesota Government Data Practices Act, chapter 13, and the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Screening results shall be considered private data and the commissioner shall not collect individual screening results.

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

Subd. 2. **Responsibility not duplicated.** For individuals that have health care coverage, the county board is not responsible for providing mental health services which are covered by the entity which administers the health care coverage.

Sec. 5. **[245.4889] CHILDREN'S MENTAL HEALTH GRANTS.**

Subdivision 1. **Establishment and authority.** The commissioner is authorized to make grants from available appropriations to assist counties, Indian tribes, children's collaboratives under section 124D.23 or 245.493, or mental health service providers for providing services to children with emotional disturbances as defined in section 245.4871, subdivision 15, and their families; and to young adults meeting the criteria for transition services in section 245.4875, subdivision 8, and their families. Services must be designed to help each child to function and remain with the child's family in the community and delivered consistent with the child's treatment plan. Transition services to eligible young adults must be designed to foster independent living in the community.

Subd. 2. **Grant application and reporting requirements.** To apply for a grant an applicant organization shall submit an application and budget for the use of the money in the form specified by the commissioner. The commissioner shall make grants only to entities whose applications and budgets are approved by the commissioner. In awarding grants, the commissioner shall give priority to applications that indicate plans to collaborate in the development, funding, and delivery of services with other agencies in the local system of care. The commissioner shall specify requirements for reports, including quarterly fiscal reports, according to section 256.01, subdivision 2, paragraph (q). The commissioner shall require collection of data and periodic reports that the commissioner deems necessary to demonstrate the effectiveness of each service.

Sec. 6. Minnesota Statutes 2004, section 246.54, subdivision 1, is amended to read:

Subdivision 1. **County portion for cost of care.** Except for chemical dependency services provided under sections 254B.01 to 254B.09, the client's county shall pay to the state of Minnesota a portion of the cost of care provided in a regional treatment center or a state nursing facility to a client legally settled in that county. A county's payment shall be made from the county's own sources of revenue and payments shall be paid as follows: payments to the state from the county shall equal 20 percent of the cost of care, as determined by the commissioner, for each ~~day~~ of the first 60 days, or the portion thereof, that the client spends at a regional treatment center or a state nursing facility. After the first 60 days, the county share is 50 percent. If payments received by the state under sections 246.50 to 246.53 exceed 80 percent of the cost of care for the first 60 days or 50 percent for any additional days, the county shall be responsible for paying the state only the remaining amount. The county shall not be entitled to reimbursement from the client, the client's estate, or from the client's relatives, except as provided in section 246.53. ~~No such payments shall be made for any client who was last committed prior to July 1, 1947.~~

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 7. Minnesota Statutes 2004, section 246.54, is amended by adding a subdivision to read:

Subd. 3. **Additional exception for community behavioral health hospitals.** Subdivision 1 does not apply to services provided at state-operated community behavioral health hospitals. For services at these facilities, a county's payment shall be made from the county's own sources of revenue and payments shall be paid as follows: payments to the state from the county shall equal 50 percent of the cost of care, as determined by the commissioner, for each day, or the portion thereof, that the client spends at the facility. If payments received by the state under sections 246.50 to 246.53 exceed 50 percent of the cost of care, the county shall be responsible for paying the state only the remaining amount. The county shall not be entitled to reimbursement from the client, the client's estate, or from the client's relatives, except as provided in section 246.53.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 8. Minnesota Statutes 2004, section 256B.0625, subdivision 20, is amended to read:

Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the state agency, medical assistance covers case management services to persons with

serious and persistent mental illness and children with severe emotional disturbance. Services provided under this section must meet the relevant standards in sections 245.461 to 245.4887, the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

(b) Entities meeting program standards set out in rules governing family community support services as defined in section 245.4871, subdivision 17, are eligible for medical assistance reimbursement for case management services for children with severe emotional disturbance when these services meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

(c) Medical assistance and MinnesotaCare payment for mental health case management shall be made on a monthly basis. In order to receive payment for an eligible child, the provider must document at least a face-to-face contact with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:

(1) at least a face-to-face contact with the adult or the adult's legal representative; or

(2) at least a telephone contact with the adult or the adult's legal representative and document a face-to-face contact with the adult or the adult's legal representative within the preceding two months.

(d) Payment for mental health case management provided by county or state staff shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), with separate rates calculated for child welfare and mental health, and within mental health, separate rates for children and adults.

(e) Payment for mental health case management provided by Indian health services or by agencies operated by Indian tribes may be made according to this section or other relevant federally approved rate setting methodology.

(f) Payment for mental health case management provided by vendors who contract with a county or Indian tribe shall be based on a monthly rate negotiated by the host county or tribe. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county or tribe may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribe, except to reimburse the county or tribe for advance funding provided by the county or tribe to the vendor.

(g) If the service is provided by a team which includes contracted vendors, tribal staff, and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county-provided services. In this case, the contracted

vendor, the tribal agency, and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles of the team members.

~~(h) The commissioner shall calculate the nonfederal share of actual medical assistance and general assistance medical care payments for each county, based on the higher of calendar year 1995 or 1996, by service date, project that amount forward to 1999, and transfer one-half of the result from medical assistance and general assistance medical care to each county's mental health grants under section 256E.12 for calendar year 1999. The annualized minimum amount added to each county's mental health grant shall be $3,000 per year for children and $5,000 per year for adults. The commissioner may reduce the statewide growth factor in order to fund these minimums. The annualized total amount transferred shall become part of the base for future mental health grants for each county.~~

~~(i) Any net increase in revenue to the county or tribe as a result of the change in this section must be used to provide expanded mental health services as defined in sections 245.461 to 245.4887, the Comprehensive Adult and Children's Mental Health Acts, excluding inpatient and residential treatment. For adults, increased revenue may also be used for services and consumer supports which are part of adult mental health projects approved under Laws 1997, chapter 203, article 7, section 25. For children, increased revenue may also be used for respite care and nonresidential individualized rehabilitation services as defined in section 245.492, subdivisions 17 and 23. "Increased revenue" has the meaning given in Minnesota Rules, part 9520.0903, subpart 3.~~

~~(j)~~ (h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for mental health case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds. If the service is provided by a tribal agency, the nonfederal share, if any, shall be provided by the recipient's tribe. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the recipient's county of responsibility.

(i) Notwithstanding Minnesota Rules to the contrary, prepaid medical assistance, general assistance medical care, and MinnesotaCare include mental health case management. When the service is provided through prepaid capitation, the nonfederal share is paid by the state and there is no county share.

~~(k)~~ (j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal

agency, is responsible for any federal disallowances. The county or tribe may share this responsibility with its contracted vendors.

~~(l)~~ (k) The commissioner shall set aside a portion of the federal funds earned for county expenditures under this section to repay the special revenue maximization account under section 256.01, subdivision 2, clause (15). The repayment is limited to:

(1) the costs of developing and implementing this section; and

(2) programming the information systems.

~~(m)~~ (l) Payments to counties and tribal agencies for case management expenditures under this section shall only be made from federal earnings from services provided under this section. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors shall include ~~both~~ the federal earnings, the state share, and the county share.

~~(n) Notwithstanding section 256B.041, county payments for the cost of mental health case management services provided by county or state staff shall not be made to the commissioner of finance. For the purposes of mental health case management services provided by county or state staff under this section, the centralized disbursement of payments to counties under section 256B.041 consists only of federal earnings from services provided under this section.~~

~~(o)~~ (m) Case management services under this subdivision do not include therapy, treatment, legal, or outreach services.

~~(p)~~ (n) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for case management services under this subdivision is limited to the last 180 days of the recipient's residency in that facility and may not exceed more than six months in a calendar year.

~~(q)~~ (o) Payment for case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

~~(r) By July 1, 2000, the commissioner shall evaluate the effectiveness of the changes required by this section, including changes in number of persons receiving mental health case management, changes in hours of service per person, and changes in caseload size.~~

~~(s) For each calendar year beginning with the calendar year 2001, the annualized amount of state funds for each county determined under paragraph (h) shall be adjusted by the county's percentage change in the average number of clients per month who received case management under this section during the fiscal year that ended six months prior to the calendar year in question, in comparison to the prior fiscal year.~~

~~(t) For counties receiving the minimum allocation of $3,000 or $5,000 described in paragraph (h), the adjustment in paragraph (s) shall be determined so that the county receives the higher of the following amounts:~~

~~(1) a continuation of the minimum allocation in paragraph (h); or~~

~~(2) an amount based on that county's average number of clients per month who received case management under this section during the fiscal year that ended six months prior to the calendar year in question, times the average statewide grant per person per month for counties not receiving the minimum allocation.~~

~~(u) The adjustments in paragraphs (s) and (t) shall be calculated separately for children and adults.~~

EFFECTIVE DATE. This section is effective January 1, 2008.

Sec. 9. Minnesota Statutes 2004, section 256B.0625, subdivision 28, is amended to read:

Subd. 28. **Certified nurse practitioner services.** Medical assistance covers services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, ~~or~~ a certified geriatric nurse practitioner, a clinical nurse specialist in mental health, or a certified psychiatric nurse practitioner in independent practice, if:

(1) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate;

(2) the service is otherwise covered under this chapter as a physician service; and

(3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171.

Sec. 10. Minnesota Statutes 2004, section 256B.0945, subdivision 1, is amended to read:

Subdivision 1. **Provider qualifications.** Counties must arrange to provide residential services for children with severe emotional disturbance according to sections 245.4882, 245.4885, and this section. Services must be provided by a facility that is licensed according to section 245.4882 and administrative rules promulgated thereunder, and under contract with the county. ~~Facilities providing services under subdivision 2, paragraph (a), must be accredited as a psychiatric facility by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of~~

~~Rehabilitation Facilities, or the Council on Accreditation. Accreditation is not required for facilities providing services under subdivision 2, paragraph (b).~~

Sec. 11. Minnesota Statutes 2004, section 256B.0945, subdivision 4, is amended to read:

Subd. 4. **Payment rates.** (a) Notwithstanding sections 256B.19 and 256B.041, payments to counties for residential services provided by a residential facility shall only be made of federal earnings for services provided under this section, and the nonfederal share of costs for services provided under this section shall be paid by the county from sources other than federal funds or funds used to match other federal funds. Payment to counties for services provided according to this section shall be a proportion of the per day contract rate that relates to rehabilitative mental health services and shall not include payment for costs or services that are billed to the IV-E program as room and board.

(b) Per diem rates paid to providers under this section by prepaid plans shall be the proportion of the per day contract rate that relates to rehabilitative mental health services and shall not include payment for costs or services that are billed to the IV-E program as room and board.

(c) The commissioner shall set aside a portion not to exceed five percent of the federal funds earned for county expenditures under this section to cover the state costs of administering this section. Any unexpended funds from the set-aside shall be distributed to the counties in proportion to their earnings under this section.

EFFECTIVE DATE. This section is effective January 1, 2008.

Sec. 12. Minnesota Statutes 2005 Supplement, section 256B.0946, subdivision 1, is amended to read:

Subdivision 1. **Covered service.** (a) Effective July 1, 2006, and subject to federal approval, medical assistance covers medically necessary services described under paragraph (b) that are provided by a provider entity eligible under subdivision 3 to a client eligible under subdivision 2 who is placed in a treatment foster home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340.

(b) Services to children with severe emotional disturbance residing in treatment foster care settings must meet the relevant standards for mental health services under sections 245.487 to 245.4887. In addition, specific service components reimbursed by medical assistance must meet the following standards:

(1) case management service component must meet the standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10;

(2) psychotherapy, crisis assistance, and skills training components must meet the standards for children's therapeutic services and supports in section 256B.0943; and

(3) family psychoeducation services under supervision of a mental health professional.

Sec. 13. Minnesota Statutes 2004, section 256B.69, subdivision 5g, is amended to read:

Subd. 5g. **Payment for covered services.** For services rendered on or after January 1, 2003, the total payment made to managed care plans for providing covered services under the medical assistance and general assistance medical care programs is reduced by .5 percent from their current statutory rates. This provision excludes payments for nursing home services, home and community-based waivers, ~~and~~ payments to demonstration projects for persons with disabilities, and mental health services added as covered benefits after December 31, 2006.

Sec. 14. Minnesota Statutes 2004, section 256B.69, subdivision 5h, is amended to read:

Subd. 5h. **Payment reduction.** In addition to the reduction in subdivision 5g, the total payment made to managed care plans under the medical assistance program is reduced 1.0 percent for services provided on or after October 1, 2003, and an additional 1.0 percent for services provided on or after January 1, 2004. This provision excludes payments for nursing home services, home and community-based waivers, ~~and~~ payments to demonstration projects for persons with disabilities, and mental health services added as covered benefits after December 31, 2006.

Sec. 15. **[256B.763] CRITICAL ACCESS MENTAL HEALTH RATE INCREASE.**

(a) For services defined in paragraph (b) and rendered on or after July 1, 2007, payment rates shall be increased by 23.7 percent over the rates in effect on January 1, 2006, for:

(1) psychiatrists and advanced practice registered nurses with a psychiatric specialty;

(2) community mental health centers under section 256B.0625, subdivision 5; and

(3) mental health clinics and centers certified under Minnesota Rules, parts 9520.0750 to 9520.0870, or hospital outpatient psychiatric departments that are designated as essential community providers under section 62Q.19.

(b) This increase applies to group skills training when provided as a component of children's therapeutic services and support, psychotherapy, medication management, evaluation and management, diagnostic assessment, explanation of findings, psychological

testing, neuropsychological services, direction of behavioral aides, and inpatient consultation.

(c) This increase does not apply to rates that are governed by section 256B.0625, subdivision 30, or 256B.761, paragraph (b), other cost-based rates, rates that are negotiated with the county, rates that are established by the federal government, or rates that increased between January 1, 2004, and January 1, 2005.

(d) The commissioner shall adjust rates paid to prepaid health plans under contract with the commissioner to reflect the rate increases provided in paragraph (a). The prepaid health plan must pass this rate increase to the providers identified in paragraph (a).

Sec. 16. Minnesota Statutes 2005 Supplement, section 256D.03, subdivision 4, is amended to read:

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

(1) inpatient hospital services;

(2) outpatient hospital services;

(3) services provided by Medicare certified rehabilitation agencies;

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

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

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

(7) hearing aids;

(8) prosthetic devices;

(9) laboratory and X-ray services;

(10) physician's services;

(11) medical transportation except special transportation;

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

(13) podiatric services;

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

(15) ~~outpatient services provided by a mental health center or clinic that is under contract with the county board and is established under section 245.62~~ mental health services covered under chapter 256B;

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

~~(17)~~ (16) prescribed medications for persons who have been diagnosed as mentally ill as necessary to prevent more restrictive institutionalization;

~~(18) psychological services;~~ (17) medical supplies and equipment, and Medicare premiums, coinsurance and deductible payments;

~~(19)~~ (18) medical equipment not specifically listed in this paragraph when the use of the equipment will prevent the need for costlier services that are reimbursable under this subdivision;

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

~~(21)~~ (20) services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health nurse's license as a registered nurse, as defined in section 148.171; and

~~(22)~~ (21) telemedicine consultations, to the extent they are covered under section 256B.0625, subdivision 3b~~; and~~.

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

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

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

(c) In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall where possible contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for prepaid health plans, competitive bidding programs, block grants, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are

provided. Before implementing prepaid programs in counties with a county operated or affiliated public teaching hospital or a hospital or clinic operated by the University of Minnesota, the commissioner shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the opportunity to participate in the program in a manner that reflects the risk of adverse selection and the nature of the patients served by the hospital, provided the terms of participation in the program are competitive with the terms of other participants considering the nature of the population served. Payment for services provided pursuant to this subdivision shall be as provided to medical assistance vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For payments made during fiscal year 1990 and later years, the commissioner shall consult with an independent actuary in establishing prepayment rates, but shall retain final control over the rate methodology.

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

(1) $25 for eyeglasses;

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

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

(4) 50 percent coinsurance on restorative dental services.

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

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

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

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

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

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

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

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

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

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

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

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

(q) Payments for mental health services added as covered benefits after December 31, 2006, are not subject to the reductions in paragraphs (i), (k), (l), and (m).

EFFECTIVE DATE. This section is effective January 1, 2007, except mental health case management under paragraph (a)(i)(15) is effective January 1, 2008.

Sec. 17. Minnesota Statutes 2005 Supplement, section 256L.03, subdivision 1, is amended to read:

Subdivision 1. **Covered health services.** For individuals under section 256L.04, subdivision 7, with income no greater than 75 percent of the federal poverty guidelines or for families with children under section 256L.04, subdivision 1, all subdivisions of this section apply. "Covered health services" means the health services reimbursed

under chapter 256B, with the exception of inpatient hospital services, special education services, private duty nursing services, adult dental care services other than services covered under section 256B.0625, subdivision 9, orthodontic services, nonemergency medical transportation services, personal care assistant and case management services, nursing home or intermediate care facilities services, inpatient mental health services, and chemical dependency services. ~~Outpatient mental health services covered under the MinnesotaCare program are limited to diagnostic assessments, psychological testing, explanation of findings, mental health telemedicine, psychiatric consultation, medication management by a physician, day treatment, partial hospitalization, and individual, family, and group psychotherapy.~~

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

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

EFFECTIVE DATE. This section is effective January 1, 2007, except mental health case management under subdivision 1 is effective January 1, 2008.

Sec. 18. Minnesota Statutes 2005 Supplement, section 256L.035, is amended to read:

256L.035 LIMITED BENEFITS COVERAGE FOR CERTAIN SINGLE ADULTS AND HOUSEHOLDS WITHOUT CHILDREN.

(a) "Covered health services" for individuals under section 256L.04, subdivision 7, with income above 75 percent, but not exceeding 175 percent, of the federal poverty guideline means:

(1) inpatient hospitalization benefits with a ten percent co-payment up to $1,000 and subject to an annual limitation of $10,000;

(2) physician services provided during an inpatient stay; and

(3) physician services not provided during an inpatient stay; outpatient hospital services; freestanding ambulatory surgical center services; chiropractic services; lab and diagnostic services; diabetic supplies and equipment; mental health services as covered under chapter 256B; and prescription drugs; subject to the following co-payments:

(i) $50 co-pay per emergency room visit;

(ii) $3 co-pay per prescription drug; and

(iii) $5 co-pay per nonpreventive visit.

The services covered under this section may be provided by a physician, physician ancillary, chiropractor, psychologist, ~~or~~ licensed independent clinical social worker, or other mental health providers covered under chapter 256B if the services are within the scope of practice of that health care professional.

For purposes of this section, "a visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by any health care provider identified in this paragraph.

Enrollees are responsible for all co-payments in this section.

(b) Reimbursement to the providers shall be reduced by the amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has reached the $20 per month maximum for prescription drug co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment, except as provided in paragraph (c).

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

EFFECTIVE DATE. This section is effective January 1, 2007, except mental health case management under paragraph (a), clause (3), is effective January 1, 2008.

Sec. 19. Minnesota Statutes 2004, section 256L.12, subdivision 9a, is amended to read:

Subd. 9a. **Rate setting; ratable reduction.** For services rendered on or after October 1, 2003, the total payment made to managed care plans under the MinnesotaCare program is reduced 1.0 percent. This provision excludes payments for mental health services added as covered benefits after December 31, 2006.

Sec. 20. **REVISOR'S INSTRUCTION.**

In the next edition of Minnesota Statutes, the revisor of statutes shall change the reference to sections 245.487 to 245.4887, the Children's Mental Health Act, wherever it appears in statutes or rules to sections 245.487 to 245.4889.

Sec. 21. **REPEALER.**

Minnesota Statutes 2004, sections 245.465, subdivision 2; 256B.0945, subdivisions 5, 6, 7, 8, and 9; and 256B.83, are repealed.

245.465 DUTIES OF COUNTY BOARD.

Subd. 2. **Residential and community support programs: 1992 salary increase.** In establishing, operating, or contracting for the provision of programs licensed under Minnesota Rules, parts 9520.0500 to 9520.0690 and programs funded under Minnesota Rules, parts 9535.0100 to 9535.1600, for the fiscal year beginning July 1, 1991, a county board's contract must reflect increased salaries by multiplying the total salaries, payroll taxes, and fringe benefits related to personnel below top management by three percent. This increase shall remain in the base for purposes of wage determination in future contract years. County boards shall verify in writing to the commissioner that each program has complied with this requirement. If a county board determines that a program has not complied with this requirement for a specific contract period, the county board shall reduce the program's payment rates for the next contract period to reflect the amount of money not spent appropriately. The commissioner shall modify reporting requirements for programs and counties as necessary to monitor compliance with this provision.

256B.0945 RESIDENTIAL SERVICES FOR CHILDREN WITH SEVERE EMOTIONAL DISTURBANCE.

Subd. 5. **Quality measures.** Counties must collect and report to the commissioner information on outcomes for services provided under this section using standardized tools that measure the impact of residential treatment programs on child functioning and/or behavior, living stability, and parent and child satisfaction consistent with the goals of section 245.4876, subdivision 1. The commissioner shall designate standardized tools to be used and shall collect and analyze individualized outcome data on a statewide basis and report to the legislature by December 1, 2003. The commissioner shall provide standardized tools that measure child and adolescent functionality, placement stability, and satisfaction for youth and family members.

Subd. 6. **Federal earnings.** Use of new federal funding earned from services provided under this section is limited to:

(1) increasing prevention and early intervention and supportive services to meet the mental health and child welfare needs of the children and families in the system of care;

(2) replacing reductions in federal IV-E reimbursement resulting from new medical assistance coverage;

(3) paying the nonfederal share of additional provider costs due to accreditation and new program standards necessary for Medicaid reimbursement; and

(4) paying for the costs of complying with the data collection and reporting requirements contained in subdivision 5.

For purposes of this section, prevention, early intervention, and supportive services for children and families include alternative responses to child maltreatment reports under chapter 626 and nonresidential children's mental health services outlined in section 245.4875, subdivision 2, and family preservation services outlined in Minnesota Statutes 2002, section 256F.05, subdivision 8.

Subd. 7. **Maintenance of effort.** (a) Counties that receive payment under this section must maintain a level of expenditures such that each year's county expenditures for prevention, early intervention, and supportive services for children and families is at least equal to that county's average expenditures for those services for calendar years 1998 and 1999.

(b) The commissioner may waive the requirements in paragraph (a) if any of the conditions specified in section 256F.13, subdivision 1, paragraph (a), clause (4), items (i) to (iv), are met.

Subd. 8. **Reports.** The commissioner shall review county expenditures annually using reports required under sections 245.482 and 256.01, subdivision 2, clause (17), to ensure that counties meet their obligation under subdivision 7, and that the base level of expenditures for prevention, early intervention, and supportive services for children and families and children's mental health residential treatment is continued from sources other than federal funds earned under this section.

Subd. 9. **Sanctions.** The commissioner may suspend, reduce, or terminate funds for prevention, early intervention, and supportive services for children and families up to the limit of federal revenue earned under this section to a county that does not meet one or all of the requirements of this section. If the commissioner finds evidence of children placed in residential treatment who do not meet the criteria outlined in section 245.4885, subdivision 1, the commissioner may take action to limit inappropriate placements in residential treatment.

256B.83 MAINTENANCE OF EFFORT FOR CERTAIN MENTAL HEALTH SERVICES.

Any net increase in revenue to the county as a result of the change in section 256B.0623 or 256B.0624 must be used to provide expanded mental health services as defined in sections 245.461 to 245.486, the Comprehensive Adult Mental Health Act, excluding inpatient and residential treatment. Increased revenue may also be used for services and consumer supports, which are part of adult mental health projects approved under section 245.4661. "Increased revenue" has the meaning given in Minnesota Rules, part 9520.0903, subpart 3.

Senate Counsel, Research, and Fiscal Analysis

G-17 STATE CAPITOL
75 REV. DR. MARTIN LUTHER KING, JR. BLVD.
ST. PAUL, MN 55155-1606
(651) 296-4791
FAX: (651) 296-7747
JO ANNE ZOFF SELLNER
DIRECTOR

Senate

State of Minnesota

S.F. No. 3290 - DHS Mental Health Bill (1st Engrossment)

Author: Senator Linda Berglin

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

Date: March 28, 2006

Sections 1 (245.465) and 4 (245.4874) [Duties of the County Board] modify the duties of the county board in the adult and children's mental health acts, respectively, to clarify that the county board is not responsible for providing mental health services to individuals who have the services covered under their health care coverage.

Section 2 (245.4682) [Mental Health Service Delivery and Finance Reform] establishes the mental health service delivery and finance reform.

Subdivision 1 sets out the policy of the mental health reform, which provides that the commissioner must undertake a series of reforms to improve the underlying structural, financing, and organizational problems in the state's mental health system, with the goal of improving the availability, quality, and accountability of mental health care in the state.

Subdivision 2 provides the design and implementation of the reforms. The commissioner is required to:

(1) consult with consumers, families, counties, tribes, advocates, providers, and other stakeholders;

(2) report to the legislature and the state Mental Health Advisory Council by January 15, 2007, with any recommendations for legislative changes;

(3) ensure continuity of care for persons affected by the reforms;

(4) provide accountability for the efficient and effective use of public and private resources in achieving positive outcomes for consumers;

(5) ensure client access to applicable protections and appeals; and

(6) make budget transfers that do not increase the state or county costs to effectively implement improvements to the mental health system and efficiently allocate state funds.

Subdivision 3, paragraph (a), authorizes the commissioner to solicit, approve, and implement regional projects to demonstrate the integration of physical and mental health services within prepaid health plans and their coordination with social services. The commissioner, in consultation with consumers, families, and their representatives shall:

(1) determine criteria for approving the regional projects;

(2) require that each project be based on locally defined partnerships;

(3) allows potential bidders at least 90 days to respond to the request for proposals;

(4) waive any administrative rule not consistent with the implementation of the regional projects; and

(5) begin implementation of the regional projects no earlier than January 1, 2008, with not more than 20 percent of the population described in paragraph (b) included during 2008, and additional individuals included in subsequent years.

Paragraph (b) requires the commissioner to enroll all medical assistance eligible persons with serious and persistent mental illness or severe emotional disturbance in the prepaid plan of their choice, unless; (1) an individual has another basis for exclusion from the prepaid plan, or (2) an individual has a previously established a therapeutic relationship with a provider who is not included in the available prepaid plans.

Paragraph (c) allows the commissioner to assign a plan if a person with serious and persistent mental illness or severe emotional disturbance declines to choose a plan.

Paragraph (d) requires the commissioner, in consultation with consumers, families, and their representatives, to refine the design of the regional service integration projects and expand the number of regions engaged in the programs as additional applications are received.

Paragraph (e) requires the commissioner to apply for federal waivers necessary to implement this section.

Section 3 (245.4835) [County Maintenance of Effort] requires the counties to maintain a level of expenditures for mental health services, so that each year's county expenditures are at least equal to that county's average expenditures from 2004 and 2005. The commissioner will annually adjust the county's base level. If a county fails to maintain expenditures, the county must develop a corrective action plan. If the county fails to develop an acceptable action plan, or does not comply with the action plan, the county loses protections under Minnesota Statutes, section 245.4895, which would expose the county to possible claims against the county by recipients of services or service providers.

Section 5 (245.4889) [Children's Mental Health Grants] establishes children's mental health grants.

Subdivision 1 authorizes the commissioner to make grants to assist counties, Indian tribes, children's collaboratives, or mental health service providers in providing services to children with emotional disturbances and their families, and to young adults who are younger than 21 years of age who are receiving transition services. The services must be designed to help the child function and remain with the child's family, and must be delivered consistent with the child's treatment plan. Transition services must be designed to foster independent living in the community.

Subdivision 2 provides the grant application process and the reporting requirements. The applicant must submit an application and budget, and the commissioner must give priority to applications that indicate plans to collaborate in the development, funding, and delivery of services with other agencies in the local system of care.

Section 6 (246.54, subdivision 1) modifies the public institutions chapter of law, specifically the statute relating to the counties financial responsibility for the cost of care. Current law requires the county to pay for 20 percent of the cost of care. The bill modifies the payment provisions by requiring the county to pay for 20 percent of the cost of care for the first 60 days, and 50 percent of the cost of care for 61 or more days. This section is effective January 1, 2007.

Section 7 (246.54) provides an exception to the language in section 6, for state-operated community behavioral health hospitals. For services at the behavioral health hospitals, payments to the state from the county equal 50 percent of the cost of care. The county is not entitled to reimbursement from the client, the client's estate, or from the client's relatives, except under the existing statute related to claims against the estate of a deceased client under section 246.53.

Section 8 (256B.0625, subdivision 20) amends Medical Assistance covered services, specifically mental health case management, by striking language related to the calculation of mental health grants, payment for mental health finances, and obsolete language. New language specifies that 50 percent of the cost of mental health case management services that are paid by the state without a federal share through fee-for-service is the responsibility of the recipient's county of responsibility. Also, language is added stating that prepaid medical assistance, general assistance medical care, and MinnesotaCare include mental health case management. When the service is provided through prepaid capitation, the non federal share is paid by the state and there is no county share.

Section 9 (256B.0625, subdivision 28) expands certified nurse practitioner services under medical assistance to include a clinical nurse specialists in mental health or a certified psychiatric nurse practitioner.

Sections 10 to 12 amend residential services for children with severe emotional disturbances.

Section 10 (256B.0945, subdivision 1) strikes obsolete language.

Section 11 (256B.0945, subdivision 4) modifies the payment rates by providing that per diem rates paid to providers under this section by prepaid plans shall be the proportion of the per day contract rate that relates to rehabilitative mental health services, and must not include payments for costs or services that are billed in the IV-E program as room and board. Paragraph (c) allows the commissioner to set aside five percent of federal funds earned for county expenditures for administration.

Section 12 (256B.0946, subdivision 11) expands services covered under medical assistance to include crisis assistance.

Sections 13 and 14 (256B.69, subdivisions 5g and 5h) modify the PMAP statutes by excluding from the payment reduction provisions mental health services added as covered benefits after December 31, 2006.

Section 15 (256B.763) [Critical Access Mental Health Rate Increase] establishes the critical access mental health rate increase. The services rendered on or after July 1, 2007, specified in paragraph (b), must be increased by 23.7 percent over the rates in effect on January 1, 2006, for:

(1) psychiatrists or advanced registered nurses with a psychiatric specialty;

(2) community mental health centers; and

(3) certain mental health clinics and centers, or hospital outpatient psychiatric departments designated as essential community providers.

Paragraph (b) states that the increase under paragraph (a) applies to group skills training when provided as a component of children's therapeutic services and support, psychotherapy, medication management, evaluation and management, diagnostic assessment, explanation of findings, and psychological testing, neuropsychological services, direction of behavior aides, and inpatient consultation.

Paragraph (c) specifies that the rate increase does not apply to "other clinic services" under section 256B.0625, subdivision 30, certain outpatient mental health services under section 256B.761, paragraph (b), other cost-based rates, rates that are negotiated with the county, rates that are established by the federal government, or rates that increased between January 1, 2004, and January 1, 2005.

Paragraph (d) requires the commissioner to adjust rates paid to prepaid health plans under contract with the commissioner to reflect the rate increases in paragraph (a), and the prepaid health plan must pass the increase to the providers identified in paragraph (a).

Section 16 (256D.03, subdivision 4) modifies general assistance medical care covered services to strike outpatient services provided by a mental health center or clinic, and add mental health services covered under chapter 256B. The bill also strikes the following covered services; day treatment services for mental illness provided under contract with the county board, psychological services, and mental health telemedicine and psychiatric consultation. Further, new language provides that payments for mental health services added as covered benefits after December 31, 2006, are not subject to the reductions in other paragraphs of this section of law.

Sections 17 to 19 amend MinnesotaCare statutes.

Section 17 (256L.03, subdivision 1) modifies MinnesotaCare covered services by striking language related to mental health services.

Section 18 (256L.035) expands MinnesotaCare covered services for single adults and households without children to include mental health services under chapter 256B.

Section 19 (256L.12, subdivision 9a) excludes payments for mental health services added as a covered benefit after December 31, 2006, from the ratable reduction.

Section 20 is a technical revisor's instruction.

Section 21 repeals Minnesota Statutes 2004, section 245.465, subdivision 2 (Residential and community support programs: 1992 salary increase), section 256B.0945, subdivisions 5 (Quality measures), 6 (Federal earnings), 7 (Maintenance of effort), 8 (Reports), and 9 (Sanctions), and section 256B.83 (Maintenance of effort for certain mental health services).

JW:mvm

Fiscal Note – 2005-06 Session

Bill #: S3290-1A **Complete Date:** 03/29/06

Chief Author: BERGLIN, LINDA

Title: MODIFY MENTAL HEALTH PROV

Fiscal Impact	Yes	No
State		X
Local		X
Fee/Departmental Earnings		X
Tax Revenue		X

Agency Name: Human Services Dept

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
-- No Impact --					
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
-- No Impact --					
Revenues					
-- No Impact --					
Net Cost <Savings>					
-- No Impact --					
Total Cost <Savings> to the State					

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

NARRATIVE: SF 3290/HF 3630

Bill Description
This bill implements the Governor's Mental Health Initiative. The Initiative recommends significant investments and reforms to the financing and delivery of publicly funded mental health services for the purpose of improving service access, quality, and accountability. The recommended actions include three key elements:

- Adopting a comprehensive mental health benefit set with proven treatment across all publicly funded health care programs;
- Promoting the integration of mental and physical health care and the effective coordination of health care with social services and education; and,
- Targeting significant infrastructure investments to improve statewide access to mental health treatment.

Assumptions
The DHS 2006 Supplemental Budget provides background and additional details for each of the above key elements on pages 1 – 10

A number of clarifying amendments were added in the Senate Health and Family Security Committee and are included in SF3290 – IE. The only amendment with a potential fiscal impact had to do with the addition of clinical nurse specialists and psychiatric nurse practitioners to existing language relating to MA coverage for nurse practitioners. DHS has reviewed this language and concluded that this is a clarification of existing policy which does not have a fiscal impact.

Expenditure and/or Revenue Formula

No fiscal impact in amendments – fiscal impact of bill as a whole as shown in Governor's supplemental budget documents.

Long-Term Fiscal Considerations

N/A

Local Government Costs
N/A

References/Sources
Department of Human Service February 2006 Forecast
State of Minnesota DHS 2006 Supplemental Budget

Agency Contact Name: Don Allen 431-2325
FN Coord Signature: STEVE BARTA
Date: 03/29/06 Phone: 431-2916

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 03/29/06 Phone: 286-5618

MN Mental Health Action Group

~ STEERING COMMITTEE ~

(As of March 2006)

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Mark Kuppe, Director of Behavioral Health, Human Services Incorporated
Steve Lepinski, Executive Director, Washburn Child Guidance Center
Maureen Marrin, Executive Director, Mental Health Consumer/Survivor Network of MN
Sandra Meicher, Executive Director, Mental Health Association of MN
Cari Michaels, Coordinator, Center of Excellence in Children's MH, U of MN Children, Youth & Families Consortium
Kathy Mock, Vice President, Policy and Legislative Affairs, Blue Cross/Blue Shield of MN
Roberta Opheim, Ombudsman, Office of Ombudsman for MH and MR
Carolyn Pare, Executive Director, Buyers Health Care Action Group
Patricia Siebert, Managing Attorney, MN Disability Law Center
Jon Uecker, Co-Chair, Legislative Committee, MN Psychiatric Society
Denny Ulmer, Director, Bemidji Regional Interdistrict Council
Carol Woolverton, Assistant Commissioner, MN Department of Health
Donna Zimmerman, Vice President of Government Public Relations, HealthPartners

Staff

Sean Kershaw, President, Citizens League
Michael Scandrett, Public Policy Director, Halleland Health Consulting

LEAGUE OF WOMEN VOTERS®
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550 RICE STREET ST. PAUL, MN 55103 PHONE (651) 224- 5445 FAX (651) 290-2145 www.lwvmn.org

Testimony for the Health and Human Services Budget Division
SF 3290
March 30, 2006
Barbara Flanigan, LWVMN Mental Health Lobbyist

My name is Barbara H. Flanigan and I speak today for the League of Women Voters of Minnesota. The League must oppose SF 3290 as currently written. It fails to give a high priority to the estimated 73,000 Minnesotans with serious and persistent mental illness (SPMI). We believe it would jeopardize the excellent—though underfunded—wrap-around social services which have developed in the county based system created by the 1987 Comprehensive Mental Health Act. We do support the extension of full mental health benefits to persons on Minnesota Care and General Assistance Medical Care.

Severe mental illness is a physical illness but, unlike many other chronic illnesses, social supports may be as important in patients' functioning and avoiding re-hospitalization as medical care and powerful medications We are particularly concerned about the ability of agencies providing flexible, individualized wrap-around community support program (CSP) services to continue under the proposed new organization of public mental health care delivery. In Hennepin County CSP programs, contracted with the county, serve more than 3000 people at an average cost of $1,000 annually. They help clients find and keep housing, reapply for benefits, keep appointments, find work and interact with peers to prevent the social isolation which is known to worsen the illness. We worry that agencies relying on "medical necessity" may fail to value sufficiently crucial support services which are not strictly "medical" in nature.

These agencies will not be able to survive on the basis of fee for service payments for face to face meetings with clients alone. They need the continuation of grant funding to support infrastructure. This is particularly true in dealing with people with SPMI who may not be able to come to appointments regularly or who may, on occasion, require a staff accompanying them for an entire morning or afternoon or even a full day.

Counties will almost certainly lose millions because of federal cutbacks in MA case management funds. Can we realistically expect them to continue funding support services at the necessary levels?

People with SPMI - people with schizophrenia, bipolar disorder, severe clinical depression and other very severe forms of mental illness who are also at risk of re-hospitalization - have received state services since the establishment of St. Peter State Hospital in the 1860s. This group of vulnerable adults are unpopular, lack political clout, are hard and expensive to treat and are very rarely "cured." Without conscious, explicit provisions to meet their needs they will fall between the cracks. SPMI is a lifelong illness; we need strong ongoing flexible supports.

We would urge that the examination of the future of case management in the plan be broadened to include CSPs.

Barbara H. Flanigan
612/928-8033, bchannaf@msn.com

Hennepin County Adult Mental Health Advisory Council

Resolution on DHS Proposed Mental Health Payment Model

- Where as, the Hennepin County Adult Mental Health Advisory Council in its previous work identified the four highest priority problems and shortages for persons with Serious and Persistent Mental Illness (SPMI) to be: housing with support services, employment opportunities, case management and crisis services i.e. acute in-patient bed shortages, and it is not clear how the Department of Human Services Proposed Mental Health Payment Model (or its subsequent titles) addresses these major problems and shortages.

- Where as, the Advisory Council believes physical health and mental health services must be integrated with social services for persons with SPMI, and it is not clear how that will be accomplished under this new Model.

- Where as, it has been suggested that there will be new money appropriated to cover some of the costs of the new Model, and it is not clear where the new money will come from and what happens if this new money is unavailable or substantially less is received than needed to cover parts of the new Model.

- Where as, the Advisory Council takes very seriously its charge to make recommendations on mental health to the County Board, be involved with the County plan for mental health services, and provide the County Board with a list of unmet mental health needs of adults residing in the County, and it is concerned that it is not clear how this new Model will assure that the health plans or members of the newly restructured system are accountable to DHS, the public, and more importantly, the consumers and family members who use the services.

Therefore: The Hennepin County Adult Mental Health Advisory Council continues to recommend a "Slow Down" in the process and the involvement of more stakeholders, especially consumers, family members, advocates and community providers.

Adopted unanimously on March 16, 2006

Earlier Resolution: Adopted unanimously on January 19, 2006

Whereas, there has been inadequate time and information for consumers, family members and the mental health community as a whole to review and respond to the Mental Health Payment Model being proposed by the Department of Human Services, the Hennepin County Adult Mental Health Advisory Council recommends a "Slow Down" in the process and the involvement of more stakeholders, especially consumers, family members, advocates and community providers.

For more information contact Co-Chairs Katy Boone (612/824-155) and Max Hines (952/886-7576)

Testimony provided by Peggy Heglund re: HF 3630/SF 3290

My name is Peggy Heglund and I am the Director of the Family Service Center in Yellow Medicine County. I have also been the MACSSA representative for MHAG by serving on the Steering Committee.

My testimony is in regard to the Mental Health reform bill and in particular, Case Management. I appreciate the opportunity to provide a more in-depth perspective of what happens when someone needs this service. I must note that my experience is with Yellow Medicine County.

Case Management is a very intensive, hands-on service. The Case Manager (CM) is very active with the individual and others involved through numerous contacts, on the telephone but also in person. Case Load sizes are at a ratio of 1 CM to 15 Children and 1 to 35 adults.

Referrals come to the Family Service Center (Agency) through many sources. We get calls from the individual themselves, family members, Mental Health Professionals, providers of services, and unfortunately hospitals due to crisis admissions.

The CM starts by gathering information about the presenting problem and also the person's history. This information is compiled and used to assess the needs and strengths of the individual. A plan is then formulated that includes the CM and the adult or the child and his/her family.

This plan may include needs in the area of Mental Health therapy, medications, mediation management, assistance with activities for daily living like budgeting, shopping, homemaking, and cooking. There may be needs in personal care. Some require help in locating and maintaining housing and employment. The CM might help out with the myriad of forms required to receive MHCP and to keep the medical coverage. Transportation to the above is usually a concern. And we have even found it necessary to find care for a beloved pet.

The CM then makes referrals to appropriate service providers or assists with the concern directly. When a service package is in place, we continue to monitor to assure quality and continued appropriateness. Changes are made as needed.

If the services are for a child the CM is working with the school staff and possible corrections officers. Our first choice is to provide in-home therapy, family based therapy, and local day treatment.

Coordination is key in keeping all involved informed and working in sync. The CM will arrange for interdisciplinary team meetings as well as meet with the individual alone.

Last, we hope to be there to celebrate the successes of those who are able to benefit from the help they have received and move forward with their lives!

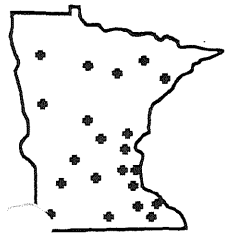
I want to state that MACSSA has been included in the development of this plan. I would ask that this involvement continue.

Based on the above, I would request that County representation be allowed in the writing of the RFP's and the Contracts. I realize some believe this could be a conflict of interest, but I more strongly believe that input regarding the intensify of CM and assuring it is defined adequately is more important. Our involvement is integral and we ask to be included.

Given our recent experience with the rollout of MSHO, I am not convinced that the Health Plans understand what we do.

I have one more comment on another matter in this bill. The state DHS is requesting a county Maintenance of Effort (MOE). They are also asking that counties share in the cost of care at state hospitals. I would ask that we not pay for hospital time, but instead use the dollars to develop community based services that would be available for persons leaving a hospital. This could include housing and intensive services not currently available.

Thank you.



Minnesota Association of Community Mental Health Programs, Inc.

Improving quality through education, public policy advocacy, and member services
Serving people of Minnesota

Ronald C. Brand
Executive Director

Position Statement on Governor's Mental Health Initiative (SF-3290/ HF-3630)

My name is Ron Brand, Executive Director of Minnesota Association of Community Mental Health Programs, Inc. (MACMHP). The Association is a statewide group of 29 nonprofit providers that deliver an array of services in about 118 locations statewide (psychiatry, outpatient therapy, residential treatment, chemical dependency, home-based rehab. services for adults and kids, community support services, and other innovative programs) The centers and clinics are safety-net providers, critical access points in the system, serving clients without regard to ability to pay. Consequently, their caseload has a high proportion of uninsured, underinsured, and government programs. In addition, MACMHP members are also key providers for private healthplans statewide. We represent a significant portion of the public and private mental health system.

I want to briefly speak in favor of the Governor's Mental Health Initiative and comment on some of the work ahead to make the vision of the proposal a fully functioning reality.

First, I want to commend DHS for their work on this project. The agency staff's work on this at all levels, Commissioner Goodno, Assistant Commissioner Wes Kooistra and their staff, have been the best in my experience: open, competent, problem solving, asking tough questions as they put together the product that you have before you.

This proposal is only possible because of the many previous efforts and successes by leaders in both parties, over many years. This is the next stage in modernizing the mental health system--overdue for investments and reform.

Our association members and staff have been very involved with MHAG, chairing a few workgroups, as members of the Steering Committee and providing advice.

Overall the proposal is founded on the right values and principles and heads in the right direction. It is an overdue investment in an under-served area that affects many aspects of our community: family stability, workplace productivity, workers compensation, long-term care, welfare-to-work, corrections, educational success, and other healthcare costs.

A basic policy assumption is that mental health should be treated as a healthcare condition--that for some social services and educational supports are necessary to support the treatment and recovery goals. To put this orientation into practice, requires adjustments to the funding and payment system. In the end, the concern must be less on how the authority is structured, but on how resources will get to the direct service delivery on the ground efficiently and effectively. As providers we can deliver the services, but must the system must maintain the financial support to do it.

We like the emphasis on earlier intervention and strengthening connections with healthcare. We need a system that provides "Help First--not Fail First". It is sad that so many people have need to wait for services, too often falling to a level of disability and poverty or civil commitment as a gateway to care.

The improved benefits, standardized for GAMC and MnCare is an excellent policy. This provides access to a more comprehensive services for all state healthcare programs.

1821 University Avenue West, Suite 307-S, St. Paul, MN 55104-2898
Phone: (651) 642-1903 Fax: (651) 645-1399 www.macmhp.org

The bill includes investments for school-based mental health, evidenced based services, services that will require subsidy to be viable such as crisis services and certain specialty services that require centers of excellence. These are all sound investments. As we develop these services, it is important to look adjust our current reimbursement policies to support the evidenced based practices and to build the services so that they are able to earn revenue from public and private sources, when available. Too often, grant funded programs are not able to be sustainable because they have not been developed and operated to meet the credentialling or certification standards of the public and private payers.

Improved reimbursement rates (Section 13) for critical access providers is an essential feature of the proposal--an investment in the service infrastructure. Under the current system, certain community providers are overburdened with uncompensated care, with long wait times for appointments, yet unable to add staff because the revenues do not support the cost of providing the care. Psychiatry is a critical shortage that will require long-term solutions. Improved rates will at least attract more psychiatrists into serving public clients and participating in healthplan networks.

As we rely more on reimbursement and less on grants or appropriations to finance services, several problems in the payment system will need to be addressed if this proposal is to be successful. This will be an ongoing discussion as we move forward.

Redirecting MH grant funds raises concerns about how services that have been supported by grant will be viable. Our understanding is that DHS staff are carefully identifying services and funds related to services that would now be covered in healthcare programs, leaving the remaining dollars in the grant funding stream to support activities that would not be reimbursable as a health benefit. For example, efforts to secure housing and prepare a landlord for placing a client in a housing plus services arrangement. Only part of this might be covered by the rehab. or case management benefit. Outreach and community support program services to build trust and get a client engaged in accepting treatment are unlikely to be covered, but are an essential part of a voluntary system.

We have been glad for the open and deliberate efforts by the Department to listen and solve problems. We see that the bill includes a commitment to continued collaboration with stakeholders on the design of "Preferred Integrated Networks" to be developed for 2008. There are several issues that will need further work and clarification in the interim. Many of these will be administrative, contractual, or operational and will not require legislation. Still, it is good that their is another legislative session next year so that we can make any midcourse corrections. For now, we are convinced that this proposal is founded on the right assumptions and is headed in the right direction. It is a worthy investment and should attract broad bipartisan support in the legislature.

ATTACHMENT "B"

03/30/06 COUNSEL JW/MM SCS3290A-7

Senator ..... moves to amend S.F. No. 3290 as follows:

Page 2, delete lines 5 to 7 and insert:

"(2) bring to the legislature, and the State Mental Health Advisory Council by January 15, 2007, recommendations for legislation to update the role of counties and to clarify the case management roles and functions of health plans and counties;"

Page 7, delete section 6 and insert:

"Sec. 6. Minnesota Statutes 2004, section 246.54, subdivision 1, is amended to read:

Subdivision 1. **County portion for cost of care.** Except for chemical dependency services provided under sections 254B.01 to 254B.09, the client's county shall pay to the state of Minnesota a portion of the cost of care provided in a regional treatment center or a state nursing facility to a client legally settled in that county. A county's payment shall be made from the county's own sources of revenue and payments shall be paid as follows: payments to the state from the county shall equal 20 percent of the cost of care, as determined by the commissioner, for each ~~day~~ of the first 60 days, or the portion thereof, that the client spends at a regional treatment center or a state nursing facility. After the first 60 days, the county share is 50 percent. This increase in the county share of payment shall not apply if the continued placement of the client in the regional treatment center, state nursing facility, or community behavior hospital is the result of one of the following:

(1) the individual has been admitted for assessment and treatment under a court order; or

(2) there has been medical certification by the head of the center, facility, or hospital that the client is in need of continued treatment at a hospital level of care.

If payments received by the state under sections 246.50 to 246.53 exceed 80 percent of the cost of care for the first 60 days or 50 percent of any additional days, the county shall be responsible for paying the state only the remaining amount. The county shall not be entitled to reimbursement from the client, the client's estate, or from the client's relatives, except as provided in section 246.53. ~~No such payments shall be made for any client who was last committed prior to July 1, 1947.~~

EFFECTIVE DATE. This section is effective January 1, 2007."

Page 7, delete section 7, and insert:

"Sec. 7. Minnesota Statutes 2004, section 246.54, is amended by adding a subdivision to read:

Subd. 3. **Additional exception for community behavioral health hospitals.** Subdivision 1 does not apply to services provided at state-operated community behavioral health hospitals. For services at these facilities, a county's payment shall be made from

the county's own sources of revenue and payments shall be paid as follows: payments to the state from the county shall equal 50 percent of the cost of care, as determined by the commissioner, for each day, or the portion thereof, that the client spends at the facility. After the first 60 days, the county share is 50 percent. This increase in the county share of payment shall not apply if the continued placement of the client in the regional treatment center, state nursing facility, or community behavior hospital is the result of one of the following:

(1) the individual has been admitted for assessment and treatment under a court order; or

(2) there has been medical certification by the head of the center, facility, or hospital that the client is in need of continued treatment at a hospital level of care.

If payments received by the state under sections 246.50 to 246.53 exceed 50 percent of the cost of care, the county shall be responsible for paying the state only the remaining amount. The county shall not be entitled to reimbursement from the client, the client's estate, or from the client's relatives, except as provided in section 246.53.

EFFECTIVE DATE. This section is effective January 1, 2007."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly