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

Author: Senator Thomas Bakk
Prepared by: David Giel, Senate Research (296-7178)
Date: March 7, 2005

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

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

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

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

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

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

Section 1
1 beds are available within 25 miles of the facility. The
2 commissioner shall exempt a facility from compliance with the
3 sole community provider requirement in clause (a) if, as of
4 January 1, 2004, the facility had an agreement with the
5 commissioner to provide medical assistance swing bed services.
6 Medical assistance also covers up to ten days of nursing care
7 provided to a patient in a swing bed if: (1) the patient's
8 physician certifies that the patient has a terminal illness or
9 condition that is likely to result in death within 30 days and
10 that moving the patient would not be in the best interests of
11 the patient and patient's family; (2) no open nursing home beds
12 are available within 25 miles of the facility; and (3) no open
13 beds are available in any Medicare hospice program within 50
14 miles of the facility. The daily medical assistance payment for
15 nursing care for the patient in the swing bed is the statewide
16 average medical assistance skilled nursing care per diem as
17 computed annually by the commissioner on July 1 of each year.
18 [EFFECTIVE DATE.] This section is effective the day
19 following final enactment and applies to medical assistance
20 payments for swing bed services provided on or after March 5,
21 2005.
S.F. No. 870 - Establishing a Crises Nursery Grant Program

Author:    Senator Yvonne Prettner Solon
Prepared by:  Joan White, Senate Counsel (651/296-3814)
Date:    March 3, 2005

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

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

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

JW:rdr
Senators Solon, Higgins, Lourey, Hottinger and Senjem introduced—

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

A bill for an act
relating to human services; establishing a crisis
nursery grant program; proposing coding for new law in
Minnesota Statutes, chapter 256F.

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

Section 1. [256F.15] [GRANT PROGRAM FOR CRISIS NURSERIES.]
Subdivision 1. [CRISIS NURSERIES.] The commissioner of
human services shall establish a grant program to assist private
and public agencies and organizations to provide crisis
nurseries to offer services and temporary care to families
experiencing crisis situations including children who are at
high risk of abuse and neglect, children who have been abused
and neglected, and children who are in families receiving child
protective services. This service shall be provided without a
fee for a maximum of 30 days in any year. Crisis nurseries
shall provide short-term case management, family support
services, parent education, crisis intervention, referrals, and
resources, as needed.

(a) The crisis nurseries must:
(1) be available 24 hours a day, seven days a week;
(2) provide services for children up to 72 hours at any one
time;
(3) provide short-term case management to bridge the gap
between crisis and successful living;
(4) make referrals for parents to counseling services and

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

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

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

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

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

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

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

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

(12) provide developmental assessments;

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

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

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

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

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

Subd. 2. [FUND DISTRIBUTION.] In distributing funds, the
commissioner shall give priority consideration to agencies and
organizations with experience in working with abused or
neglected children and their families, and with children at high
risk of abuse and neglect and their families, and serve
communities which demonstrate the greatest need for these
services. Funds shall be distributed to crisis nurseries
according to a formula developed by the commissioner in
consultation with the Minnesota Crisis Nursery Association. The
formula shall include funding for all existing crisis nursery
programs that have been previously funded through the Department
of Human Services and that meet program requirements as
specified in subdivision 1, paragraph (a), and consideration of
factors reflecting the need for services in each service area,
including, but not limited to, the number of children 18 years
of age and under living in the service area, the percent of
children 18 years of age and under living in poverty in the
service area, and factors reflecting the cost of providing
services, including, but not limited to, the number of hours of
service provided in the previous year.
Consequences to Crisis Nurseries from Choices Made in the ’03-’04 Legislative Sessions

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

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

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

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

What choices did the 2003-2004 Legislatures make?

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

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

Nonprofits can be there to help as this story from an LSS crisis shelters illustrates:

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

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>LSS Crisis Nurseries</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bethany LSS in Duluth</strong></td>
</tr>
<tr>
<td>The nursery has had to turn people away which is painful in the face of parents who say that, without Bethany LSS, they “would not have been able to make it.”</td>
</tr>
</tbody>
</table>

| **St. Cloud Area LSS Crisis Nursery** |
| One paid staff person supervises volunteers and interns from St. Cloud State. 50% of the budget was cut. One-time grants and the “grace of God” allowed them to remain open. Although more grant applications are in, some grants expire August 1, 2004. They are receiving increasing calls for child-care because of reduction in child-care assistance. |

| CAP Crisis Nursery (Scott/Carver Counties) |
| - eliminated a program designed for teen parents, an especially high-risk population |

| **Children’s Home Society (Anoka, Chisago/Isanti, Dakota, Ramsey, Washington, Wright Counties)** |
| - 20% ($342,000) cut from their crisis nursery budget meant closing 2 centers & eliminating positions. |

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

| **Itasca Area Crisis Nursery (serving Itasca & Koochiching Counties)** |
| - lost 60% of their $90,000 budget & eliminated a parent & a grandparent support program |
| Appealing to the community and churches, going through the phone book and sending fundraising letters out to the community netted checks for $5-$10 dollars “but our community has nothing more to give” |

| **Pillsbury Crisis Nursery, Minneapolis** |
| - 33% budget reduction meant relocating and eliminating their family violence program. |

2005 information from Crisis Nurseries, Inc:

**Crisis Nursery Programs in**

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

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

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

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

---

Research by Amy Swenson, LSS Public Policy Intern, 2003-2004 and information from Crisis Nurseries Inc.
Research summarized by Claire Thoen-Levin, LSS Office of Public Policy and Advocacy May 2004
For more information, please visit our website: www.lssmn.org/advocate
S.F. No. 227 - Cancer Drug Repository Program
(Delete-Everything Amendment)

Author: Senator Yvonne Prettner Solon
Prepared by: Katie Cavanor, Senate Counsel (651/296-3801)
Date: March 4, 2005

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


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

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

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

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

(2) bear an expiration date that is later than six months after the date the drug was donated;

(3) it is in its original, unopened, sealed, and tamper-evident unit dose packaging, or, if packaged in single-unit-doses, unopened; and

(4) not be adulterated or misbranded, as determined by a pharmacist who has inspected the drug or supply before it is dispensed.

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

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

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

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

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

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

Subdivision 11 provides that a medical facility, pharmacist, pharmacy or practitioner participating in the program or a donor of a cancer drug or supply are immune from civil liability for injury to or the death of the individual to whom the drug or supply is dispensed and may not be disciplined for unprofessional conduct for their acts or omissions relating to donating, accepting, distributing, or dispensing a cancer drug or supply under this program. This immunity does not apply if the act or omission involves reckless, wanton, or intentional misconduct.
A bill for an act
relating to health; establishing a cancer drug
repository program; requiring rulemaking; proposing
coding for new law in Minnesota Statutes, chapter 144.

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

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

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

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

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

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

(c) "Dispense" has the meaning given in section 151.01,
subdivision 30.

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

(e) "Medical supplies" means any medical supply needed to
administer a cancer drug.

(f) "Pharmacist" has the meaning given in section 151.01,
subdivision 3.

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

(h) "Practitioner" has the meaning given in section 151.01,
subdivision 23.

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

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

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

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

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

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

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

Subd. 4. [ADMINISTRATION COST.] No cancer drug or supply that is donated for use under this section shall be resold. The medical facility or pharmacy may charge the individual who receives a cancer drug or supply under the program a handling fee that may not exceed an amount specified by the commissioner.
Subd. 5. [PARTICIPATION.] Nothing in this section requires that a medical facility, pharmacy, pharmacist, or practitioner participate in the program.

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

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

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

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

(i) eligibility criteria;

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

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

(iv) standards and procedures for inspecting donated cancer drugs and supplies to determine that the cancer drug or supply
is not adulterated or misbranded;

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

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

(4) a list of cancer drugs and supplies arranged by category or by individual cancer drug or supply that will be accepted under the program and a list of cancer drugs and supplies that will not be accepted under the program. The list shall include a statement that specifies the reason that a cancer drug or supply is ineligible for donation.
Senator... moves to amend S.F. No. 227 as follows:

Delete everything after the enacting clause and insert:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) A pharmacy or medical facility may fully participate in the cancer drug repository program by accepting, storing, and
dispensing donated drugs and supplies, or may limit its participation to only accepting and storing donated drugs and supplies. If a pharmacy or facility chooses to limit its participation, the pharmacy or facility shall distribute any donated drugs to a fully participating cancer drug repository in accordance with subdivision 8.

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

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

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

(1) an individual who is 18 years old or older; or

(2) a pharmacy, medical facility, drug manufacturer, or wholesale drug distributor, if the donated drugs have not been previously dispensed.

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

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

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

(3) the drug is in its original, unopened, tamper-evident unit dose packaging that includes the drug’s lot number and
expiration date. Single-unit dose drugs may be accepted if the single-unit-dose packaging is unopened; and

(4) the drug is not adulterated or misbranded.

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

(1) the supplies are not adulterated or misbranded;

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

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

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

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

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

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

Subd. 6. [DISPENSING REQUIREMENTS.] (a) Drugs and supplies must be dispensed by a licensed pharmacist pursuant to a prescription by a practitioner and in accordance with the Section 1
requirements of chapter 151.

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

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

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

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

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

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

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

(1) individuals who are uninsured;

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

(3) all other individuals who are otherwise eligible under Section 1
subdivision 4 to receive drugs or supplies from a cancer drug repository.

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

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

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

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

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

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

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

(1) the date of destruction;

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

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

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

Subd. 11. [LIABILITY.] A medical facility, pharmacy, pharmacist, or practitioner participating in the program, or the donor of a cancer drug or supply is immune from civil liability for an act or omission that causes injury to or the death of an individual to whom the cancer drug or supply is dispensed and no disciplinary action shall be taken against a pharmacist or practitioner so long as the drug or supply is donated, accepted, distributed, and dispensed in accordance with the requirements of this section. This immunity does not apply if the act or omission involves reckless, wanton, or intentional misconduct."
S.F. No. 984 - Services for Persons With Disabilities

Author: Senator Becky Lourey

Prepared by: Joan White, Senate Counsel (651/296-3814)
Katie Cavanor, Senate Counsel (651/296-3801)
David Giel, Senate Research (651/296-7178)

Date: March 8, 2005

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

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

Under paragraph (2), if the household’s adjusted gross income is equal or greater than 175 percent of the federal poverty guidelines (FPG) and less than or equal to 545 percent of FPG, the parental contribution is determined using a sliding fee scale, beginning at one percent and increasing to 7.5 percent. Current law imposes an income ceiling of 375 percent of FPG.
Under paragraph (3), if the parental income is greater than 575 percent, instead of 375 percent, and less than 675 percent, the parental contribution is 7.5 percent of adjusted gross income.

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

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

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

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

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

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

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

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

Section 8 (256B.0621, subdivision 4) requires the commissioner to ensure that each eligible person is given a choice of county and private agency relocation targeted case management service providers. (Relocation targeted case management assists recipients in gaining access to services when moving from an institution to the community.) This section also requires that a subcontracted provider of relocation targeted case management must have a procedure in place that provides full disclosure to the recipient, instead of notifies the recipient, of any conflict of interest if the provider provides or will provide the recipient's housing, services, or supports. This section is effective July 1, 2005, or, if federal waiver is required, on the date the federal waiver is granted.
Section 9 (256B.0621, subdivision 6) modifies MA-eligible services by striking language that stated the assessment of a recipient’s need for targeted case management services is eligible for medical assistance reimbursement. This section creates a new paragraph for targeted relocation case management administrative activities. The new language provides that these activities are the responsibility of the county or the agency under contract, and they include: (1) assessment of the recipient’s need for targeted case management services; (2) eligibility determination; (3) providing information and assistance to the recipient sufficient to choose a provider of targeted case management services; (4) approval of service plans and necessary contracts; and (5) monitoring spending and evaluating health, safety, welfare, and service outcomes.

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

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

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

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

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

Section 16 (256B.49, subdivision 13) amends the home and community-based waiver for chronically ill children and disabled persons by requiring the recipient of services to choose a vendor of case management services coordination among qualified public and private vendors. Current law requires the recipient to be provided with a vendor for services. This section also provides case management service “coordination” activities, which include assessing the needs of the individual “as changes occur, but at least annually.” Current law requires that case management service activities include assessing the individual within 20 working days of the recipient’s request.
A new paragraph is added creating case management administrative activities, which are the responsibility of the county or agency under contract. Case management administrative functions include: (1) screening; (2) assistance with obtaining diagnoses and necessary medical or health reports; (3) eligibility determination; (4) initial assessment within 20 days of request for waiver services; (5) providing information and assistance to the person sufficient to allow the person to choose a vendor of case management services coordination; (6) determination of resources needed to meet assessed needs; (7) approval of services plans and necessary contracts; and (8) monitoring spending and evaluating health, safety, welfare, and service outcomes. This section is effective July 1, 2005, or, if a federal waiver is required, on the date the federal waiver is granted.

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

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

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

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

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

Sections 22, 23, and 24 (256L.03) restore the adult dental benefits in MinnesotaCare as follows: for adult enrollees with income no greater than 75 percent of FPG, dental coverage is the same as in the MA program, except there is no coverage for orthodontic services and a 50 percent co-payment for services other than preventive care. For pregnant women and children, dental services are the same as in the medical assistance program.
Section 25 requires DHS to request any federal approvals and plan amendments necessary to implement the transitional supports allowance and the case management service coordination choices authorized under this bill.
A bill for an act relating to human services; modifying programs and services for persons with disabilities; amending Minnesota Statutes 2004, sections 252.27, subdivision 2a; 256B.04, by adding a subdivision; 256B.056, subdivisions 3, 5c; 256B.057, subdivision 9; 256B.0575; 256B.0621, subdivisions 4, 6, by adding a subdivision; 256B.0625, subdivision 9; 256B.0916, by adding a subdivision; 256B.092, subdivisions 2a, 4b; 256B.35, subdivision 1; 256B.49, subdivisions 13, 16; 256B.5012, by adding a subdivision; 256B.69, subdivision 23; 256B.765; 256D.03, subdivision 4; 256L.03, subdivisions 1, 5, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 256.

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

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

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

(b) For households with adjusted gross income equal to or greater than 100 percent of federal poverty guidelines, the parental contribution shall be computed by applying the
following schedule of rates to the adjusted gross income of the natural or adoptive parents:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. the parent applied for insurance for the child;
2. the insurer denied insurance;
3. the parents submitted a complaint or appeal, in writing to the insurer, submitted a complaint or appeal, in writing, to the commissioner of health or the commissioner of commerce, or litigated the complaint or appeal; and
4. as a result of the dispute, the insurer reversed its decision and granted insurance.
For purposes of this section, "insurance" has the meaning given in paragraph (h).

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

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

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

(1) promoting development of affordable and accessible housing;
(2) improving the recruitment and retention of direct care support staff;
(3) providing information and referral as well as person-centered assessments;
(4) allowing funding to follow the individual, rather than the providers;
(5) reducing the waiting lists for home and community-based services;
(6) increasing employment opportunities for people with disabilities;
(7) enhancing data collection activities and systems;
(8) improving transportation that complies with the Americans with Disabilities Act; and
(9) assuring quality of services based on outcomes.

Subd. 2. [MEMBERSHIP.] The governor must appoint ten members to the Disability Services Coordination Commission. The
speaker of the house of representatives must appoint three
members of the house of representatives to the commission. The
president of the senate must appoint three members of the senate
to the commission. The commission membership appointed by the
governor must include the following individuals:

(1) the commissioner of the Department of Human Services;
(2) the commissioner of the Department of Health;
(3) the commissioner of the Department of Corrections;
(4) the commissioner of the Department of Finance;
(5) the commissioner of the Department of Employment and
Economic Development;
(6) the commissioner of the Department of Education;
(7) the commissioner of the Minnesota Housing Finance
Agency;
(8) the Metropolitan Council housing planner;
(9) a representative of a public housing authority; and
(10) a representative of the counties.

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

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

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

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

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

(5) appointing individuals within various state agencies to
continue ongoing coordination efforts and annual reports to the
legislature and the Disability Services Coordination Commission;
(6) developing a forum for integrating state agency work plans to implement Minnesota's coordinated plan and ensure open, regular, public discussion of the plans; and

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

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

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

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

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

Subd. 20. [INCENTIVE FOR WELLNESS VISITS.] The commissioner of human services shall consult with private sector health plan companies and shall develop an incentive program to encourage medical assistance enrollees with disabilities to have regular wellness exams conducted by a primary care physician.

The commissioner shall implement the incentive program beginning January 1, 2006.

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

Subd. 3. [ASSET LIMITATIONS FOR INDIVIDUALS-AND FAMILIES THE AGED, BLIND, OR DISABLED.] To be eligible for medical assistance, a person eligible under section 256B.055, subdivision 7, 7a, or 12 must not individually own more than $37,000 $10,000 in assets, or if a member of a household with two family-members—husband-and-wife, or-parent-and-child or more persons, the household must not own more than $67,000 $18,000 in assets—for-each-additional legal-dependent. In addition to these maximum amounts, an
eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The accumulation of the clothing and personal needs allowance according to section 256B.35 must also be reduced to the maximum at the time of the eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance is the value of those assets excluded under the supplemental security income program for aged, blind, and disabled persons, with the following exceptions:

(a) Household goods and personal effects are not considered.
(b) Capital and operating assets of a trade or business that the local agency determines are necessary to the person's ability to earn an income are not considered.
(c) Motor vehicles are excluded to the same extent excluded by the supplemental security income program.
(d) Assets designated as burial expenses are excluded to the same extent excluded by the supplemental security income program. Burial expenses funded by annuity contracts or life insurance policies must irrevocably designate the individual's estate as contingent beneficiary to the extent proceeds are not used for payment of selected burial expenses.
(e) Effective upon federal approval, for a person who no longer qualifies as an employed person with a disability due to loss of earnings, assets allowed while eligible for medical assistance under section 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility as an employed person with a disability, to the extent that the person's total assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (b).

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

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

(b) The excess income standard for a person whose

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans, Keogh plans, and pension plans; and
(3) medical expense accounts set up through the person's employer.

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

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

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

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

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

(4) Effective November 1, 2003 July 1, 2005, for enrollees whose income does not exceed 200 percent of the federal poverty guidelines and who are also enrolled in Medicare, the commissioner must reimburse the enrollee for Medicare Part B premiums under section 256B.0625, subdivision 15, paragraph (a).
(5) Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year.

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

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

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

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

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

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

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

Section 7
When an institutionalized person is determined eligible for medical assistance, the income that exceeds the deductions in paragraphs (a) and (b) must be applied to the cost of institutional care.

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

1. the personal needs allowance under section 256B.35 or, for a veteran who does not have a spouse or child, or a surviving spouse of a veteran having no child, the amount of an improved pension received from the veteran's administration not exceeding $90 per month;
2. the personal allowance for disabled individuals under section 256B.36;
3. if the institutionalized person has a legally appointed guardian or conservator, five percent of the recipient's gross monthly income up to $100 as reimbursement for guardianship or conservatorship services;
4. a monthly income allowance determined under section 256B.058, subdivision 2, but only to the extent income of the institutionalized spouse is made available to the community spouse;
5. a monthly allowance for children under age 18 which, together with the net income of the children, would provide income equal to the medical assistance standard for families and children according to section 256B.056, subdivision 4, for a family size that includes only the minor children. This deduction applies only if the children do not live with the community spouse and only to the extent that the deduction is not included in the personal needs allowance under section 256B.35, subdivision 1, as child support garnished under a court order;
6. a monthly family allowance for other family members, equal to one-third of the difference between 122 percent of the federal poverty guidelines and the monthly income for that family member;
7. reparations payments made by the Federal Republic of
Germany and reparations payments made by the Netherlands for victims of Nazi persecution between 1940 and 1945;
(8) all other exclusions from income for institutionalized persons as mandated by federal law; and
(9) amounts for reasonable expenses incurred for necessary medical or remedial care for the institutionalized person that are not medical assistance covered expenses and that are not subject to payment by a third party.

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

(b) Income shall be allocated to an institutionalized person for a period of up to three six calendar months, in an amount equal to 100 percent of the medical-assistance-standard federal poverty guidelines for a family size of one if:
(1) a physician certifies that the person is expected to reside in the long-term care facility for three six calendar months or less;
(2) if the person has expenses of maintaining a residence in the community; and
(3) if one of the following circumstances apply:
   (i) the person was not living together with a spouse or a family member as defined in paragraph (a) when the person entered a long-term care facility; or
   (ii) the person and the person's spouse become institutionalized on the same date, in which case the allocation shall be applied to the income of one of the spouses.

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

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

Section 8
Subd. 4. [RELOCATION TARGETED CASE MANAGEMENT PROVIDER QUALIFICATIONS.] (a) A relocation targeted case management provider is an enrolled medical assistance provider who is determined by the commissioner to have all of the following characteristics:

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

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

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

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

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

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

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

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

(d) A relocation targeted case management provider may subcontract with another provider to deliver relocation targeted case management services. Subcontracted providers must demonstrate the ability to provide the services outlined in subdivision 6, and have a procedure in place that notifies provides full disclosure to the recipient and the recipient's legal representative of any conflict of interest if the
contracted targeted case management provider also provides, or will provide, the recipient's housing, services and, or supports. Contracted providers must provide information on all conflicts of interest and obtain the recipient's informed consent or provide the recipient with alternatives. [EFFECTIVE DATE.] This section is effective July 1, 2005, or, if a federal waiver is required, on the date the federal waiver is granted.

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

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

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

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

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

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

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

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

(7) traveling to conduct a visit with the recipient or
other relevant person necessary to develop or implement the
goals of the individual service plan; and

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

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

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

(2) eligibility determination;

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

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

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

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

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

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

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

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

(1) diagnostic and preventative services;
(2) restorative services; and

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

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

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

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

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

(b) The commissioner shall ensure that each eligible person is given a choice of county and private agency case management service coordination vendors.
(c) The commissioner shall, with consumer input, develop standards, notice requirements, and basic consumer rights so that full disclosure is provided in cases in which a case manager may be providing relocation services, housing, or other support services to the same individual.

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

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

Subd. 4b. [CASE MANAGEMENT FOR PERSONS RECEIVING HOME AND COMMUNITY-BASED SERVICES.] (a) Persons authorized for and receiving home and community-based services may select from public and private vendors of case management which have provider agreements with the state to provide home and community-based case management service activities. This subdivision becomes effective July 1, 1999, only if the state agency is unable to secure federal approval for limiting choice of case management vendors to the county of financial responsibility.

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

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

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

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

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

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

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

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

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

(1) assessing the needs of the individual within 20 working days of a recipient’s request as changes occur, but at least
annually;
(2) developing the written individual service plan within ten working days after the assessment is completed;
(3) informing the recipient or the recipient's legal guardian or conservator of service options;
(4) assisting the recipient in the identification of potential service providers;
(5) assisting the recipient to access services;
(6) coordinating, evaluating, and monitoring of the services identified in the service plan;
(7) completing the annual reviews of the service plan; and
(8) informing the recipient or legal representative of the right to have assessments completed and service plans developed within specified time periods, and to appeal county action or inaction under section 256.045, subdivision 3.
(b) Case management administrative activities are the responsibility of the county or agency under contract. Case management administrative functions include:
(1) screening;
(2) assistance with obtaining diagnoses and necessary medical or health reports;
(3) eligibility determination;
(4) initial assessment within 20 days of a request for waiver services;
(5) providing information and assistance to the person or their legal representative sufficient to allow the person to choose a vendor of case management service coordination;
(6) determination of resources needed to meet assessed needs;
(7) approval of service plans and necessary contracts; and
(8) monitoring spending and evaluating health, safety, welfare, and service outcomes.
(c) The case manager may delegate certain aspects of the case management service activities to another individual provided there is oversight by the case manager. The case manager may not delegate those aspects which require
professional judgment including assessments, reassessments, and
care plan development.

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 23. [ALTERNATIVE INTEGRATED LONG-TERM CARE SERVICES; ELDERLY AND DISABLED PERSONS.] (a) The commissioner may implement demonstration projects to create alternative integrated delivery systems for acute and long-term care
services to elderly persons and persons with disabilities as defined in section 256B.77, subdivision 7a, that provide increased coordination, improve access to quality services, and mitigate future cost increases. The commissioner may seek federal authority to combine Medicare and Medicaid capitation payments for the purpose of such demonstrations. Medicare funds and services shall be administered according to the terms and conditions of the federal waiver and demonstration provisions.

For the purpose of administering medical assistance funds, demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations, with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1, items B and C, which do not apply to persons enrolling in demonstrations under this section. An initial open enrollment period may be provided. Persons who disenroll from demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and the health plan's participation is subsequently terminated for any reason, the person shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health plan. Persons required to participate in health plans under this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations. Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision, the commissioner may contract with managed care organizations, including counties, to serve only elderly persons eligible for medical assistance, elderly and disabled persons, or disabled persons only. For persons with primary diagnoses of mental retardation or a related condition, serious and persistent mental illness, or serious emotional disturbance, the commissioner must ensure that the county authority has approved Section 19
the demonstration and contracting design. Enrollment in these
projects for persons with disabilities shall be voluntary. The
commissioner shall not implement any demonstration project under
this subdivision for persons with primary diagnoses of mental
retardation or a related condition, serious and persistent
mental illness, or serious emotional disturbance, without
approval of the county board of the county in which the
demonstration is being implemented.

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

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

Section 19
groups in the design of the demonstration projects.

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

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

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

256B.765 [PROVIDER RATE INCREASES.]

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

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

(c) Subd. 2. [ELIGIBLE PROVIDERS.] The annual adjustment under subdivision 1, paragraph (a), shall be provided for home and community-based waiver services for persons with mental
1 retardation or related conditions under section 256B.501; home
2 and community-based waiver services for the elderly under
3 section 256B.0915; waivered services under community
4 alternatives for disabled individuals under section 256B.49;
5 community alternative care waivered services under section
6 256B.49; traumatic brain injury waivered services under section
7 256B.49; nursing services and home health services under section
8 256B.0625, subdivision 6a; personal care services and nursing
9 supervision of personal care services under section 256B.0625,
10 subdivision 19a; private duty nursing services under section
11 256B.0625, subdivision 7; day training and habilitation services
12 for adults with mental retardation or related conditions under
13 sections 252.40 to 252.46; physical therapy services under
14 sections 256B.0625, subdivision 8, and 256D.03, subdivision 4;
15 occupational therapy services under sections 256B.0625,
16 subdivision 8a, and 256D.03, subdivision 4; speech-language
17 therapy services under section 256D.03, subdivision 4, and
18 Minnesota Rules, part 9505.0390; respiratory therapy services
19 under section 256D.03, subdivision 4, and Minnesota Rules, part
20 9505.0295; alternative care services under section 256B.0913;
21 adult residential program grants under Minnesota Rules, parts
22 9535.2000 to 9535.3000; adult and family community support
23 grants under Minnesota Rules, parts 9535.1700 to 9535.1760;
24 semi-independent living services under section 252.275 including
25 SILS funding under county social services grants formerly funded
26 under chapter 256I; and community support services for deaf and
27 hard-of-hearing adults with mental illness who use or wish to
28 use sign language as their primary means of communication.
29 Subd. 3. [RATE INCREASE FOR BIENNium BEGINNING JULY 1,
30 2005.] For the fiscal years beginning July 1, 2005, and July 1,
31 2006, the commissioner shall increase reimbursement rates for
32 the providers listed in subdivision 2 by ...... percent. At
33 least two-thirds of each year's adjustment must be used for
34 increased costs of employee salaries and benefits and associated
35 costs for FICA, the Medicare tax, workers' compensation
36 premiums, and federal and state unemployment insurance. Each
provider receiving an adjustment shall report to the
commissioner, in the form and manner specified by the
commissioner, on how the additional funding was used.

Sec. 21. Minnesota Statutes 2004, 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 and dentures, subject to the
limitations specified in section 256B.0625, subdivision 9 as
covered under the medical assistance program;

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

(16) day treatment services for mental illness provided

Section 21
under contract with the county board;

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

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

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

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

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

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

(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
1 deductible is required for each inpatient hospitalization.
2
3 (b) Gender reassignment surgery and related services are not covered services under this subdivision unless the
4 individual began receiving gender reassignment services prior to July 1, 1995.
5
6 (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.
7
8 (d) Recipients eligible under subdivision 3, paragraph (a), clause (2), item (i), shall pay the following co-payments for services provided on or after October 1, 2003:
9
10 (1) $3 per nonpreventive visit. For purposes of this subdivision, a visit means an episode of service which is
required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) $25 for eyeglasses;

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

(4) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $20 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

(5) 50-percent-copay-insurance-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 $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 (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.

Sec. 22. Minnesota Statutes 2004, 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 except as covered under section 256B.0625, subdivision 9, paragraph (b), 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, 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.

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

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

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

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

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

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

(1) ten percent of the paid charges for inpatient hospital services for adult enrollees, subject to an annual inpatient out-of-pocket maximum of $1,000 per individual and $3,000 per
family;
(2) $3 per prescription for adult enrollees;
(3) $25 for eyeglasses for adult enrollees; and
(4) 50 percent of the fee-for-service rate for adult dental
care services other than preventive care services for persons
eligible under section 256B.047 subdivisions 1 to 7, with income
equal to or less than 175 percent of the federal poverty
guidelines subdivision 3b, paragraph (b).
(b) Paragraph (a), clause (1), does not apply to parents
and relative caretakers of children under the age of 21 in
households with family income equal to or less than 175 percent
of the federal poverty guidelines. Paragraph (a), clause (1),
does not apply to parents and relative caretakers of children
under the age of 21 in households with family income greater
than 175 percent of the federal poverty guidelines for inpatient
hospital admissions occurring on or after January 1, 2001.
(c) Paragraph (a), clauses (1) to (4), do not apply to
pregnant women and children under the age of 21.
(d) Adult enrollees with family gross income that exceeds
175 percent of the federal poverty guidelines and who are not
pregnant shall be financially responsible for the coinsurance
amount, if applicable, and amounts which exceed the $10,000
inpatient hospital benefit limit.
(e) When a MinnesotaCare enrollee becomes a member of a
prepaid health plan, or changes from one prepaid health plan to
another during a calendar year, any charges submitted towards
the $10,000 annual inpatient benefit limit, and any
out-of-pocket expenses incurred by the enrollee for inpatient
services, that were submitted or incurred prior to enrollment,
or prior to the change in health plans, shall be disregarded.
Sec. 25. [FEDERAL APPROVAL.]
By August 1, 2005, the commissioner of human services shall
request any federal approval and plan amendments necessary to
implement (1) the transitional supports allowance under
Minnesota Statutes, sections 256B.0916, subdivision 10; and
256B.49, subdivision 16; and (2) the choice of case management
Section 25
service coordination provisions under Minnesota Statutes, sections 256B.0621, subdivision 4; 256B.092, subdivisions 2a and 4b; and 256B.49, subdivision 13.
S.F. No. 984 - Services for Persons With Disabilities (The Delete-Everything Amendment)

Author: Senator Becky Lourey
Prepared by: Joan White, Senate Counsel (651/296-3814)
Katie Cavanor, Senate Counsel (651/296-3801)
David Giel, Senate Research (651/296-7178)
Date: March 10, 2005

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

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

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

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

Section 4 (256B.057, subdivision 9) states that in the MA employed persons with disabilities program for enrollees who are also enrolled in Medicare, the commissioner will reimburse the enrollee for Medicare part B premiums regardless of income. This section also states that increases
in benefits under Title II of the Social Security Act shall not be counted as income until July 1 of each year.

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

Sections 6 to 11 modify MA targeted case management services.

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

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

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

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

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

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

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

Section 13 (256B.0622, subdivision 2) modifies several definitions.
Section 14 (256B.0625, subdivision 9) removes the $500 annual benefit limit on dental services for adults in the MA program and restores the benefits to what they were prior to 2003.

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

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

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

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

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

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

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

Section 22 (256B.69, subdivision 23) requires DHS to seek federal approval to expand the Minnesota Disability Health Options (MnDHO) Program in stages, beginning with population centers outside the seven-county metro area and then expanding to all areas of the state.
Section 23 (256B.765) provides an unspecified rate increase each year of the upcoming biennium for a variety of community-based providers. At least two-thirds of the increase must be used to increase employee salaries and benefits and pay related costs. Providers must report to DHS on how the additional funding was used.

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

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

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

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

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

JW/KC/DG:rdr
Senator .... moves to amend S.F. No. 984 as follows:

Delete everything after the enacting clause and insert:

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

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

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

Subd. 3. [ASSET LIMITATIONS FOR INDIVIDUALS AND FAMILIES THE AGED, BLIND, OR DISABLED.] To be eligible for medical assistance, a person whose eligibility category is based on blindness, disability, or age of 65 or more years must not individually own more than $7,000 in assets, or if a member of a household with two family members, the household must not own more than $18,000 in assets (plus $200 for each additional legal dependent). In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The accumulation of the clothing and personal needs allowance according to section 256B.35 must also be reduced to the maximum at the time of the eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance is the value of those assets excluded under the supplemental security income program for aged, blind, and disabled persons, with the following exceptions:

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

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

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

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

(f) Assets owned by children are not considered.

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

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

(b) The excess income standard for a person whose eligibility is based on blindness, disability, or age of 65 or more years is 70 percent of the federal poverty guidelines for the family size. Effective July 1, 2002, the excess income standard for this paragraph shall equal 75 percent of the federal poverty guidelines.

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

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

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

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

(3) meets the asset limits in paragraph (b); and
(4) effective November 1, 2003, pays a premium and other obligations under paragraph (d).

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

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

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

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

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

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

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

(3) medical expense accounts set up through the person’s employer.

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

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

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

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

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

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

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

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

(f) Any required premium shall be determined at application and redetermined at the enrollee's six-month income review or when a change in income or household size is reported. Enrollees must report any change in income or household size within ten days of when the change occurs. A decreased premium resulting from a reported change in income or household size shall be effective the first day of the next available billing
1 month after the change is reported. Except for changes occurring from annual cost-of-living increases, a change resulting in an increased premium shall not affect the premium amount until the next six-month review.

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

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

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

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

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

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

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

(2) the personal allowance for disabled individuals under section 256B.36;
if the institutionalized person has a legally appointed
guardian or conservator, five percent of the recipient’s gross
monthly income up to $100 as reimbursement for guardianship or
conservatorship services;

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

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

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

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

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

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

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

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

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

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

(3) if one of the following circumstances apply:

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

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

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

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

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

(1) "home care service recipients" means those individuals receiving the following services under section 256B.0627:

skilled nursing visits, home health aide visits, private duty nursing, personal care assistants, or therapies provided through a home health agency;

(2) "home care targeted case management" means the provision of targeted case management services for the purpose of assisting home care service recipients to gain access to needed services and supports so that they may remain in the community;
Federal Regulations, title 42, section 440.10; regional
treatment center inpatient services, consistent with section
245.474; nursing facilities; and intermediate care facilities
for persons with mental retardation;

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

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

Sec. 7. Minnesota Statutes 2004, section 256B.0621,
subdivision 3, is amended to read:
Subd. 3. [ELIGIBILITY.] The following persons are eligible
for relocation targeted case management or home care-targeted
care targeted case management:
(1) medical assistance eligible persons residing in
institutions who choose to move into the community are eligible
for relocation targeted case management services; and
(2) medical assistance eligible persons receiving home care
services, who are not eligible for any other medical assistance
reimbursable case management service, are eligible for home
care-targeted care targeted case management services beginning
January 1, 2005.

Sec. 8. Minnesota Statutes 2004, section 256B.0621,
subdivision 4, is amended to read:
Subd. 4. [RELOCATION COUNTY TARGETED CASE MANAGEMENT
PROVIDER QUALIFICATIONS.] (a) A relocation targeted county case
management provider is an enrolled medical assistance provider
who is determined by the commissioner to have all of the
following characteristics:

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

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

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

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

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

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

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

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

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

Subd. 5. [HOME CARE TARGETED CASE MANAGEMENT AND
RELOCATION SERVICE COORDINATION PROVIDER QUALIFICATIONS. The following qualifications and certification standards must be met by Providers of home care targeted case management and relocation service coordination must meet the qualifications under subdivision 4 or the following qualifications and certification standards.

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

(b) Both home care targeted case management providers and relocation service coordination providers are enrolled medical assistance provider providers who have a minimum of a bachelor's degree or a license in a health or human services field, or comparable training and two years of experience in human services, and have been determined by the commissioner to have all of the following characteristics:

1. The demonstrated capacity and experience to provide the components of case management to coordinate and link community resources needed by the eligible population;
2. The administrative capacity and experience to serve the target population for whom it will provide services and ensure quality of services under state and federal requirements;
3. A financial management system that provides accurate documentation of services and costs under state and federal requirements;
4. The capacity to document and maintain individual case records under state and federal requirements; and
5. The capacity to coordinate with county administrative functions;
6. Have no financial interest in the provision of out-of-home residential services to persons for whom targeted case management or relocation service coordination is provided;

Section 9
(7) if a provider has a financial interest in services other than out-of-home residential services provided to persons for whom targeted case management or relocation service coordination is also provided, the county must determine each year that:

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

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

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

Subd. 6. [ELIGIBLE SERVICES.] Services eligible for medical assistance reimbursement as targeted case management include:

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

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

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

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

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

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

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

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

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

Sec. 11. Minnesota Statutes 2004, section 256B.0621,
subdivision 7, is amended to read:
Subd. 7. [TIME LINES.] The following time lines must be
met for assigning a case manager:
(a) For relocation targeted case management, an eligible
recipient must be assigned a county case manager who visits the
person within 20 working days of requesting a case manager from
their county of financial responsibility as determined under
chapter 256G.

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

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

(3) Providers of relocation targeted case management
enrolled under this subdivision shall:

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

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

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

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

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

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

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

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

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

Section 12
Sec. 13. Minnesota Statutes 2004, section 256B.0625, subdivision 9, is amended to read:

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

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

- diagnostic and preventative services;
- restorative services; and
- emergency services.

Emergency services, dentures, and extractions related to dentures are not included in the $500 annual benefit limit.

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

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

- lease or rent deposits;
- security deposits;
- utilities set-up costs, including telephone;
- essential furnishings and supplies; and
- personal supports and transports needed to locate and transition to community settings.

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

Sec. 15. Minnesota Statutes 2004, section 256B.092, subdivision 4b, is amended to read:
Subd. 4b. [COUNTY CASE MANAGEMENT AND SERVICE COORDINATION FOR PERSONS RECEIVING HOME AND COMMUNITY-BASED SERVICES.] (a) Persons authorized for and receiving home and community-based services may select from public vendors of county case management which have provider agreements with the state to provide home and community-based case management service activities. This subdivision becomes effective July 1, 1992, only if the state agency is unable to secure federal approval for limiting choice of case management vendors to the county of financial responsibility.

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

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

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

Subdivision 1. [PERSONAL NEEDS ALLOWANCE.] (a) Notwithstanding any law to the contrary, welfare allowances for clothing and personal needs for individuals receiving medical assistance while residing in any skilled nursing home, intermediate care facility, or medical institution including recipients of supplemental security income, in this state shall not be less than $45 $150 per month from all sources. When benefit amounts for Social Security or supplemental security income recipients are increased pursuant to United States Code, title 42, sections 415(i) and 1382f, the commissioner shall, effective in the month in which the increase takes effect, increase by the same percentage to the nearest whole dollar the clothing and personal needs allowance for individuals receiving medical assistance while residing in any skilled nursing home, medical institution, or intermediate care facility. The commissioner shall provide timely notice to local agencies, providers, and recipients of increases under this provision.
(b) The personal needs allowance may be paid as part of the Minnesota supplemental aid program, notwithstanding the provisions of section 256D.37, subdivision 2, and payments to recipients of Minnesota supplemental aid may be made once each three months covering liabilities that accrued during the preceding three months.

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

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

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

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

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

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

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

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

(1) assisting the recipient to provide medical and other
information to determine services needs;

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

(? (3) assisting the recipient to access services;

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

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

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

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

(8) informing-the-recipient-or-legal-representative-of-the
right-to-have-assessments-completed-and-service-plans-developed
within-specified-time-periods-and-to-appeal-county-action-or
inaction-under-section-256.8457-subdivision-9 if a provider has
a financial interest in services other than out-of-home
residential services provided to persons for whom targeted case
management or relocation service coordination is also provided,
the county must determine each year that:

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

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

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

Section 17
assessments, reassessments, and care plan development.

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

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

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

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

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

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

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

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

Section 19
(c) Consumer directed community support services shall be offered as an option to all persons eligible for services under subdivision 11, by January 1, 2002.

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

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

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

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

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

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

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

Sec. 21. Minnesota Statutes 2004, section 256B.69, subdivision 23, is amended to read:
Subd. 23. [ALTERNATIVE INTEGRATED LONG-TERM CARE SERVICES; ELDERLY AND DISABLED PERSONS.] (a) The commissioner may implement demonstration projects to create alternative integrated delivery systems for acute and long-term care services to elderly persons and persons with disabilities as defined in section 256B.77, subdivision 7a, that provide increased coordination, improve access to quality services, and mitigate future cost increases. The commissioner may seek federal authority to combine Medicare and Medicaid capitation payments for the purpose of such demonstrations. Medicare funds and services shall be administered according to the terms and conditions of the federal waiver and demonstration provisions. For the purpose of administering medical assistance funds, demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations, with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1, items B and C, which do not apply to persons enrolling in demonstrations under this section. An initial open enrollment period may be provided. Persons who disenroll from demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and the
health plan's participation is subsequently terminated for any reason, the person shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health plan. Persons required to participate in health plans under this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations. Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision, the commissioner may contract with managed care organizations, including counties, to serve only elderly persons eligible for medical assistance, elderly and disabled persons, or disabled persons only. For persons with primary diagnoses of mental retardation or a related condition, serious and persistent mental illness, or serious emotional disturbance, the commissioner must ensure that the county authority has approved the demonstration and contracting design. Enrollment in these projects for persons with disabilities shall be voluntary. The commissioner shall not implement any demonstration project under this subdivision for persons with primary diagnoses of mental retardation or a related condition, serious and persistent mental illness, or serious emotional disturbance, without approval of the county board of the county in which the demonstration is being implemented.

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

Section 21
individualized and developed in accordance with a person-centered plan. Costs under these projects may not exceed costs that would have been incurred under fee-for-service. Beginning July 1, 2003, and until two years after the pilot project implementation date, subcontractor participation in the long-term care developmental disability pilot is limited to a nonprofit long-term care system providing ICF/MR services, home and community-based waiver services, and in-home services to no more than 120 consumers with developmental disabilities in Carver, Hennepin, and Scott Counties. The commissioner shall report to the legislature prior to expansion of the developmental disability pilot project. This paragraph expires two years after the implementation date of the pilot project.

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

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

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

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

256B.765 [PROVIDER RATE INCREASES.]

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

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

{e} Subd. 2. [ELIGIBLE PROVIDERS.] The annual adjustment under subdivision 1, paragraph (a), shall be provided for home and community-based waiver services for persons with mental retardation or related conditions under section 256B.501; home and community-based waiver services for the elderly under section 256B.0915; waivered services under community alternatives for disabled individuals under section 256B.49; community alternative care waivered services under section 256B.49; traumatic brain injury waivered services under section 256B.49; nursing services and home health services under section 256B.0625, subdivision 6a; personal care services and nursing supervision of personal care services under section 256B.0625, subdivision 19a; private duty nursing services under section 256B.0625, subdivision 7; day training and habilitation services for adults with mental retardation or related conditions under sections 252.40 to 252.46; physical therapy services under sections 256B.0625, subdivision 8, and 256D.03, subdivision 4; occupational therapy services under sections 256B.0625, subdivision 8a, and 256D.03, subdivision 4; speech-language therapy services under section 256D.03, subdivision 4, and Minnesota Rules, part 9505.0390; respiratory therapy services under section 256D.03, subdivision 4, and Minnesota Rules, part 9505.0390.
1 9505.0295; alternative care services under section 256B.0913;
2 adult residential program grants under Minnesota Rules, parts
3 9535.2000 to 9535.3000; adult and family community support
4 grants under Minnesota Rules, parts 9535.1700 to 9535.1760;
5 semi-independent living services under section 252.275 including
6 SILS funding under county social services grants formerly funded
7 under chapter 256I; and community support services for deaf and
8 hard-of-hearing adults with mental illness who use or wish to
9 use sign language as their primary means of communication.

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

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

Subd. 4. [GENERAL ASSISTANCE MEDICAL CARE; SERVICES.]
24 (a)(i) For a person who is eligible under subdivision 3,
25 paragraph (a), clause (2), item (i), general assistance medical
26 care covers, except as provided in paragraph (c):
27 (1) inpatient hospital services;
28 (2) outpatient hospital services;
29 (3) services provided by Medicare certified rehabilitation
30 agencies;
31 (4) prescription drugs and other products recommended
32 through the process established in section 256B.0625,
33 subdivision 13;
34 (5) equipment necessary to administer insulin and
35 diagnostic supplies and equipment for diabetics to monitor blood
36 sugar level;

Section 23
(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 and dentures, subject to the limitations specified in section 256B.0625, subdivision 9 as covered under the medical assistance program;
(15) outpatient services provided by a mental health center or clinic that is under contract with the county board and is established under section 245.62;
(16) day treatment services for mental illness provided under contract with the county board;
(17) prescribed medications for persons who have been diagnosed as mentally ill as necessary to prevent more restrictive institutionalization;
(18) psychological services, medical supplies and equipment, and Medicare premiums, coinsurance and deductible payments;
(19) medical equipment not specifically listed in this paragraph when the use of the equipment will prevent the need for costlier services that are reimbursable under this subdivision;
(20) services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if (1) the service is otherwise covered under this chapter as a physician service, (2) the service provided on an inpatient basis is not included as part of the cost for

Section 23
inpatient services included in the operating payment rate, and (3) the service is within the scope of practice of the nurse practitioner’s license as a registered nurse, as defined in section 148.171;

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

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

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

(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), clause (2), item (i), shall pay the following co-payments for services provided on or after October 1, 2003:

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

(2) $25 for eyeglasses;

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

(4) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $20 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

(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

Section 23
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 $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 (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.

Sec. 24. Minnesota Statutes 2004, 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 except as covered under section
256B.0625, subdivision 9, paragraph (b)-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, 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.

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

Subd. 5. [CO-PAYMENTS AND COINSURANCE.] (a) Except as
provided in paragraphs (b) and (c), the MinnesotaCare benefit
plan shall include the following co-payments and coinsurance
requirements for all enrollees:
(1) ten percent of the paid charges for inpatient hospital services for adult enrollees, subject to an annual inpatient out-of-pocket maximum of $1,000 per individual and $3,000 per family;

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

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

(4) fifty percent of the fee for service rate for adult dental care services other than preventive care services for persons eligible under section 256b.047, subdivisions 1 to 7, with income equal to or less than 175 percent of the federal poverty guidelines.

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

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

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

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

Sec. 26. [FEDERAL APPROVAL.]

By August 1, 2005, the commissioner of human services shall request any federal approval and plan amendments necessary to
implement (1) the transitional supports allowance under
Minnesota Statutes, sections 256B.0916, subdivision 10; and
256B.49, subdivision 16; and (2) the choice of case management
service coordination provisions under Minnesota Statutes,
sections 256B.0621, subdivision 4; 256B.092, subdivisions 2a and
4b; and 256B.49, subdivision 13.

Sec. 27. [DENTAL ACCESS FOR PERSONS WITH DISABILITIES.] The commissioner of human services shall study access to
dental services for persons with disabilities, and shall present recommendations for improving access to dental services to the
legislature by January 15, 2006. The study must examine
physical and geographic access, the willingness of dentists to
serve persons with disabilities enrolled in state health care
programs, reimbursement rates for dental service providers, and
other factors identified by the commissioner as potential
barriers to accessing dental services.

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

Subd. 2. [WORK GROUP ACTIVITIES.] The work group shall
make recommendations to the state agencies and the legislature
related to:
(1) coordinating the availability of housing,
transportation, and support services needed to discharge persons
with disabilities from institutions;
(2) improving information and assistance needed to make an
informed choice about relocating from an institutional placement
to community-based services;

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

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

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

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

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

Delete the title and insert:

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

32
Senator .... moves to amend the delete-everything amendment (SCS0984A-3) to S.F. No. 984 as follows:

Page 13, after line 36, insert:

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

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

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

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

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

(d) "Overnight staff" means a member of the intensive residential rehabilitative mental health treatment team who is responsible during hours when recipients are typically asleep.
(e) "Treatment team" means all staff who provide services under this section to recipients. At a minimum, this includes the clinical supervisor, mental health professionals, mental health practitioners, and mental health rehabilitation workers."

Renumber the sections in sequence and correct the internal references

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

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

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

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

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

I currently have an open bedsore that is efficiently being treated at home by nurses and personal care attendants. This does not involve expensive hospitals or doctors. Unfortunately, this program is only available in a few counties in the Metro area, so I support this bill's goal to expand the program to people with disabilities throughout the state.
Mr. Chairman, members of the committee, good morning. My name is Tom Gode; I am the Executive Director of the Brain Injury Association of Minnesota. Thank you for the opportunity to speak to you today in support of SF 984. The Brain Injury Association is a statewide nonprofit organization that supports the more than 94,000 Minnesotan's who have a disability as a result of traumatic brain injury (TBI).

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

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

SF 984 strengthens the ability of individuals on Home and Community based waivers, as well as individuals in nursing facilities, to have real choice in relocation service coordination and case management. The Brain Injury Association of Minnesota, along with a small group of other private case management vendors, currently contract out to several counties to provide these services and we know that it can be a success. These contracts were put into place as a convenience for the counties as case load sizes continue to increase and the county's abilities to meet these demands has become more and more challenging. Private vendors provide counties the flexibility to handle changing case loads, expertise on particular disabilities, cultural or language that compliment and expands that of their own staff and effectively meet the needs of Minnesotans with disabilities. The addition of consumer choice in case management and relocation service coordination empowers consumers, eliminates some current inequities, enhances the overall performance of the waivers and results in increased consumer satisfaction.

We recognize that language allowing counties to contract relocation service coordination and case management services with private vendors needs to be strengthened to allow for real consumer choice. The Consortium of Citizens with Disabilities is continuing conversations with representatives from the counties as well as with DHS on language to
ensure that the potential for conflict of interest and the separation of the roles of service coordination and eligibility determination are clearly addressed. The potential for conflict of interest is a real concern, and one that we take very seriously. The Brain Injury Association's experience is that counties want to contract with vendors who do not have a potential conflict of interest, but the pool of vendors needs to be large enough to provide real choice.

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

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

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

Author: Senator Julie Rosen
Prepared by: David Giel, Senate Research (296-7178)
Date: March 7, 2005

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

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

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

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

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

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

A bill for an act
relating to health; modifying certain critical access hospital provisions; amending Minnesota Statutes 2004, sections 144.147, subdivision 1; 144.148, subdivision 1; 144.551, subdivision 1; 144.562, subdivision 2.

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

Section 1. Minnesota Statutes 2004, section 144.147, subdivision 1, is amended to read:

Subdivision 1. [DEFINITION.]
"Eligible rural hospital"
means any nonfederal, general acute care hospital that:

(1) is either located in a rural area, as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 405.1041, or located in a community with a population of less than 15,000, according to United States Census Bureau statistics, outside the seven-county metropolitan area;

(2) has 50 or fewer beds; and

(3) is not for profit.

Sec. 2. Minnesota Statutes 2004, section 144.148, subdivision 1, is amended to read:

Subdivision 1. [DEFINITION.] (a) For purposes of this section, the following definitions apply.

(b) "Eligible rural hospital" means any nonfederal, general acute care hospital that:

(1) is either located in a rural area, as defined in the
federal Medicare regulations, Code of Federal Regulations, title 42, section 405.1041, or located in a community with a population of less than 15,000, according to United States Census Bureau statistics, outside the seven-county metropolitan area;

(2) has 50 or fewer beds; and

(3) is not for profit.

"Eligible project" means a modernization project to update, remodel, or replace aging hospital facilities and equipment necessary to maintain the operations of a hospital.

Sec. 3. Minnesota Statutes 2004, section 144.551, subdivision 1, is amended to read:

Subdivision 1. [RESTRICTED CONSTRUCTION OR MODIFICATION.]

(a) The following construction or modification may not be commenced:

(1) any erection, building, alteration, reconstruction, modernization, improvement, extension, lease, or other acquisition by or on behalf of a hospital that increases the bed capacity of a hospital, relocates hospital beds from one physical facility, complex, or site to another, or otherwise results in an increase or redistribution of hospital beds within the state; and

(2) the establishment of a new hospital.

(b) This section does not apply to:

(1) construction or relocation within a county by a hospital, clinic, or other health care facility that is a national referral center engaged in substantial programs of patient care, medical research, and medical education meeting state and national needs that receives more than 40 percent of its patients from outside the state of Minnesota;

(2) a project for construction or modification for which a health care facility held an approved certificate of need on May 1, 1984, regardless of the date of expiration of the certificate;

(3) a project for which a certificate of need was denied before July 1, 1990, if a timely appeal results in an order
reversing the denial;

(4) a project exempted from certificate of need requirements by Laws 1981, chapter 200, section 2;

(5) a project involving consolidation of pediatric specialty hospital services within the Minneapolis-St. Paul metropolitan area that would not result in a net increase in the number of pediatric specialty hospital beds among the hospitals being consolidated;

(6) a project involving the temporary relocation of pediatric-orthopedic hospital beds to an existing licensed hospital that will allow for the reconstruction of a new philanthropic, pediatric-orthopedic hospital on an existing site and that will not result in a net increase in the number of hospital beds. Upon completion of the reconstruction, the licenses of both hospitals must be reinstated at the capacity that existed on each site before the relocation;

(7) the relocation or redistribution of hospital beds within a hospital building or identifiable complex of buildings provided the relocation or redistribution does not result in: (i) an increase in the overall bed capacity at that site; (ii) relocation of hospital beds from one physical site or complex to another; or (iii) redistribution of hospital beds within the state or a region of the state;

(8) relocation or redistribution of hospital beds within a hospital corporate system that involves the transfer of beds from a closed facility site or complex to an existing site or complex provided that: (i) no more than 50 percent of the capacity of the closed facility is transferred; (ii) the capacity of the site or complex to which the beds are transferred does not increase by more than 50 percent; (iii) the beds are not transferred outside of a federal health systems agency boundary in place on July 1, 1983; and (iv) the relocation or redistribution does not involve the construction of a new hospital building;

(9) a construction project involving up to 35 new beds in a psychiatric hospital in Rice County that primarily serves.

Section 3
adolescents and that receives more than 70 percent of its
patients from outside the state of Minnesota;

(10) a project to replace a hospital or hospitals with a
combined licensed capacity of 130 beds or less if: (i) the new
hospital site is located within five miles of the current site;
and (ii) the total licensed capacity of the replacement
hospital, either at the time of construction of the initial
building or as the result of future expansion, will not exceed
70 licensed hospital beds, or the combined licensed capacity of
the hospitals, whichever is less;

(11) the relocation of licensed hospital beds from an
existing state facility operated by the commissioner of human
services to a new or existing facility, building, or complex
operated by the commissioner of human services; from one
regional treatment center site to another; or from one building
or site to a new or existing building or site on the same
campus;

(12) the construction or relocation of hospital beds
operated by a hospital having a statutory obligation to provide
hospital and medical services for the indigent that does not
result in a net increase in the number of hospital beds;

(13) a construction project involving the addition of up to
31 new beds in an existing nonfederal hospital in Beltrami
County;

(14) a construction project involving the addition of up to
eight new beds in an existing nonfederal hospital in Otter Tail
County with 100 licensed acute care beds;

(15) a construction project involving the addition of 20
new hospital beds used for rehabilitation services in an
existing hospital in Carver County serving the southwest
suburban metropolitan area. Beds constructed under this clause
shall not be eligible for reimbursement under medical
assistance, general assistance medical care, or MinnesotaCare;

(16) a project for the construction or relocation of up to
20 hospital beds for the operation of up to two psychiatric
facilities or units for children provided that the operation of
the facilities or units have received the approval of the commissioner of human services;

(17) a project involving the addition of 14 new hospital beds to be used for rehabilitation services in an existing hospital in Itasca County; or

(18) a project to add 20 licensed beds in existing space at a hospital in Hennepin County that closed 20 rehabilitation beds in 2002, provided that the beds are used only for rehabilitation in the hospital's current rehabilitation building. If the beds are used for another purpose or moved to another location, the hospital's licensed capacity is reduced by 20 beds; or

(19) a critical access hospital established under section 144.1483, clause (10), and section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that delicensed beds since enactment of the Balanced Budget Act of 1997, Public Law 105-33, to the extent that the critical access hospital does not seek to exceed the maximum number of beds permitted such hospital under federal law.

Sec. 4. Minnesota Statutes 2004, section 144.562, subdivision 2, is amended to read:

Subd. 2. [ELIGIBILITY FOR LICENSE CONDITION.] A hospital is not eligible to receive a license condition for swing beds unless (1) it either has a licensed bed capacity of less than 50 beds defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66, or it has a licensed bed capacity of 50 beds or more and has swing beds that were approved for Medicare reimbursement before May 1, 1985, or it has a licensed bed capacity of less than 65 beds and the available nursing homes within 50 miles have had, in the aggregate, an average occupancy rate of 96 percent or higher in the most recent two years as documented on the statistical reports to the Department of Health; and (2) it is located in a rural area as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66. Except for critical access hospitals established under section 144.1483, clause (10), and section 1820 of the federal Social Security Act.
Act, United States Code, title 42, section 1395i-4, eligible hospitals are allowed a total of 1,460 days of swing bed use per year, provided that no more than ten hospital beds are used as swing beds at any one time. Except for critical access hospitals, the commissioner of health must approve swing bed use beyond 1,460 days as long as there are no Medicare certified skilled nursing facility beds available within 25 miles of that hospital. Critical access hospitals are allowed swing bed use as provided in federal law.
Create Conformity with Federal Law for Critical Access Hospitals
M.S. 144.562, M.S. 144.147, M.S. 144.148, M.S. 144.551

Problem statement
Recent changes were made to federal law and the regulations applicable to rural Minnesota’s 65 Critical Access Hospitals. These changes resulted in two major inconsistencies with state statutes: the definitions of a rural hospital and the limit on swing beds. Hospital swing beds provide patients brief transitional care at the hospital following their acute care stay. The 2003 federal legislation also changed these bed limits upward. However, Minnesota law retains the earlier 10 bed limit, instead of the federal 25 bed limit.

In addition, several Critical Access Hospitals reduced their number of licensed beds between 1998 and 2003 to comply with the limit of 15 beds provided in the 1997 federal law creating the Critical Access Hospital option. In 2003, federal legislation raised the bed limit for Critical Access Hospitals to 25. However, Minnesota’s hospital construction moratorium prohibits these hospitals from adjusting to this federal change.

How does this legislation address the problem?
The following amendments will bring state law into conformity with new federal regulations. This will allow Critical Access Hospitals to provide all the services established under federal law for rural communities:

- Amend M.S. 144.562 to exempt Critical Access Hospitals from the daily limit of 10 swing beds and the annual limit of 1,460 swing bed days. Critical Access Hospitals could then use any of their 25 beds for swing bed patients.

- Amend the definition of rural hospitals in M.S. 144.147 and 144.148 to retain eligibility for current and prospective Critical Access Hospitals.

- Amend M.S. 144.551 to allow Critical Access Hospitals a moratorium exception to increase up to the 25 beds allowed under federal law.

Move backed by stakeholders
The Minnesota Hospital Association already supports the initiative. The support of the Minnesota Rural Health Association is expected. There are no known opponents.

Consequences if this legislation does not pass:
- If the more restrictive state limit on swing bed use is not revised, recovering patients could be unnecessarily transferred from the hospital even though Critical Access Hospitals could provide the needed care.

- One hospital would lose its status as a Critical Access Hospital, if the state definition of a rural hospital is not revised to include it. Yet other hospitals—in similar circumstances—would continue operating as Critical Access Hospitals.

- Patients could be forced to travel farther for hospital services than necessary, if Critical Access Hospitals are not allowed to regain the beds they gave up to comply with the 1997 federal requirements.
What is a Critical Access Hospital (CAH)?

- A CAH is a small, rural, acute care facility that provides outpatient, emergency, and limited inpatient services.

- Is located outside of a Metropolitan Statistical Area, and not classified as "urban" for Medicare standardized payment or by the Medicare Geographic Review Board; be in a rural urban commuting area in an MSA or be designated by the State as a necessary provider.

- Receives enhanced Medicare reimbursement of 101 percent of reasonable costs.

- May have up to 25 beds with any combination of acute or swing (semi-skilled beds for patients meeting certain criteria).

- Provides inpatient care for no more than a 96 hour average length of stay.

- Must be more than a 35-mile drive or 15 miles in mountainous terrain or areas with only secondary roads, from another hospital or CAH. The State may also certify a hospital as being a "necessary provider" according to State guidelines (will end January 1, 2006)

- Must make available 24-hour emergency care but doesn’t need to meet all the staffing and service requirements that apply to full service hospitals (e.g. some ancillary and support services may be provided on a part-time off-site basis). Inpatient care in a CAH may be provided by a mid-level practitioner under the remote supervision of a physician.

- Can have 10 bed distinct part units (rehab and/or psych, but only one of each) that does not count against the bed limit and is paid under PPS. (goes into effect 10/1/2004)
Senator .... moves to amend the SCS1266A-1 amendment to S.F. No. 1266 as follows:

Page 2, after line 8, insert:

"(e) A health care system that is in full compliance with this subdivision may allocate its total limit of swing bed days among the hospitals within the system, provided that no hospital in the system without an attached nursing home may exceed 4,000 swing bed days per year."
Senator ..... moves to amend S.F. No. 1266 as follows:

Pages 5 and 6, delete section 4 and insert:

"Sec. 4. Minnesota Statutes 2004, section 144.562, subdivision 2, is amended to read:

Subd. 2. [ELIGIBILITY FOR LICENSE CONDITION.] (a) A hospital is not eligible to receive a license condition for swing beds unless (1) it either has a licensed bed capacity of less than 50 beds defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66, or it has a licensed bed capacity of 50 beds or more and has swing beds that were approved for Medicare reimbursement before May 1, 1985, or it has a licensed bed capacity of less than 65 beds and the available nursing homes within 50 miles have had, in the aggregate, an average occupancy rate of 96 percent or higher in the most recent two years as documented on the statistical reports to the Department of Health; and (2) it is located in a rural area as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66.

(b) Except for those critical access hospitals established under section 144.1483, clause (10), and section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that have an attached nursing home, eligible hospitals are allowed a total of 2,000 days of swing bed use per year, provided that no more than ten hospital beds are used as swing beds at any one time. Critical access hospitals that have an attached nursing home are allowed swing bed use as provided in federal law. Except for critical access hospitals that have an attached nursing home, the commissioner of health must approve swing bed use beyond 2,000 days as long as there are no Medicare certified skilled nursing facility beds available within 25 miles of that hospital that are willing to admit the patient.

(c) Critical access hospitals exceeding 2,000 swing bed days must maintain documentation that they have contacted skilled nursing facilities within 25 miles to determine if any skilled nursing facility beds are available. The commissioner
is authorized to request copies of this documentation.

(d) After reaching 2,000 days of swing bed use in a year, an eligible hospital to which this limit applies may admit six additional patients to swing beds each year without seeking approval from the commissioner or being in violation of this subdivision. These six swing bed admissions are exempt from the limit of 2,000 annual swing bed days for hospitals subject to this limit.

Sec. 5. [REPORT TO THE LEGISLATURE ON SWING BED USAGE.]
The commissioner of health shall review swing bed and related data reported under Minnesota Statutes, sections 144.562, subdivision 3, paragraph (f); 144.564; and 144.698. The commissioner shall report to the legislature by January 31, 2007, on:

(1) the use of swing bed days by all hospitals and by critical access hospitals;

(2) occupancy rates in skilled nursing facilities within 25 miles of hospitals with swing beds; and

(3) information provided by rural providers on the use of swing beds and the impact of that use on the rural health care infrastructure."