State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-EIGHTH SESSION

H. F. No. 2150

02/25/2014 Authored by Huntley
The bill was read for the first time and referred to the Committee on Health and Human Services Policy
03/03/2014 Adoption of Report: Re-referred to the Committee on Health and Human Services Finance
03/28/2014 Adoption of Report: Amended and re-referred to the Committee on Ways and Means

A bill for an act

relating to state government; making adjustments to health and human services appropriations; making changes to provisions governing the Department of Health, Department of Human Services, Northstar Care for Children program, continuing care, community first services and supports, health care, public assistance programs, and chemical dependency; modifying the hospital payment system; modifying provisions governing background studies and home and community-based services standards; modifying rulemaking authority; setting fees; providing rate increases; establishing grant programs; modifying medical assistance provisions; modifying the use of positive support strategies and emergency manual restraint; requiring certain studies and reports; appropriating money; amending Minnesota Statutes 2012, sections 13.46, subdivision 4; 144.0724, as amended; 144.551, subdivision 1; 245C.03, by adding a subdivision; 245C.04, by adding a subdivision; 245C.05, subdivision 5; 245C.10, by adding a subdivision; 245C.33, subdivisions 1, 4; 252.451, subdivision 2; 254B.12; 256.01, by adding a subdivision; 256.9685, subdivisions 1, 1a; 256.9686, subdivision 2; 256.969, subdivisions 1, 2, 2b, 2c, 3a, 3b, 3c, 6a, 9, 10, 14, 17, 30, by adding subdivisions; 256.9752, subdivision 2; 256B.04, by adding a subdivision; 256B.0625, subdivision 30; 256B.0751, by adding a subdivision; 256B.199; 256B.35, subdivision 1; 256B.441, by adding a subdivision; 256B.5012, by adding a subdivision; 256I.04, subdivision 2b; 256I.05, subdivision 2; 256J.49, subdivision 13; 256J.53, subdivisions 1, 2, 5; 256J.531; 257.85, subdivision 11; 260C.212, subdivision 1; 260C.515, subdivision 4; 260C.611; Minnesota Statutes 2013 Supplement, sections 16A.724, subdivision 2; 145.4716, subdivision 2; 245.8251; 245A.03, subdivision 7; 245A.042, subdivision 3; 245A.16, subdivision 1; 245C.08, subdivision 1; 245D.02, subdivisions 3, 4b, 8b, 11, 15b, 29, 34, 34a, by adding a subdivision; 245D.03, subdivisions 1, 2, 3, by adding a subdivision; 245D.04, subdivision 3; 245D.05, subdivisions 1, 1a, 1b, 2, 4, 5; 245D.051; 245D.06, subdivisions 1, 2, 4, 6, 7, 8; 245D.071, subdivisions 3, 4, 5; 245D.081, subdivision 2; 245D.09, subdivisions 3, 4a; 245D.091, subdivisions 2, 3, 4; 245D.10, subdivisions 3, 4; 245D.11, subdivision 2; 256B.04, subdivision 21; 256B.056, subdivision 5c; 256B.0949, subdivision 4; 256B.439, subdivisions 1, 7; 256B.441, subdivision 53; 256B.4912, subdivision 1; 256B.492; 256B.69, subdivision 34; 256B.85, subdivisions 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, 15, 16, 17, 18, 23, 24, by adding subdivisions; 256N.22, subdivisions 1, 2, 4; 256N.23, subdivision 4; 256N.25, subdivisions 2, 3; 256N.26, subdivision 1; 256N.27, subdivision 4; Laws 2013, chapter 1, section 6, as amended; Laws 2013, chapter 108, article 3, section 48; article 7, sections 14; 49; article 14, sections 2, subdivisions 1, 4, as amended, 5, 6, as amended, 6; 3, subdivisions 1, 4; 4,

subdivision 8; 12; proposing coding for new law in Minnesota Statutes, chapters 144; 144A; repealing Minnesota Statutes 2012, sections 256.969, subdivisions 8b, 9a, 9b, 11, 13, 20, 21, 22, 25, 26, 27, 28; 256.9695, subdivisions 3, 4; Minnesota Statutes 2013 Supplement, section 256N.26, subdivision 7.

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

ARTICLE 1

HEALTH DEPARTMENT

Section 1. Minnesota Statutes 2012, 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 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, notwithstanding section 144.552, 27 beds, of which 12 serve mental health needs, may be transferred from Hennepin County Medical Center to Regions Hospital under this clause;

(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;

(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;

(19) a critical access hospital established under section 144.1483, clause (9), 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;

(20) notwithstanding section 144.552, a project for the construction of a new hospital in the city of Maple Grove with a licensed capacity of up to 300 beds provided that:

(i) the project, including each hospital or health system that will own or control the entity that will hold the new hospital license, is approved by a resolution of the Maple Grove City Council as of March 1, 2006;

(ii) the entity that will hold the new hospital license will be owned or controlled by one or more not-for-profit hospitals or health systems that have previously submitted a plan or plans for a project in Maple Grove as required under section 144.552, and the plan or plans have been found to be in the public interest by the commissioner of health as of April 1, 2005;

(iii) the new hospital's initial inpatient services must include, but are not limited to, medical and surgical services, obstetrical and gynecological services, intensive care services, orthopedic services, pediatric services, noninvasive cardiac diagnostics, behavioral health services, and emergency room services;

(iv) the new hospital:

(A) will have the ability to provide and staff sufficient new beds to meet the growing needs of the Maple Grove service area and the surrounding communities currently being

served by the hospital or health system that will own or control the entity that will hold the new hospital license;

(B) will provide uncompensated care;

(C) will provide mental health services, including inpatient beds;

(D) will be a site for workforce development for a broad spectrum of health-care-related occupations and have a commitment to providing clinical training programs for physicians and other health care providers;

(E) will demonstrate a commitment to quality care and patient safety;

(F) will have an electronic medical records system, including physician order entry;

(G) will provide a broad range of senior services;

(H) will provide emergency medical services that will coordinate care with regional providers of trauma services and licensed emergency ambulance services in order to enhance the continuity of care for emergency medical patients; and

(I) will be completed by December 31, 2009, unless delayed by circumstances beyond the control of the entity holding the new hospital license; and

(v) as of 30 days following submission of a written plan, the commissioner of health has not determined that the hospitals or health systems that will own or control the entity that will hold the new hospital license are unable to meet the criteria of this clause;

(21) a project approved under section 144.553;

(22) a project for the construction of a hospital with up to 25 beds in Cass County within a 20-mile radius of the state Ah-Gwah-Ching facility, provided the hospital's license holder is approved by the Cass County Board;

(23) a project for an acute care hospital in Fergus Falls that will increase the bed capacity from 108 to 110 beds by increasing the rehabilitation bed capacity from 14 to 16 and closing a separately licensed 13-bed skilled nursing facility; ~~or~~

(24) notwithstanding section 144.552, a project for the construction and expansion of a specialty psychiatric hospital in Hennepin County for up to 50 beds, exclusively for patients who are under 21 years of age on the date of admission. The commissioner conducted a public interest review of the mental health needs of Minnesota and the Twin Cities metropolitan area in 2008. No further public interest review shall be conducted for the construction or expansion project under this clause; or

(25) a project for a 16-bed psychiatric hospital in the city of Thief River Falls, if the commissioner finds the project is in the public interest after the public interest review conducted under section 144.552 is complete.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 2. **[144.9513] HEALTHY HOUSING GRANTS.**

Subdivision 1. **Definitions.** For purposes of this section and sections 144.9501 to 144.9512, the following terms have the meanings given.

(a) "Housing" means a room or group of rooms located within a dwelling forming a single habitable unit with facilities used or intended to be used for living, sleeping, cooking, and eating.

(b) "Healthy housing" means housing that is sited, designed, built, renovated, and maintained in ways that supports the health of residents.

(c) "Housing-based health threat" means a chemical, biologic, or physical agent in the immediate housing environment which constitutes a potential or actual hazard to human health at acute or chronic exposure levels.

(d) "Primary prevention" means preventing exposure to housing-based health threats before seeing clinical symptoms or a diagnosis.

Subd. 2. **Grants; administration.** Grant applicants shall submit applications to the commissioner as directed by a request for proposals. Grants must be competitively awarded and recipients of a grant under this section must prepare and submit a quarterly progress report to the commissioner beginning three months after receipt of the grant. The commissioner shall provide technical assistance and program support as needed to ensure that housing-based health threats are effectively identified, mitigated, and evaluated by grantees.

Subd. 3. **Education and training grant; eligible activities.** (a) Within the limits of available appropriations, the commissioner shall make grants to nonprofit organizations, community health boards, and community action agencies under section 256E.31 with expertise in providing outreach, education, and training on healthy homes subjects and in providing comprehensive healthy homes assessments and interventions to provide healthy housing education, training, and technical assistance services for persons engaged in addressing housing-based health threats and other individuals impacted by housing-based health threats.

(b) The grantee may conduct the following activities:

(1) implement and maintain primary prevention programs to reduce housing-based health threats that include the following:

(i) providing education materials to the general public and to property owners, contractors, code officials, health care providers, public health professionals, health educators, nonprofit organizations, and other persons and organizations engaged in housing and health issues;

(ii) promoting awareness of community, legal, and housing resources; and

(iii) promoting the use of hazard reduction measures in new housing construction and housing rehabilitation programs;

(2) provide training on identifying and addressing housing-based health threats;

(3) provide technical assistance on the implementation of mitigation measures;

(4) promote adoption of evidence-based best practices for mitigation of housing-based health threats; or

(5) develop work practices for addressing specific housing-based health threats.

Sec. 3. **[144A.484] INTEGRATED LICENSURE; HOME AND COMMUNITY-BASED SERVICES DESIGNATION.**

Subdivision 1. **Integrated licensing established.** (a) From January 1, 2014, to June 30, 2015, the commissioner of health shall enforce the home and community-based services standards under chapter 245D for those providers who also have a home care license pursuant to chapter 144A as required under Laws 2013, chapter 108, article 11, section 31, and article 8, section 60. During this period, the commissioner shall provide technical assistance on how to achieve and maintain compliance with applicable law or rules governing the provision of home and community-based services, including complying with the service recipient rights notice in subdivision 4, clause (4). If, during the survey, the commissioner finds that the licensee has failed to achieve compliance with an applicable law or rule under chapter 245D and this failure does not imminently endanger the health, safety, or rights of the persons served by the program, the commissioner may issue a licensing survey report with recommendations for achieving and maintaining compliance.

(b) Beginning July 1, 2015, a home care provider applicant or license holder may apply to the commissioner of health for a home and community-based services designation for the provision of basic home and community-based services identified under section 245D.03, subdivision 1, paragraph (b). The designation allows the license holder to provide basic home and community-based services that would otherwise require licensure under chapter 245D, under the license holder's home care license governed by sections 144A.43 to 144A.481.

Subd. 2. **Application for home and community-based services designation.** An application for a home and community-based services designation must be made on the forms and in the manner prescribed by the commissioner. The commissioner shall provide the applicant with instruction for completing the application and provide information about the requirements of other state agencies that affect the applicant. Application for the home and community-based services designation is subject to the requirements under section 144A.473.

Subd. 3. **Home and community-based services designation fees.** A home care provider applicant or licensee applying for the home and community-based services designation or renewal of a home and community-based services designation must submit a fee in the amount specified in subdivision 8.

Subd. 4. **Applicability of home and community-based services requirements.** A home care provider with a home and community-based services designation must comply with the requirements for home care services governed by this chapter. For the provision of basic home and community-based services, the home care provider must also comply with the following home and community-based services licensing requirements:

(1) person-centered planning requirements in section 245D.07;

(2) protection standards in section 245D.06;

(3) emergency use of manual restraints in section 245D.061; and

(4) service recipient rights in section 245D.04, subdivision 3, paragraph (a), clauses (5), (7), (8), (12), and (13), and paragraph (b).

A home care provider with the integrated license-HCBS designation may utilize a bill of rights which incorporates the service recipient rights in section 245D.04, subdivision 3, paragraph (a), clauses (5), (7), (8), (12), and (13), and paragraph (b) with the home care bill of rights in section 144A.44.

Subd. 5. **Monitoring and enforcement.** (a) The commissioner shall monitor for compliance with the home and community-based services requirements identified in subdivision 5, in accordance with this section and any agreements by the commissioners of health and human services.

(b) The commissioner shall enforce compliance with applicable home and community-based services licensing requirements as follows:

(1) the commissioner may deny a home and community-based services designation in accordance with section 144A.473 or 144A.475; and

(2) if the commissioner finds that the applicant or license holder has failed to comply with the applicable home and community-based services designation requirements the commissioner may issue:

(i) a correction order in accordance with section 144A.474;

(ii) an order of conditional license in accordance with section 144A.475;

(iii) a sanction in accordance with section 144A.475; or

(iv) any combination of clauses (i) to (iii).

Subd. 6. **Appeals.** A home care provider applicant that has been denied a temporary license will also be denied their application for the home and community-based services designation. The applicant may request reconsideration in accordance with section

144A.473, subdivision 3. A licensed home care provider whose application for a home and community-based services designation has been denied or whose designation has been suspended or revoked may appeal the denial, suspension, revocation, or refusal to renew a home and community-based services designation in accordance with section 144A.475. A license holder may request reconsideration of a correction order in accordance with section 144A.474, subdivision 12.

Subd. 7. **Agreements.** The commissioners of health and human services shall enter into any agreements necessary to implement this section.

Subd. 8. **Fees; home and community-based services designation.** (a) The initial fee for a basic home and community-based services designation is $155. A home care provider who is seeking to renew the provider's home and community-based services designation must pay an annual nonrefundable fee with the annual home care license fee according to the following schedule and based on revenues from the home and community-based services:

Provider Annual Revenue from HCBS	HCBS Designation
greater than $1,500,000	$320
greater than $1,275,000 and no more than $1,500,000	$300
greater than $1,100,000 and no more than $1,275,000	$280
greater than $950,000 and no more than $1,100,000	$260
greater than $850,000 and no more than $950,000	$240
greater than $750,000 and no more than $850,000	$220
greater than $650,000 and no more than $750,000	$200
greater than $550,000 and no more than $650,000	$180
greater than $450,000 and no more than $550,000	$160
greater than $350,000 and no more than $450,000	$140
greater than $250,000 and no more than $350,000	$120
greater than $100,000 and no more than $250,000	$100
greater than $50,000 and no more than $100,000	$80
greater than $25,000 and no more than $50,000	$60
no more than $25,000	$40

(b) Fees and penalties collected under this section shall be deposited in the state treasury and credited to the state government special revenue fund.

Subd. 9. **Study and report about client bill of rights.** The commissioner shall consult with Aging Services of Minnesota, Care Providers of Minnesota, Minnesota Home Care Association, Department of Human Services, the Ombudsman for Long-Term Care, and other stakeholders to review how to streamline the client bill of rights requirements in sections 144A.44, 144A.441, and 245D.04 for providers whose practices fit into one or several of these practice areas, while assuring and maintaining the health and safety

of clients. The evaluation shall consider the federal client bill of rights requirements for Medicare-certified home care providers. The evaluation must determine whether there are duplications or conflicts of client rights, evaluate how to reduce the complexity of the client bill of rights requirements for providers and consumers, determine which of the rights must be included in a client bill of rights document, and evaluate whether there are other ways to ensure that consumers know their rights. The commissioner shall report to the chairs of the health and human services committees of the legislature no later than February 15, 2015, along with any recommendations for legislative changes.

EFFECTIVE DATE. Minnesota Statutes, section 144A.484, subdivisions 2 to 9, are effective July 1, 2015.

Sec. 4. Minnesota Statutes 2013 Supplement, section 145.4716, subdivision 2, is amended to read:

Subd. 2. **Duties of director.** The director of child sex trafficking prevention is responsible for the following:

(1) developing and providing comprehensive training on sexual exploitation of youth for social service professionals, medical professionals, public health workers, and criminal justice professionals;

(2) collecting, organizing, maintaining, and disseminating information on sexual exploitation and services across the state, including maintaining a list of resources on the Department of Health Web site;

(3) monitoring and applying for federal funding for antitrafficking efforts that may benefit victims in the state;

(4) managing grant programs established under sections 145.4716 to 145.4718;

(5) managing the request for proposals for grants for comprehensive services, including trauma-informed, culturally specific services;

(6) identifying best practices in serving sexually exploited youth, as defined in section 260C.007, subdivision 31;

~~(6)~~ (7) providing oversight of and technical support to regional navigators pursuant to section 145.4717;

~~(7)~~ (8) conducting a comprehensive evaluation of the statewide program for safe harbor of sexually exploited youth; and

~~(8)~~ (9) developing a policy consistent with the requirements of chapter 13 for sharing data related to sexually exploited youth, as defined in section 260C.007, subdivision 31, among regional navigators and community-based advocates.

Sec. 5. Minnesota Statutes 2013 Supplement, section 256B.04, subdivision 21, is amended to read:

Subd. 21. **Provider enrollment.** (a) If the commissioner or the Centers for Medicare and Medicaid Services determines that a provider is designated "high-risk," the commissioner may withhold payment from providers within that category upon initial enrollment for a 90-day period. The withholding for each provider must begin on the date of the first submission of a claim.

(b) An enrolled provider that is also licensed by the commissioner under chapter 245A or that is licensed by the Department of Health under chapter 144A and has a HCBS designation on the home care license must designate an individual as the entity's compliance officer. The compliance officer must:

(1) develop policies and procedures to assure adherence to medical assistance laws and regulations and to prevent inappropriate claims submissions;

(2) train the employees of the provider entity, and any agents or subcontractors of the provider entity including billers, on the policies and procedures under clause (1);

(3) respond to allegations of improper conduct related to the provision or billing of medical assistance services, and implement action to remediate any resulting problems;

(4) use evaluation techniques to monitor compliance with medical assistance laws and regulations;

(5) promptly report to the commissioner any identified violations of medical assistance laws or regulations; and

(6) within 60 days of discovery by the provider of a medical assistance reimbursement overpayment, report the overpayment to the commissioner and make arrangements with the commissioner for the commissioner's recovery of the overpayment.

The commissioner may require, as a condition of enrollment in medical assistance, that a provider within a particular industry sector or category establish a compliance program that contains the core elements established by the Centers for Medicare and Medicaid Services.

(c) The commissioner may revoke the enrollment of an ordering or rendering provider for a period of not more than one year, if the provider fails to maintain and, upon request from the commissioner, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such provider, when the commissioner has identified a pattern of a lack of documentation. A pattern means a failure to maintain documentation or provide access to documentation on more than one occasion. Nothing in this paragraph limits the authority of the commissioner to sanction a provider under the provisions of section 256B.064.

(d) The commissioner shall terminate or deny the enrollment of any individual or entity if the individual or entity has been terminated from participation in Medicare or under the Medicaid program or Children's Health Insurance Program of any other state.

(e) As a condition of enrollment in medical assistance, the commissioner shall require that a provider designated "moderate" or "high-risk" by the Centers for Medicare and Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid Services, its agents, or its designated contractors and the state agency, its agents, or its designated contractors to conduct unannounced on-site inspections of any provider location. The commissioner shall publish in the Minnesota Health Care Program Provider Manual a list of provider types designated "limited," "moderate," or "high-risk," based on the criteria and standards used to designate Medicare providers in Code of Federal Regulations, title 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14. The commissioner's designations are not subject to administrative appeal.

(f) As a condition of enrollment in medical assistance, the commissioner shall require that a high-risk provider, or a person with a direct or indirect ownership interest in the provider of five percent or higher, consent to criminal background checks, including fingerprinting, when required to do so under state law or by a determination by the commissioner or the Centers for Medicare and Medicaid Services that a provider is designated high-risk for fraud, waste, or abuse.

(g)(1) Upon initial enrollment, reenrollment, and revalidation, all durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is annually renewed and designates the Minnesota Department of Human Services as the obligee, and must be submitted in a form approved by the commissioner.

(2) At the time of initial enrollment or reenrollment, the provider agency must purchase a performance bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a performance bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is over $300,000, the provider agency must purchase a performance bond of $100,000. The performance bond must allow for recovery of costs and fees in pursuing a claim on the bond.

(h) The Department of Human Services may require a provider to purchase a performance surety bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment if: (1) the provider fails to demonstrate financial viability, (2) the department determines there is significant evidence of or potential for fraud and abuse by the provider, or (3) the provider or category of providers is designated high-risk pursuant

to paragraph (a) and as per Code of Federal Regulations, title 42, section 455.450. The performance bond must be in an amount of $100,000 or ten percent of the provider's payments from Medicaid during the immediately preceding 12 months, whichever is greater. The performance bond must name the Department of Human Services as an obligee and must allow for recovery of costs and fees in pursuing a claim on the bond.

Sec. 6. **LEGISLATIVE HEALTH CARE WORKFORCE COMMISSION.**

Subdivision 1. **Legislative oversight.** The Legislative Health Care Workforce Commission is created to study and make recommendations to the legislature on how to achieve the goal of strengthening the workforce in healthcare.

Subd. 2. **Membership.** The Legislative Health Care Workforce Commission consists of five members of the senate appointed by the Subcommittee on Committees of the Committee on Rules and Administration and five members of the house of representatives appointed by the speaker of the house. The Legislative Health Care Workforce Commission must include three members of the majority party and two members of the minority party in each house.

Subd. 3. **Report to the legislature.** The Legislative Health Care Workforce Commission must provide a report making recommendations to the legislature by December 31, 2014. The report must:

(1) identify current and anticipated health care workforce shortages, by both provider type and geography;

(2) evaluate the effectiveness of incentives currently available to develop, attract, and retain a highly skilled health care workforce;

(3) study alternative incentives to develop, attract, and retain a highly skilled and diverse health care workforce; and

(4) identify current causes and potential solutions to barriers related to the primary care workforce, including, but not limited to:

(i) training and residency shortages;

(ii) disparities in income between primary care and other providers; and

(iii) negative perceptions of primary care among students.

Subd. 4. **Assistance to the commission.** The commissioners of health, human services, commerce, and other state agencies shall provide assistance and technical support to the commission at the request of the commission. The commission may convene subcommittees to provide additional assistance and advice to the commission.

Subd. 5. **Expiration.** The Legislative Health Care Workforce Commission expires on January 1, 2015.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 7. **GRANT PROGRAMS TO ADDRESS MINORITY HEALTH DISPARITIES.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Dementia" means a condition ascribed within the brain that leads to confusion, lack of focus, and decreased memory.

(c) "Education activities" means providing materials related to health care topics in ethnic-specific languages through materials including, but not limited to, Web sites, brochures, flyers, and other similar vehicles.

(d) "Minority populations" means racial and ethnic groups including, but not limited to, African-Americans, Native Americans, Hmong, Asians, and other similar groups.

(e) "Outreach" means the active pursuit of people within the minority groups through specific and targeted activities to contact individuals who may not regularly be contacted by health care professionals.

Subd. 2. **Grants; distribution.** The commissioner of health shall distribute grant funds to grantees for the following purposes:

(1) dementia education and training to specific minority and under-represented groups;

(2) a training conference related to immigrant and refugee mental health issues; and

(3) other programs, as prioritized by the commissioner, relating to health disparities in minority populations, including, but not limited to, a Somali women-led prevention health care agency located in Minnesota focused on minority women's health disparities.

Subd. 3. **Grants; administration.** Grant applicants shall submit applications to the commissioner of health as directed by a request for proposals. Grants must be competitively awarded and recipients of a grant under this section must prepare and submit a quarterly progress report to the commissioner beginning three months after receipt of the grant. The commissioner shall provide technical assistance and program support as needed, including, but not limited to, assurance that minority individuals with dementia are effectively identified, mitigated, and evaluated by grantees.

Subd. 4. **Dementia education and training grant; eligible activities for dementia outreach.** (a) Within the limits of available appropriations, the commissioner shall make a grant to a nonprofit organization with expertise in providing outreach, education, and training on dementia, Alzheimer's, and other related disabilities within specific minority and under-represented groups.

(b) The grantee must conduct the following activities:

(1) providing and making available educational materials to the general public as well as specific minority populations;

(2) promoting awareness of dementia-related resources and educational materials; and

(3) promoting the use of materials within health care organizations.

Sec. 8. **FULL-TIME EMPLOYEE RESTRICTION.**

No more than one full-time employee may be hired by the Department of Health to administer the grants under Minnesota Statutes, section 144.9513.

ARTICLE 2

HEALTH CARE

Section 1. Minnesota Statutes 2012, section 256.01, is amended by adding a subdivision to read:

Subd. 38. **Contract to match recipient third-party liability information.** The commissioner may enter into a contract with a national organization to match recipient third-party liability information and provide coverage and insurance primacy information to the department at no charge to providers and the clearinghouses.

Sec. 2. Minnesota Statutes 2012, section 256.9685, subdivision 1, is amended to read:

Subdivision 1. **Authority.** (a) The commissioner shall establish procedures for determining medical assistance ~~and general assistance medical care~~ payment rates under a prospective payment system for inpatient hospital services in hospitals that qualify as vendors of medical assistance. The commissioner shall establish, by rule, procedures for implementing this section and sections 256.9686, 256.969, and 256.9695. Services must meet the requirements of section 256B.04, subdivision 15, ~~or 256D.03, subdivision 7, paragraph (b),~~ to be eligible for payment.

(b) The commissioner may reduce the types of inpatient hospital admissions that are required to be certified as medically necessary after notice in the State Register and a 30-day comment period.

Sec. 3. Minnesota Statutes 2012, section 256.9685, subdivision 1a, is amended to read:

Subd. 1a. **Administrative reconsideration.** Notwithstanding ~~sections~~ section 256B.04, subdivision 15, ~~and 256D.03, subdivision 7,~~ the commissioner shall establish an administrative reconsideration process for appeals of inpatient hospital services

determined to be medically unnecessary. A physician or hospital may request a reconsideration of the decision that inpatient hospital services are not medically necessary by submitting a written request for review to the commissioner within 30 days after receiving notice of the decision. The reconsideration process shall take place prior to the procedures of subdivision 1b and shall be conducted by physicians that are independent of the case under reconsideration. A majority decision by the physicians is necessary to make a determination that the services were not medically necessary.

Sec. 4. Minnesota Statutes 2012, section 256.9686, subdivision 2, is amended to read:

Subd. 2. **Base year.** "Base year" means a hospital's fiscal year or years that is recognized by the Medicare program or a hospital's fiscal year specified by the commissioner if a hospital is not required to file information by the Medicare program from which cost and statistical data are used to establish medical assistance ~~and general assistance medical care~~ payment rates.

Sec. 5. Minnesota Statutes 2012, section 256.969, subdivision 1, is amended to read:

Subdivision 1. **Hospital cost index.** (a) The hospital cost index shall be the change in the Consumer Price Index-All Items (United States city average) (CPI-U) forecasted by Data Resources, Inc. The commissioner shall use the indices as forecasted in the third quarter of the calendar year prior to the rate year. The hospital cost index may be used to adjust the base year operating payment rate through the rate year on an annually compounded basis.

(b) ~~For fiscal years beginning on or after July 1, 1993, the commissioner of human services shall not provide automatic annual inflation adjustments for hospital payment rates under medical assistance, nor under general assistance medical care, except that the inflation adjustments under paragraph (a) for medical assistance, excluding general assistance medical care, shall apply through calendar year 2001. The index for calendar year 2000 shall be reduced 2.5 percentage points to recover overprojections of the index from 1994 to 1996.~~ The commissioner of management and budget shall include as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11 annual adjustments in hospital payment rates under medical assistance ~~and general assistance medical care,~~ based upon the hospital cost index.

Sec. 6. Minnesota Statutes 2012, section 256.969, subdivision 2, is amended to read:

Subd. 2. **Diagnostic categories.** The commissioner shall use to the extent possible existing diagnostic classification systems, including the system ~~used by the Medicare~~

~~program~~ created by 3M for all patient refined diagnosis-related groups (APR-DRGs) to determine the relative values of inpatient services and case mix indices. The commissioner may combine diagnostic classifications into diagnostic categories and may establish separate categories and numbers of categories based on ~~program eligibility or~~ hospital peer group. Relative values shall be recalculated when the base year is changed. Relative value determinations shall include paid claims for admissions during each hospital's base year. The commissioner may ~~extend the time period forward to obtain sufficiently valid information to establish relative values~~ supplement the APR-DRG data with national averages. Relative value determinations shall not include property cost data, Medicare crossover data, and data on admissions that are paid a per day transfer rate under subdivision 14. The computation of the base year cost per admission must include identified outlier cases and their weighted costs up to the point that they become outlier cases, but must exclude costs recognized in outlier payments beyond that point. The commissioner may recategorize the diagnostic classifications and recalculate relative values and case mix indices to reflect actual hospital practices, the specific character of specialty hospitals, or to reduce variances within the diagnostic categories after notice in the State Register ~~and a 30-day comment period. The commissioner shall recategorize the diagnostic classifications and recalculate relative values and case mix indices based on the two-year schedule in effect prior to January 1, 2013, reflected in subdivision 2b. The first recategorization shall occur January 1, 2013, and shall occur every two years after. When rates are not rebased under subdivision 2b, the commissioner may establish relative values and case mix indices based on charge data and may update the base year to the most recent data available~~.

Sec. 7. Minnesota Statutes 2012, section 256.969, subdivision 2b, is amended to read:

Subd. 2b. **Operating payment rates.** ~~In determining operating payment rates for admissions occurring on or after the rate year beginning January 1, 1991, and every two years after, or more frequently as determined by the commissioner, the commissioner shall obtain operating data from an updated base year and establish operating payment rates per admission for each hospital based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year. Rates under the general assistance medical care, medical assistance, and MinnesotaCare programs shall not be rebased to more current data on January 1, 1997, January 1, 2005, for the first 24 months of the rebased period beginning January 1, 2009.~~ For the rebased period beginning January 1, 2011, rates shall not be rebased, except that a Minnesota long-term hospital shall be rebased effective January 1, 2011, based on its most recent Medicare cost report ending on or before September 1, 2008, with the provisions under subdivisions 9 and 23, based on

the rates in effect on December 31, 2010. For subsequent rate setting periods in which the base years are updated, a Minnesota long-term hospital's base year shall remain within the same period as other hospitals. ~~Effective January 1, 2013, and after, rates shall not be rebased.~~ The base year operating payment rate per admission is standardized by the case mix index and adjusted by the hospital cost index, relative values, and disproportionate population adjustment. The cost and charge data used to establish operating rates shall only reflect inpatient services covered by medical assistance ~~and shall not include property cost information and costs recognized in outlier payments~~. In determining operating payment rates for admissions occurring on or after the rate year beginning January 1, 2011, through December 31, 2012, the operating payment rate per admission must be based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year or years.

Sec. 8. Minnesota Statutes 2012, section 256.969, subdivision 2c, is amended to read:

Subd. 2c. **Property payment rates.** ~~For each hospital's first two consecutive fiscal years beginning on or after July 1, 1988, the commissioner shall limit the annual increase in property payment rates for depreciation, rents and leases, and interest expense to the annual growth in the hospital cost index derived from the methodology in effect on the day before July 1, 1989. When computing budgeted and settlement property payment rates, the commissioner shall use the annual increase in the hospital cost index forecasted by Data Resources, Inc., consistent with the quarter of the hospital's fiscal year end. For admissions occurring on or after the rate year beginning January 1, 1991, the commissioner shall obtain property data from an updated base year and establish property payment rates per admission for each hospital.~~ Property payment rates shall be derived from data from the same base year that is used to establish operating payment rates. The property information shall include cost categories not subject to the hospital cost index and shall reflect the cost-finding methods and allowable costs of the Medicare program. ~~The base year property payment rates shall be adjusted for increases in the property cost by increasing the base year property payment rate 85 percent of the percentage change from the base year through the year for which a Medicare cost report has been submitted to the Medicare program and filed with the department by the October 1 before the rate year.~~ The property rates shall only reflect inpatient services covered by medical assistance. ~~The commissioner shall adjust rates for the rate year beginning January 1, 1991, to ensure that all hospitals are subject to the hospital cost index limitation for two complete years.~~

Sec. 9. Minnesota Statutes 2012, section 256.969, is amended by adding a subdivision to read:

Subd. 2d. **Budget neutrality factor.** For the rebased period effective September 1, 2014, when rebasing rates under subdivisions 2b and 2c, the commissioner must apply a budget neutrality factor (BNF) to a hospital's conversion factor to ensure that total DRG payments to hospitals do not exceed total DRG payments that would have been made to hospitals if the relative rates and weights had not been recalibrated. For the purposes of this section, BNF equals the percentage change from total aggregate payments calculated under a new payment system to total aggregate payments calculated under the old system.

Sec. 10. Minnesota Statutes 2012, section 256.969, subdivision 3a, is amended to read:

Subd. 3a. **Payments.** ~~(a)~~ Acute care hospital billings under the medical assistance program must not be submitted until the recipient is discharged. However, the commissioner shall establish monthly interim payments for inpatient hospitals that have individual patient lengths of stay over 30 days regardless of diagnostic category. Except as provided in section 256.9693, medical assistance reimbursement for treatment of mental illness shall be reimbursed based on diagnostic classifications. Individual hospital payments established under this section and sections 256.9685, 256.9686, and 256.9695, in addition to third-party and recipient liability, for discharges occurring during the rate year shall not exceed, in aggregate, the charges for the medical assistance covered inpatient services paid for the same period of time to the hospital. ~~This payment limitation shall be calculated separately for medical assistance and general assistance medical care services. The limitation on general assistance medical care shall be effective for admissions occurring on or after July 1, 1991.~~ Services that have rates established under subdivision 11 or 12, must be limited separately from other services. After consulting with the affected hospitals, the commissioner may consider related hospitals one entity and may merge the payment rates while maintaining separate provider numbers. The operating and property base rates per admission or per day shall be derived from the best Medicare and claims data available when rates are established. The commissioner shall determine the best Medicare and claims data, taking into consideration variables of recency of the data, audit disposition, settlement status, and the ability to set rates in a timely manner. The commissioner shall notify hospitals of payment rates ~~by December 1 of the year preceding the rate year~~ 30 days prior to implementation. The rate setting data must reflect the admissions data used to establish relative values. ~~Base year changes from 1981 to the base year established for the rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited to the limits ending June 30, 1987, on the maximum rate of increase~~

~~under subdivision 1.~~ The commissioner may adjust base year cost, relative value, and case mix index data to exclude the costs of services that have been discontinued by the October 1 of the year preceding the rate year or that are paid separately from inpatient services. Inpatient stays that encompass portions of two or more rate years shall have payments established based on payment rates in effect at the time of admission unless the date of admission preceded the rate year in effect by six months or more. In this case, operating payment rates for services rendered during the rate year in effect and established based on the date of admission shall be adjusted to the rate year in effect by the hospital cost index.

~~(b) For fee-for-service admissions occurring on or after July 1, 2002, the total payment, before third-party liability and spenddown, made to hospitals for inpatient services is reduced by .5 percent from the current statutory rates.~~

~~(c) In addition to the reduction in paragraph (b), the total payment for fee-for-service admissions occurring on or after July 1, 2003, made to hospitals for inpatient services before third-party liability and spenddown, is reduced five percent from the current statutory rates. Mental health services within diagnosis related groups 424 to 432, and facilities defined under subdivision 16 are excluded from this paragraph.~~

~~(d) In addition to the reduction in paragraphs (b) and (c), the total payment for fee-for-service admissions occurring on or after August 1, 2005, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 6.0 percent from the current statutory rates. Mental health services within diagnosis related groups 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph. Notwithstanding section 256.9686, subdivision 7, for purposes of this paragraph, medical assistance does not include general assistance medical care. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2006, to reflect this reduction.~~

~~(e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 3.46 percent from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2009, through June 30, 2009, to reflect this reduction.~~

~~(f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.9 percent from the current statutory rates. Mental health services with diagnosis related~~

~~groups 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after July 1, 2009, through June 30, 2011, to reflect this reduction.~~

~~(g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.79 percent from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after July 1, 2011, to reflect this reduction.~~

~~(h) In addition to the reductions in paragraphs (b), (c), (d), (f), and (g), the total payment for fee-for-service admissions occurring on or after July 1, 2009, made to hospitals for inpatient services before third-party liability and spenddown, is reduced one percent from the current statutory rates. Facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after October 1, 2009, to reflect this reduction.~~

~~(i) In addition to the reductions in paragraphs (b), (c), (d), (g), and (h), the total payment for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.96 percent from the current statutory rates. Facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2011, to reflect this reduction.~~

Sec. 11. Minnesota Statutes 2012, section 256.969, subdivision 3b, is amended to read:

Subd. 3b. **Nonpayment for hospital-acquired conditions and for certain treatments.** (a) The commissioner must not make medical assistance payments to a hospital for any costs of care that result from a condition listed in paragraph (c), if the condition was hospital acquired.

(b) For purposes of this subdivision, a condition is hospital acquired if it is not identified by the hospital as present on admission. For purposes of this subdivision, medical assistance includes ~~general assistance medical care and~~ MinnesotaCare.

(c) The prohibition in paragraph (a) applies to payment for each hospital-acquired condition listed in this paragraph that is represented by an ~~ICD-9-CM~~ ICD-10-CM diagnosis code ~~and is designated as a complicating condition or a major complicating condition:~~. The list of conditions is defined by the Centers for Medicare and Medicaid Services on an annual basis with the hospital-acquired conditions (HAC) list:

(1) foreign object retained after surgery ~~(ICD-9-CM codes 998.4 or 998.7)~~;

(2) air embolism ~~(ICD-9-CM code 999.1)~~;

(3) blood incompatibility ~~(ICD-9-CM code 999.6)~~;

(4) pressure ulcers stage III or IV ~~(ICD-9-CM codes 707.23 or 707.24)~~;

(5) falls and trauma, including fracture, dislocation, intracranial injury, crushing injury, burn, and electric shock ~~(ICD-9-CM codes with these ranges on the complicating condition and major complicating condition list: 800-829; 830-839; 850-854; 925-929; 940-949; and 991-994)~~;

(6) catheter-associated urinary tract infection ~~(ICD-9-CM code 996.64)~~;

(7) vascular catheter-associated infection ~~(ICD-9-CM code 999.31)~~;

(8) manifestations of poor glycemic control ~~(ICD-9-CM codes 249.10; 249.11; 249.20; 249.21; 250.10; 250.11; 250.12; 250.13; 250.20; 250.21; 250.22; 250.23; and 251.0)~~;

(9) surgical site infection ~~(ICD-9-CM codes 996.67 or 998.59)~~ following certain orthopedic procedures ~~(procedure codes 81.01; 81.02; 81.03; 81.04; 81.05; 81.06; 81.07; 81.08; 81.23; 81.24; 81.31; 81.32; 81.33; 81.34; 81.35; 81.36; 81.37; 81.38; 81.83; and 81.85)~~;

(10) surgical site infection ~~(ICD-9-CM code 998.59)~~ following bariatric surgery ~~(procedure codes 44.38; 44.39; or 44.95)~~ for a principal diagnosis of morbid obesity ~~(ICD-9-CM code 278.01)~~;

(11) surgical site infection, mediastinitis ~~(ICD-9-CM code 519.2)~~ following coronary artery bypass graft ~~(procedure codes 36.10 to 36.19)~~; and

(12) deep vein thrombosis ~~(ICD-9-CM codes 453.40 to 453.42)~~ or pulmonary embolism ~~(ICD-9-CM codes 415.11 or 415.19)~~ following total knee replacement ~~(procedure code 81.54)~~ or hip replacement ~~(procedure codes 00.85 to 00.87 or 81.51 to 81.52)~~.

(d) The prohibition in paragraph (a) applies to any additional payments that result from a hospital-acquired condition listed in paragraph (c), including, but not limited to, additional treatment or procedures, readmission to the facility after discharge, increased length of stay, change to a higher diagnostic category, or transfer to another hospital. In the event of a transfer to another hospital, the hospital where the condition listed under paragraph (c) was acquired is responsible for any costs incurred at the hospital to which the patient is transferred.

(e) A hospital shall not bill a recipient of services for any payment disallowed under this subdivision.

Sec. 12. Minnesota Statutes 2012, section 256.969, subdivision 3c, is amended to read:

Subd. 3c. **Rateable reduction and readmissions reduction.** (a) The total payment for fee for service admissions occurring on or after September 1, 2011, through June 30, 2015, made to hospitals for inpatient services before third-party liability and spenddown, is reduced ten percent from the current statutory rates. Facilities defined under subdivision 16, long-term hospitals as determined under the Medicare program, children's hospitals whose inpatients are predominantly under 18 years of age, and payments under managed care are excluded from this paragraph.

(b) Effective for admissions occurring during calendar year 2010 and each year after, the commissioner shall calculate a regional readmission rate for admissions to all hospitals occurring within 30 days of a previous discharge. The commissioner may adjust the readmission rate taking into account factors such as the medical relationship, complicating conditions, and sequencing of treatment between the initial admission and subsequent readmissions.

(c) Effective for payments to all hospitals on or after July 1, 2013, through June 30, 2015, the reduction in paragraph (a) is reduced one percentage point for every percentage point reduction in the overall readmissions rate between the two previous calendar years to a maximum of five percent.

(d) A hospital with at least 1,700 licensed beds on January 1, 2012, located in Hennepin County is excluded from the reduction in paragraph (a) for admissions occurring on or after September 1, 2011, through August 30, 2013, but is subject to the reduction in paragraph (a) for admissions occurring on or after September 1, 2013, through June 30, 2015.

EFFECTIVE DATE. This section is effectively retroactively from September 1, 2011.

Sec. 13. Minnesota Statutes 2012, section 256.969, is amended by adding a subdivision to read:

Subd. 4b. **Medical assistance cost reports for services.** (a) A hospital that meets one of the following criteria must annually file medical assistance cost reports within six months of the end of the hospital's fiscal year:

(1) a hospital designated as a critical access hospital that receives medical assistance payments; or

(2) a Minnesota hospital or out-of-state hospital located within a Minnesota local trade area that receives a disproportionate population adjustment under subdivision 9.

For purposes of this subdivision, local trade area has the meaning given in subdivision 17.

(b) The Department of Human Services must suspend payments to any hospital that fails to file a report required under this subdivision. Payments must remain suspended until the report has been filed with and accepted by the Department of Human Services inpatient rates unit.

Sec. 14. Minnesota Statutes 2012, section 256.969, subdivision 6a, is amended to read:

Subd. 6a. **Special considerations.** In determining the payment rates, the commissioner shall consider whether the circumstances in subdivisions ~~7~~ 8 to 14 exist.

Sec. 15. Minnesota Statutes 2012, section 256.969, is amended by adding a subdivision to read:

Subd. 8c. **Hospital residents.** Payments for hospital residents shall be made as follows:

(1) payments for the first 180 days of inpatient care shall be the APR-DRG payment plus any appropriate outliers; and

(2) payment for all medically necessary patient care subsequent to 180 days shall be reimbursed at a rate computed by multiplying the statewide average cost-to-charge ratio by the usual and customary charges.

Sec. 16. Minnesota Statutes 2012, section 256.969, subdivision 9, is amended to read:

Subd. 9. **Disproportionate numbers of low-income patients served.** (a) For admissions occurring on or after October 1, 1992, through December 31, 1992, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service but less than or equal to one standard deviation above the mean, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1. If federal matching funds are not available for all adjustments under this subdivision, the commissioner shall reduce payments on a pro rata basis so that all adjustments qualify for federal match. ~~The commissioner may establish a separate disproportionate population operating payment rate adjustment under the general assistance medical care program. For purposes of this subdivision medical assistance does not include general assistance medical care.~~ The commissioner shall report annually on the number of hospitals likely to receive the adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class.

(b) For admissions occurring on or after July 1, 1993, the medical assistance disproportionate population adjustment shall comply with federal law and shall be paid to a hospital, excluding regional treatment centers, critical access hospitals, and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers, critical access hospitals, and facilities of the federal Indian Health Service but less than or equal to one standard deviation above the mean, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment that would be determined under clause (1) for that hospital by 1.1. ~~The commissioner may establish a separate disproportionate population operating payment rate adjustment under the general assistance medical care program. For purposes of this subdivision, medical assistance does not include general assistance medical care.~~ The commissioner shall report annually on the number of hospitals likely to receive the adjustment authorized by this paragraph. The commissioner shall specifically report on the adjustments received by public hospitals and public hospital corporations located in cities of the first class~~;~~.

~~(3) for a hospital that had medical assistance fee-for-service payment volume during calendar year 1991 in excess of 13 percent of total medical assistance fee-for-service~~

~~payment volume, a medical assistance disproportionate population adjustment shall be paid in addition to any other disproportionate payment due under this subdivision as follows: $1,515,000 due on the 15th of each month after noon, beginning July 15, 1995. For a hospital that had medical assistance fee-for-service payment volume during calendar year 1991 in excess of eight percent of total medical assistance fee-for-service payment volume and was the primary hospital affiliated with the University of Minnesota, a medical assistance disproportionate population adjustment shall be paid in addition to any other disproportionate payment due under this subdivision as follows: $505,000 due on the 15th of each month after noon, beginning July 15, 1995; and~~

~~(4) effective August 1, 2005, the payments in paragraph (b), clause (3), shall be reduced to zero.~~

~~(c) The commissioner shall adjust rates paid to a health maintenance organization under contract with the commissioner to reflect rate increases provided in paragraph (b), clauses (1) and (2), on a nondiscounted hospital-specific basis but shall not adjust those rates to reflect payments provided in clause (3).~~

~~(d) If federal matching funds are not available for all adjustments under paragraph (b), the commissioner shall reduce payments under paragraph (b), clauses (1) and (2), on a pro rata basis so that all adjustments under paragraph (b) qualify for federal match.~~

~~(e) For purposes of this subdivision, medical assistance does not include general assistance medical care.~~

~~(f) For hospital services occurring on or after July 1, 2005, to June 30, 2007:~~

~~(1) general assistance medical care expenditures for fee-for-service inpatient and outpatient hospital payments made by the department shall be considered Medicaid disproportionate share hospital payments, except as limited below:~~

~~(i) only the portion of Minnesota's disproportionate share hospital allotment under section 1923(f) of the Social Security Act that is not spent on the disproportionate population adjustments in paragraph (b), clauses (1) and (2), may be used for general assistance medical care expenditures;~~

~~(ii) only those general assistance medical care expenditures made to hospitals that qualify for disproportionate share payments under section 1923 of the Social Security Act and the Medicaid state plan may be considered disproportionate share hospital payments;~~

~~(iii) only those general assistance medical care expenditures made to an individual hospital that would not cause the hospital to exceed its individual hospital limits under section 1923 of the Social Security Act may be considered; and~~

~~(iv) general assistance medical care expenditures may be considered only to the extent of Minnesota's aggregate allotment under section 1923 of the Social Security Act.~~

~~All hospitals and prepaid health plans participating in general assistance medical care must provide any necessary expenditure, cost, and revenue information required by the commissioner as necessary for purposes of obtaining federal Medicaid matching funds for general assistance medical care expenditures; and~~

~~(2)~~ (c) Certified public expenditures made by Hennepin County Medical Center shall be considered Medicaid disproportionate share hospital payments. Hennepin County and Hennepin County Medical Center shall report by June 15, 2007, on payments made beginning July 1, 2005, or another date specified by the commissioner, that may qualify for reimbursement under federal law. Based on these reports, the commissioner shall apply for federal matching funds.

~~(g)~~ (d) Upon federal approval of the related state plan amendment, paragraph ~~(f)~~ (c) is effective retroactively from July 1, 2005, or the earliest effective date approved by the Centers for Medicare and Medicaid Services.

Sec. 17. Minnesota Statutes 2012, section 256.969, subdivision 10, is amended to read:

Subd. 10. **Separate billing by certified registered nurse anesthetists.** Hospitals ~~may~~ must exclude certified registered nurse anesthetist costs from the operating payment rate ~~as allowed by section 256B.0625, subdivision 11. To be eligible, a hospital must notify the commissioner in writing by October 1 of even-numbered years to exclude certified registered nurse anesthetist costs. The hospital must agree that all hospital claims for the cost and charges of certified registered nurse anesthetist services will not be included as part of the rates for inpatient services provided during the rate year. In this case, the operating payment rate shall be adjusted to exclude the cost of certified registered nurse anesthetist services~~.

~~For admissions occurring on or after July 1, 1991, and until the expiration date of section 256.9695, subdivision 3, services of certified registered nurse anesthetists provided on an inpatient basis may be paid as allowed by section 256B.0625, subdivision 11, when the hospital's base year did not include the cost of these services. To be eligible, a hospital must notify the commissioner in writing by July 1, 1991, of the request and must comply with all other requirements of this subdivision.~~

Sec. 18. Minnesota Statutes 2012, section 256.969, subdivision 14, is amended to read:

Subd. 14. **Transfers.** ~~Except as provided in subdivisions 11 and 13,~~ Operating and property payment rates for admissions that result in transfers and transfers shall be established on a per day payment system. The per day payment rate shall be the sum of the adjusted operating and property payment rates determined under this subdivision and

subdivisions 2, 2b, 2c, 3a, 4a, 5a, and ~~7~~ 8 to 12, divided by the arithmetic mean length of stay for the diagnostic category. Each admission that results in a transfer and each transfer is considered a separate admission to each hospital, and the total of the admission and transfer payments to each hospital must not exceed the total per admission payment that would otherwise be made to each hospital under this subdivision and subdivisions 2, 2b, 2c, 3a, 4a, 5a, and ~~7 to 13~~ 8 to 12.

Sec. 19. Minnesota Statutes 2012, section 256.969, subdivision 17, is amended to read:

Subd. 17. **Out-of-state hospitals in local trade areas.** Out-of-state hospitals that are located within a Minnesota local trade area and that have more than 20 admissions in the base year or years shall have rates established using the same procedures and methods that apply to Minnesota hospitals. For this subdivision and subdivision 18, local trade area means a county contiguous to Minnesota and located in a metropolitan statistical area as determined by Medicare for October 1 prior to the most current rebased rate year. Hospitals that are not required by law to file information in a format necessary to establish rates shall have rates established based on the commissioner's estimates of the information. Relative values of the diagnostic categories shall not be redetermined under this subdivision until required by ~~rule~~ statute. Hospitals affected by this subdivision shall then be included in determining relative values. However, hospitals that have rates established based upon the commissioner's estimates of information shall not be included in determining relative values. This subdivision is effective for hospital fiscal years beginning on or after July 1, 1988. A hospital shall provide the information necessary to establish rates under this subdivision at least 90 days before the start of the hospital's fiscal year.

Sec. 20. Minnesota Statutes 2012, section 256.969, subdivision 30, is amended to read:

Subd. 30. **Payment rates for births.** (a) For admissions occurring on or after ~~October 1, 2009~~ September 1, 2014, the total operating and property payment rate, excluding disproportionate population adjustment, for the following diagnosis-related groups, as they fall within the ~~diagnostic~~ APR-DRG categories: (1) ~~371 cesarean section without complicating diagnosis~~ 5601, 5602, 5603, 5604 vaginal delivery; and (2) ~~372 vaginal delivery with complicating diagnosis; and (3) 373 vaginal delivery without complicating diagnosis~~ 5401, 5402, 5403, 5404 cesarean section, shall be no greater than $3,528.

(b) The rates described in this subdivision do not include newborn care.

(c) Payments to managed care and county-based purchasing plans under section 256B.69, 256B.692, or 256L.12 shall be reduced for services provided on or after October 1, 2009, to reflect the adjustments in paragraph (a).

(d) Prior authorization shall not be required before reimbursement is paid for a cesarean section delivery.

Sec. 21. Minnesota Statutes 2012, section 256B.04, is amended by adding a subdivision to read:

Subd. 24. **Medicaid waiver requests and state plan amendments.** Prior to submitting any Medicaid waiver request or Medicaid state plan amendment to the federal government for approval, the commissioner shall publish the text of the waiver request or state plan amendment, and a summary of and explanation of the need for the request, on the agency's Web site and provide a 30-day public comment period. The commissioner shall notify the public of the availability of this information through the agency's electronic subscription service. The commissioner shall consider public comments when preparing the final waiver request or state plan amendment that is to be submitted to the federal government for approval. The commissioner shall also publish on the agency's Web site notice of any federal decision related to the state request for approval, within 30 days of the decision. This notice must describe any modifications to the state request that have been agreed to by the commissioner as a condition of receiving federal approval.

Sec. 22. Minnesota Statutes 2013 Supplement, section 256B.056, subdivision 5c, is amended to read:

Subd. 5c. **Excess income standard.** (a) The excess income standard for parents and caretaker relatives, pregnant women, infants, and children ages two through 20 is the standard specified in subdivision 4, paragraph (b).

(b) The excess income standard for a person whose eligibility is based on blindness, disability, or age of 65 or more years shall equal 75 percent of the federal poverty guidelines. The excess income standard under this paragraph shall equal 80 percent of the federal poverty guidelines, effective January 1, 2017.

Sec. 23. Minnesota Statutes 2012, section 256B.0625, subdivision 30, is amended to read:

Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, and public health clinic services. Rural health clinic services and federally

qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

(b) A federally qualified health center that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. A federally qualified health center that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, a federally qualified health center shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. Federally qualified health centers that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with the Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), a federally qualified health center or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the Department of Health according to section 62Q.19, subdivision 7. For those federally qualified health centers and rural health clinics that have applied for essential community provider status within the six-month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years after application. For federally qualified health centers and rural health clinics that either do not apply within the time specified above or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions applicable to the same service provided by health care providers that are not federally qualified health centers or rural health clinics.

(d) Effective July 1, 1999, the provisions of paragraph (c) requiring a federally qualified health center or a rural health clinic to make application for an essential community provider designation in order to have cost-based payments made according to paragraphs (a) and (b) no longer apply.

(e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

(f) Effective January 1, 2001, each federally qualified health center and rural health clinic may elect to be paid either under the prospective payment system established

in United States Code, title 42, section 1396a(aa), or under an alternative payment methodology consistent with the requirements of United States Code, title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services. The alternative payment methodology shall be 100 percent of cost as determined according to Medicare cost principles.

(g) For purposes of this section, "nonprofit community clinic" is a clinic that:

(1) has nonprofit status as specified in chapter 317A;

(2) has tax exempt status as provided in Internal Revenue Code, section 501(c)(3);

(3) is established to provide health services to low-income population groups, uninsured, high-risk and special needs populations, underserved and other special needs populations;

(4) employs professional staff at least one-half of which are familiar with the cultural background of their clients;

(5) charges for services on a sliding fee scale designed to provide assistance to low-income clients based on current poverty income guidelines and family size; and

(6) does not restrict access or services because of a client's financial limitations or public assistance status and provides no-cost care as needed.

(h) Effective for dates of service on and after January 1, 2015, all claims for payment of clinic services provided by federally qualified health centers and rural health clinics shall be submitted directly to the commissioner and paid by the commissioner. The commissioner shall provide claims information received by the commissioner under this paragraph for recipients enrolled in managed care to managed care organizations on a regular basis.

(i) For clinic services provided prior to January 1, 2015, the commissioner shall calculate and pay monthly the proposed managed care supplemental payments to clinics and clinics shall conduct a timely review of the payment calculation data in order to finalize all supplemental payments in accordance with federal law. Any issues arising from a clinic's review must be reported to the commissioner by January 1, 2017. Upon final agreement between the commissioner and a clinic on issues identified under this subdivision, and in accordance with United States Code, title 42, section 1396a(bb), no supplemental payments for managed care claims for dates of service prior to January 1, 2015, shall be made after June 30, 2017. If the commissioner and clinics are unable to resolve issues under this subdivision, the parties shall submit the dispute to the arbitration process under section 14.57.

Sec. 24. Minnesota Statutes 2012, section 256B.0751, is amended by adding a subdivision to read:

Subd. 10. **Health care homes advisory committee.** (a) The commissioners of health and human services shall establish a health care homes advisory committee to advise the commissioners on the ongoing statewide implementation of the health care homes program authorized in this section.

(b) The commissioners shall establish an advisory committee that includes representatives of the health care professions such as primary care providers; mental health providers; nursing and care coordinators; certified health care home clinics with statewide representation; health plan companies; state agencies; employers; academic researchers; consumers; and organizations that work to improve health care quality in Minnesota. At least 25 percent of the committee members must be consumers or patients in health care homes. The commissioners, in making appointments to the committee, shall ensure geographic representation of all regions of the state.

(c) The advisory committee shall advise the commissioners on ongoing implementation of the health care homes program, including, but not limited to, the following activities:

(1) implementation of certified health care homes across the state on performance management and implementation of benchmarking;

(2) implementation of modifications to the health care homes program based on results of the legislatively mandated health care home evaluation;

(3) statewide solutions for engagement of employers and commercial payers;

(4) potential modifications of the health care home rules or statutes;

(5) consumer engagement, including patient and family-centered care, patient activation in health care, and shared decision making;

(6) oversight for health care home subject matter task forces or workgroups; and

(7) other related issues as requested by the commissioners.

(d) The advisory committee shall have the ability to establish subcommittees on specific topics. The advisory committee is governed by section 15.059. Notwithstanding section 15.059, the advisory committee does not expire.

Sec. 25. Minnesota Statutes 2012, section 256B.199, is amended to read:

256B.199 PAYMENTS REPORTED BY GOVERNMENTAL ENTITIES.

(a) ~~Effective July 1, 2007,~~ The commissioner shall apply for federal matching funds for the expenditures in paragraphs (b) and (c). ~~Effective September 1, 2011, the commissioner shall apply for matching funds for expenditures in paragraph (c).~~

(b) The commissioner shall apply for federal matching funds for certified public expenditures as follows~~:~~.

~~(1) Hennepin County, Hennepin County Medical Center, Ramsey County, Regions Hospital, the University of Minnesota, and Fairview-University Medical Center shall report quarterly to the commissioner beginning June 1, 2007, payments made during the second previous quarter that may qualify for reimbursement under federal law;~~

~~(2) based on these reports, the commissioner shall apply for federal matching funds. These funds are appropriated to the commissioner for the payments under section 256.969, subdivision 27; and~~

~~(3)~~ By May 1 of each year, beginning May 1, 2007, the commissioner shall inform the nonstate entities listed in paragraph (a) of the amount of federal disproportionate share hospital payment money expected to be available in the current federal fiscal year.

~~(c) The commissioner shall apply for federal matching funds for general assistance medical care expenditures as follows:~~

~~(1) for hospital services occurring on or after July 1, 2007, general assistance medical care expenditures for fee-for-service inpatient and outpatient hospital payments made by the department shall be used to apply for federal matching funds, except as limited below:~~

~~(i) only those general assistance medical care expenditures made to an individual hospital that would not cause the hospital to exceed its individual hospital limits under section 1923 of the Social Security Act may be considered; and~~

~~(ii) general assistance medical care expenditures may be considered only to the extent of Minnesota's aggregate allotment under section 1923 of the Social Security Act; and~~

~~(2) all hospitals must provide any necessary expenditure, cost, and revenue information required by the commissioner as necessary for purposes of obtaining federal Medicaid matching funds for general assistance medical care expenditures.~~

~~(d) For the period from April 1, 2009, to September 30, 2010, the commissioner shall apply for additional federal matching funds available as disproportionate share hospital payments under the American Recovery and Reinvestment Act of 2009. These funds shall be made available as the state share of payments under section 256.969, subdivision 28. The entities required to report certified public expenditures under paragraph (b), clause (1), shall report additional certified public expenditures as necessary under this paragraph.~~

~~(e)~~ (c) For services provided on or after September 1, 2011, the commissioner shall apply for additional federal matching funds available as disproportionate share hospital payments under the MinnesotaCare program ~~according to the requirements and conditions of paragraph (c)~~. A hospital may elect on an annual basis to not be a disproportionate

share hospital for purposes of this paragraph, if the hospital does not qualify for a payment under section 256.969, subdivision 9, paragraph (b).

Sec. 26. Minnesota Statutes 2012, 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 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, 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).

(d) Solely for the purpose of section 256B.0575, subdivision 1, paragraph (a), clause (1), the personal needs allowance shall be increased to include income garnished for spousal maintenance under a judgment and decree for dissolution of marriage, and any administrative fees garnished for collection efforts.

Sec. 27. Minnesota Statutes 2013 Supplement, section 256B.69, subdivision 34, is amended to read:

Subd. 34. **Supplemental recovery program.** The commissioner shall conduct a supplemental recovery program for third-party liabilities, identified through coordination of benefits, not recovered by managed care plans and county-based purchasing plans for state public health programs. Any third-party liability identified through coordination of benefits, and recovered by the commissioner more than ~~six~~ eight months after the date a managed care plan or county-based purchasing plan ~~receives~~ adjudicates a health

care claim, based on accurate and timely coordination of benefits information from the commissioner, shall be retained by the commissioner and deposited in the general fund. The commissioner shall establish a mechanism, including a reconciliation process, for managed care plans and county-based purchasing plans to coordinate third-party liability collections efforts resulting from coordination of benefits under this subdivision with the commissioner to ensure there is no duplication of efforts. The coordination mechanism must be consistent with the reporting requirements in subdivision 9c.

Sec. 28. **MEDICAL ASSISTANCE SPENDDOWN REQUIREMENTS.**

The commissioner of human services, in consultation with interested stakeholders, shall review medical assistance spenddown requirements and processes, including those used in other states, for individuals with disabilities and seniors age 65 years of age or older. Based on this review, the commissioner shall recommend alternative medical assistance spenddown payment requirements and processes that:

(1) are practical for current and potential medical assistance recipients, providers, and the Department of Human Services;

(2) improve the medical assistance payment process for providers; and

(3) allow current and potential medical assistance recipients to obtain consistent and affordable medical coverage.

The commissioner shall report these recommendations, along with the projected cost, to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health and human services policy and finance by November 15, 2015.

Sec. 29. **REPEALER.**

Minnesota Statutes 2012, sections 256.969, subdivisions 8b, 9a, 9b, 11, 13, 20, 21, 22, 25, 26, 27, and 28; and 256.9695, subdivisions 3 and 4, are repealed.

ARTICLE 3

NORTHSTAR CARE FOR CHILDREN

Section 1. Minnesota Statutes 2012, section 245C.05, subdivision 5, is amended to read:

Subd. 5. **Fingerprints.** (a) Except as provided in paragraph (c), for any background study completed under this chapter, when the commissioner has reasonable cause to believe that further pertinent information may exist on the subject of the background study, the subject shall provide the commissioner with a set of classifiable fingerprints obtained from an authorized agency.

(b) For purposes of requiring fingerprints, the commissioner has reasonable cause when, but not limited to, the:

(1) information from the Bureau of Criminal Apprehension indicates that the subject is a multistate offender;

(2) information from the Bureau of Criminal Apprehension indicates that multistate offender status is undetermined; or

(3) commissioner has received a report from the subject or a third party indicating that the subject has a criminal history in a jurisdiction other than Minnesota.

(c) Except as specified under section 245C.04, subdivision 1, paragraph (d), for background studies conducted by the commissioner for child foster care ~~or~~, adoptions, or a transfer of permanent legal and physical custody of a child, the subject of the background study, who is 18 years of age or older, shall provide the commissioner with a set of classifiable fingerprints obtained from an authorized agency.

Sec. 2. Minnesota Statutes 2013 Supplement, section 245C.08, subdivision 1, is amended to read:

Subdivision 1. **Background studies conducted by Department of Human Services.** (a) For a background study conducted by the Department of Human Services, the commissioner shall review:

(1) information related to names of substantiated perpetrators of maltreatment of vulnerable adults that has been received by the commissioner as required under section 626.557, subdivision 9c, paragraph (j);

(2) the commissioner's records relating to the maltreatment of minors in licensed programs, and from findings of maltreatment of minors as indicated through the social service information system;

(3) information from juvenile courts as required in subdivision 4 for individuals listed in section 245C.03, subdivision 1, paragraph (a), when there is reasonable cause;

(4) information from the Bureau of Criminal Apprehension, including information regarding a background study subject's registration in Minnesota as a predatory offender under section 243.166;

(5) except as provided in clause (6), information from the national crime information system when the commissioner has reasonable cause as defined under section 245C.05, subdivision 5; and

(6) for a background study related to a child foster care application for licensure, a transfer of permanent legal and physical custody of a child under sections 260C.503 to 260C.515, or adoptions, the commissioner shall also review:

(i) information from the child abuse and neglect registry for any state in which the background study subject has resided for the past five years; and

(ii) information from national crime information databases, when the background study subject is 18 years of age or older.

(b) Notwithstanding expungement by a court, the commissioner may consider information obtained under paragraph (a), clauses (3) and (4), unless the commissioner received notice of the petition for expungement and the court order for expungement is directed specifically to the commissioner.

(c) The commissioner shall also review criminal case information received according to section 245C.04, subdivision 4a, from the Minnesota court information system that relates to individuals who have already been studied under this chapter and who remain affiliated with the agency that initiated the background study.

Sec. 3. Minnesota Statutes 2012, section 245C.33, subdivision 1, is amended to read:

Subdivision 1. **Background studies conducted by commissioner.** (a) Before placement of a child for purposes of adoption, the commissioner shall conduct a background study on individuals listed in ~~section~~ sections 259.41, subdivision 3, and 260C.611, for county agencies and private agencies licensed to place children for adoption. When a prospective adoptive parent is seeking to adopt a child who is currently placed in the prospective adoptive parent's home and is under the guardianship of the commissioner according to section 260C.325, subdivision 1, paragraph (b), and the prospective adoptive parent holds a child foster care license, a new background study is not required when:

(1) a background study was completed on persons required to be studied under section 245C.03 in connection with the application for child foster care licensure after July 1, 2007;

(2) the background study included a review of the information in section 245C.08, subdivisions 1, 3, and 4; and

(3) as a result of the background study, the individual was either not disqualified or, if disqualified, the disqualification was set aside under section 245C.22, or a variance was issued under section 245C.30.

(b) Before the kinship placement agreement is signed for the purpose of transferring permanent legal and physical custody to a relative under sections 260C.503 to 260C.515, the commissioner shall conduct a background study on each person age 13 or older living in the home. When a prospective relative custodian has a child foster care license, a new background study is not required when:

(1) a background study was completed on persons required to be studied under section 245C.03 in connection with the application for child foster care licensure after July 1, 2007;

(2) the background study included a review of the information in section 245C.08, subdivisions 1, 3, and 4; and

(3) as a result of the background study, the individual was either not disqualified or, if disqualified, the disqualification was set aside under section 245C.22, or a variance was issued under section 245C.30. The commissioner and the county agency shall expedite any request for a set aside or variance for a background study required under chapter 256N.

Sec. 4. Minnesota Statutes 2012, section 245C.33, subdivision 4, is amended to read:

Subd. 4. **Information commissioner reviews.** (a) The commissioner shall review the following information regarding the background study subject:

(1) the information under section 245C.08, subdivisions 1, 3, and 4;

(2) information from the child abuse and neglect registry for any state in which the subject has resided for the past five years; and

(3) information from national crime information databases, when required under section 245C.08.

(b) The commissioner shall provide any information collected under this subdivision to the county or private agency that initiated the background study. The commissioner shall also provide the agency:

(1) notice whether the information collected shows that the subject of the background study has a conviction listed in United States Code, title 42, section 671(a)(20)(A); and

(2) for background studies conducted under subdivision 1, paragraph (a), the date of all adoption-related background studies completed on the subject by the commissioner after June 30, 2007, and the name of the county or private agency that initiated the adoption-related background study.

Sec. 5. Minnesota Statutes 2013 Supplement, section 256N.22, subdivision 1, is amended to read:

Subdivision 1. **General eligibility requirements.** (a) To be eligible for guardianship assistance under this section, there must be a judicial determination under section 260C.515, subdivision 4, that a transfer of permanent legal and physical custody to a relative is in the child's best interest. For a child under jurisdiction of a tribal court, a judicial determination under a similar provision in tribal code indicating that a relative will assume the duty and authority to provide care, control, and protection of a child who is residing in foster care, and to make decisions regarding the child's education, health care, and general welfare until adulthood, and that this is in the child's best interest is considered equivalent. Additionally, a child must:

(1) have been removed from the child's home pursuant to a voluntary placement agreement or court order;

(2)(i) have resided ~~in~~ with the prospective relative custodian who has been a licensed child foster ~~care~~ parent for at least six consecutive months ~~in the home of the prospective relative custodian~~; or

(ii) have received from the commissioner an exemption from the requirement in item (i) ~~from the court~~ that the prospective relative custodian has been a licensed child foster parent for at least six consecutive months, based on a determination that:

(A) an expedited move to permanency is in the child's best interest;

(B) expedited permanency cannot be completed without provision of guardianship assistance; ~~and~~

(C) the prospective relative custodian is uniquely qualified to meet the child's needs, as defined in section 260C.212, subdivision 2, on a permanent basis;

(D) the child and prospective relative custodian meet the eligibility requirements of this section; and

(E) efforts were made by the legally responsible agency to place the child with the prospective relative custodian as a licensed child foster parent for six consecutive months before permanency, or an explanation why these efforts were not in the child's best interests;

(3) meet the agency determinations regarding permanency requirements in subdivision 2;

(4) meet the applicable citizenship and immigration requirements in subdivision 3;

(5) have been consulted regarding the proposed transfer of permanent legal and physical custody to a relative, if the child is at least 14 years of age or is expected to attain 14 years of age prior to the transfer of permanent legal and physical custody; and

(6) have a written, binding agreement under section 256N.25 among the caregiver or caregivers, the financially responsible agency, and the commissioner established prior to transfer of permanent legal and physical custody.

(b) In addition to the requirements in paragraph (a), the child's prospective relative custodian or custodians must meet the applicable background study requirements in subdivision 4.

(c) To be eligible for title IV-E guardianship assistance, a child must also meet any additional criteria in section 473(d) of the Social Security Act. The sibling of a child who meets the criteria for title IV-E guardianship assistance in section 473(d) of the Social Security Act is eligible for title IV-E guardianship assistance if the child and sibling are placed with the same prospective relative custodian or custodians, and the legally responsible agency, relatives, and commissioner agree on the appropriateness of

the arrangement for the sibling. A child who meets all eligibility criteria except those specific to title IV-E guardianship assistance is entitled to guardianship assistance paid through funds other than title IV-E.

Sec. 6. Minnesota Statutes 2013 Supplement, section 256N.22, subdivision 2, is amended to read:

Subd. 2. **Agency determinations regarding permanency.** (a) To be eligible for guardianship assistance, the legally responsible agency must complete the following determinations regarding permanency for the child prior to the transfer of permanent legal and physical custody:

(1) a determination that reunification and adoption are not appropriate permanency options for the child; and

(2) a determination that the child demonstrates a strong attachment to the prospective relative custodian and the prospective relative custodian has a strong commitment to caring permanently for the child.

(b) The legally responsible agency shall document the determinations in paragraph (a) and ~~the~~ eligibility requirements in this section that comply with United States Code, title 42, sections 673(d) and 675(1)(F). These determinations must be documented in a kinship placement agreement, which must be in the format prescribed by the commissioner and must be signed by the prospective relative custodian and the legally responsible agency. In the case of a Minnesota tribe, the determinations and eligibility requirements in this section may be provided in an alternative format approved by the commissioner. Supporting information for completing each determination must be documented in the legally responsible agency's case file and ~~make them~~ available for review as requested by the financially responsible agency and the commissioner during the guardianship assistance eligibility determination process.

Sec. 7. Minnesota Statutes 2013 Supplement, section 256N.22, subdivision 4, is amended to read:

Subd. 4. **Background study.** (a) A background study ~~under section 245C.33~~ must be completed on each prospective relative custodian and any other adult residing in the home of the prospective relative custodian. The background study must meet the requirements of United States Code, title 42, section 671(a)(20). A study completed under section 245C.33 meets this requirement. A background study on the prospective relative custodian or adult residing in the household previously completed under ~~section 245C.04~~ chapter 245C for the purposes of child foster care licensure ~~may~~ under chapter 245A or licensure by a Minnesota

tribe, shall be used for the purposes of this section, provided that the background study ~~is current~~ meets the requirements of this subdivision and the prospective relative custodian is a licensed child foster parent at the time of the application for guardianship assistance.

(b) If the background study reveals:

(1) a felony conviction at any time for:

(i) child abuse or neglect;

(ii) spousal abuse;

(iii) a crime against a child, including child pornography; or

(iv) a crime involving violence, including rape, sexual assault, or homicide, but not including other physical assault or battery; or

(2) a felony conviction within the past five years for:

(i) physical assault;

(ii) battery; or

(iii) a drug-related offense;

the prospective relative custodian is prohibited from receiving guardianship assistance on behalf of an otherwise eligible child.

Sec. 8. Minnesota Statutes 2013 Supplement, section 256N.23, subdivision 4, is amended to read:

Subd. 4. **Background study.** (a) A background study ~~under section 259.41~~ must be completed on each prospective adoptive parent~~.~~ and all other adults residing in the home. A background study must meet the requirements of United States Code, title 42, section 671(a)(20). A study completed under section 245C.33 meets this requirement. If the prospective adoptive parent is a licensed child foster parent licensed under chapter 245A or by a Minnesota tribe, the background study previously completed for the purposes of child foster care licensure shall be used for the purpose of this section, provided that the background study meets all other requirements of this subdivision and the prospective adoptive parent is a licensed child foster parent at the time of the application for adoption assistance.

(b) If the background study reveals:

(1) a felony conviction at any time for:

(i) child abuse or neglect;

(ii) spousal abuse;

(iii) a crime against a child, including child pornography; or

(iv) a crime involving violence, including rape, sexual assault, or homicide, but not including other physical assault or battery; or

(2) a felony conviction within the past five years for:

(i) physical assault;

(ii) battery; or

(iii) a drug-related offense;

the adoptive parent is prohibited from receiving adoption assistance on behalf of an otherwise eligible child.

Sec. 9. Minnesota Statutes 2013 Supplement, section 256N.25, subdivision 2, is amended to read:

Subd. 2. **Negotiation of agreement.** (a) When a child is determined to be eligible for guardianship assistance or adoption assistance, the financially responsible agency, or, if there is no financially responsible agency, the agency designated by the commissioner, must negotiate with the caregiver to develop an agreement under subdivision 1. If and when the caregiver and agency reach concurrence as to the terms of the agreement, both parties shall sign the agreement. The agency must submit the agreement, along with the eligibility determination outlined in sections 256N.22, subdivision 7, and 256N.23, subdivision 7, to the commissioner for final review, approval, and signature according to subdivision 1.

(b) A monthly payment is provided as part of the adoption assistance or guardianship assistance agreement to support the care of children unless the child is eligible for adoption assistance and determined to be an at-risk child, in which case ~~the special at-risk monthly payment under section 256N.26, subdivision 7, must~~ no payment will be made unless and until the caregiver obtains written documentation from a qualified expert that the potential disability upon which eligibility for the agreement was based has manifested itself.

(1) The amount of the payment made on behalf of a child eligible for guardianship assistance or adoption assistance is determined through agreement between the prospective relative custodian or the adoptive parent and the financially responsible agency, or, if there is no financially responsible agency, the agency designated by the commissioner, using the assessment tool established by the commissioner in section 256N.24, subdivision 2, and the associated benefit and payments outlined in section 256N.26. Except as provided under section 256N.24, subdivision 1, paragraph (c), the assessment tool establishes the monthly benefit level for a child under foster care. The monthly payment under a guardianship assistance agreement or adoption assistance agreement may be negotiated up to the monthly benefit level under foster care. In no case may the amount of the payment under a guardianship assistance agreement or adoption assistance agreement exceed the foster care maintenance payment which would have been paid during the month if the

child with respect to whom the guardianship assistance or adoption assistance payment is made had been in a foster family home in the state.

(2) The rate schedule for the agreement is determined based on the age of the child on the date that the prospective adoptive parent or parents or relative custodian or custodians sign the agreement.

(3) The income of the relative custodian or custodians or adoptive parent or parents must not be taken into consideration when determining eligibility for guardianship assistance or adoption assistance or the amount of the payments under section 256N.26.

(4) With the concurrence of the relative custodian or adoptive parent, the amount of the payment may be adjusted periodically using the assessment tool established by the commissioner in section 256N.24, subdivision 2, and the agreement renegotiated under subdivision 3 when there is a change in the child's needs or the family's circumstances.

(5) ~~The guardianship assistance or adoption assistance agreement of a child who is identified as at-risk receives the special at-risk monthly payment under section 256N.26, subdivision 7, unless and until the potential disability manifests itself, as documented by an appropriate professional, and the commissioner authorizes commencement of payment by modifying the agreement accordingly. A relative custodian or~~ An adoptive parent of an at-risk child with ~~a guardianship assistance or~~ an adoption assistance agreement may request a reassessment of the child under section 256N.24, subdivision ~~9~~ 10, and renegotiation of the ~~guardianship assistance or~~ adoption assistance agreement under subdivision 3 to include a monthly payment, if the caregiver has written documentation from a qualified expert that the potential disability upon which eligibility for the agreement was based has manifested itself. Documentation of the disability must be limited to evidence deemed appropriate by the commissioner.

(c) For guardianship assistance agreements:

(1) the initial amount of the monthly guardianship assistance payment must be equivalent to the foster care rate in effect at the time that the agreement is signed less any offsets under section 256N.26, subdivision 11, or a lesser negotiated amount if agreed to by the prospective relative custodian and specified in that agreement, unless ~~the child is identified as at-risk or~~ the guardianship assistance agreement is entered into when a child is under the age of six; and

~~(2) an at-risk child must be assigned level A as outlined in section 256N.26 and receive the special at-risk monthly payment under section 256N.26, subdivision 7, unless and until the potential disability manifests itself, as documented by a qualified expert, and the commissioner authorizes commencement of payment by modifying the agreement accordingly; and~~

~~(3)~~ (2) the amount of the monthly payment for a guardianship assistance agreement for a child~~, other than an at-risk child,~~ who is under the age of six must be as specified in section 256N.26, subdivision 5.

(d) For adoption assistance agreements:

(1) for a child in foster care with the prospective adoptive parent immediately prior to adoptive placement, the initial amount of the monthly adoption assistance payment must be equivalent to the foster care rate in effect at the time that the agreement is signed less any offsets in section 256N.26, subdivision 11, or a lesser negotiated amount if agreed to by the prospective adoptive parents and specified in that agreement, unless the child is identified as at-risk or the adoption assistance agreement is entered into when a child is under the age of six;

(2) for an at-risk child who must be assigned level A as outlined in section 256N.26 ~~and receive the special at-risk monthly payment under section 256N.26, subdivision 7~~, no payment will be made unless and until the potential disability manifests itself, as documented by an appropriate professional, and the commissioner authorizes commencement of payment by modifying the agreement accordingly;

(3) the amount of the monthly payment for an adoption assistance agreement for a child under the age of six, other than an at-risk child, must be as specified in section 256N.26, subdivision 5;

(4) for a child who is in the guardianship assistance program immediately prior to adoptive placement, the initial amount of the adoption assistance payment must be equivalent to the guardianship assistance payment in effect at the time that the adoption assistance agreement is signed or a lesser amount if agreed to by the prospective adoptive parent and specified in that agreement, unless the child is identified as an at-risk child; and

(5) for a child who is not in foster care placement or the guardianship assistance program immediately prior to adoptive placement or negotiation of the adoption assistance agreement, the initial amount of the adoption assistance agreement must be determined using the assessment tool and process in this section and the corresponding payment amount outlined in section 256N.26.

Sec. 10. Minnesota Statutes 2013 Supplement, section 256N.25, subdivision 3, is amended to read:

Subd. 3. **Renegotiation of agreement.** (a) A relative custodian or adoptive parent of a child with a guardianship assistance or adoption assistance agreement may request renegotiation of the agreement when there is a change in the needs of the child or in the family's circumstances. When a relative custodian or adoptive parent requests

renegotiation of the agreement, a reassessment of the child must be completed consistent with section 256N.24, subdivisions 9 and 10. If the reassessment indicates that the child's level has changed, the financially responsible agency or, if there is no financially responsible agency, the agency designated by the commissioner or the commissioner's designee, and the caregiver must renegotiate the agreement to include a payment with the level determined through the reassessment process. The agreement must not be renegotiated unless the commissioner, the financially responsible agency, and the caregiver mutually agree to the changes. The effective date of any renegotiated agreement must be determined by the commissioner.

(b) ~~A relative custodian or~~ An adoptive parent of an at-risk child with ~~a guardianship assistance or~~ an adoption assistance agreement may request renegotiation of the agreement to include a monthly payment ~~higher than the special at-risk monthly payment~~ under section 256N.26~~, subdivision 7,~~ if the caregiver has written documentation from a qualified expert that the potential disability upon which eligibility for the agreement was based has manifested itself. Documentation of the disability must be limited to evidence deemed appropriate by the commissioner. Prior to renegotiating the agreement, a reassessment of the child must be conducted as outlined in section 256N.24, subdivision 9. The reassessment must be used to renegotiate the agreement to include an appropriate monthly payment. The agreement must not be renegotiated unless the commissioner, the financially responsible agency, and the caregiver mutually agree to the changes. The effective date of any renegotiated agreement must be determined by the commissioner.

(c) Renegotiation of a guardianship assistance or adoption assistance agreement is required when one of the circumstances outlined in section 256N.26, subdivision 13, occurs.

Sec. 11. Minnesota Statutes 2013 Supplement, section 256N.26, subdivision 1, is amended to read:

Subdivision 1. **Benefits.** (a) There are three benefits under Northstar Care for Children: medical assistance, basic payment, and supplemental difficulty of care payment.

(b) A child is eligible for medical assistance under subdivision 2.

(c) A child is eligible for the basic payment under subdivision 3, except for a child assigned level A under section 256N.24, subdivision 1, because the child is determined to be an at-risk child receiving ~~guardianship assistance or~~ adoption assistance.

(d) A child, including a foster child age 18 to 21, is eligible for an additional supplemental difficulty of care payment under subdivision 4, as determined by the assessment under section 256N.24.

(e) An eligible child entering guardianship assistance or adoption assistance under the age of six receives a basic payment and supplemental difficulty of care payment as specified in subdivision 5.

(f) A child transitioning in from a pre-Northstar Care for Children program under section 256N.28, subdivision 7, shall receive basic and difficulty of care supplemental payments according to those provisions.

Sec. 12. Minnesota Statutes 2013 Supplement, section 256N.27, subdivision 4, is amended to read:

Subd. 4. **Nonfederal share.** (a) The commissioner shall establish a percentage share of the maintenance payments, reduced by federal reimbursements under title IV-E of the Social Security Act, to be paid by the state and to be paid by the financially responsible agency.

(b) These state and local shares must initially be calculated based on the ratio of the average appropriate expenditures made by the state and all financially responsible agencies during calendar years 2011, 2012, 2013, and 2014. For purposes of this calculation, appropriate expenditures for the financially responsible agencies must include basic and difficulty of care payments for foster care reduced by federal reimbursements, but not including any initial clothing allowance, administrative payments to child care agencies specified in section 317A.907, child care, or other support or ancillary expenditures. For purposes of this calculation, appropriate expenditures for the state shall include adoption assistance and relative custody assistance, reduced by federal reimbursements.

(c) For each of the periods January 1, 2015, to June 30, 2016, and fiscal years 2017, 2018, and 2019, the commissioner shall adjust this initial percentage of state and local shares to reflect the relative expenditure trends during calendar years 2011, 2012, 2013, and 2014, taking into account appropriations for Northstar Care for Children and the turnover rates of the components. In making these adjustments, the commissioner's goal shall be to make these state and local expenditures other than the appropriations for Northstar Care for Children to be the same as they would have been had Northstar Care for Children not been implemented, or if that is not possible, proportionally higher or lower, as appropriate. Except for adjustments so that the costs of the phase-in are borne by the state, the state and local share percentages for fiscal year 2019 must be used for all subsequent years.

Sec. 13. Minnesota Statutes 2012, section 257.85, subdivision 11, is amended to read:

Subd. 11. **Financial considerations.** (a) Payment of relative custody assistance under a relative custody assistance agreement is subject to the availability of state funds

and payments may be reduced or suspended on order of the commissioner if insufficient funds are available.

(b) ~~Upon receipt from a local agency of a claim for reimbursement, the commissioner shall reimburse the local agency in an amount equal to 100 percent of the relative custody assistance payments provided to relative custodians. The~~ A local agency may not seek and the commissioner shall not provide reimbursement for the administrative costs associated with performing the duties described in subdivision 4.

(c) For the purposes of determining eligibility or payment amounts under MFIP, relative custody assistance payments shall be excluded in determining the family's available income.

(d) For expenditures made on or before December 31, 2014, upon receipt from a local agency of a claim for reimbursement, the commissioner shall reimburse the local agency in an amount equal to 100 percent of the relative custody assistance payments provided to relative custodians.

(e) For expenditures made on or after January 1, 2015, upon receipt from a local agency of a claim for reimbursement, the commissioner shall reimburse the local agency as part of the Northstar Care for Children fiscal reconciliation process under section 256N.27.

Sec. 14. Minnesota Statutes 2012, section 260C.212, subdivision 1, is amended to read:

Subdivision 1. **Out-of-home placement; plan.** (a) An out-of-home placement plan shall be prepared within 30 days after any child is placed in foster care by court order or a voluntary placement agreement between the responsible social services agency and the child's parent pursuant to section 260C.227 or chapter 260D.

(b) An out-of-home placement plan means a written document which is prepared by the responsible social services agency jointly with the parent or parents or guardian of the child and in consultation with the child's guardian ad litem, the child's tribe, if the child is an Indian child, the child's foster parent or representative of the foster care facility, and, where appropriate, the child. For a child in voluntary foster care for treatment under chapter 260D, preparation of the out-of-home placement plan shall additionally include the child's mental health treatment provider. As appropriate, the plan shall be:

(1) submitted to the court for approval under section 260C.178, subdivision 7;

(2) ordered by the court, either as presented or modified after hearing, under section 260C.178, subdivision 7, or 260C.201, subdivision 6; and

(3) signed by the parent or parents or guardian of the child, the child's guardian ad litem, a representative of the child's tribe, the responsible social services agency, and, if possible, the child.

(c) The out-of-home placement plan shall be explained to all persons involved in its implementation, including the child who has signed the plan, and shall set forth:

(1) a description of the foster care home or facility selected, including how the out-of-home placement plan is designed to achieve a safe placement for the child in the least restrictive, most family-like, setting available which is in close proximity to the home of the parent or parents or guardian of the child when the case plan goal is reunification, and how the placement is consistent with the best interests and special needs of the child according to the factors under subdivision 2, paragraph (b);

(2) the specific reasons for the placement of the child in foster care, and when reunification is the plan, a description of the problems or conditions in the home of the parent or parents which necessitated removal of the child from home and the changes the parent or parents must make in order for the child to safely return home;

(3) a description of the services offered and provided to prevent removal of the child from the home and to reunify the family including:

(i) the specific actions to be taken by the parent or parents of the child to eliminate or correct the problems or conditions identified in clause (2), and the time period during which the actions are to be taken; and

(ii) the reasonable efforts, or in the case of an Indian child, active efforts to be made to achieve a safe and stable home for the child including social and other supportive services to be provided or offered to the parent or parents or guardian of the child, the child, and the residential facility during the period the child is in the residential facility;

(4) a description of any services or resources that were requested by the child or the child's parent, guardian, foster parent, or custodian since the date of the child's placement in the residential facility, and whether those services or resources were provided and if not, the basis for the denial of the services or resources;

(5) the visitation plan for the parent or parents or guardian, other relatives as defined in section 260C.007, subdivision 27, and siblings of the child if the siblings are not placed together in foster care, and whether visitation is consistent with the best interest of the child, during the period the child is in foster care;

(6) when a child cannot return to or be in the care of either parent, documentation of steps to finalize the permanency plan for the child, including:

(i) reasonable efforts to place the child for adoption ~~or legal guardianship of the child if the court has issued an order terminating the rights of both parents of the child or of the only known, living parent of the child~~. At a minimum, the documentation must include consideration of whether adoption is in the best interests of the child, child-specific recruitment efforts such as relative search and the use of state, regional, and national

adoption exchanges to facilitate orderly and timely placements in and outside of the state. A copy of this documentation shall be provided to the court in the review required under section 260C.317, subdivision 3, paragraph (b); and

(ii) documentation necessary to support the requirements of the kinship placement agreement under section 256N.22 when adoption is determined not to be in the child's best interest;

(7) efforts to ensure the child's educational stability while in foster care, including:

(i) efforts to ensure that the child remains in the same school in which the child was enrolled prior to placement or upon the child's move from one placement to another, including efforts to work with the local education authorities to ensure the child's educational stability; or

(ii) if it is not in the child's best interest to remain in the same school that the child was enrolled in prior to placement or move from one placement to another, efforts to ensure immediate and appropriate enrollment for the child in a new school;

(8) the educational records of the child including the most recent information available regarding:

(i) the names and addresses of the child's educational providers;

(ii) the child's grade level performance;

(iii) the child's school record;

(iv) a statement about how the child's placement in foster care takes into account proximity to the school in which the child is enrolled at the time of placement; and

(v) any other relevant educational information;

(9) the efforts by the local agency to ensure the oversight and continuity of health care services for the foster child, including:

(i) the plan to schedule the child's initial health screens;

(ii) how the child's known medical problems and identified needs from the screens, including any known communicable diseases, as defined in section 144.4172, subdivision 2, will be monitored and treated while the child is in foster care;

(iii) how the child's medical information will be updated and shared, including the child's immunizations;

(iv) who is responsible to coordinate and respond to the child's health care needs, including the role of the parent, the agency, and the foster parent;

(v) who is responsible for oversight of the child's prescription medications;

(vi) how physicians or other appropriate medical and nonmedical professionals will be consulted and involved in assessing the health and well-being of the child and determine the appropriate medical treatment for the child; and

(vii) the responsibility to ensure that the child has access to medical care through either medical insurance or medical assistance;

(10) the health records of the child including information available regarding:

(i) the names and addresses of the child's health care and dental care providers;

(ii) a record of the child's immunizations;

(iii) the child's known medical problems, including any known communicable diseases as defined in section 144.4172, subdivision 2;

(iv) the child's medications; and

(v) any other relevant health care information such as the child's eligibility for medical insurance or medical assistance;

(11) an independent living plan for a child age 16 or older. The plan should include, but not be limited to, the following objectives:

(i) educational, vocational, or employment planning;

(ii) health care planning and medical coverage;

(iii) transportation including, where appropriate, assisting the child in obtaining a driver's license;

(iv) money management, including the responsibility of the agency to ensure that the youth annually receives, at no cost to the youth, a consumer report as defined under section 13C.001 and assistance in interpreting and resolving any inaccuracies in the report;

(v) planning for housing;

(vi) social and recreational skills; and

(vii) establishing and maintaining connections with the child's family and community; and

(12) for a child in voluntary foster care for treatment under chapter 260D, diagnostic and assessment information, specific services relating to meeting the mental health care needs of the child, and treatment outcomes.

(d) The parent or parents or guardian and the child each shall have the right to legal counsel in the preparation of the case plan and shall be informed of the right at the time of placement of the child. The child shall also have the right to a guardian ad litem. If unable to employ counsel from their own resources, the court shall appoint counsel upon the request of the parent or parents or the child or the child's legal guardian. The parent or parents may also receive assistance from any person or social services agency in preparation of the case plan.

After the plan has been agreed upon by the parties involved or approved or ordered by the court, the foster parents shall be fully informed of the provisions of the case plan and shall be provided a copy of the plan.

Upon discharge from foster care, the parent, adoptive parent, or permanent legal and physical custodian, as appropriate, and the child, if appropriate, must be provided with a current copy of the child's health and education record.

Sec. 15. Minnesota Statutes 2012, section 260C.515, subdivision 4, is amended to read:

Subd. 4. **Custody to relative.** The court may order permanent legal and physical custody to a fit and willing relative in the best interests of the child according to the following ~~conditions~~ requirements:

(1) an order for transfer of permanent legal and physical custody to a relative shall only be made after the court has reviewed the suitability of the prospective legal and physical custodian;

(2) in transferring permanent legal and physical custody to a relative, the juvenile court shall follow the standards applicable under this chapter and chapter 260, and the procedures in the Minnesota Rules of Juvenile Protection Procedure;

(3) a transfer of legal and physical custody includes responsibility for the protection, education, care, and control of the child and decision making on behalf of the child;

(4) a permanent legal and physical custodian may not return a child to the permanent care of a parent from whom the court removed custody without the court's approval and without notice to the responsible social services agency;

(5) the social services agency may file a petition naming a fit and willing relative as a proposed permanent legal and physical custodian. A petition for transfer of permanent legal and physical custody to a relative who is not a parent shall be accompanied by a kinship placement agreement under section 256N.22, subdivision 2, between the agency and proposed permanent legal and physical custodian;

(6) another party to the permanency proceeding regarding the child may file a petition to transfer permanent legal and physical custody to a relative~~, but the~~. The petition must include facts upon which the court can make the determination required under clause (7) and must be filed not later than the date for the required admit-deny hearing under section 260C.507; or if the agency's petition is filed under section 260C.503, subdivision 2, the petition must be filed not later than 30 days prior to the trial required under section 260C.509; ~~and~~

(7) where a petition is for transfer of permanent legal and physical custody to a relative who is not a parent, the court must find that:

(i) transfer of permanent legal and physical custody and receipt of Northstar kinship assistance under chapter 256N, when requested and the child is eligible, is in the child's best interests;

(ii) adoption is not in the child's best interests based on the determinations in the kinship placement agreement required under section 256N.22, subdivision 2;

(iii) the agency made efforts to discuss adoption with the child's parent or parents, or the agency did not make efforts to discuss adoption and the reasons why efforts were not made; and

(iv) there are reasons to separate siblings during placement, if applicable;

(8) the court may defer finalization of an order transferring permanent legal and physical custody to a relative when deferring finalization is necessary to determine eligibility for Northstar kinship assistance under chapter 256N;

(9) the court may finalize a permanent transfer of physical and legal custody to a relative regardless of eligibility for Northstar kinship assistance under chapter 256N; and

~~(7)~~ (10) the juvenile court may maintain jurisdiction over the responsible social services agency, the parents or guardian of the child, the child, and the permanent legal and physical custodian for purposes of ensuring appropriate services are delivered to the child and permanent legal custodian for the purpose of ensuring conditions ordered by the court related to the care and custody of the child are met.

Sec. 16. Minnesota Statutes 2012, section 260C.611, is amended to read:

260C.611 ADOPTION STUDY REQUIRED.

(a) An adoption study under section 259.41 approving placement of the child in the home of the prospective adoptive parent shall be completed before placing any child under the guardianship of the commissioner in a home for adoption. If a prospective adoptive parent has a current child foster care license under chapter 245A and is seeking to adopt a foster child who is placed in the prospective adoptive parent's home and is under the guardianship of the commissioner according to section 260C.325, subdivision 1, the child foster care home study meets the requirements of this section for an approved adoption home study if:

(1) the written home study on which the foster care license was based is completed in the commissioner's designated format, consistent with the requirements in sections 260C.215, subdivision 4, clause (5); and 259.41, subdivision 2; and Minnesota Rules, part 2960.3060, subpart 4;

(2) the background studies on each prospective adoptive parent and all required household members were completed according to section 245C.33;

(3) the commissioner has not issued, within the last three years, a sanction on the license under section 245A.07 or an order of a conditional license under section 245A.06; and

(4) the legally responsible agency determines that the individual needs of the child are being met by the prospective adoptive parent through an assessment under section 256N.24, subdivision 2, or a documented placement decision consistent with section 260C.212, subdivision 2.

(b) If a prospective adoptive parent has previously held a foster care license or adoptive home study, any update necessary to the foster care license, or updated or new adoptive home study, if not completed by the licensing authority responsible for the previous license or home study, shall include collateral information from the previous licensing or approving agency, if available.

Sec. 17. **REVISOR'S INSTRUCTION.**

The revisor of statutes shall change the term "guardianship assistance" to "Northstar kinship assistance" wherever it appears in Minnesota Statutes and Minnesota Rules to refer to the program components related to Northstar Care for Children under Minnesota Statutes, chapter 256N.

Sec. 18. **REPEALER.**

Minnesota Statutes 2013 Supplement, section 256N.26, subdivision 7, is repealed.

ARTICLE 4

COMMUNITY FIRST SERVICES AND SUPPORTS

Section 1. Minnesota Statutes 2012, section 245C.03, is amended by adding a subdivision to read:

Subd. 8. **Community first services and supports organizations.** The commissioner shall conduct background studies on any individual required under section 256B.85 to have a background study completed under this chapter.

Sec. 2. Minnesota Statutes 2012, section 245C.04, is amended by adding a subdivision to read:

Subd. 7. **Community first services and supports organizations.** (a) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 8, at least upon application for initial enrollment under section 256B.85.

(b) Before an individual described in section 245C.03, subdivision 8, begins a position allowing direct contact with a person served by an organization required to initiate

a background study under section 256B.85, the organization must receive a notice from the commissioner that the support worker is:

(1) not disqualified under section 245C.14; or

(2) disqualified, but the individual has received a set-aside of the disqualification under section 245C.22.

Sec. 3. Minnesota Statutes 2012, section 245C.10, is amended by adding a subdivision to read:

Subd. 10. **Community first services and supports organizations.** The commissioner shall recover the cost of background studies initiated by an agency-provider delivering services under section 256B.85, subdivision 11, or a financial management services contractor providing service functions under section 256B.85, subdivision 13, through a fee of no more than $20 per study, charged to the organization responsible for submitting the background study form. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 4. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For the purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Activities of daily living" or "ADLs" means eating, toileting, grooming, dressing, bathing, mobility, positioning, and transferring.

(c) "Agency-provider model" means a method of CFSS under which a qualified agency provides services and supports through the agency's own employees and policies. The agency must allow the participant to have a significant role in the selection and dismissal of support workers of their choice for the delivery of their specific services and supports.

(d) "Behavior" means a description of a need for services and supports used to determine the home care rating and additional service units. The presence of Level I behavior is used to determine the home care rating. "Level I behavior" means physical aggression towards self or others or destruction of property that requires the immediate response of another person. If qualified for a home care rating as described in subdivision 8, additional service units can be added as described in subdivision 8, paragraph (f), for the following behaviors:

(1) Level I behavior;

(2) increased vulnerability due to cognitive deficits or socially inappropriate behavior; or

(3) increased need for assistance for ~~recipients~~ participants who are verbally aggressive or resistive to care so that time needed to perform activities of daily living is increased.

(e) "Budget model" means a service delivery method of CFSS that allows the use of a service budget and assistance from a vendor fiscal/employer agent financial management services (FMS) contractor for a participant to directly employ support workers and purchase supports and goods.

~~(e)~~ (f) "Complex health-related needs" means an intervention listed in clauses (1) to (8) that has been ordered by a physician, and is specified in a community support plan, including:

(1) tube feedings requiring:

(i) a gastrojejunostomy tube; or

(ii) continuous tube feeding lasting longer than 12 hours per day;

(2) wounds described as:

(i) stage III or stage IV;

(ii) multiple wounds;

(iii) requiring sterile or clean dressing changes or a wound vac; or

(iv) open lesions such as burns, fistulas, tube sites, or ostomy sites that require specialized care;

(3) parenteral therapy described as:

(i) IV therapy more than two times per week lasting longer than four hours for each treatment; or

(ii) total parenteral nutrition (TPN) daily;

(4) respiratory interventions, including:

(i) oxygen required more than eight hours per day;

(ii) respiratory vest more than one time per day;

(iii) bronchial drainage treatments more than two times per day;

(iv) sterile or clean suctioning more than six times per day;

(v) dependence on another to apply respiratory ventilation augmentation devices such as BiPAP and CPAP; and

(vi) ventilator dependence under section 256B.0652;

(5) insertion and maintenance of catheter, including:

(i) sterile catheter changes more than one time per month;

(ii) clean intermittent catheterization, and including self-catheterization more than six times per day; or

(iii) bladder irrigations;

(6) bowel program more than two times per week requiring more than 30 minutes to perform each time;

(7) neurological intervention, including:

(i) seizures more than two times per week and requiring significant physical assistance to maintain safety; or

(ii) swallowing disorders diagnosed by a physician and requiring specialized assistance from another on a daily basis; and

(8) other congenital or acquired diseases creating a need for significantly increased direct hands-on assistance and interventions in six to eight activities of daily living.

~~(f)~~ (g) "Community first services and supports" or "CFSS" means the assistance and supports program under this section needed for accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance to accomplish the task or constant supervision and cueing to accomplish the task, or the purchase of goods as defined in subdivision 7, ~~paragraph (a),~~ clause (3), that replace the need for human assistance.

~~(g)~~ (h) "Community first services and supports service delivery plan" or "service delivery plan" means a written ~~summary of~~ document detailing the services and supports chosen by the participant to meet assessed needs that ~~is~~ are within the approved CFSS service authorization amount. Services and supports are based on the community support plan identified in section 256B.0911 and coordinated services and support plan and budget identified in section 256B.0915, subdivision 6, if applicable, that is determined by the participant to meet the assessed needs, using a person-centered planning process.

(i) "Consultation services" means a Minnesota health care program enrolled provider organization that is under contract with the department and has the knowledge, skills, and ability to assist CFSS participants in using either the agency-provider model under subdivision 11 or the budget model under subdivision 13.

~~(h)~~ (j) "Critical activities of daily living" means transferring, mobility, eating, and toileting.

~~(i)~~ (k) "Dependency" in activities of daily living means a person requires hands-on assistance or constant supervision and cueing to accomplish one or more of the activities of daily living every day or on the days during the week that the activity is performed; however, a child may not be found to be dependent in an activity of daily living if, because of the child's age, an adult would either perform the activity for the child or assist

the child with the activity and the assistance needed is the assistance appropriate for a typical child of the same age.

~~(j)~~ (l) "Extended CFSS" means CFSS services and supports ~~under the agency-provider model~~ included in a service plan through one of the home and community-based services waivers and as approved and authorized under sections 256B.0915; 256B.092, subdivision 5; and 256B.49, which exceed the amount, duration, and frequency of the state plan CFSS services for participants.

~~(k)~~ (m) "Financial management services contractor or vendor" or "FMS contractor" means a qualified organization ~~having~~ necessary to use the budget model under subdivision 13 that has a written contract with the department to provide vendor fiscal/employer agent financial management services ~~necessary to use the budget model under subdivision 13 that~~ (FMS). Services include but are not limited to: ~~participant education and technical assistance; CFSS service delivery planning and budgeting;~~ filing and payment of federal and state payroll taxes on behalf of the participant; initiating criminal background checks; billing~~, making payments, and~~ for approved CFSS services with authorized funds; monitoring ~~of spending~~ expenditures; accounting for and disbursing CFSS funds; providing assistance in obtaining and filing for liability, workers' compensation, and unemployment coverage; and ~~assisting~~ participant instruction and technical assistance to the participant in fulfilling employer-related requirements in accordance with Section 3504 of the Internal Revenue Code and ~~the Internal Revenue Service Revenue Procedure 70-6~~ related regulations and interpretations, including Code of Federal Regulations, title 26, section 31.3504-1.

~~(l) "Budget model" means a service delivery method of CFSS that allows the use of an individualized CFSS service delivery plan and service budget and provides assistance from the financial management services contractor to facilitate participant employment of support workers and the acquisition of supports and goods.~~

~~(m)~~ (n) "Health-related procedures and tasks" means procedures and tasks related to the specific needs of an individual that can be ~~delegated~~ taught or assigned by a state-licensed healthcare or mental health professional and performed by a support worker.

~~(n)~~ (o) "Instrumental activities of daily living" means activities related to living independently in the community, including but not limited to: meal planning, preparation, and cooking; shopping for food, clothing, or other essential items; laundry; housecleaning; assistance with medications; managing finances; communicating needs and preferences during activities; arranging supports; and assistance with traveling around and participating in the community.

~~(o)~~ (p) "Legal representative" means parent of a minor, a court-appointed guardian, or another representative with legal authority to make decisions about services and supports for the participant. Other representatives with legal authority to make decisions include but are not limited to a health care agent or an attorney-in-fact authorized through a health care directive or power of attorney.

~~(p)~~ (q) "Medication assistance" means providing verbal or visual reminders to take regularly scheduled medication, and includes any of the following supports listed in clauses (1) to (3) and other types of assistance, except that a support worker may not determine medication dose or time for medication or inject medications into veins, muscles, or skin:

(1) under the direction of the participant or the participant's representative, bringing medications to the participant including medications given through a nebulizer, opening a container of previously set-up medications, emptying the container into the participant's hand, opening and giving the medication in the original container to the participant, or bringing to the participant liquids or food to accompany the medication;

(2) organizing medications as directed by the participant or the participant's representative; and

(3) providing verbal or visual reminders to perform regularly scheduled medications.

~~(q)~~ (r) "Participant's representative" means a parent, family member, advocate, or other adult authorized by the participant to serve as a representative in connection with the provision of CFSS. This authorization must be in writing or by another method that clearly indicates the participant's free choice. The participant's representative must have no financial interest in the provision of any services included in the participant's service delivery plan and must be capable of providing the support necessary to assist the participant in the use of CFSS. If through the assessment process described in subdivision 5 a participant is determined to be in need of a participant's representative, one must be selected. If the participant is unable to assist in the selection of a participant's representative, the legal representative shall appoint one. Two persons may be designated as a participant's representative for reasons such as divided households and court-ordered custodies. Duties of a participant's representatives may include:

(1) being available while ~~care is~~ services are provided in a method agreed upon by the participant or the participant's legal representative and documented in the participant's CFSS service delivery plan;

(2) monitoring CFSS services to ensure the participant's CFSS service delivery plan is being followed; and

(3) reviewing and signing CFSS time sheets after services are provided to provide verification of the CFSS services.

~~(r)~~ (s) "Person-centered planning process" means a process that is directed by the participant to plan for services and supports. The person-centered planning process must:

(1) include people chosen by the participant;

(2) provide necessary information and support to ensure that the participant directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;

(3) be timely and occur at time and locations of convenience to the participant;

(4) reflect cultural considerations of the participant;

(5) include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning;

(6) provide the participant choices of the services and supports they receive and the staff providing those services and supports;

(7) include a method for the participant to request updates to the plan; and

(8) record the alternative home and community-based settings that were considered by the participant.

~~(s)~~ (t) "Shared services" means the provision of CFSS services by the same CFSS support worker to two or three participants who voluntarily enter into an agreement to receive services at the same time and in the same setting by the same ~~provider~~ employer.

~~(t) "Support specialist" means a professional with the skills and ability to assist the participant using either the agency-provider model under subdivision 11 or the flexible spending model under subdivision 13, in services including but not limited to assistance regarding:~~

~~(1) the development, implementation, and evaluation of the CFSS service delivery plan under subdivision 6;~~

~~(2) recruitment, training, or supervision, including supervision of health-related tasks or behavioral supports appropriately delegated or assigned by a health care professional, and evaluation of support workers; and~~

~~(3) facilitating the use of informal and community supports, goods, or resources.~~

(u) "Support worker" means ~~an~~ a qualified and trained employee of the ~~agency provider~~ agency-provider or of the participant employer under the budget model who has direct contact with the participant and provides services as specified within the participant's service delivery plan.

(v) "Wages and benefits" means the hourly wages and salaries, the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, mileage reimbursement, health and dental insurance, life insurance,

disability insurance, long-term care insurance, uniform allowance, contributions to employee retirement accounts, or other forms of employee compensation and benefits.

(w) "Worker training and development" means services for developing workers' skills as required by the participant's individual CFSS delivery plan that are arranged for or provided by the agency-provider or purchased by the participant employer. These services include training, education, direct observation and supervision, and evaluation and coaching of job skills and tasks, including supervision of health-related tasks or behavioral supports.

Sec. 5. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** (a) CFSS is available to a person who meets one of the following:

(1) is ~~a recipient~~ an enrollee of medical assistance as determined under section 256B.055, 256B.056, or 256B.057, subdivisions 5 and 9;

(2) is a ~~recipient of~~ participant in the alternative care program under section 256B.0913;

(3) is a waiver ~~recipient~~ participant as defined under section 256B.0915, 256B.092, 256B.093, or 256B.49; or

(4) has medical services identified in a participant's individualized education program and is eligible for services as determined in section 256B.0625, subdivision 26.

(b) In addition to meeting the eligibility criteria in paragraph (a), a person must also meet all of the following:

(1) require assistance and be determined dependent in one activity of daily living or Level I behavior based on assessment under section 256B.0911; and

(2) is not a ~~recipient of~~ participant under a family support grant under section 252.32~~;~~.

~~(3) lives in the person's own apartment or home including a family foster care setting licensed under chapter 245A, but not in corporate foster care under chapter 245A; or a noncertified boarding care home or a boarding and lodging establishment under chapter 157.~~

Sec. 6. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 5, is amended to read:

Subd. 5. **Assessment requirements.** (a) The assessment of functional need must:

(1) be conducted by a certified assessor according to the criteria established in section 256B.0911, subdivision 3a;

(2) be conducted face-to-face, initially and at least annually thereafter, or when there is a significant change in the participant's condition or a change in the need for services and supports, or at the request of the participant when there is a change in condition or a change in the need for services or supports; and

(3) be completed using the format established by the commissioner.

~~(b) A participant who is residing in a facility may be assessed and choose CFSS for the purpose of using CFSS to return to the community as described in subdivisions 3 and 7, paragraph (a), clause (5).~~

~~(c)~~ (b) The results of the assessment and any recommendations and authorizations for CFSS must be determined and communicated in writing by the lead agency's certified assessor as defined in section 256B.0911 to the participant and the agency-provider or ~~financial management services provider~~ FMS contractor chosen by the participant within 40 calendar days and must include the participant's right to appeal under section 256.045, subdivision 3.

~~(d)~~ (c) The lead agency assessor may ~~request~~ authorize a temporary authorization for CFSS services to be provided under the agency-provider model. Authorization for a temporary level of CFSS services under the agency-provider model is limited to the time specified by the commissioner, but shall not exceed 45 days. The level of services authorized under this ~~provision~~ paragraph shall have no bearing on a future authorization.

Sec. 7. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 6, is amended to read:

Subd. 6. **Community first services and support service delivery plan.** (a) The CFSS service delivery plan must be developed~~, implemented,~~ and evaluated through a person-centered planning process by the participant, or the participant's representative or legal representative who may be assisted by a ~~support specialist~~ consultation services provider. The CFSS service delivery plan must reflect the services and supports that are important to the participant and for the participant to meet the needs assessed by the certified assessor and identified in the community support plan under section 256B.0911, subdivision 3, or the coordinated services and support plan identified in section 256B.0915, subdivision 6, if applicable. The CFSS service delivery plan must be reviewed by the participant, the consultation services provider, and the agency-provider or ~~financial management services~~ FMS contractor prior to starting services and at least annually upon reassessment, or when there is a significant change in the participant's condition, or a change in the need for services and supports.

(b) The commissioner shall establish the format and criteria for the CFSS service delivery plan.

(c) The CFSS service delivery plan must be person-centered and:

(1) specify the consultation services provider, agency-provider, or ~~financial management services~~ FMS contractor selected by the participant;

(2) reflect the setting in which the participant resides that is chosen by the participant;

(3) reflect the participant's strengths and preferences;

(4) include the means to address the clinical and support needs as identified through an assessment of functional needs;

(5) include individually identified goals and desired outcomes;

(6) reflect the services and supports, paid and unpaid, that will assist the participant to achieve identified goals, including the costs of the services and supports, and the providers of those services and supports, including natural supports;

(7) identify the amount and frequency of face-to-face supports and amount and frequency of remote supports and technology that will be used;

(8) identify risk factors and measures in place to minimize them, including individualized backup plans;

(9) be understandable to the participant and the individuals providing support;

(10) identify the individual or entity responsible for monitoring the plan;

(11) be finalized and agreed to in writing by the participant and signed by all individuals and providers responsible for its implementation;

(12) be distributed to the participant and other people involved in the plan; ~~and~~

(13) prevent the provision of unnecessary or inappropriate care~~.~~;

(14) include a detailed budget for expenditures for budget model participants or participants under the agency-provider model if purchasing goods; and

(15) include a plan for worker training and development detailing what service components will be used, when the service components will be used, how they will be provided, and how these service components relate to the participant's individual needs and CFSS support worker services.

(d) The total units of agency-provider services or the service budget ~~allocation~~ amount for the budget model include both annual totals and a monthly average amount that cover the number of months of the service authorization. The amount used each month may vary, but additional funds must not be provided above the annual service authorization amount unless a change in condition is assessed and authorized by the certified assessor and documented in the community support plan, coordinated services and supports plan, and CFSS service delivery plan.

(e) In assisting with the development or modification of the plan during the authorization time period, the consultation services provider shall:

(1) consult with the FMS contractor on the spending budget when applicable; and

(2) consult with the participant or participant's representative, agency-provider, and case manager/care coordinator.

(f) The service plan must be approved by the consultation services provider for participants without a case manager/care coordinator. A case manager/care coordinator must approve the plan for a waiver or alternative care program participant.

Sec. 8. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 7, is amended to read:

Subd. 7. **Community first services and supports; covered services.** Within the service unit authorization or service budget ~~allocation~~ amount, services and supports covered under CFSS include:

(1) assistance to accomplish activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related procedures and tasks through hands-on assistance to accomplish the task or constant supervision and cueing to accomplish the task;

(2) assistance to acquire, maintain, or enhance the skills necessary for the participant to accomplish activities of daily living, instrumental activities of daily living, or health-related tasks;

(3) expenditures for items, services, supports, environmental modifications, or goods, including assistive technology. These expenditures must:

(i) relate to a need identified in a participant's CFSS service delivery plan;

(ii) increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance for the participant's assessed needs;

(4) observation and redirection for behavior or symptoms where there is a need for assistance. An assessment of behaviors must meet the criteria in this clause. A ~~recipient~~ participant qualifies as having a need for assistance due to behaviors if the ~~recipient's~~ participant's behavior requires assistance at least four times per week and shows one or more of the following behaviors:

(i) physical aggression towards self or others, or destruction of property that requires the immediate response of another person;

(ii) increased vulnerability due to cognitive deficits or socially inappropriate behavior; or

(iii) increased need for assistance for ~~recipients~~ participants who are verbally aggressive or resistive to care so that time needed to perform activities of daily living is increased;

(5) back-up systems or mechanisms, such as the use of pagers or other electronic devices, to ensure continuity of the participant's services and supports;

~~(6) transition costs, including:~~

~~(i) deposits for rent and utilities;~~

~~(ii) first month's rent and utilities;~~

~~(iii) bedding;~~

~~(iv) basic kitchen supplies;~~

~~(v) other necessities, to the extent that these necessities are not otherwise covered under any other funding that the participant is eligible to receive; and~~

~~(vi) other required necessities for an individual to make the transition from a nursing facility, institution for mental diseases, or intermediate care facility for persons with developmental disabilities to a community-based home setting where the participant resides; and~~

~~(7)~~ (6) services provided by a ~~support specialist~~ consultation services provider under contract with the department and enrolled as a Minnesota health care program provider as defined under subdivision ~~2 that are chosen by the participant.~~ 17;

(7) services provided by an FMS contractor under contract with the department as defined under subdivision 13;

(8) CFSS services provided by a qualified support worker who is a parent, stepparent, or legal guardian of a participant under age 18, or who is the participant's spouse. These support workers shall not provide any medical assistance home and community-based services in excess of 40 hours per seven-day period regardless of the number of parents, combination of parents and spouses, or number of children who receive medical assistance services; and

(9) worker training and development services as defined in subdivision 2, paragraph (w), and described in subdivision 18a.

Sec. 9. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 8, is amended to read:

Subd. 8. **Determination of CFSS service methodology.** (a) All community first services and supports must be authorized by the commissioner or the commissioner's designee before services begin, except for the assessments established in section

256B.0911. The authorization for CFSS must be completed as soon as possible following an assessment but no later than 40 calendar days from the date of the assessment.

(b) The amount of CFSS authorized must be based on the ~~recipient's~~ participant's home care rating described in paragraphs (d) and (e) and any additional service units for which the ~~person~~ participant qualifies as described in paragraph (f).

(c) The home care rating shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner identifying the following for a ~~recipient~~ participant:

(1) the total number of dependencies of activities of daily living as defined in subdivision 2, paragraph (b);

(2) the presence of complex health-related needs as defined in subdivision 2, paragraph (e); and

(3) the presence of Level I behavior as defined in subdivision 2, paragraph (d)~~, clause (1)~~.

(d) The methodology to determine the total service units for CFSS for each home care rating is based on the median paid units per day for each home care rating from fiscal year 2007 data for the PCA program.

(e) Each home care rating is designated by the letters P through Z and EN and has the following base number of service units assigned:

(1) P home care rating requires Level I behavior or one to three dependencies in ADLs and qualifies one for five service units;

(2) Q home care rating requires Level I behavior and one to three dependencies in ADLs and qualifies one for six service units;

(3) R home care rating requires a complex health-related need and one to three dependencies in ADLs and qualifies one for seven service units;

(4) S home care rating requires four to six dependencies in ADLs and qualifies one for ten service units;

(5) T home care rating requires four to six dependencies in ADLs and Level I behavior and qualifies one for 11 service units;

(6) U home care rating requires four to six dependencies in ADLs and a complex health-related need and qualifies one for 14 service units;

(7) V home care rating requires seven to eight dependencies in ADLs and qualifies one for 17 service units;

(8) W home care rating requires seven to eight dependencies in ADLs and Level I behavior and qualifies one for 20 service units;

(9) Z home care rating requires seven to eight dependencies in ADLs and a complex health-related need and qualifies one for 30 service units; and

(10) EN home care rating includes ventilator dependency as defined in section 256B.0651, subdivision 1, paragraph (g). ~~Recipients~~ Participants who meet the definition of ventilator-dependent and the EN home care rating and utilize a combination of CFSS and other home care services are limited to a total of 96 service units per day for those services in combination. Additional units may be authorized when a ~~recipient's~~ participant's assessment indicates a need for two staff to perform activities. Additional time is limited to 16 service units per day.

(f) Additional service units are provided through the assessment and identification of the following:

(1) 30 additional minutes per day for a dependency in each critical activity of daily living as defined in subdivision 2, paragraph ~~(h)~~ (j);

(2) 30 additional minutes per day for each complex health-related function as defined in subdivision 2, paragraph ~~(e)~~ (f); and

(3) 30 additional minutes per day for each behavior issue as defined in subdivision 2, paragraph (d).

(g) The service budget for budget model participants shall be based on:

(1) assessed units as determined by the home care rating; and

(2) an adjustment needed for administrative expenses.

Sec. 10. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 9, is amended to read:

Subd. 9. **Noncovered services.** (a) Services or supports that are not eligible for payment under this section include those that:

(1) are not authorized by the certified assessor or included in the written service delivery plan;

(2) are provided prior to the authorization of services and the approval of the written CFSS service delivery plan;

(3) are duplicative of other paid services in the written service delivery plan;

(4) supplant natural unpaid supports that appropriately meet a need in the service plan, are provided voluntarily to the participant, and are selected by the participant in lieu of other services and supports;

(5) are not effective means to meet the participant's needs; and

(6) are available through other funding sources, including, but not limited to, funding through title IV-E of the Social Security Act.

(b) Additional services, goods, or supports that are not covered include:

(1) those that are not for the direct benefit of the participant, except that services for caregivers such as training to improve the ability to provide CFSS are considered to directly benefit the participant if chosen by the participant and approved in the support plan;

(2) any fees incurred by the participant, such as Minnesota health care programs fees and co-pays, legal fees, or costs related to advocate agencies;

(3) insurance, except for insurance costs related to employee coverage;

(4) room and board costs for the participant ~~with the exception of allowable transition costs in subdivision 7, clause (6)~~;

(5) services, supports, or goods that are not related to the assessed needs;

(6) special education and related services provided under the Individuals with Disabilities Education Act and vocational rehabilitation services provided under the Rehabilitation Act of 1973;

(7) assistive technology devices and assistive technology services other than those for back-up systems or mechanisms to ensure continuity of service and supports listed in subdivision 7;

(8) medical supplies and equipment covered under medical assistance;

(9) environmental modifications, except as specified in subdivision 7;

(10) expenses for travel, lodging, or meals related to training the participant~~,~~ or the participant's representative~~,~~ or legal representative~~, or paid or unpaid caregivers that exceed $500 in a 12-month period~~;

(11) experimental treatments;

(12) any service or good covered by other medical assistance state plan services, including prescription and over-the-counter medications, compounds, and solutions and related fees, including premiums and co-payments;

(13) membership dues or costs, except when the service is necessary and appropriate to treat a ~~physical~~ health condition or to improve or maintain the participant's ~~physical~~ health condition. The condition must be identified in the participant's CFSS plan and monitored by a ~~physician enrolled in a~~ Minnesota health care program enrolled physician;

(14) vacation expenses other than the cost of direct services;

(15) vehicle maintenance or modifications not related to the disability, health condition, or physical need; ~~and~~

(16) tickets and related costs to attend sporting or other recreational or entertainment events~~.~~;

(17) services provided and billed by a provider who is not an enrolled CFSS provider;

(18) CFSS provided by a participant's representative or paid legal guardian;

(19) services that are used solely as a child care or babysitting service;

(20) services that are the responsibility or in the daily rate of a residential or program license holder under the terms of a service agreement and administrative rules;

(21) sterile procedures;

(22) giving of injections into veins, muscles, or skin;

(23) homemaker services that are not an integral part of the assessed CFSS service;

(24) home maintenance or chore services;

(25) home care services, including hospice services if elected by the participant, covered by Medicare or any other insurance held by the participant;

(26) services to other members of the participant's household;

(27) services not specified as covered under medical assistance as CFSS;

(28) application of restraints or implementation of deprivation procedures;

(29) assessments by CFSS provider organizations or by independently enrolled registered nurses;

(30) services provided in lieu of legally required staffing in a residential or child care setting; and

(31) services provided by the residential or program license holder in a residence for more than four persons.

Sec. 11. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 10, is amended to read:

Subd. 10. **~~Provider~~ Agency-provider and FMS contractor qualifications ~~and,~~ general requirements, and duties.** (a) Agency-providers delivering services under the agency-provider model under subdivision 11 or ~~financial management service (FMS)~~ FMS contractors under subdivision 13 shall:

(1) enroll as a medical assistance Minnesota health care programs provider and meet all applicable provider standards and requirements;

~~(2) comply with medical assistance provider enrollment requirements;~~

~~(3)~~ (2) demonstrate compliance with ~~law~~ federal and state laws and policies ~~of~~ for CFSS as determined by the commissioner;

~~(4)~~ (3) comply with background study requirements under chapter 245C and maintain documentation of background study requests and results;

~~(5)~~ (4) verify and maintain records of all services and expenditures by the participant, including hours worked by support workers ~~and support specialists~~;

~~(6)~~ (5) not engage in any agency-initiated direct contact or marketing in person, by telephone, or other electronic means to potential participants, guardians, family members, or participants' representatives;

(6) directly provide services and not use a subcontractor or reporting agent;

(7) meet the financial requirements established by the commissioner for financial solvency;

(8) have never had a lead agency contract or provider agreement discontinued due to fraud, or have never had an owner, board member, or manager fail a state or FBI-based criminal background check while enrolled or seeking enrollment as a Minnesota health care programs provider;

(9) have established business practices that include written policies and procedures, internal controls, and a system that demonstrates the organization's ability to deliver quality CFSS; and

(10) have an office located in Minnesota.

(b) In conducting general duties, agency-providers and FMS contractors shall:

~~(7)~~ (1) pay support workers ~~and support specialists~~ based upon actual hours of services provided;

(2) pay for worker training and development services based upon actual hours of services provided or the unit cost of the training session purchased;

~~(8)~~ (3) withhold and pay all applicable federal and state payroll taxes;

~~(9)~~ (4) make arrangements and pay unemployment insurance, taxes, workers' compensation, liability insurance, and other benefits, if any;

~~(10)~~ (5) enter into a written agreement with the participant, participant's representative, or legal representative that assigns roles and responsibilities to be performed before services, supports, or goods are provided using a format established by the commissioner;

~~(11)~~ (6) report maltreatment as required under sections 626.556 and 626.557; ~~and~~

~~(12)~~ (7) provide the participant with a copy of the service-related rights under subdivision 20 at the start of services and supports~~.~~; and

(8) comply with any data requests from the department consistent with the Minnesota Government Data Practices Act under chapter 13.

Sec. 12. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 11, is amended to read:

Subd. 11. **Agency-provider model.** (a) The agency-provider model ~~is limited to the~~ includes services provided by support workers and ~~support specialists~~ staff providing

worker training and development services who are employed by an agency-provider that is licensed according to chapter 245A or meets other criteria established by the commissioner, including required training.

(b) The agency-provider shall allow the participant to have a significant role in the selection and dismissal of the support workers for the delivery of the services and supports specified in the participant's service delivery plan.

(c) A participant may use authorized units of CFSS services as needed within a service authorization that is not greater than 12 months. Using authorized units in a flexible manner in either the agency-provider model or the budget model does not increase the total amount of services and supports authorized for a participant or included in the participant's service delivery plan.

(d) A participant may share CFSS services. Two or three CFSS participants may share services at the same time provided by the same support worker.

(e) The agency-provider must use a minimum of 72.5 percent of the revenue generated by the medical assistance payment for CFSS for support worker wages and benefits. The agency-provider must document how this requirement is being met. The revenue generated by the ~~support specialist~~ worker training and development services and the reasonable costs associated with the ~~support specialist~~ worker training and development services must not be used in making this calculation.

(f) The agency-provider model must be used by individuals who have been restricted by the Minnesota restricted recipient program under Minnesota Rules, parts 9505.2160 to 9505.2245.

(g) Participants purchasing goods under this model, along with support worker services, must:

(1) specify the goods in the service delivery plan and detailed budget for expenditures that must be approved by the consultation services provider or the case manager/care coordinator; and

(2) use the FMS contractor for the billing and payment of such goods.

Sec. 13. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 12, is amended to read:

Subd. 12. **Requirements for enrollment of CFSS ~~provider~~ agency-provider agencies.** (a) All CFSS ~~provider agencies~~ agency-providers must provide, at the time of enrollment, reenrollment, and revalidation as a CFSS ~~provider agency~~ agency-provider in a format determined by the commissioner, information and documentation that includes, but is not limited to, the following:

(1) the CFSS ~~provider agency's~~ agency-provider's current contact information including address, telephone number, and e-mail address;

(2) proof of surety bond coverage. Upon new enrollment, or if the ~~provider agency's~~ agency-provider's Medicaid revenue in the previous calendar year is less than or equal to $300,000, the ~~provider agency~~ agency-provider must purchase a performance bond of $50,000. If the ~~provider agency's~~ agency-provider's Medicaid revenue in the previous calendar year is greater than $300,000, the ~~provider agency~~ agency-provider must purchase a performance bond of $100,000. The performance bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond;

(3) proof of fidelity bond coverage in the amount of $20,000;

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

(6) a description of the CFSS ~~provider agency's~~ agency-provider's organization identifying the names of all owners, managing employees, staff, board of directors, and the affiliations of the directors~~,~~ and owners~~, or staff~~ to other service providers;

(7) a copy of the CFSS ~~provider agency's~~ agency-provider's written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety including process for notification and resolution of consumer grievances, identification and prevention of communicable diseases, and employee misconduct;

(8) copies of all other forms the CFSS ~~provider agency~~ agency-provider uses in the course of daily business including, but not limited to:

(i) a copy of the CFSS ~~provider agency's~~ agency-provider's time sheet if the time sheet varies from the standard time sheet for CFSS services approved by the commissioner, and a letter requesting approval of the CFSS ~~provider agency's~~ agency-provider's nonstandard time sheet; and

(ii) ~~the~~ a copy of the participant's individual CFSS ~~provider agency's template for the CFSS care~~ service delivery plan;

(9) a list of all training and classes that the CFSS ~~provider agency~~ agency-provider requires of its staff providing CFSS services;

(10) documentation that the CFSS ~~provider agency~~ agency-provider and staff have successfully completed all the training required by this section;

(11) documentation of the ~~agency's~~ agency-provider's marketing practices;

(12) disclosure of ownership, leasing, or management of all residential properties that are used or could be used for providing home care services;

(13) documentation that the ~~agency~~ agency-provider will use at least the following percentages of revenue generated from the medical assistance rate paid for CFSS services for ~~employee personal care assistant~~ CFSS support worker wages and benefits: 72.5 percent of revenue from CFSS providers. The revenue generated by the ~~support specialist~~ worker training and development services and the reasonable costs associated with the ~~support specialist~~ worker training and development services shall not be used in making this calculation; and

(14) documentation that the ~~agency~~ agency-provider does not burden ~~recipients'~~ participants' free exercise of their right to choose service providers by requiring ~~personal care assistants~~ CFSS support workers to sign an agreement not to work with any particular CFSS ~~recipient~~ participant or for another CFSS ~~provider agency~~ agency-provider after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) CFSS ~~provider agencies~~ agency-providers shall provide to the commissioner the information specified in paragraph (a).

(c) All CFSS ~~provider agencies~~ agency-providers shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a CFSS ~~provider agency~~ agency-provider do not need to repeat the required training if they are hired by another agency, if they have completed the training within the past three years. CFSS ~~provider agency~~ agency-provider billing staff shall complete training about CFSS program financial management. Any new owners or employees in management and supervisory positions involved in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency. ~~CFSS provider agencies certified for participation in Medicare as home health agencies are exempt from the training required in this subdivision.~~

(d) The commissioner shall send annual review notifications to agency-providers 30 days prior to renewal. The notification must:

(1) list the materials and information the agency-provider is required to submit;

(2) provide instructions on submitting information to the commissioner; and

(3) provide a due date by which the commissioner must receive the requested information.

Agency-providers shall submit the required documentation for annual review within 30 days of notification from the commissioner. If no documentation is submitted, the agency-provider enrollment number must be terminated or suspended.

Sec. 14. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 13, is amended to read:

Subd. 13. **Budget model.** (a) Under the budget model participants ~~can~~ may exercise ~~more~~ responsibility and control over the services and supports described and budgeted within the CFSS service delivery plan. Participants must use services provided by an FMS contractor as defined in subdivision 2, paragraph (m). Under this model, participants may use their approved service budget allocation to:

(1) directly employ support workers, and pay wages, federal and state payroll taxes, and premiums for workers' compensation, liability, and health insurance coverage; and

(2) obtain supports and goods as defined in subdivision 7~~; and~~.

~~(3) choose a range of support assistance services from the financial management services (FMS) contractor related to:~~

~~(i) assistance in managing the budget to meet the service delivery plan needs, consistent with federal and state laws and regulations;~~

~~(ii) the employment, training, supervision, and evaluation of workers by the participant;~~

~~(iii) acquisition and payment for supports and goods; and~~

~~(iv) evaluation of individual service outcomes as needed for the scope of the participant's degree of control and responsibility.~~

(b) Participants who are unable to fulfill any of the functions listed in paragraph (a) may authorize a legal representative or participant's representative to do so on their behalf.

(c) The commissioner shall disenroll or exclude participants from the budget model and transfer them to the agency-provider model under the following circumstances that include but are not limited to:

(1) when a participant has been restricted by the Minnesota restricted recipient program, in which case the participant may be excluded for a specified time period under Minnesota Rules, parts 9505.2160 to 9505.2245;

(2) when a participant exits the budget model during the participant's service plan year. Upon transfer, the participant shall not access the budget model for the remainder of that service plan year; or

(3) when the department determines that the participant or participant's representative or legal representative cannot manage participant responsibilities under the budget model.

The commissioner must develop policies for determining if a participant is unable to manage responsibilities under the budget model.

(d) A participant may appeal in writing to the department under section 256.045, subdivision 3, to contest the department's decision under paragraph (c), clause (3), to disenroll or exclude the participant from the budget model.

~~(c)~~ (e) The FMS contractor shall not provide CFSS services and supports under the agency-provider service model.

(f) The FMS contractor shall provide service functions as determined by the commissioner for budget model participants that include but are not limited to:

~~(1) information and consultation about CFSS;~~

~~(2)~~ (1) assistance with the development of the detailed budget for expenditures portion of the service delivery plan ~~and budget model~~ as requested by the consultation services provider or participant;

~~(3)~~ (2) billing and making payments for budget model expenditures;

~~(4)~~ (3) assisting participants in fulfilling employer-related requirements according to ~~Internal Revenue Service Revenue Procedure 70-6, section 3504, Agency Employer Tax Liability, regulation 137036-08~~ section 3504 of the Internal Revenue Code and related regulations and interpretations, including Code of Federal Regulations, title 26, section 31.3504-1, which includes assistance with filing and paying payroll taxes, and obtaining worker compensation coverage;

~~(5)~~ (4) data recording and reporting of participant spending; ~~and~~

~~(6)~~ (5) other duties established in the contract with the department, including with respect to providing assistance to the participant, participant's representative, or legal representative in performing their employer responsibilities regarding support workers. The support worker shall not be considered the employee of the ~~financial management services~~ FMS contractor~~.~~; and

(6) billing, payment, and accounting of approved expenditures for goods for agency-provider participants.

~~(d) A participant who requests to purchase goods and supports along with support worker services under the agency-provider model must use the budget model with a service delivery plan that specifies the amount of services to be authorized to the agency-provider and the expenditures to be paid by the FMS contractor.~~

~~(e)~~ (g) The FMS contractor shall:

(1) not limit or restrict the participant's choice of service or support providers or service delivery models consistent with any applicable state and federal requirements;

(2) provide the participant, consultation services provider, and the ~~targeted~~ case manager, if applicable, with a monthly written summary of the spending for services and supports that were billed against the spending budget;

(3) be knowledgeable of state and federal employment regulations, including those under the Fair Labor Standards Act of 1938, and comply with the requirements under ~~the Internal Revenue Service Revenue Procedure 70-6, Section 3504,~~ section 3504 of the Internal Revenue Code and related regulations and interpretations, including Code of Federal Regulations, title 26, section 31.3504-1, regarding agency employer tax liability for vendor or fiscal employer agent, and any requirements necessary to process employer and employee deductions, provide appropriate and timely submission of employer tax liabilities, and maintain documentation to support medical assistance claims;

(4) have current and adequate liability insurance and bonding and sufficient cash flow as determined by the commissioner and have on staff or under contract a certified public accountant or an individual with a baccalaureate degree in accounting;

(5) assume fiscal accountability for state funds designated for the program and be held liable for any overpayments or violations of applicable statutes or rules, including but not limited to the Minnesota False Claims Act; and

(6) maintain documentation of receipts, invoices, and bills to track all services and supports expenditures for any goods purchased and maintain time records of support workers. The documentation and time records must be maintained for a minimum of five years from the claim date and be available for audit or review upon request by the commissioner. Claims submitted by the FMS contractor to the commissioner for payment must correspond with services, amounts, and time periods as authorized in the participant's ~~spending~~ service budget and service plan and must contain specific identifying information as determined by the commissioner.

~~(f)~~ (h) The commissioner of human services shall:

(1) establish rates and payment methodology for the FMS contractor;

(2) identify a process to ensure quality and performance standards for the FMS contractor and ensure statewide access to FMS contractors; and

(3) establish a uniform protocol for delivering and administering CFSS services to be used by eligible FMS contractors.

~~(g) The commissioner of human services shall disenroll or exclude participants from the budget model and transfer them to the agency-provider model under the following circumstances that include but are not limited to:~~

~~(1) when a participant has been restricted by the Minnesota restricted recipient program, the participant may be excluded for a specified time period under Minnesota Rules, parts 9505.2160 to 9505.2245;~~

~~(2) when a participant exits the budget model during the participant's service plan year. Upon transfer, the participant shall not access the budget model for the remainder of that service plan year; or~~

~~(3) when the department determines that the participant or participant's representative or legal representative cannot manage participant responsibilities under the budget model. The commissioner must develop policies for determining if a participant is unable to manage responsibilities under a budget model.~~

~~(h) A participant may appeal under section 256.045, subdivision 3, in writing to the department to contest the department's decision under paragraph (c), clause (3), to remove or exclude the participant from the budget model.~~

Sec. 15. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 15, is amended to read:

Subd. 15. **Documentation of support services provided.** (a) Support services provided to a participant by a support worker employed by either an agency-provider or the participant acting as the employer must be documented daily by each support worker, on a time sheet form approved by the commissioner. All documentation may be Web-based, electronic, or paper documentation. The completed form must be submitted on a ~~monthly~~ regular basis to the provider or the participant and the FMS contractor selected by the participant to provide assistance with meeting the participant's employer obligations and kept in the ~~recipient's health~~ participant's record.

(b) The activity documentation must correspond to the written service delivery plan and be reviewed by the agency-provider or the participant and the FMS contractor when the participant is ~~acting as~~ the employer of the support worker.

(c) The time sheet must be on a form approved by the commissioner documenting time the support worker provides services ~~in the home~~ to the participant. The following criteria must be included in the time sheet:

(1) full name of the support worker and individual provider number;

(2) ~~provider~~ agency-provider name and telephone numbers, if ~~an agency-provider is~~ responsible for delivery services under the written service plan;

(3) full name of the participant;

(4) consecutive dates, including month, day, and year, and arrival and departure times with a.m. or p.m. notations;

(5) signatures of the participant or the participant's representative;

(6) personal signature of the support worker;

(7) any shared care provided, if applicable;

(8) a statement that it is a federal crime to provide false information on CFSS billings for medical assistance payments; and

(9) dates and location of ~~recipient~~ participant stays in a hospital, care facility, or incarceration.

Sec. 16. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 16, is amended to read:

Subd. 16. **Support workers requirements.** (a) Support workers shall:

(1) enroll with the department as a support worker after a background study under chapter 245C has been completed and the support worker has received a notice from the commissioner that:

(i) the support worker is not disqualified under section 245C.14; or

(ii) is disqualified, but the support worker has received a set-aside of the disqualification under section 245C.22;

(2) have the ability to effectively communicate with the participant or the participant's representative;

(3) have the skills and ability to provide the services and supports according to the ~~person's~~ participant's CFSS service delivery plan and respond appropriately to the participant's needs;

(4) not be a participant of CFSS, unless the support services provided by the support worker differ from those provided to the support worker;

(5) complete the basic standardized training as determined by the commissioner before completing enrollment. The training must be available in languages other than English and to those who need accommodations due to disabilities. Support worker training must include successful completion of the following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of support workers including information about basic body mechanics, emergency preparedness, orientation to positive behavioral practices, orientation to responding to a mental health crisis, fraud issues, time cards and documentation, and an overview of person-centered planning and self-direction. Upon completion of the training components, the support worker must pass the certification test to provide assistance to participants;

(6) complete training and orientation on the participant's individual needs; and

(7) maintain the privacy and confidentiality of the participant, and not independently determine the medication dose or time for medications for the participant.

(b) The commissioner may deny or terminate a support worker's provider enrollment and provider number if the support worker:

(1) lacks the skills, knowledge, or ability to adequately or safely perform the required work;

(2) fails to provide the authorized services required by the participant employer;

(3) has been intoxicated by alcohol or drugs while providing authorized services to the participant or while in the participant's home;

(4) has manufactured or distributed drugs while providing authorized services to the participant or while in the participant's home; or

(5) has been excluded as a provider by the commissioner of human services, or the United States Department of Health and Human Services, Office of Inspector General, from participation in Medicaid, Medicare, or any other federal health care program.

(c) A support worker may appeal in writing to the commissioner to contest the decision to terminate the support worker's provider enrollment and provider number.

(d) A support worker must not provide or be paid for more than 275 hours of CFSS per month, regardless of the number of participants the support worker serves or the number of agency-providers or participant employers by which the support worker is employed. The department shall not disallow the number of hours per day a support worker works unless it violates other law.

Sec. 17. Minnesota Statutes 2013 Supplement, section 256B.85, is amended by adding a subdivision to read:

Subd. 16a. **Exception to support worker requirements for continuity of services.** The support worker for a participant may be allowed to enroll with a different CFSS agency-provider or FMS contractor upon initiation, rather than completion, of a new background study according to chapter 245C, if the following conditions are met:

(1) the commissioner determines that the support worker's change in enrollment or affiliation is needed to ensure continuity of services and protect the health and safety of the participant;

(2) the chosen agency-provider or FMS contractor has been continuously enrolled as a CFSS agency-provider or FMS contractor for at least two years or since the inception of the CFSS program, whichever is shorter;

(3) the participant served by the support worker chooses to transfer to the CFSS agency-provider or the FMS contractor to which the support worker is transferring;

(4) the support worker has been continuously enrolled with the former CFSS agency-provider or FMS contractor since the support worker's last background study was completed; and

(5) the support worker continues to meet requirements of subdivision 16, excluding paragraph (a), clause (1).

Sec. 18. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 17, is amended to read:

Subd. 17. ~~**Support specialist requirements and payments**~~ **Consultation services description and duties.** ~~The commissioner shall develop qualifications, scope of functions, and payment rates and service limits for a support specialist that may provide additional or specialized assistance necessary to plan, implement, arrange, augment, or evaluate services and supports.~~

(a) Consultation services means providing assistance to the participant in making informed choices regarding CFSS services in general and self-directed tasks in particular and in developing a person-centered service delivery plan to achieve quality service outcomes.

(b) Consultation services is a required service that may include but is not limited to:

(1) an initial and annual orientation to CFSS information and policies, including selecting a service model;

(2) assistance with the development, implementation, management, and evaluation of the person-centered service delivery plan;

(3) consultation on recruiting, selecting, training, managing, directing, evaluating, and supervising support workers;

(4) reviewing the use of and access to informal and community supports, goods, or resources;

(5) assistance with fulfilling responsibilities and requirements of CFSS including modifying service delivery plans and changing service models; and

(6) assistance with accessing FMS contractors or agency-providers.

(c) Duties of a consultation services provider shall include but are not limited to:

(1) review and finalization of the CFSS service delivery plan by the consultation services provider organization;

(2) distribution of copies of the final service delivery plan to the participant and to the agency-provider or FMS contractor, case manager/care coordinator, and other designated parties;

(3) an evaluation of services upon receiving information from an FMS contractor indicating spending or participant employer concerns;

(4) a semiannual review of services if the participant does not have a case manager/care coordinator and when the support worker is a paid parent of a minor participant or the participant's spouse;

(5) collection and reporting of data as required by the department; and

(6) providing the participant with a copy of the service-related rights under subdivision 20 at the start of consultation services.

Sec. 19. Minnesota Statutes 2013 Supplement, section 256B.85, is amended by adding a subdivision to read:

Subd. 17a. **Consultation service provider qualifications and requirements.** The commissioner shall develop the qualifications and requirements for providers of consultation services under subdivision 17. These providers must satisfy at least the following qualifications and requirements:

(1) are under contract with the department;

(2) are not the FMS contractor as defined in subdivision 2, paragraph (m), the CFSS or HCBS waiver agency-provider or vendor to the participant, or a lead agency;

(3) meet the service standards as established by the commissioner;

(4) employ lead professional staff with a minimum of three years of experience in providing support planning, support broker, or consultation services and consumer education to participants using a self-directed program using FMS under medical assistance;

(5) are knowledgeable about CFSS roles and responsibilities including those of the certified assessor, FMS contractor, agency-provider, and case manager/care coordinator;

(6) comply with medical assistance provider requirements;

(7) understand the CFSS program and its policies;

(8) are knowledgeable about self-directed principles and the application of the person-centered planning process;

(9) have general knowledge of the FMS contractor duties and participant employment model, including all applicable federal, state, and local laws and regulations regarding tax, labor, employment, and liability and workers' compensation coverage for household workers; and

(10) have all employees, including lead professional staff, staff in management and supervisory positions, and owners of the agency who are active in the day-to-day

management and operations of the agency, complete training as specified in the contract with the department.

Sec. 20. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 18, is amended to read:

Subd. 18. **Service unit and budget allocation requirements and limits.** (a) For the agency-provider model, services will be authorized in units of service. The total service unit amount must be established based upon the assessed need for CFSS services, and must not exceed the maximum number of units available as determined under subdivision 8.

(b) For the budget model, the service budget allocation allowed for services and supports is ~~established by multiplying the number of units authorized under subdivision 8 by the payment rate established by the commissioner~~ defined in subdivision 8, paragraph (g).

Sec. 21. Minnesota Statutes 2013 Supplement, section 256B.85, is amended by adding a subdivision to read:

Subd. 18a. **Worker training and development services.** (a) The commissioner shall develop the scope of tasks and functions, service standards, and service limits for worker training and development services.

(b) Worker training and development services are in addition to the participant's assessed service units or service budget. Services provided according to this subdivision must:

(1) help support workers obtain and expand the skills and knowledge necessary to ensure competency in providing quality services as needed and defined in the participant's service delivery plan;

(2) be provided or arranged for by the agency-provider under subdivision 11 or purchased by the participant employer under the budget model under subdivision 13; and

(3) be described in the participant's CFSS service delivery plan and documented in the participant's file.

(c) Services covered under worker training and development shall include:

(1) support worker training on the participant's individual assessed needs, condition, or both, provided individually or in a group setting by a skilled and knowledgeable trainer beyond any training the participant or participant's representative provides;

(2) tuition for professional classes and workshops for the participant's support workers that relate to the participant's assessed needs, condition, or both;

(3) direct observation, monitoring, coaching, and documentation of support worker job skills and tasks, beyond any training the participant or participant's representative provides, including supervision of health-related tasks or behavioral supports that is conducted by an appropriate professional based on the participant's assessed needs. These services must be provided within 14 days of the start of services or the start of a new support worker and must be specified in the participant's service delivery plan; and

(4) reporting service and support concerns to the appropriate provider.

(d) Worker training and development services shall not include:

(1) general agency training, worker orientation, or training on CFSS self-directed models;

(2) payment for preparation or development time for the trainer or presenter;

(3) payment of the support worker's salary or compensation during the training;

(4) training or supervision provided by the participant, the participant's support worker, or the participant's informal supports, including the participant's representative; or

(5) services in excess of 96 units per annual service authorization, unless approved by the department.

Sec. 22. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 23, is amended to read:

Subd. 23. **Commissioner's access.** When the commissioner is investigating a possible overpayment of Medicaid funds, the commissioner must be given immediate access without prior notice to the ~~agency provider~~ agency-provider or FMS contractor's office during regular business hours and to documentation and records related to services provided and submission of claims for services provided. Denying the commissioner access to records is cause for immediate suspension of payment and terminating the agency provider's enrollment according to section 256B.064 or terminating the FMS contract.

Sec. 23. Minnesota Statutes 2013 Supplement, section 256B.85, subdivision 24, is amended to read:

Subd. 24. **CFSS agency-providers; background studies.** CFSS agency-providers enrolled to provide ~~personal care assistance~~ CFSS services under the medical assistance program shall comply with the following:

(1) owners who have a five percent interest or more and all managing employees are subject to a background study as provided in chapter 245C. This applies to currently enrolled CFSS agency-providers and those agencies seeking enrollment as a CFSS

agency-provider. "Managing employee" has the same meaning as Code of Federal Regulations, title 42, section 455. An organization is barred from enrollment if:

(i) the organization has not initiated background studies on owners managing employees; or

(ii) the organization has initiated background studies on owners and managing employees, but the commissioner has sent the organization a notice that an owner or managing employee of the organization has been disqualified under section 245C.14, and the owner or managing employee has not received a set-aside of the disqualification under section 245C.22;

(2) a background study must be initiated and completed for all ~~support specialists~~ staff who will have direct contact with the participant to provide worker training and development; and

(3) a background study must be initiated and completed for all support workers.

Sec. 24. Laws 2013, chapter 108, article 7, section 49, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective upon federal approval but no earlier than April 1, 2014. The service will begin 90 days after federal approval ~~or April 1, 2014, whichever is later~~. The commissioner of human services shall notify the revisor of statutes when this occurs.

ARTICLE 5

CONTINUING CARE

Section 1. Minnesota Statutes 2012, section 13.46, subdivision 4, is amended to read:

Subd. 4. **Licensing data.** (a) As used in this subdivision:

(1) "licensing data" are all data collected, maintained, used, or disseminated by the welfare system pertaining to persons licensed or registered or who apply for licensure or registration or who formerly were licensed or registered under the authority of the commissioner of human services;

(2) "client" means a person who is receiving services from a licensee or from an applicant for licensure; and

(3) "personal and personal financial data" are Social Security numbers, identity of and letters of reference, insurance information, reports from the Bureau of Criminal Apprehension, health examination reports, and social/home studies.

(b)(1)(i) Except as provided in paragraph (c), the following data on applicants, license holders, and former licensees are public: name, address, telephone number of licensees, date of receipt of a completed application, dates of licensure, licensed capacity, type of client preferred, variances granted, record of training and education in child care and child development, type of dwelling, name and relationship of other family members, previous license history, class of license, the existence and status of complaints, and the number of serious injuries to or deaths of individuals in the licensed program as reported to the commissioner of human services, the local social services agency, or any other county welfare agency. For purposes of this clause, a serious injury is one that is treated by a physician.

(ii) When a correction order, an order to forfeit a fine, an order of license suspension, an order of temporary immediate suspension, an order of license revocation, an order of license denial, or an order of conditional license has been issued, or a complaint is resolved, the following data on current and former licensees and applicants are public: the substance and investigative findings of the licensing or maltreatment complaint, licensing violation, or substantiated maltreatment; the record of informal resolution of a licensing violation; orders of hearing; findings of fact; conclusions of law; specifications of the final correction order, fine, suspension, temporary immediate suspension, revocation, denial, or conditional license contained in the record of licensing action; whether a fine has been paid; and the status of any appeal of these actions.

(iii) When a license denial under section 245A.05 or a sanction under section 245A.07 is based on a determination that the license holder or applicant is responsible for maltreatment under section 626.556 or 626.557, the identity of the applicant or license holder as the individual responsible for maltreatment is public data at the time of the issuance of the license denial or sanction.

(iv) When a license denial under section 245A.05 or a sanction under section 245A.07 is based on a determination that the license holder or applicant is disqualified under chapter 245C, the identity of the license holder or applicant as the disqualified individual and the reason for the disqualification are public data at the time of the issuance of the licensing sanction or denial. If the applicant or license holder requests reconsideration of the disqualification and the disqualification is affirmed, the reason for the disqualification and the reason to not set aside the disqualification are public data.

(2) Notwithstanding sections 626.556, subdivision 11, and 626.557, subdivision 12b, when any person subject to disqualification under section 245C.14 in connection with a license to provide family day care for children, child care center services, foster care for children in the provider's home, or foster care or day care services for adults in the provider's

home is a substantiated perpetrator of maltreatment, and the substantiated maltreatment is a reason for a licensing action, the identity of the substantiated perpetrator of maltreatment is public data. For purposes of this clause, a person is a substantiated perpetrator if the maltreatment determination has been upheld under section 256.045; 626.556, subdivision 10i; 626.557, subdivision 9d; or chapter 14, or if an individual or facility has not timely exercised appeal rights under these sections, except as provided under clause (1).

(3) For applicants who withdraw their application prior to licensure or denial of a license, the following data are public: the name of the applicant, the city and county in which the applicant was seeking licensure, the dates of the commissioner's receipt of the initial application and completed application, the type of license sought, and the date of withdrawal of the application.

(4) For applicants who are denied a license, the following data are public: the name and address of the applicant, the city and county in which the applicant was seeking licensure, the dates of the commissioner's receipt of the initial application and completed application, the type of license sought, the date of denial of the application, the nature of the basis for the denial, the record of informal resolution of a denial, orders of hearings, findings of fact, conclusions of law, specifications of the final order of denial, and the status of any appeal of the denial.

(5) The following data on persons subject to disqualification under section 245C.14 in connection with a license to provide family day care for children, child care center services, foster care for children in the provider's home, or foster care or day care services for adults in the provider's home, are public: the nature of any disqualification set aside under section 245C.22, subdivisions 2 and 4, and the reasons for setting aside the disqualification; the nature of any disqualification for which a variance was granted under sections 245A.04, subdivision 9; and 245C.30, and the reasons for granting any variance under section 245A.04, subdivision 9; and, if applicable, the disclosure that any person subject to a background study under section 245C.03, subdivision 1, has successfully passed a background study. If a licensing sanction under section 245A.07, or a license denial under section 245A.05, is based on a determination that an individual subject to disqualification under chapter 245C is disqualified, the disqualification as a basis for the licensing sanction or denial is public data. As specified in clause (1), item (iv), if the disqualified individual is the license holder or applicant, the identity of the license holder or applicant and the reason for the disqualification are public data; and, if the license holder or applicant requested reconsideration of the disqualification and the disqualification is affirmed, the reason for the disqualification and the reason to not set aside the disqualification are

public data. If the disqualified individual is an individual other than the license holder or applicant, the identity of the disqualified individual shall remain private data.

(6) When maltreatment is substantiated under section 626.556 or 626.557 and the victim and the substantiated perpetrator are affiliated with a program licensed under chapter 245A, the commissioner of human services, local social services agency, or county welfare agency may inform the license holder where the maltreatment occurred of the identity of the substantiated perpetrator and the victim.

(7) Notwithstanding clause (1), for child foster care, only the name of the license holder and the status of the license are public if the county attorney has requested that data otherwise classified as public data under clause (1) be considered private data based on the best interests of a child in placement in a licensed program.

(c) The following are private data on individuals under section 13.02, subdivision 12, or nonpublic data under section 13.02, subdivision 9: personal and personal financial data on family day care program and family foster care program applicants and licensees and their family members who provide services under the license.

(d) The following are private data on individuals: the identity of persons who have made reports concerning licensees or applicants that appear in inactive investigative data, and the records of clients or employees of the licensee or applicant for licensure whose records are received by the licensing agency for purposes of review or in anticipation of a contested matter. The names of reporters of complaints or alleged violations of licensing standards under chapters 245A, 245B, 245C, and 245D, and applicable rules and alleged maltreatment under sections 626.556 and 626.557, are confidential data and may be disclosed only as provided in section 626.556, subdivision 11, or 626.557, subdivision 12b.

(e) Data classified as private, confidential, nonpublic, or protected nonpublic under this subdivision become public data if submitted to a court or administrative law judge as part of a disciplinary proceeding in which there is a public hearing concerning a license which has been suspended, immediately suspended, revoked, or denied.

(f) Data generated in the course of licensing investigations that relate to an alleged violation of law are investigative data under subdivision 3.

(g) Data that are not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report as defined in section 626.556, subdivision 2, or 626.5572, subdivision 18, are subject to the destruction provisions of sections 626.556, subdivision 11c, and 626.557, subdivision 12b.

(h) Upon request, not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report of substantiated maltreatment as defined in section 626.556 or 626.557 may be exchanged with the Department of Health

for purposes of completing background studies pursuant to section 144.057 and with the Department of Corrections for purposes of completing background studies pursuant to section 241.021.

(i) Data on individuals collected according to licensing activities under chapters 245A and 245C, data on individuals collected by the commissioner of human services according to investigations under chapters 245A, 245B, ~~and~~ 245C, and 245D, and sections 626.556 and 626.557 may be shared with the Department of Human Rights, the Department of Health, the Department of Corrections, the ombudsman for mental health and developmental disabilities, and the individual's professional regulatory board when there is reason to believe that laws or standards under the jurisdiction of those agencies may have been violated or the information may otherwise be relevant to the board's regulatory jurisdiction. Background study data on an individual who is the subject of a background study under chapter 245C for a licensed service for which the commissioner of human services is the license holder may be shared with the commissioner and the commissioner's delegate by the licensing division. Unless otherwise specified in this chapter, the identity of a reporter of alleged maltreatment or licensing violations may not be disclosed.

(j) In addition to the notice of determinations required under section 626.556, subdivision 10f, if the commissioner or the local social services agency has determined that an individual is a substantiated perpetrator of maltreatment of a child based on sexual abuse, as defined in section 626.556, subdivision 2, and the commissioner or local social services agency knows that the individual is a person responsible for a child's care in another facility, the commissioner or local social services agency shall notify the head of that facility of this determination. The notification must include an explanation of the individual's available appeal rights and the status of any appeal. If a notice is given under this paragraph, the government entity making the notification shall provide a copy of the notice to the individual who is the subject of the notice.

(k) All not public data collected, maintained, used, or disseminated under this subdivision and subdivision 3 may be exchanged between the Department of Human Services, Licensing Division, and the Department of Corrections for purposes of regulating services for which the Department of Human Services and the Department of Corrections have regulatory authority.

Sec. 2. Minnesota Statutes 2012, section 144.0724, as amended by Laws 2014, chapter 147, section 1, is amended to read:

144.0724 RESIDENT REIMBURSEMENT CLASSIFICATION.

Subdivision 1. **Resident reimbursement case mix classifications.** The commissioner of health shall establish resident reimbursement classifications based upon the assessments of residents of nursing homes and boarding care homes conducted under this section and according to section 256B.438.

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

(a) "Assessment reference date" or "ARD" means the specific end point for look-back periods in the MDS assessment process. This look-back period is also called the observation or assessment period.

(b) "Case mix index" means the weighting factors assigned to the RUG-IV classifications.

(c) "Index maximization" means classifying a resident who could be assigned to more than one category, to the category with the highest case mix index.

(d) "Minimum data set" or "MDS" means a core set of screening, clinical assessment, and functional status elements, that include common definitions and coding categories specified by the Centers for Medicare and Medicaid Services and designated by the Minnesota Department of Health.

(e) "Representative" means a person who is the resident's guardian or conservator, the person authorized to pay the nursing home expenses of the resident, a representative of the Office of Ombudsman for Long-Term Care whose assistance has been requested, or any other individual designated by the resident.

(f) "Resource utilization groups" or "RUG" means the system for grouping a nursing facility's residents according to their clinical and functional status identified in data supplied by the facility's minimum data set.

(g) "Activities of daily living" means grooming, dressing, bathing, transferring, mobility, positioning, eating, and toileting.

(h) "Nursing facility level of care determination" means the assessment process that results in a determination of a resident's or prospective resident's need for nursing facility level of care as established in subdivision 11 for purposes of medical assistance payment of long-term care services for:

(1) nursing facility services under section 256B.434 or 256B.441;

(2) elderly waiver services under section 256B.0915;

(3) CADI and BI waiver services under section 256B.49; and

(4) state payment of alternative care services under section 256B.0913.

Subd. 3a. **Resident reimbursement classifications beginning January 1, 2012.** (a) Beginning January 1, 2012, resident reimbursement classifications shall be based

on the minimum data set, version 3.0 assessment instrument, or its successor version mandated by the Centers for Medicare and Medicaid Services that nursing facilities are required to complete for all residents. The commissioner of health shall establish resident classifications according to the RUG-IV, 48 group, resource utilization groups. Resident classification must be established based on the individual items on the minimum data set, which must be completed according to the Long Term Care Facility Resident Assessment Instrument User's Manual Version 3.0 or its successor issued by the Centers for Medicare and Medicaid Services.

(b) Each resident must be classified based on the information from the minimum data set according to general categories as defined in the Case Mix Classification Manual for Nursing Facilities issued by the Minnesota Department of Health.

Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically submit to the commissioner of health MDS assessments that conform with the assessment schedule defined by Code of Federal Regulations, title 42, section 483.20, and published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, in the Long Term Care Assessment Instrument User's Manual, version 3.0, and subsequent updates when issued by the Centers for Medicare and Medicaid Services. The commissioner of health may substitute successor manuals or question and answer documents published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, to replace or supplement the current version of the manual or document.

(b) The assessments used to determine a case mix classification for reimbursement include the following:

(1) a new admission assessment;

(2) an annual assessment which must have an assessment reference date (ARD) within 92 days of the previous assessment and within 366 days of the ARD of the previous comprehensive assessment;

(3) a significant change in status assessment must be completed within 14 days of the identification of a significant change;

(4) all quarterly assessments must have an assessment reference date (ARD) within 92 days of the ARD of the previous assessment;

(5) any significant correction to a prior comprehensive assessment, if the assessment being corrected is the current one being used for RUG classification; and

(6) any significant correction to a prior quarterly assessment, if the assessment being corrected is the current one being used for RUG classification.

(c) In addition to the assessments listed in paragraph (b), the assessments used to determine nursing facility level of care include the following:

(1) preadmission screening completed under section 256B.0911, subdivision 4a, by a county, tribe, or managed care organization under contract with the Department of Human Services; and

(2) a face-to-face long-term care consultation assessment completed under section 256B.0911, subdivision 3a, 3b, or 4d, by a county, tribe, or managed care organization under contract with the Department of Human Services.

Subd. 5. **Short stays.** (a) A facility must submit to the commissioner of health an admission assessment for all residents who stay in the facility 14 days or less.

(b) Notwithstanding the admission assessment requirements of paragraph (a), a facility may elect to accept a short stay rate with a case mix index of 1.0 for all facility residents who stay 14 days or less in lieu of submitting an admission assessment. Facilities shall make this election annually.

(c) Nursing facilities must elect one of the options described in paragraphs (a) and (b) by reporting to the commissioner of health, as prescribed by the commissioner. The election is effective on July 1 each year.

Subd. 6. **Penalties for late or nonsubmission.** (a) A facility that fails to complete or submit an assessment according to subdivisions 4 and 5 for a RUG-IV classification within seven days of the time requirements listed in the Long-Term Care Facility Resident Assessment Instrument User's Manual is subject to a reduced rate for that resident. The reduced rate shall be the lowest rate for that facility. The reduced rate is effective on the day of admission for new admission assessments, on the ARD for significant change in status assessments, or on the day that the assessment was due for all other assessments and continues in effect until the first day of the month following the date of submission and acceptance of the resident's assessment.

(b) If loss of revenue due to penalties incurred by a facility for any period of 92 days are equal to or greater than 1.0 percent of the total operating costs on the facility's most recent annual statistical and cost report, a facility may apply to the commissioner of human services for a reduction in the total penalty amount. The commissioner of human services, in consultation with the commissioner of health, may, at the sole discretion of the commissioner of human services, limit the penalty for residents covered by medical assistance to 15 days.

Subd. 7. **Notice of resident reimbursement classification.** (a) The commissioner of health shall provide to a nursing facility a notice for each resident of the reimbursement classification established under subdivision 1. The notice must inform the resident of the

classification that was assigned, the opportunity to review the documentation supporting the classification, the opportunity to obtain clarification from the commissioner, and the opportunity to request a reconsideration of the classification and the address and telephone number of the Office of Ombudsman for Long-Term Care. The commissioner must transmit the notice of resident classification by electronic means to the nursing facility. A nursing facility is responsible for the distribution of the notice to each resident, to the person responsible for the payment of the resident's nursing home expenses, or to another person designated by the resident. This notice must be distributed within three working days after the facility's receipt of the electronic file of notice of case mix classifications from the commissioner of health.

(b) If a facility submits a modification to the most recent assessment used to establish a case mix classification conducted under subdivision 3 that results in a change in case mix classification, the facility shall give written notice to the resident or the resident's representative about the item that was modified and the reason for the modification. The notice of modified assessment may be provided at the same time that the resident or resident's representative is provided the resident's modified notice of classification.

Subd. 8. **Request for reconsideration of resident classifications.** (a) The resident, or resident's representative, or the nursing facility or boarding care home may request that the commissioner of health reconsider the assigned reimbursement classification. The request for reconsideration must be submitted in writing to the commissioner within 30 days of the day the resident or the resident's representative receives the resident classification notice. The request for reconsideration must include the name of the resident, the name and address of the facility in which the resident resides, the reasons for the reconsideration, and documentation supporting the request. The documentation accompanying the reconsideration request is limited to a copy of the MDS that determined the classification and other documents that would support or change the MDS findings.

(b) Upon request, the nursing facility must give the resident or the resident's representative a copy of the assessment form and the other documentation that was given to the commissioner of health to support the assessment findings. The nursing facility shall also provide access to and a copy of other information from the resident's record that has been requested by or on behalf of the resident to support a resident's reconsideration request. A copy of any requested material must be provided within three working days of receipt of a written request for the information. Notwithstanding any law to the contrary, the facility may not charge a fee for providing copies of the requested documentation. If a facility fails to provide the material within this time, it is subject to the issuance of a correction order and penalty assessment under sections 144.653 and 144A.10.

Notwithstanding those sections, any correction order issued under this subdivision must require that the nursing facility immediately comply with the request for information and that as of the date of the issuance of the correction order, the facility shall forfeit to the state a $100 fine for the first day of noncompliance, and an increase in the $100 fine by $50 increments for each day the noncompliance continues.

(c) In addition to the information required under paragraphs (a) and (b), a reconsideration request from a nursing facility must contain the following information: (i) the date the reimbursement classification notices were received by the facility; (ii) the date the classification notices were distributed to the resident or the resident's representative; and (iii) a copy of a notice sent to the resident or to the resident's representative. This notice must inform the resident or the resident's representative that a reconsideration of the resident's classification is being requested, the reason for the request, that the resident's rate will change if the request is approved by the commissioner, the extent of the change, that copies of the facility's request and supporting documentation are available for review, and that the resident also has the right to request a reconsideration. If the facility fails to provide the required information listed in item (iii) with the reconsideration request, the commissioner may request that the facility provide the information within 14 calendar days. The reconsideration request must be denied if the information is then not provided, and the facility may not make further reconsideration requests on that specific reimbursement classification.

(d) Reconsideration by the commissioner must be made by individuals not involved in reviewing the assessment, audit, or reconsideration that established the disputed classification. The reconsideration must be based upon the assessment that determined the classification and upon the information provided to the commissioner under paragraphs (a) and (b). If necessary for evaluating the reconsideration request, the commissioner may conduct on-site reviews. Within 15 working days of receiving the request for reconsideration, the commissioner shall affirm or modify the original resident classification. The original classification must be modified if the commissioner determines that the assessment resulting in the classification did not accurately reflect characteristics of the resident at the time of the assessment. The resident and the nursing facility or boarding care home shall be notified within five working days after the decision is made. A decision by the commissioner under this subdivision is the final administrative decision of the agency for the party requesting reconsideration.

(e) The resident classification established by the commissioner shall be the classification that applies to the resident while the request for reconsideration is pending. If a request for reconsideration applies to an assessment used to determine nursing facility

level of care under subdivision 4, paragraph (c), the resident shall continue to be eligible for nursing facility level of care while the request for reconsideration is pending.

(f) The commissioner may request additional documentation regarding a reconsideration necessary to make an accurate reconsideration determination.

Subd. 9. **Audit authority.** (a) The commissioner shall audit the accuracy of resident assessments performed under section 256B.438 through any of the following: desk audits; on-site review of residents and their records; and interviews with staff, residents, or residents' families. The commissioner shall reclassify a resident if the commissioner determines that the resident was incorrectly classified.

(b) The commissioner is authorized to conduct on-site audits on an unannounced basis.

(c) A facility must grant the commissioner access to examine the medical records relating to the resident assessments selected for audit under this subdivision. The commissioner may also observe and speak to facility staff and residents.

(d) The commissioner shall consider documentation under the time frames for coding items on the minimum data set as set out in the Long-Term Care Facility Resident Assessment Instrument User's Manual published by the Centers for Medicare and Medicaid Services.

(e) The commissioner shall develop an audit selection procedure that includes the following factors:

(1) Each facility shall be audited annually. If a facility has two successive audits in which the percentage of change is five percent or less and the facility has not been the subject of a special audit in the past 36 months, the facility may be audited biannually. A stratified sample of 15 percent, with a minimum of ten assessments, of the most current assessments shall be selected for audit. If more than 20 percent of the RUG-IV classifications are changed as a result of the audit, the audit shall be expanded to a second 15 percent sample, with a minimum of ten assessments. If the total change between the first and second samples is 35 percent or greater, the commissioner may expand the audit to all of the remaining assessments.

(2) If a facility qualifies for an expanded audit, the commissioner may audit the facility again within six months. If a facility has two expanded audits within a 24-month period, that facility will be audited at least every six months for the next 18 months.

(3) The commissioner may conduct special audits if the commissioner determines that circumstances exist that could alter or affect the validity of case mix classifications of residents. These circumstances include, but are not limited to, the following:

(i) frequent changes in the administration or management of the facility;

(ii) an unusually high percentage of residents in a specific case mix classification;

(iii) a high frequency in the number of reconsideration requests received from a facility;

(iv) frequent adjustments of case mix classifications as the result of reconsiderations or audits;

(v) a criminal indictment alleging provider fraud;

(vi) other similar factors that relate to a facility's ability to conduct accurate assessments;

(vii) an atypical pattern of scoring minimum data set items;

(viii) nonsubmission of assessments;

(ix) late submission of assessments; or

(x) a previous history of audit changes of 35 percent or greater.

(f) Within 15 working days of completing the audit process, the commissioner shall make available electronically the results of the audit to the facility. If the results of the audit reflect a change in the resident's case mix classification, a case mix classification notice will be made available electronically to the facility, using the procedure in subdivision 7, paragraph (a). The notice must contain the resident's classification and a statement informing the resident, the resident's authorized representative, and the facility of their right to review the commissioner's documents supporting the classification and to request a reconsideration of the classification. This notice must also include the address and telephone number of the Office of Ombudsman for Long-Term Care.

Subd. 10. **Transition.** After implementation of this section, reconsiderations requested for classifications made under section 144.0722, subdivision 1, shall be determined under section 144.0722, subdivision 3.

Subd. 11. **Nursing facility level of care.** (a) For purposes of medical assistance payment of long-term care services, a recipient must be determined, using assessments defined in subdivision 4, to meet one of the following nursing facility level of care criteria:

(1) the person requires formal clinical monitoring at least once per day;

(2) the person needs the assistance of another person or constant supervision to begin and complete at least four of the following activities of living: bathing, bed mobility, dressing, eating, grooming, toileting, transferring, and walking;

(3) the person needs the assistance of another person or constant supervision to begin and complete toileting, transferring, or positioning and the assistance cannot be scheduled;

(4) the person has significant difficulty with memory, using information, daily decision making, or behavioral needs that require intervention;

(5) the person has had a qualifying nursing facility stay of at least 90 days;

(6) the person meets the nursing facility level of care criteria determined 90 days after admission or on the first quarterly assessment after admission, whichever is later; or

(7) the person is determined to be at risk for nursing facility admission or readmission through a face-to-face long-term care consultation assessment as specified in section 256B.0911, subdivision 3a, 3b, or 4d, by a county, tribe, or managed care organization under contract with the Department of Human Services. The person is considered at risk under this clause if the person currently lives alone or will live alone ~~upon discharge~~ or be homeless without the person's current housing type and also meets one of the following criteria:

(i) the person has experienced a fall resulting in a fracture;

(ii) the person has been determined to be at risk of maltreatment or neglect, including self-neglect; or

(iii) the person has a sensory impairment that substantially impacts functional ability and maintenance of a community residence.

(b) The assessment used to establish medical assistance payment for nursing facility services must be the most recent assessment performed under subdivision 4, paragraph (b), that occurred no more than 90 calendar days before the effective date of medical assistance eligibility for payment of long-term care services. In no case shall medical assistance payment for long-term care services occur prior to the date of the determination of nursing facility level of care.

(c) The assessment used to establish medical assistance payment for long-term care services provided under sections 256B.0915 and 256B.49 and alternative care payment for services provided under section 256B.0913 must be the most recent face-to-face assessment performed under section 256B.0911, subdivision 3a, 3b, or 4d, that occurred no more than 60 calendar days before the effective date of medical assistance eligibility for payment of long-term care services.

Subd. 12. **Appeal of nursing facility level of care determination.** A resident or prospective resident whose level of care determination results in a denial of long-term care services can appeal the determination as outlined in section 256B.0911, subdivision 3a, paragraph (h), clause (9). The commissioner of human services shall ensure that notice of changes in eligibility due to a nursing facility level of care determination is provided to each affected recipient or the recipient's guardian at least 30 days before the effective date of the change. The notice shall include the following information:

(1) how to obtain further information on the changes;

(2) how to receive assistance in obtaining other services;

(3) a list of community resources; and

(4) appeal rights.

A recipient who meets the criteria in section 256B.0922, subdivision 2, paragraph (a), clauses (1) and (2), may request continued services pending appeal within the time period allowed to request an appeal under section 256.045, subdivision 3, paragraph (h).

EFFECTIVE DATE. This section is effective January 1, 2015.

Sec. 3. Minnesota Statutes 2013 Supplement, section 245.8251, is amended to read:

245.8251 POSITIVE SUPPORT STRATEGIES AND EMERGENCY MANUAL RESTRAINT; LICENSED FACILITIES AND PROGRAMS.

Subdivision 1. **Rules governing the use of positive support strategies and restricting or prohibiting restrictive interventions.** The commissioner of human services shall, ~~within 24 months of May 23, 2013~~ by August 31, 2015, adopt rules governing the use of positive support strategies, ~~safety interventions, and~~ emergency use of manual restraint, and restricting or prohibiting the use of restrictive interventions, in all facilities and services licensed under chapter 245D~~.~~, and in all licensed facilities and licensed services serving persons with a developmental disability or related condition. For the purposes of this section, "developmental disability or related condition" has the meaning given in Minnesota Rules, part 9525.0016, subpart 2, items A to E.

Subd. 2. **Data collection.** (a) The commissioner shall, with stakeholder input, ~~develop~~ identify data ~~collection~~ elements specific to incidents of emergency use of manual restraint and positive support transition plans for persons receiving services from ~~providers governed~~ licensed facilities and licensed services under chapter 245D and in licensed facilities and licensed services serving persons with a developmental disability or related condition as defined in Minnesota Rules, part 9525.0016, subpart 2, effective January 1, 2014. ~~Providers~~ Licensed facilities and licensed services shall report the data in a format and at a frequency determined by the commissioner of human services~~. Providers shall submit the data~~ to the commissioner and the Office of the Ombudsman for Mental Health and Developmental Disabilities.

(b) Beginning July 1, 2013, ~~providers~~ licensed facilities and licensed services regulated under Minnesota Rules, parts 9525.2700 to 9525.2810, shall submit data regarding the use of all controlled procedures identified in Minnesota Rules, part 9525.2740, in a format and at a frequency determined by the commissioner~~. Providers shall submit the data~~ to the commissioner and the Office of the Ombudsman for Mental Health and Developmental Disabilities.

Subd. 3. **External program review committee.** Rules adopted according to this section shall establish requirements for an external program review committee appointed by the commissioner to monitor implementation of the rules and make recommendations to the commissioner about any needed policy changes after adoption of the rules.

Subd. 4. **Interim review panel.** (a) The commissioner shall establish an interim review panel by August 15, 2014, for the purpose of reviewing requests for emergency use of procedures that have been part of an approved positive support transition plan when necessary to protect a person from imminent risk of serious injury as defined in section 245.91, subdivision 6, due to self-injurious behavior. The panel must make recommendations to the commissioner to approve or deny these requests based on criteria to be established by the interim review panel. The interim review panel shall operate until the external program review committee is established as required under subdivision 3.

(b) Members of the interim review panel shall be selected based on their expertise and knowledge related to the use of positive support strategies as alternatives to the use of restrictive interventions. The commissioner shall seek input and recommendations in establishing the interim review panel. Members of the interim review panel shall include the following representatives:

(1) an expert in positive supports;

(2) a mental health professional, as defined in section 245.462;

(3) a licensed health professional as defined in section 245D.02, subdivision 14; and

(4) a representative of the Department of Health.

Sec. 4. Minnesota Statutes 2013 Supplement, section 245A.03, subdivision 7, is amended to read:

Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter for a physical location that will not be the primary residence of the license holder for the entire period of licensure. If a license is issued during this moratorium, and the license holder changes the license holder's primary residence away from the physical location of the foster care license, the commissioner shall revoke the license according to section 245A.07. The commissioner shall not issue an initial license for a community residential setting licensed under chapter 245D. Exceptions to the moratorium include:

(1) foster care settings that are required to be registered under chapter 144D;

(2) foster care licenses replacing foster care licenses in existence on May 15, 2009, or community residential setting licenses replacing adult foster care licenses in existence on December 31, 2013, and determined to be needed by the commissioner under paragraph (b);

(3) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD, or regional treatment center; restructuring of state-operated services that limits the capacity of state-operated facilities; or allowing movement to the community for people who no longer require the level of care provided in state-operated facilities as provided under section 256B.092, subdivision 13, or 256B.49, subdivision 24;

(4) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under paragraph (b) for persons requiring hospital level care; or

(5) new foster care licenses or community residential setting licenses determined to be needed by the commissioner for the transition of people from personal care assistance to the home and community-based services.

(b) The commissioner shall determine the need for newly licensed foster care homes or community residential settings as defined under this subdivision. As part of the determination, the commissioner shall consider the availability of foster care capacity in the area in which the licensee seeks to operate, and the recommendation of the local county board. The determination by the commissioner must be final. A determination of need is not required for a change in ownership at the same address.

(c) When an adult resident served by the program moves out of a foster home that is not the primary residence of the license holder according to section 256B.49, subdivision 15, paragraph (f), or the adult community residential setting, the county shall immediately inform the Department of Human Services Licensing Division. The department shall decrease the statewide licensed capacity for adult foster care settings where the physical location is not the primary residence of the license holder, or for adult community residential settings, if the voluntary changes described in paragraph (e) are not sufficient to meet the savings required by reductions in licensed bed capacity under Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40, paragraph (f), and maintain statewide long-term care residential services capacity within budgetary limits. Implementation of the statewide licensed capacity reduction shall begin on July 1, 2013. The commissioner shall delicense up to 128 beds by June 30, 2014, using the needs determination process. Prior to any involuntary reduction of licensed capacity, the commissioner shall consult with lead agencies and license holders to determine which adult foster care settings where the physical location is not the primary residence of the

license holder, or community residential settings, are licensed for up to five beds but have operated at less than full capacity for 12 or more months as of March 1, 2014. The settings that meet these criteria shall be the first to be considered for any involuntary decrease in statewide licensed capacity, up to a maximum of 35 beds. If more than 35 beds are identified that meet these criteria, the commissioner shall prioritize the selection of those beds to be closed based on the length of time the beds have been vacant. The longer a bed has been vacant, the higher priority it must be given for closure. Under this paragraph, the commissioner has the authority to reduce unused licensed capacity of a current foster care program, or the community residential settings, to accomplish the consolidation or closure of settings. Under this paragraph, the commissioner has the authority to manage statewide capacity, including adjusting the capacity available to each county and adjusting statewide available capacity, to meet the statewide needs identified through the process in paragraph (e). A decreased licensed capacity according to this paragraph is not subject to appeal under this chapter.

(d) Residential settings that would otherwise be subject to the decreased license capacity established in paragraph (c) shall be exempt under the following circumstances:

(1) until August 1, 2013, the license holder's beds occupied by residents whose primary diagnosis is mental illness and the license holder is:

(i) a provider of assertive community treatment (ACT) or adult rehabilitative mental health services (ARMHS) as defined in section 256B.0623;

(ii) a mental health center certified under Minnesota Rules, parts 9520.0750 to 9520.0870;

(iii) a mental health clinic certified under Minnesota Rules, parts 9520.0750 to 9520.0870; or

(iv) a provider of intensive residential treatment services (IRTS) licensed under Minnesota Rules, parts 9520.0500 to 9520.0670; or

(2) the license holder's beds occupied by residents whose primary diagnosis is mental illness and the license holder is certified under the requirements in subdivision 6a or section 245D.33.

(e) A resource need determination process, managed at the state level, using the available reports required by section 144A.351, and other data and information shall be used to determine where the reduced capacity required under paragraph (c) will be implemented. The commissioner shall consult with the stakeholders described in section 144A.351, and employ a variety of methods to improve the state's capacity to meet long-term care service needs within budgetary limits, including seeking proposals from service providers or lead agencies to change service type, capacity, or location to improve

services, increase the independence of residents, and better meet needs identified by the long-term care services reports and statewide data and information. By February 1, 2013, and August 1, 2014, and each following year, the commissioner shall provide information and data on the overall capacity of licensed long-term care services, actions taken under this subdivision to manage statewide long-term care services and supports resources, and any recommendations for change to the legislative committees with jurisdiction over health and human services budget.

(f) At the time of application and reapplication for licensure, the applicant and the license holder that are subject to the moratorium or an exclusion established in paragraph (a) are required to inform the commissioner whether the physical location where the foster care will be provided is or will be the primary residence of the license holder for the entire period of licensure. If the primary residence of the applicant or license holder changes, the applicant or license holder must notify the commissioner immediately. The commissioner shall print on the foster care license certificate whether or not the physical location is the primary residence of the license holder.

(g) License holders of foster care homes identified under paragraph (f) that are not the primary residence of the license holder and that also provide services in the foster care home that are covered by a federally approved home and community-based services waiver, as authorized under section 256B.0915, 256B.092, or 256B.49, must inform the human services licensing division that the license holder provides or intends to provide these waiver-funded services.

Sec. 5. Minnesota Statutes 2013 Supplement, section 245A.042, subdivision 3, is amended to read:

Subd. 3. **Implementation.** (a) The commissioner shall implement the responsibilities of this chapter according to the timelines in paragraphs (b) and (c) only within the limits of available appropriations or other administrative cost recovery methodology.

(b) The licensure of home and community-based services according to this section shall be implemented January 1, 2014. License applications shall be received and processed on a phased-in schedule as determined by the commissioner beginning July 1, 2013. Licenses will be issued thereafter upon the commissioner's determination that the application is complete according to section 245A.04.

(c) Within the limits of available appropriations or other administrative cost recovery methodology, implementation of compliance monitoring must be phased in after January 1, 2014.

(1) Applicants who do not currently hold a license issued under chapter 245B must receive an initial compliance monitoring visit after 12 months of the effective date of the initial license for the purpose of providing technical assistance on how to achieve and maintain compliance with the applicable law or rules governing the provision of home and community-based services under chapter 245D. If during the review the commissioner finds that the license holder has failed to achieve compliance with an applicable law or rule and this failure does not imminently endanger the health, safety, or rights of the persons served by the program, the commissioner may issue a licensing review report with recommendations for achieving and maintaining compliance.

(2) Applicants who do currently hold a license issued under this chapter must receive a compliance monitoring visit after 24 months of the effective date of the initial license.

(d) Nothing in this subdivision shall be construed to limit the commissioner's authority to suspend or revoke a license or issue a fine at any time under section 245A.07, or issue correction orders and make a license conditional for failure to comply with applicable laws or rules under section 245A.06, based on the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of persons served by the program.

(e) License holders governed under chapter 245D must ensure compliance with the following requirements within the stated timelines:

(1) service initiation and service planning requirements must be met at the next annual meeting of the person's support team or by January 1, 2015, whichever is later, for the following:

(i) provision of a written notice that identifies the service recipient rights and an explanation of those rights as required under section 245D.04, subdivision 1;

(ii) service planning for basic support services as required under section 245D.07, subdivision 2; and

(iii) service planning for intensive support services under section 245D.071, subdivisions 3 and 4;

(2) staff orientation to program requirements as required under section 245D.09, subdivision 4, for staff hired before January 1, 2014, must be met by January 1, 2015. The license holder may otherwise provide documentation verifying these requirements were met before January 1, 2014;

(3) development of policy and procedures as required under section 245D.11, must be completed no later than August 31, 2014;

(4) written or electronic notice and copies of policies and procedures must be provided to all persons or their legal representatives and case managers as required under

section 245D.10, subdivision 4, paragraphs (b) and (c), by September 15, 2014, or within 30 days of development of the required policies and procedures, whichever is earlier; and

(5) all employees must be informed of the revisions and training must be provided on implementation of the revised policies and procedures as required under section 245D.10, subdivision 4, paragraph (d), by September 15, 2014, or within 30 days of development of the required policies and procedures, whichever is earlier.

Sec. 6. Minnesota Statutes 2013 Supplement, section 245A.16, subdivision 1, is amended to read:

Subdivision 1. **Delegation of authority to agencies.** (a) County agencies and private agencies that have been designated or licensed by the commissioner to perform licensing functions and activities under section 245A.04 and background studies for family child care under chapter 245C; to recommend denial of applicants under section 245A.05; to issue correction orders, to issue variances, and recommend a conditional license under section 245A.06, or to recommend suspending or revoking a license or issuing a fine under section 245A.07, shall comply with rules and directives of the commissioner governing those functions and with this section. The following variances are excluded from the delegation of variance authority and may be issued only by the commissioner:

(1) dual licensure of family child care and child foster care, dual licensure of child and adult foster care, and adult foster care and family child care;

(2) adult foster care maximum capacity;

(3) adult foster care minimum age requirement;

(4) child foster care maximum age requirement;

(5) variances regarding disqualified individuals except that county agencies may issue variances under section 245C.30 regarding disqualified individuals when the county is responsible for conducting a consolidated reconsideration according to sections 245C.25 and 245C.27, subdivision 2, clauses (a) and (b), of a county maltreatment determination and a disqualification based on serious or recurring maltreatment;

(6) the required presence of a caregiver in the adult foster care residence during normal sleeping hours; and

(7) variances for community residential setting licenses under chapter 245D.

Except as provided in section 245A.14, subdivision 4, paragraph (e), a county agency must not grant a license holder a variance to exceed the maximum allowable family child care license capacity of 14 children.

(b) County agencies must report information about disqualification reconsiderations under sections 245C.25 and 245C.27, subdivision 2, paragraphs (a) and (b), and variances

granted under paragraph (a), clause (5), to the commissioner at least monthly in a format prescribed by the commissioner.

(c) For family day care programs, the commissioner may authorize licensing reviews every two years after a licensee has had at least one annual review.

(d) For family adult day services programs, the commissioner may authorize licensing reviews every two years after a licensee has had at least one annual review.

(e) A license issued under this section may be issued for up to two years.

(f) During implementation of chapter 245D, the commissioner shall consider:

(1) the role of counties in quality assurance;

(2) the duties of county licensing staff; and

(3) the possible use of joint powers agreements, according to section 471.59, with counties through which some licensing duties under chapter 245D may be delegated by the commissioner to the counties.

Any consideration related to this paragraph must meet all of the requirements of the corrective action plan ordered by the federal Centers for Medicare and Medicaid Services.

(g) Licensing authority specific to section 245D.06, subdivisions 5, 6, 7, and 8, or successor provisions; and section 245D.061 or successor provisions, for family child foster care programs providing out-of-home respite, as identified in section 245D.03, subdivision 1, paragraph (b), clause (1), is excluded from the delegation of authority to county and private agencies.

Sec. 7. Minnesota Statutes 2013 Supplement, section 245D.02, subdivision 3, is amended to read:

Subd. 3. **Case manager.** "Case manager" means the individual designated to provide waiver case management services, care coordination, or long-term care consultation, as specified in sections 256B.0913, 256B.0915, 256B.092, and 256B.49, or successor provisions. For purposes of this chapter, "case manager" includes case management services as defined in Minnesota Rules, part 9520.0902, subpart 3.

Sec. 8. Minnesota Statutes 2013 Supplement, section 245D.02, subdivision 4b, is amended to read:

Subd. 4b. **Coordinated service and support plan.** "Coordinated service and support plan" has the meaning given in sections 256B.0913, subdivision 8; 256B.0915, subdivision 6; 256B.092, subdivision 1b; and 256B.49, subdivision 15, or successor provisions. For purposes of this chapter, "coordinated service and support plan" includes

the individual program plan or individual treatment plan as defined in Minnesota Rules, part 9520.0510, subpart 12.

Sec. 9. Minnesota Statutes 2013 Supplement, section 245D.02, subdivision 8b, is amended to read:

Subd. 8b. **Expanded support team.** "Expanded support team" means the members of the support team defined in subdivision ~~46~~ 34 and a licensed health or mental health professional or other licensed, certified, or qualified professionals or consultants working with the person and included in the team at the request of the person or the person's legal representative.

Sec. 10. Minnesota Statutes 2013 Supplement, section 245D.02, subdivision 11, is amended to read:

Subd. 11. **Incident.** "Incident" means an occurrence which involves a person and requires the program to make a response that is not a part of the program's ordinary provision of services to that person, and includes:

(1) serious injury of a person as determined by section 245.91, subdivision 6;

(2) a person's death;

(3) any medical emergency, unexpected serious illness, or significant unexpected change in an illness or medical condition of a person that requires the program to call 911, physician treatment, or hospitalization;

(4) any mental health crisis that requires the program to call 911 ~~or~~, a mental health crisis intervention team, or a similar mental health response team or service when available and appropriate;

(5) an act or situation involving a person that requires the program to call 911, law enforcement, or the fire department;

(6) a person's unauthorized or unexplained absence from a program;

(7) conduct by a person receiving services against another person receiving services that:

(i) is so severe, pervasive, or objectively offensive that it substantially interferes with a person's opportunities to participate in or receive service or support;

(ii) places the person in actual and reasonable fear of harm;

(iii) places the person in actual and reasonable fear of damage to property of the person; or

(iv) substantially disrupts the orderly operation of the program;

(8) any sexual activity between persons receiving services involving force or coercion as defined under section 609.341, subdivisions 3 and 14;

(9) any emergency use of manual restraint as identified in section 245D.061 or successor provisions; or

(10) a report of alleged or suspected child or vulnerable adult maltreatment under section 626.556 or 626.557.

Sec. 11. Minnesota Statutes 2013 Supplement, section 245D.02, subdivision 15b, is amended to read:

Subd. 15b. **Mechanical restraint.** (a) ~~Except for devices worn by the person that trigger electronic alarms to warn staff that a person is leaving a room or area, which do not, in and of themselves, restrict freedom of movement, or the use of adaptive aids or equipment or orthotic devices ordered by a health care professional used to treat or manage a medical condition,~~ "Mechanical restraint" means the use of devices, materials, or equipment attached or adjacent to the person's body, or the use of practices that are intended to restrict freedom of movement or normal access to one's body or body parts, or limits a person's voluntary movement or holds a person immobile as an intervention precipitated by a person's behavior. The term applies to the use of mechanical restraint used to prevent injury with persons who engage in self-injurious behaviors, such as head-banging, gouging, or other actions resulting in tissue damage that have caused or could cause medical problems resulting from the self-injury.

(b) Mechanical restraint does not include the following:

(1) devices worn by the person that trigger electronic alarms to warn staff that a person is leaving a room or area, which do not, in and of themselves, restrict freedom of movement; or

(2) the use of adaptive aids or equipment or orthotic devices ordered by a health care professional used to treat or manage a medical condition.

Sec. 12. Minnesota Statutes 2013 Supplement, section 245D.02, subdivision 29, is amended to read:

Subd. 29. **Seclusion.** "Seclusion" means ~~the placement of a person alone in~~: (1) removing a person involuntarily to a room from which exit is prohibited by a staff person or a mechanism such as a lock, a device, or an object positioned to hold the door closed or otherwise prevent the person from leaving the room~~.~~; or (2) otherwise involuntarily removing or separating a person from an area, activity, situation, or social contact with others and blocking or preventing the person's return.

Sec. 13. Minnesota Statutes 2013 Supplement, section 245D.02, subdivision 34, is amended to read:

Subd. 34. **Support team.** "Support team" means the service planning team identified in section 256B.49, subdivision 15~~, or~~; the interdisciplinary team identified in Minnesota Rules, part 9525.0004, subpart 14; or the case management team as defined in Minnesota Rules, part 9520.0902, subpart 6.

Sec. 14. Minnesota Statutes 2013 Supplement, section 245D.02, subdivision 34a, is amended to read:

Subd. 34a. **Time out.** "Time out" means ~~removing a person involuntarily from an ongoing activity to a room, either locked or unlocked, or otherwise separating a person from others in a way that prevents social contact and prevents the person from leaving the situation if the person chooses~~ the involuntary removal of a person for a period of time to a designated area from which the person is not prevented from leaving. For the purpose of this chapter, "time out" does not mean voluntary removal or self-removal for the purpose of calming, prevention of escalation, or de-escalation of behavior ~~for a period of up to 15 minutes. "Time out" does not include a person voluntarily moving from an ongoing activity to an unlocked room or otherwise separating from a situation or social contact with others if the person chooses. For the purposes of this definition, "voluntarily" means without being forced, compelled, or coerced.~~; nor does it mean taking a brief "break" or "rest" from an activity for the purpose of providing the person an opportunity to regain self-control.

Sec. 15. Minnesota Statutes 2013 Supplement, section 245D.02, is amended by adding a subdivision to read:

Subd. 35b. **Unlicensed staff.** "Unlicensed staff" means individuals not otherwise licensed or certified by a governmental health board or agency.

Sec. 16. Minnesota Statutes 2013 Supplement, section 245D.03, subdivision 1, is amended to read:

Subdivision 1. **Applicability.** (a) The commissioner shall regulate the provision of home and community-based services to persons with disabilities and persons age 65 and older pursuant to this chapter. The licensing standards in this chapter govern the provision of basic support services and intensive support services.

(b) Basic support services provide the level of assistance, supervision, and care that is necessary to ensure the health and safety of the person and do not include services that

are specifically directed toward the training, treatment, habilitation, or rehabilitation of the person. Basic support services include:

(1) in-home and out-of-home respite care services as defined in section 245A.02, subdivision 15, and under the brain injury, community alternative care, community alternatives for disabled individuals, developmental disability, and elderly waiver plans, excluding out-of-home respite care provided to children in a family child foster care home licensed under Minnesota Rules, parts 2960.3000 to 2960.3100, when the child foster care license holder complies with the requirements under section 245D.06, subdivisions 5, 6, 7, and 8, or successor provisions; and section 245D.061 or successor provisions, which must be stipulated in the statement of intended use required under Minnesota Rules, part 2960.3000, subpart 4;

(2) adult companion services as defined under the brain injury, community alternatives for disabled individuals, and elderly waiver plans, excluding adult companion services provided under the Corporation for National and Community Services Senior Companion Program established under the Domestic Volunteer Service Act of 1973, Public Law 98-288;

(3) personal support as defined under the developmental disability waiver plan;

(4) 24-hour emergency assistance, personal emergency response as defined under the community alternatives for disabled individuals and developmental disability waiver plans;

(5) night supervision services as defined under the brain injury waiver plan; and

(6) homemaker services as defined under the community alternatives for disabled individuals, brain injury, community alternative care, developmental disability, and elderly waiver plans, excluding providers licensed by the Department of Health under chapter 144A and those providers providing cleaning services only.

(c) Intensive support services provide assistance, supervision, and care that is necessary to ensure the health and safety of the person and services specifically directed toward the training, habilitation, or rehabilitation of the person. Intensive support services include:

(1) intervention services, including:

(i) behavioral support services as defined under the brain injury and community alternatives for disabled individuals waiver plans;

(ii) in-home or out-of-home crisis respite services as defined under the developmental disability waiver plan; and

(iii) specialist services as defined under the current developmental disability waiver plan;

(2) in-home support services, including:

(i) in-home family support and supported living services as defined under the developmental disability waiver plan;

(ii) independent living services training as defined under the brain injury and community alternatives for disabled individuals waiver plans; and

(iii) semi-independent living services;

(3) residential supports and services, including:

(i) supported living services as defined under the developmental disability waiver plan provided in a family or corporate child foster care residence, a family adult foster care residence, a community residential setting, or a supervised living facility;

(ii) foster care services as defined in the brain injury, community alternative care, and community alternatives for disabled individuals waiver plans provided in a family or corporate child foster care residence, a family adult foster care residence, or a community residential setting; and

(iii) residential services provided to more than four persons with developmental disabilities in a supervised living facility ~~that is certified by the Department of Health as an ICF/DD~~, including ICFs/DD;

(4) day services, including:

(i) structured day services as defined under the brain injury waiver plan;

(ii) day training and habilitation services under sections 252.40 to 252.46, and as defined under the developmental disability waiver plan; and

(iii) prevocational services as defined under the brain injury and community alternatives for disabled individuals waiver plans; and

(5) supported employment as defined under the brain injury, developmental disability, and community alternatives for disabled individuals waiver plans.

Sec. 17. Minnesota Statutes 2013 Supplement, section 245D.03, is amended by adding a subdivision to read:

Subd. 1a. **Effect.** The home and community-based services standards establish health, safety, welfare, and rights protections for persons receiving services governed by this chapter. The standards recognize the diversity of persons receiving these services and require that these services are provided in a manner that meets each person's individual needs and ensures continuity in service planning, care, and coordination between the license holder and members of each person's support team or expanded support team.

Sec. 18. Minnesota Statutes 2013 Supplement, section 245D.03, subdivision 2, is amended to read:

Subd. 2. **Relationship to other standards governing home and community-based services.** (a) A license holder governed by this chapter is also subject to the licensure requirements under chapter 245A.

(b) ~~A corporate or family child foster care site controlled by a license holder and providing services governed by this chapter is exempt from compliance with section 245D.04. This exemption applies to foster care homes where at least one resident is receiving residential supports and services licensed according to this chapter.~~ This chapter does not apply to corporate or family child foster care homes that do not provide services licensed under this chapter.

(c) A family adult foster care site controlled by a license holder ~~and~~ providing services governed by this chapter is exempt from compliance with Minnesota Rules, parts 9555.6185; 9555.6225, subpart 8; 9555.6245; 9555.6255; and 9555.6265. These exemptions apply to family adult foster care homes where at least one resident is receiving residential supports and services licensed according to this chapter. This chapter does not apply to family adult foster care homes that do not provide services licensed under this chapter.

(d) A license holder providing services licensed according to this chapter in a supervised living facility is exempt from compliance with ~~sections~~ section 245D.04~~;~~ ~~245D.05, subdivision 2; and 245D.06, subdivision 2, clauses (1), (4), and (5)~~.

(e) A license holder providing residential services to persons in an ICF/DD is exempt from compliance with sections 245D.04; 245D.05, subdivision 1b; 245D.06, subdivision 2, clauses (4) and (5); 245D.071, subdivisions 4 and 5; 245D.081, subdivision 2; 245D.09, subdivision 7; 245D.095, subdivision 2; and 245D.11, subdivision 3.

(f) A license holder providing homemaker services licensed according to this chapter and registered according to chapter 144A is exempt from compliance with section 245D.04.

(g) Nothing in this chapter prohibits a license holder from concurrently serving persons without disabilities or people who are or are not age 65 and older, provided this chapter's standards are met as well as other relevant standards.

(h) The documentation required under sections 245D.07 and 245D.071 must meet the individual program plan requirements identified in section 256B.092 or successor provisions.

Sec. 19. Minnesota Statutes 2013 Supplement, section 245D.03, subdivision 3, is amended to read:

Subd. 3. **Variance.** If the conditions in section 245A.04, subdivision 9, are met, the commissioner may grant a variance to any of the requirements in this chapter, except

sections 245D.04; 245D.06, subdivision 4, paragraph (b), and subdivision 6, or successor provisions; and ~~245D.061, subdivision 3, or~~ provisions governing data practices and information rights of persons.

Sec. 20. Minnesota Statutes 2013 Supplement, section 245D.04, subdivision 3, is amended to read:

Subd. 3. **Protection-related rights.** (a) A person's protection-related rights include the right to:

(1) have personal, financial, service, health, and medical information kept private, and be advised of disclosure of this information by the license holder;

(2) access records and recorded information about the person in accordance with applicable state and federal law, regulation, or rule;

(3) be free from maltreatment;

(4) be free from restraint, time out, ~~or~~ seclusion, restrictive intervention, or other prohibited procedure identified in section 245D.06, subdivision 5, or successor provisions, except for: (i) emergency use of manual restraint to protect the person from imminent danger to self or others according to the requirements in section ~~245D.06;~~ 245D.061 or successor provisions; or (ii) the use of safety interventions as part of a positive support transition plan under section 245D.06, subdivision 8, or successor provisions;

(5) receive services in a clean and safe environment when the license holder is the owner, lessor, or tenant of the service site;

(6) be treated with courtesy and respect and receive respectful treatment of the person's property;

(7) reasonable observance of cultural and ethnic practice and religion;

(8) be free from bias and harassment regarding race, gender, age, disability, spirituality, and sexual orientation;

(9) be informed of and use the license holder's grievance policy and procedures, including knowing how to contact persons responsible for addressing problems and to appeal under section 256.045;

(10) know the name, telephone number, and the Web site, e-mail, and street addresses of protection and advocacy services, including the appropriate state-appointed ombudsman, and a brief description of how to file a complaint with these offices;

(11) assert these rights personally, or have them asserted by the person's family, authorized representative, or legal representative, without retaliation;

(12) give or withhold written informed consent to participate in any research or experimental treatment;

(13) associate with other persons of the person's choice;

(14) personal privacy; and

(15) engage in chosen activities.

(b) For a person residing in a residential site licensed according to chapter 245A, or where the license holder is the owner, lessor, or tenant of the residential service site, protection-related rights also include the right to:

(1) have daily, private access to and use of a non-coin-operated telephone for local calls and long-distance calls made collect or paid for by the person;

(2) receive and send, without interference, uncensored, unopened mail or electronic correspondence or communication;

(3) have use of and free access to common areas in the residence; and

(4) privacy for visits with the person's spouse, next of kin, legal counsel, religious advisor, or others, in accordance with section 363A.09 of the Human Rights Act, including privacy in the person's bedroom.

(c) Restriction of a person's rights under ~~subdivision 2, clause (10), or~~ paragraph (a), clauses (13) to (15), or paragraph (b) is allowed only if determined necessary to ensure the health, safety, and well-being of the person. Any restriction of those rights must be documented in the person's coordinated service and support plan or coordinated service and support plan addendum. The restriction must be implemented in the least restrictive alternative manner necessary to protect the person and provide support to reduce or eliminate the need for the restriction in the most integrated setting and inclusive manner. The documentation must include the following information:

(1) the justification for the restriction based on an assessment of the person's vulnerability related to exercising the right without restriction;

(2) the objective measures set as conditions for ending the restriction;

(3) a schedule for reviewing the need for the restriction based on the conditions for ending the restriction to occur semiannually from the date of initial approval, at a minimum, or more frequently if requested by the person, the person's legal representative, if any, and case manager; and

(4) signed and dated approval for the restriction from the person, or the person's legal representative, if any. A restriction may be implemented only when the required approval has been obtained. Approval may be withdrawn at any time. If approval is withdrawn, the right must be immediately and fully restored.

Sec. 21. Minnesota Statutes 2013 Supplement, section 245D.05, subdivision 1, is amended to read:

Subdivision 1. **Health needs.** (a) The license holder is responsible for meeting health service needs assigned in the coordinated service and support plan or the coordinated service and support plan addendum, consistent with the person's health needs. The license holder is responsible for promptly notifying the person's legal representative, if any, and the case manager of changes in a person's physical and mental health needs affecting health service needs assigned to the license holder in the coordinated service and support plan or the coordinated service and support plan addendum, when discovered by the license holder, unless the license holder has reason to know the change has already been reported. The license holder must document when the notice is provided.

(b) If responsibility for meeting the person's health service needs has been assigned to the license holder in the coordinated service and support plan or the coordinated service and support plan addendum, the license holder must maintain documentation on how the person's health needs will be met, including a description of the procedures the license holder will follow in order to:

(1) provide medication setup, assistance, or ~~medication~~ administration according to this chapter. Unlicensed staff responsible for medication setup or medication administration under this section must complete training according to section 245D.09, subdivision 4a, paragraph (d);

(2) monitor health conditions according to written instructions from a licensed health professional;

(3) assist with or coordinate medical, dental, and other health service appointments; or

(4) use medical equipment, devices, or adaptive aides or technology safely and correctly according to written instructions from a licensed health professional.

Sec. 22. Minnesota Statutes 2013 Supplement, section 245D.05, subdivision 1a, is amended to read:

Subd. 1a. **Medication setup.** (a) For the purposes of this subdivision, "medication setup" means the arranging of medications according to instructions from the pharmacy, the prescriber, or a licensed nurse, for later administration when the license holder is assigned responsibility ~~for medication assistance or medication administration~~ in the coordinated service and support plan or the coordinated service and support plan addendum. A prescription label or the prescriber's written or electronically recorded order for the prescription is sufficient to constitute written instructions from the prescriber.

(b) If responsibility for medication setup is assigned to the license holder in the coordinated service and support plan or the coordinated service and support plan addendum, or if the license holder provides it as part of medication assistance or

medication administration, the license holder must document in the person's medication administration record: dates of setup, name of medication, quantity of dose, times to be administered, and route of administration at time of setup; and, when the person will be away from home, to whom the medications were given.

Sec. 23. Minnesota Statutes 2013 Supplement, section 245D.05, subdivision 1b, is amended to read:

Subd. 1b. **Medication assistance.** (a) For purposes of this subdivision, "medication assistance" means any of the following:

(1) bringing to the person and opening a container of previously set up medications, emptying the container into the person's hand, or opening and giving the medications in the original container to the person under the direction of the person;

(2) bringing to the person liquids or food to accompany the medication; or

(3) providing reminders to take regularly scheduled medication or perform regularly scheduled treatments and exercises.

(b) If responsibility for medication assistance is assigned to the license holder in the coordinated service and support plan or the coordinated service and support plan addendum, the license holder must ensure that ~~the requirements of subdivision 2, paragraph (b), have been met when staff provides~~ medication assistance ~~to enable~~ is provided in a manner that enables a person to self-administer medication or treatment when the person is capable of directing the person's own care, or when the person's legal representative is present and able to direct care for the person. ~~For the purposes of this subdivision, "medication assistance" means any of the following:~~

~~(1) bringing to the person and opening a container of previously set up medications, emptying the container into the person's hand, or opening and giving the medications in the original container to the person;~~

~~(2) bringing to the person liquids or food to accompany the medication; or~~

~~(3) providing reminders to take regularly scheduled medication or perform regularly scheduled treatments and exercises.~~

Sec. 24. Minnesota Statutes 2013 Supplement, section 245D.05, subdivision 2, is amended to read:

Subd. 2. **Medication administration.** (a) ~~If responsibility for medication administration is assigned to the license holder in the coordinated service and support plan or the coordinated service and support plan addendum, the license holder must implement the following medication administration procedures to ensure a person takes~~

~~medications and treatments as prescribed~~ For purposes of this subdivision, "medication administration" means:

(1) checking the person's medication record;

(2) preparing the medication as necessary;

(3) administering the medication or treatment to the person;

(4) documenting the administration of the medication or treatment or the reason for not administering the medication or treatment; and

(5) reporting to the prescriber or a nurse any concerns about the medication or treatment, including side effects, effectiveness, or a pattern of the person refusing to take the medication or treatment as prescribed. Adverse reactions must be immediately reported to the prescriber or a nurse.

(b)(1) If responsibility for medication administration is assigned to the license holder in the coordinated service and support plan or the coordinated service and support plan addendum, the license holder must implement medication administration procedures to ensure a person takes medications and treatments as prescribed. The license holder must ensure that the requirements in clauses (2) ~~to (4)~~ and (3) have been met before administering medication or treatment.

(2) The license holder must obtain written authorization from the person or the person's legal representative to administer medication or treatment and must obtain reauthorization annually as needed. This authorization shall remain in effect unless it is withdrawn in writing and may be withdrawn at any time. If the person or the person's legal representative refuses to authorize the license holder to administer medication, the medication must not be administered. The refusal to authorize medication administration must be reported to the prescriber as expediently as possible.

~~(3) The staff person responsible for administering the medication or treatment must complete medication administration training according to section 245D.09, subdivision 4a, paragraphs (a) and (c), and, as applicable to the person, paragraph (d).~~

~~(4)~~ (3) For a license holder providing intensive support services, the medication or treatment must be administered according to the license holder's medication administration policy and procedures as required under section 245D.11, subdivision 2, clause (3).

(c) The license holder must ensure the following information is documented in the person's medication administration record:

(1) the information on the current prescription label or the prescriber's current written or electronically recorded order or prescription that includes the person's name, description of the medication or treatment to be provided, and the frequency and other

information needed to safely and correctly administer the medication or treatment to ensure effectiveness;

(2) information on any risks or other side effects that are reasonable to expect, and any contraindications to its use. This information must be readily available to all staff administering the medication;

(3) the possible consequences if the medication or treatment is not taken or administered as directed;

(4) instruction on when and to whom to report the following:

(i) if a dose of medication is not administered or treatment is not performed as prescribed, whether by error by the staff or the person or by refusal by the person; and

(ii) the occurrence of possible adverse reactions to the medication or treatment;

(5) notation of any occurrence of a dose of medication not being administered or treatment not performed as prescribed, whether by error by the staff or the person or by refusal by the person, or of adverse reactions, and when and to whom the report was made; and

(6) notation of when a medication or treatment is started, administered, changed, or discontinued.

Sec. 25. Minnesota Statutes 2013 Supplement, section 245D.05, subdivision 4, is amended to read:

Subd. 4. **Reviewing and reporting medication and treatment issues.** (a) When assigned responsibility for medication administration, the license holder must ensure that the information maintained in the medication administration record is current and is regularly reviewed to identify medication administration errors. At a minimum, the review must be conducted every three months, or more frequently as directed in the coordinated service and support plan or coordinated service and support plan addendum or as requested by the person or the person's legal representative. Based on the review, the license holder must develop and implement a plan to correct patterns of medication administration errors when identified.

(b) If assigned responsibility for medication assistance or medication administration, the license holder must report the following to the person's legal representative and case manager as they occur or as otherwise directed in the coordinated service and support plan or the coordinated service and support plan addendum:

(1) any reports ~~made to the person's physician or prescriber~~ required under subdivision 2, paragraph (c), clause (4);

(2) a person's refusal or failure to take or receive medication or treatment as prescribed; or

(3) concerns about a person's self-administration of medication or treatment.

Sec. 26. Minnesota Statutes 2013 Supplement, section 245D.05, subdivision 5, is amended to read:

Subd. 5. **Injectable medications.** Injectable medications may be administered according to a prescriber's order and written instructions when one of the following conditions has been met:

(1) a registered nurse or licensed practical nurse will administer the ~~subcutaneous or intramuscular~~ injection;

(2) a supervising registered nurse with a physician's order has delegated the administration of ~~subcutaneous~~ injectable medication to an unlicensed staff member and has provided the necessary training; or

(3) there is an agreement signed by the license holder, the prescriber, and the person or the person's legal representative specifying what ~~subcutaneous~~ injections may be given, when, how, and that the prescriber must retain responsibility for the license holder's giving the injections. A copy of the agreement must be placed in the person's service recipient record.

Only licensed health professionals are allowed to administer psychotropic medications by injection.

Sec. 27. Minnesota Statutes 2013 Supplement, section 245D.051, is amended to read:

245D.051 PSYCHOTROPIC MEDICATION USE AND MONITORING.

Subdivision 1. **Conditions for psychotropic medication administration.** (a) When a person is prescribed a psychotropic medication and the license holder is assigned responsibility for administration of the medication in the person's coordinated service and support plan or the coordinated service and support plan addendum, the license holder must ensure that the requirements in ~~paragraphs (b) to (d) and~~ section 245D.05, subdivision 2, are met.

~~(b) Use of the medication must be included in the person's coordinated service and support plan or in the coordinated service and support plan addendum and based on a prescriber's current written or electronically recorded prescription.~~

~~(c)~~ (b) The license holder must develop, implement, and maintain the following documentation in the person's coordinated service and support plan addendum according to the requirements in sections 245D.07 and 245D.071:

(1) a description of the target symptoms that the psychotropic medication is to alleviate; and

(2) documentation methods the license holder will use to monitor and measure changes in the target symptoms that are to be alleviated by the psychotropic medication if required by the prescriber. The license holder must collect and report on medication and symptom-related data as instructed by the prescriber. The license holder must provide the monitoring data to the expanded support team for review every three months, or as otherwise requested by the person or the person's legal representative.

For the purposes of this section, "target symptom" refers to any perceptible diagnostic criteria for a person's diagnosed mental disorder, as defined by the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition Text Revision (DSM-IV-TR) or successive editions, that has been identified for alleviation.

Subd. 2. **Refusal to authorize psychotropic medication.** If the person or the person's legal representative refuses to authorize the administration of a psychotropic medication as ordered by the prescriber, the license holder must ~~follow the requirement in section 245D.05, subdivision 2, paragraph (b), clause (2).~~ not administer the medication. The refusal to authorize medication administration must be reported to the prescriber as expediently as possible. After reporting the refusal to the prescriber, the license holder must follow any directives or orders given by the prescriber. ~~A court order must be obtained to override the refusal.~~ A refusal may not be overridden without a court order. Refusal to authorize administration of a specific psychotropic medication is not grounds for service termination and does not constitute an emergency. A decision to terminate services must be reached in compliance with section 245D.10, subdivision 3.

Sec. 28. Minnesota Statutes 2013 Supplement, section 245D.06, subdivision 1, is amended to read:

Subdivision 1. **Incident response and reporting.** (a) The license holder must respond to incidents under section 245D.02, subdivision 11, that occur while providing services to protect the health and safety of and minimize risk of harm to the person.

(b) The license holder must maintain information about and report incidents to the person's legal representative or designated emergency contact and case manager within 24 hours of an incident occurring while services are being provided, within 24 hours of discovery or receipt of information that an incident occurred, unless the license holder has reason to know that the incident has already been reported, or as otherwise directed in a person's coordinated service and support plan or coordinated service and support plan addendum. An incident of suspected or alleged maltreatment must be reported as

required under paragraph (d), and an incident of serious injury or death must be reported as required under paragraph (e).

(c) When the incident involves more than one person, the license holder must not disclose personally identifiable information about any other person when making the report to each person and case manager unless the license holder has the consent of the person.

(d) Within 24 hours of reporting maltreatment as required under section 626.556 or 626.557, the license holder must inform the case manager of the report unless there is reason to believe that the case manager is involved in the suspected maltreatment. The license holder must disclose the nature of the activity or occurrence reported and the agency that received the report.

(e) The license holder must report the death or serious injury of the person as required in paragraph (b) and to the Department of Human Services Licensing Division, and the Office of Ombudsman for Mental Health and Developmental Disabilities as required under section 245.94, subdivision 2a, within 24 hours of the death, or receipt of information that the death occurred, unless the license holder has reason to know that the death has already been reported.

(f) When a death or serious injury occurs in a facility certified as an intermediate care facility for persons with developmental disabilities, the death or serious injury must be reported to the Department of Health, Office of Health Facility Complaints, and the Office of Ombudsman for Mental Health and Developmental Disabilities, as required under sections 245.91 and 245.94, subdivision 2a, unless the license holder has reason to know that the death has already been reported.

(g) The license holder must conduct an internal review of incident reports of deaths and serious injuries that occurred while services were being provided and that were not reported by the program as alleged or suspected maltreatment, for identification of incident patterns, and implementation of corrective action as necessary to reduce occurrences. The review must include an evaluation of whether related policies and procedures were followed, whether the policies and procedures were adequate, whether there is a need for additional staff training, whether the reported event is similar to past events with the persons or the services involved, and whether there is a need for corrective action by the license holder to protect the health and safety of persons receiving services. Based on the results of this review, the license holder must develop, document, and implement a corrective action plan designed to correct current lapses and prevent future lapses in performance by staff or the license holder, if any.

(h) The license holder must verbally report the emergency use of manual restraint of a person as required in paragraph (b) within 24 hours of the occurrence. The license

holder must ensure the written report and internal review of all incident reports of the emergency use of manual restraints are completed according to the requirements in section 245D.061 or successor provisions.

Sec. 29. Minnesota Statutes 2013 Supplement, section 245D.06, subdivision 2, is amended to read:

Subd. 2. **Environment and safety.** The license holder must:

(1) ensure the following when the license holder is the owner, lessor, or tenant of the service site:

(i) the service site is a safe and hazard-free environment;

(ii) that toxic substances or dangerous items are inaccessible to persons served by the program only to protect the safety of a person receiving services when a known safety threat exists and not as a substitute for staff supervision or interactions with a person who is receiving services. If toxic substances or dangerous items are made inaccessible, the license holder must document an assessment of the physical plant, its environment, and its population identifying the risk factors which require toxic substances or dangerous items to be inaccessible and a statement of specific measures to be taken to minimize the safety risk to persons receiving services and to restore accessibility to all persons receiving services at the service site;

(iii) doors are locked from the inside to prevent a person from exiting only when necessary to protect the safety of a person receiving services and not as a substitute for staff supervision or interactions with the person. If doors are locked from the inside, the license holder must document an assessment of the physical plant, the environment and the population served, identifying the risk factors which require the use of locked doors, and a statement of specific measures to be taken to minimize the safety risk to persons receiving services at the service site; and

(iv) a staff person is available at the service site who is trained in basic first aid and, when required in a person's coordinated service and support plan or coordinated service and support plan addendum, cardiopulmonary resuscitation (CPR) whenever persons are present and staff are required to be at the site to provide direct support service. The CPR training must include in-person instruction, hands-on practice, and an observed skills assessment under the direct supervision of a CPR instructor;

(2) maintain equipment, vehicles, supplies, and materials owned or leased by the license holder in good condition when used to provide services;

(3) follow procedures to ensure safe transportation, handling, and transfers of the person and any equipment used by the person, when the license holder is responsible for transportation of a person or a person's equipment;

(4) be prepared for emergencies and follow emergency response procedures to ensure the person's safety in an emergency; and

(5) follow universal precautions and sanitary practices, including hand washing, for infection prevention and control, and to prevent communicable diseases.

Sec. 30. Minnesota Statutes 2013 Supplement, section 245D.06, subdivision 4, is amended to read:

Subd. 4. **Funds and property; legal representative restrictions.** (a) Whenever the license holder assists a person with the safekeeping of funds or other property according to section 245A.04, subdivision 13, the license holder must obtain written authorization to do so from the person or the person's legal representative and the case manager. Authorization must be obtained within five working days of service initiation and renewed annually thereafter. At the time initial authorization is obtained, the license holder must survey, document, and implement the preferences of the person or the person's legal representative and the case manager for frequency of receiving a statement that itemizes receipts and disbursements of funds or other property. The license holder must document changes to these preferences when they are requested.

(b) A license holder or staff person may not accept powers-of-attorney from a person receiving services from the license holder for any purpose. This does not apply to license holders that are Minnesota counties or other units of government or to staff persons employed by license holders who were acting as attorney-in-fact for specific individuals prior to implementation of this chapter. The license holder must maintain documentation of the power-of-attorney in the service recipient record.

(c) A license holder or staff person is restricted from accepting an appointment as a guardian as follows:

(1) under section 524.5-309 of the Uniform Probate Code, any individual or agency that provides residence, custodial care, medical care, employment training, or other care or services for which the individual or agency receives a fee may not be appointed as guardian unless related to the respondent by blood, marriage, or adoption; and

(2) under section 245A.03, subdivision 2, paragraph (a), clause (1), a related individual as defined under section 245A.02, subdivision 13, is excluded from licensure. Services provided by a license holder to a person under the license holder's guardianship are not licensed services.

~~(c)~~ (d) Upon the transfer or death of a person, any funds or other property of the person must be surrendered to the person or the person's legal representative, or given to the executor or administrator of the estate in exchange for an itemized receipt.

Sec. 31. Minnesota Statutes 2013 Supplement, section 245D.06, subdivision 6, is amended to read:

Subd. 6. **Restricted procedures.** (a) The following procedures are allowed when the procedures are implemented in compliance with the standards governing their use as identified in clauses (1) to (3). Allowed but restricted procedures include:

(1) permitted actions and procedures subject to the requirements in subdivision 7;

(2) procedures identified in a positive support transition plan subject to the requirements in subdivision 8; or

(3) emergency use of manual restraint subject to the requirements in section 245D.061.

For purposes of this chapter, this section supersedes the requirements identified in Minnesota Rules, part 9525.2740.

(b) A restricted procedure identified in paragraph (a) must not:

(1) be implemented with a child in a manner that constitutes sexual abuse, neglect, physical abuse, or mental injury, as defined in section 626.556, subdivision 2;

(2) be implemented with an adult in a manner that constitutes abuse or neglect as defined in section 626.5572, subdivision 2 or 17;

(3) be implemented in a manner that violates a person's rights identified in section 245D.04;

(4) restrict a person's normal access to a nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, necessary clothing, or any protection required by state licensing standards or federal regulations governing the program;

(5) deny the person visitation or ordinary contact with legal counsel, a legal representative, or next of kin;

(6) be used for the convenience of staff, as punishment, as a substitute for adequate staffing, or as a consequence if the person refuses to participate in the treatment or services provided by the program;

(7) use prone restraint. For purposes of this section, "prone restraint" means use of manual restraint that places a person in a face-down position. Prone restraint does not include brief physical holding of a person who, during an emergency use of manual

restraint, rolls into a prone position, if the person is restored to a standing, sitting, or side-lying position as quickly as possible;

(8) apply back or chest pressure while a person is in a prone position as identified in clause (7), supine position, or side-lying position; or

(9) be implemented in a manner that is contraindicated for any of the person's known medical or psychological limitations.

Sec. 32. Minnesota Statutes 2013 Supplement, section 245D.06, subdivision 7, is amended to read:

Subd. 7. **Permitted actions and procedures.** (a) Use of the instructional techniques and intervention procedures as identified in paragraphs (b) and (c) is permitted when used on an intermittent or continuous basis. When used on a continuous basis, it must be addressed in a person's coordinated service and support plan addendum as identified in sections 245D.07 and 245D.071. For purposes of this chapter, the requirements of this subdivision supersede the requirements identified in Minnesota Rules, part 9525.2720.

(b) Physical contact or instructional techniques must use the least restrictive alternative possible to meet the needs of the person and may be used:

(1) to calm or comfort a person by holding that person with no resistance from that person;

(2) to protect a person known to be at risk ~~or~~ of injury due to frequent falls as a result of a medical condition;

(3) to facilitate the person's completion of a task or response when the person does not resist or the person's resistance is minimal in intensity and duration; ~~or~~

(4) to ~~briefly~~ block or redirect a person's limbs or body without holding the person or limiting the person's movement to interrupt the person's behavior that may result in injury to self or others~~.~~ with less than 60 seconds of physical contact by staff; or

(5) to redirect a person's behavior when the behavior does not pose a serious threat to the person or others and the behavior is effectively redirected with less than 60 seconds of physical contact by staff.

(c) Restraint may be used as an intervention procedure to:

(1) allow a licensed health care professional to safely conduct a medical examination or to provide medical treatment ordered by a licensed health care professional to a person necessary to promote healing or recovery from an acute, meaning short-term, medical condition;

(2) assist in the safe evacuation or redirection of a person in the event of an emergency and the person is at imminent risk of harm~~.~~; or

~~Any use of manual restraint as allowed in this paragraph must comply with the restrictions identified in section 245D.061, subdivision 3; or~~

(3) position a person with physical disabilities in a manner specified in the person's coordinated service and support plan addendum.

Any use of manual restraint as allowed in this paragraph must comply with the restrictions identified in subdivision 6, paragraph (b).

(d) Use of adaptive aids or equipment, orthotic devices, or other medical equipment ordered by a licensed health professional to treat a diagnosed medical condition do not in and of themselves constitute the use of mechanical restraint.

(e) Use of an auxiliary device to ensure a person does not unfasten a seat belt when being transported in a vehicle in accordance with seat belt use requirements in section 169.686 does not constitute the use of mechanical restraint.

Sec. 33. Minnesota Statutes 2013 Supplement, section 245D.06, subdivision 8, is amended to read:

Subd. 8. **Positive support transition plan.** (a) License holders must develop a positive support transition plan on the forms and in the manner prescribed by the commissioner for a person who requires intervention in order to maintain safety when it is known that the person's behavior poses an immediate risk of physical harm to self or others. The positive support transition plan forms and instructions will supersede the requirements in Minnesota Rules, parts 9525.2750; 9525.2760; and 9525.2780. The positive support transition plan must phase out any existing plans for the emergency or programmatic use of ~~aversive or deprivation procedures~~ restrictive interventions prohibited under this chapter within the following timelines:

(1) for persons receiving services from the license holder before January 1, 2014, the plan must be developed and implemented by February 1, 2014, and phased out no later than December 31, 2014; and

(2) for persons admitted to the program on or after January 1, 2014, the plan must be developed and implemented within 30 calendar days of service initiation and phased out no later than 11 months from the date of plan implementation.

(b) The commissioner has limited authority to grant approval for the emergency use of procedures identified in subdivision 6 that had been part of an approved positive support transition plan when a person is at imminent risk of serious injury as defined in section 245.91, subdivision 6, due to self-injurious behavior and the following conditions are met:

(1) the person's expanded support team approves the emergency use of the procedures; and

(2) the interim review panel established in section 245.8251, subdivision 4, recommends commissioner approval of the emergency use of the procedures.

(c) Written requests for the emergency use of the procedures must be developed and submitted to the commissioner by the designated coordinator with input from the person's expanded support team in accordance with the requirements set by the interim review panel, in addition to the following:

(1) a copy of the person's current positive support transition plan and copies of each positive support transition plan review containing data on the progress of the plan from the previous year;

(2) documentation of a good faith effort to eliminate the use of the procedures that had been part of an approved positive support transition plan;

(3) justification for the continued use of the procedures that identifies the imminent risk of serious injury due to the person's self-injurious behavior if the procedures were eliminated;

(4) documentation of the clinicians consulted in creating and maintaining the positive support transition plan; and

(5) documentation of the expanded support team's approval and the recommendation from the interim panel required under paragraph (b).

(d) A copy of the written request, supporting documentation, and the commissioner's final determination on the request must be maintained in the person's service recipient record.

Sec. 34. Minnesota Statutes 2013 Supplement, section 245D.071, subdivision 3, is amended to read:

Subd. 3. **Assessment and initial service planning.** (a) Within 15 days of service initiation the license holder must complete a preliminary coordinated service and support plan addendum based on the coordinated service and support plan.

~~(b) Within 45 days of service initiation the license holder must meet with the person, the person's legal representative, the case manager, and other members of the support team or expanded support team to assess and determine the following based on the person's coordinated service and support plan and the requirements in subdivision 4 and section 245D.07, subdivision 1a:~~

~~(1) the scope of the services to be provided to support the person's daily needs and activities;~~

~~(2) the person's desired outcomes and the supports necessary to accomplish the person's desired outcomes;~~

~~(3) the person's preferences for how services and supports are provided;~~

~~(4) whether the current service setting is the most integrated setting available and appropriate for the person; and~~

~~(5) how services must be coordinated across other providers licensed under this chapter serving the same person to ensure continuity of care for the person.~~

~~(c) Within the scope of services, the license holder must, at a minimum, assess the following areas:~~

~~(1) the person's ability to self-manage health and medical needs to maintain or improve physical, mental, and emotional well-being, including, when applicable, allergies, seizures, choking, special dietary needs, chronic medical conditions, self-administration of medication or treatment orders, preventative screening, and medical and dental appointments;~~

~~(2) the person's ability to self-manage personal safety to avoid injury or accident in the service setting, including, when applicable, risk of falling, mobility, regulating water temperature, community survival skills, water safety skills, and sensory disabilities; and~~

~~(3) the person's ability to self-manage symptoms or behavior that may otherwise result in an incident as defined in section 245D.02, subdivision 11, clauses (4) to (7), suspension or termination of services by the license holder, or other symptoms or behaviors that may jeopardize the health and safety of the person or others. The assessments must produce information about the person that is descriptive of the person's overall strengths, functional skills and abilities, and behaviors or symptoms.~~

(b) Within the scope of services, the license holder must, at a minimum, complete assessments in the following areas before the 45-day planning meeting:

(1) the person's ability to self-manage health and medical needs to maintain or improve physical, mental, and emotional well-being, including, when applicable, allergies, seizures, choking, special dietary needs, chronic medical conditions, self-administration of medication or treatment orders, preventative screening, and medical and dental appointments;

(2) the person's ability to self-manage personal safety to avoid injury or accident in the service setting, including, when applicable, risk of falling, mobility, regulating water temperature, community survival skills, water safety skills, and sensory disabilities; and

(3) the person's ability to self-manage symptoms or behavior that may otherwise result in an incident as defined in section 245D.02, subdivision 11, clauses (4) to (7), suspension or termination of services by the license holder, or other symptoms or behaviors that may jeopardize the health and safety of the person or others.

Assessments must produce information about the person that describes the person's overall strengths, functional skills and abilities, and behaviors or symptoms. Assessments must be based on the person's status within the last 12 months at the time of service initiation. Assessments based on older information must be documented and justified. Assessments must be conducted annually at a minimum or within 30 days of a written request from the person or the person's legal representative or case manager. The results must be reviewed by the support team or expanded support team as part of a service plan review.

(c) Within 45 days of service initiation, the license holder must meet with the person, the person's legal representative, the case manager, and other members of the support team or expanded support team to determine the following based on information obtained from the assessments identified in paragraph (b), the person's identified needs in the coordinated service and support plan, and the requirements in subdivision 4 and section 245D.07, subdivision 1a:

(1) the scope of the services to be provided to support the person's daily needs and activities;

(2) the person's desired outcomes and the supports necessary to accomplish the person's desired outcomes;

(3) the person's preferences for how services and supports are provided;

(4) whether the current service setting is the most integrated setting available and appropriate for the person; and

(5) how services must be coordinated across other providers licensed under this chapter serving the person and members of the support team or expanded support team to ensure continuity of care and coordination of services for the person.

Sec. 35. Minnesota Statutes 2013 Supplement, section 245D.071, subdivision 4, is amended to read:

Subd. 4. **Service outcomes and supports.** (a) Within ten working days of the 45-day planning meeting, the license holder must develop ~~and document~~ a service plan that documents the service outcomes and supports based on the assessments completed under subdivision 3 and the requirements in section 245D.07, subdivision 1a. The outcomes and supports must be included in the coordinated service and support plan addendum.

(b) The license holder must document the supports and methods to be implemented to support the ~~accomplishment of~~ person and accomplish outcomes related to acquiring, retaining, or improving skills and physical, mental, and emotional health and well-being. The documentation must include:

(1) the methods or actions that will be used to support the person and to accomplish the service outcomes, including information about:

(i) any changes or modifications to the physical and social environments necessary when the service supports are provided;

(ii) any equipment and materials required; and

(iii) techniques that are consistent with the person's communication mode and learning style;

(2) the measurable and observable criteria for identifying when the desired outcome has been achieved and how data will be collected;

(3) the projected starting date for implementing the supports and methods and the date by which progress towards accomplishing the outcomes will be reviewed and evaluated; and

(4) the names of the staff or position responsible for implementing the supports and methods.

(c) Within 20 working days of the 45-day meeting, the license holder must obtain dated signatures from the person or the person's legal representative and case manager to document completion and approval of the assessment and coordinated service and support plan addendum.

Sec. 36. Minnesota Statutes 2013 Supplement, section 245D.071, subdivision 5, is amended to read:

Subd. 5. ~~**Progress reviews**~~ **Service plan review and evaluation.** (a) The license holder must give the person or the person's legal representative and case manager an opportunity to participate in the ongoing review and development of the service plan and the methods used to support the person and accomplish outcomes identified in subdivisions 3 and 4. The license holder, in coordination with the person's support team or expanded support team, must meet with the person, the person's legal representative, and the case manager, and participate in ~~progress~~ service plan review meetings following stated timelines established in the person's coordinated service and support plan or coordinated service and support plan addendum or within 30 days of a written request by the person, the person's legal representative, or the case manager, at a minimum of once per year. The purpose of the service plan review is to determine whether changes are needed to the service plan based on the assessment information, the license holder's evaluation of progress towards accomplishing outcomes, or other information provided by the support team or expanded support team.

(b) The license holder must summarize the person's status and progress toward achieving the identified outcomes and make recommendations and identify the rationale for changing, continuing, or discontinuing implementation of supports and methods identified in subdivision 4 in a written report sent to the person or the person's legal representative and case manager five working days prior to the review meeting, unless the person, the person's legal representative, or the case manager requests to receive the report at the time of the meeting.

(c) Within ten working days of the progress review meeting, the license holder must obtain dated signatures from the person or the person's legal representative and the case manager to document approval of any changes to the coordinated service and support plan addendum.

Sec. 37. Minnesota Statutes 2013 Supplement, section 245D.081, subdivision 2, is amended to read:

Subd. 2. **Coordination and evaluation of individual service delivery.** (a) Delivery and evaluation of services provided by the license holder must be coordinated by a designated staff person. The designated coordinator must provide supervision, support, and evaluation of activities that include:

(1) oversight of the license holder's responsibilities assigned in the person's coordinated service and support plan and the coordinated service and support plan addendum;

(2) taking the action necessary to facilitate the accomplishment of the outcomes according to the requirements in section 245D.07;

(3) instruction and assistance to direct support staff implementing the coordinated service and support plan and the service outcomes, including direct observation of service delivery sufficient to assess staff competency; and

(4) evaluation of the effectiveness of service delivery, methodologies, and progress on the person's outcomes based on the measurable and observable criteria for identifying when the desired outcome has been achieved according to the requirements in section 245D.07.

(b) The license holder must ensure that the designated coordinator is competent to perform the required duties identified in paragraph (a) through education ~~and~~, training ~~in human services and disability-related fields~~, and work experience ~~in providing direct care services and supports to persons with disabilities~~ relevant to the needs of the general population of persons served by the license holder and the individual persons for whom the designated coordinator is responsible. The designated coordinator must have the skills and ability necessary to develop effective plans and to design and use data systems

to measure effectiveness of services and supports. The license holder must verify and document competence according to the requirements in section 245D.09, subdivision 3. The designated coordinator must minimally have:

(1) a baccalaureate degree in a field related to human services, and one year of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older;

(2) an associate degree in a field related to human services, and two years of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older;

(3) a diploma in a field related to human services from an accredited postsecondary institution and three years of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older; or

(4) a minimum of 50 hours of education and training related to human services and disabilities; and

(5) four years of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older under the supervision of a staff person who meets the qualifications identified in clauses (1) to (3).

Sec. 38. Minnesota Statutes 2013 Supplement, section 245D.09, subdivision 3, is amended to read:

Subd. 3. **Staff qualifications.** (a) The license holder must ensure that staff providing direct support, or staff who have responsibilities related to supervising or managing the provision of direct support service, are competent as demonstrated through skills and knowledge training, experience, and education to meet the person's needs and additional requirements as written in the coordinated service and support plan or coordinated service and support plan addendum, or when otherwise required by the case manager or the federal waiver plan. The license holder must verify and maintain evidence of staff competency, including documentation of:

(1) education and experience qualifications relevant to the job responsibilities assigned to the staff and to the needs of the general population of persons served by the program, including a valid degree and transcript, or a current license, registration, or certification, when a degree or licensure, registration, or certification is required by this chapter or in the coordinated service and support plan or coordinated service and support plan addendum;

(2) demonstrated competency in the orientation and training areas required under this chapter, and when applicable, completion of continuing education required to

maintain professional licensure, registration, or certification requirements. Competency in these areas is determined by the license holder through knowledge testing ~~and~~ or observed skill assessment conducted by the trainer or instructor; and

(3) except for a license holder who is the sole direct support staff, periodic performance evaluations completed by the license holder of the direct support staff person's ability to perform the job functions based on direct observation.

(b) Staff under 18 years of age may not perform overnight duties or administer medication.

Sec. 39. Minnesota Statutes 2013 Supplement, section 245D.09, subdivision 4a, is amended to read:

Subd. 4a. **Orientation to individual service recipient needs.** (a) Before having unsupervised direct contact with a person served by the program, or for whom the staff person has not previously provided direct support, or any time the plans or procedures identified in paragraphs (b) to ~~(f)~~ (g) are revised, the staff person must review and receive instruction on the requirements in paragraphs (b) to ~~(f)~~ (g) as they relate to the staff person's job functions for that person.

(b) Training and competency evaluations must include the following:

(1) appropriate and safe techniques in personal hygiene and grooming, including hair care; bathing; care of teeth, gums, and oral prosthetic devices; and other activities of daily living (ADLs) as defined under section 256B.0659, subdivision 1;

(2) an understanding of what constitutes a healthy diet according to data from the Centers for Disease Control and Prevention and the skills necessary to prepare that diet;

(3) skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) as defined under section 256B.0659, subdivision 1; and

(4) demonstrated competence in providing first aid.

(c) The staff person must review and receive instruction on the person's coordinated service and support plan or coordinated service and support plan addendum as it relates to the responsibilities assigned to the license holder, and when applicable, the person's individual abuse prevention plan, to achieve and demonstrate an understanding of the person as a unique individual, and how to implement those plans.

(d) The staff person must review and receive instruction on medication setup, assistance, or administration procedures established for the person when ~~medication administration is~~ assigned to the license holder according to section 245D.05, subdivision 1, paragraph (b). Unlicensed staff may ~~administer medications~~ perform medication setup or medication administration only after successful completion of a medication setup or

medication administration training, from a training curriculum developed by a registered nurse~~, clinical nurse specialist in psychiatric and mental health nursing, certified nurse practitioner, physician's assistant, or physician~~ or appropriate licensed health professional. The training curriculum must incorporate an observed skill assessment conducted by the trainer to ensure unlicensed staff demonstrate the ability to safely and correctly follow medication procedures.

Medication administration must be taught by a registered nurse, clinical nurse specialist, certified nurse practitioner, physician's assistant, or physician if, at the time of service initiation or any time thereafter, the person has or develops a health care condition that affects the service options available to the person because the condition requires:

(1) specialized or intensive medical or nursing supervision; and

(2) nonmedical service providers to adapt their services to accommodate the health and safety needs of the person.

(e) The staff person must review and receive instruction on the safe and correct operation of medical equipment used by the person to sustain life, including but not limited to ventilators, feeding tubes, or endotracheal tubes. The training must be provided by a licensed health care professional or a manufacturer's representative and incorporate an observed skill assessment to ensure staff demonstrate the ability to safely and correctly operate the equipment according to the treatment orders and the manufacturer's instructions.

(f) The staff person must review and receive instruction on what constitutes use of restraints, time out, and seclusion, including chemical restraint, and staff responsibilities related to the prohibitions of their use according to the requirements in section 245D.06, subdivision 5 or successor provisions, why such procedures are not effective for reducing or eliminating symptoms or undesired behavior and why they are not safe, and the safe and correct use of manual restraint on an emergency basis according to the requirements in section 245D.061 or successor provisions.

(g) The staff person must review and receive instruction on mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness.

~~(g)~~ (h) In the event of an emergency service initiation, the license holder must ensure the training required in this subdivision occurs within 72 hours of the direct support staff person first having unsupervised contact with the person receiving services. The license holder must document the reason for the unplanned or emergency service initiation and maintain the documentation in the person's service recipient record.

~~(h)~~ (i) License holders who provide direct support services themselves must complete the orientation required in subdivision 4, clauses (3) to (7).

Sec. 40. Minnesota Statutes 2013 Supplement, section 245D.091, subdivision 2, is amended to read:

Subd. 2. **Behavior professional qualifications.** A behavior professional providing behavioral support services as identified in section 245D.03, subdivision 1, paragraph (c), clause (1), item (i), ~~as defined in the brain injury and community alternatives for disabled individuals waiver plans or successor plans,~~ must have competencies in the following areas ~~related to~~ as required under the brain injury and community alternatives for disabled individuals waiver plans or successor plans:

(1) ethical considerations;

(2) functional assessment;

(3) functional analysis;

(4) measurement of behavior and interpretation of data;

(5) selecting intervention outcomes and strategies;

(6) behavior reduction and elimination strategies that promote least restrictive approved alternatives;

(7) data collection;

(8) staff and caregiver training;

(9) support plan monitoring;

(10) co-occurring mental disorders or neurocognitive disorder;

(11) demonstrated expertise with populations being served; and

(12) must be a:

(i) psychologist licensed under sections 148.88 to 148.98, who has stated to the Board of Psychology competencies in the above identified areas;

(ii) clinical social worker licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the areas identified in clauses (1) to (11);

(iii) physician licensed under chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry with competencies in the areas identified in clauses (1) to (11);

(iv) licensed professional clinical counselor licensed under sections 148B.29 to 148B.39 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services who has demonstrated competencies in the areas identified in clauses (1) to (11);

(v) person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's

supervised experience in the delivery of clinical services with demonstrated competencies in the areas identified in clauses (1) to (11); or

(vi) registered nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization, or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services.

Sec. 41. Minnesota Statutes 2013 Supplement, section 245D.091, subdivision 3, is amended to read:

Subd. 3. **Behavior analyst qualifications.** (a) A behavior analyst providing behavioral support services as identified in section 245D.03, subdivision 1, paragraph (c), clause (1), item (i), ~~as defined in the brain injury and community alternatives for disabled individuals waiver plans or successor plans,~~ must have competencies in the following areas as required under the brain injury and community alternatives for disabled individuals waiver plans or successor plans:

(1) have obtained a baccalaureate degree, master's degree, or PhD in a social services discipline; or

(2) meet the qualifications of a mental health practitioner as defined in section 245.462, subdivision 17.

(b) In addition, a behavior analyst must:

(1) have four years of supervised experience working with individuals who exhibit challenging behaviors as well as co-occurring mental disorders or neurocognitive disorder;

(2) have received ten hours of instruction in functional assessment and functional analysis;

(3) have received 20 hours of instruction in the understanding of the function of behavior;

(4) have received ten hours of instruction on design of positive practices behavior support strategies;

(5) have received 20 hours of instruction on the use of behavior reduction approved strategies used only in combination with behavior positive practices strategies;

(6) be determined by a behavior professional to have the training and prerequisite skills required to provide positive practice strategies as well as behavior reduction approved and permitted intervention to the person who receives behavioral support; and

(7) be under the direct supervision of a behavior professional.

Sec. 42. Minnesota Statutes 2013 Supplement, section 245D.091, subdivision 4, is amended to read:

Subd. 4. **Behavior specialist qualifications.** (a) A behavior specialist providing behavioral support services as identified in section 245D.03, subdivision 1, paragraph (c), clause (1), item (i), ~~as defined in the brain injury and community alternatives for disabled individuals waiver plans or successor plans,~~ must ~~meet the following qualifications~~ have competencies in the following areas as required under the brain injury and community alternatives for disabled individuals waiver plans or successor plans:

(1) have an associate's degree in a social services discipline; or

(2) have two years of supervised experience working with individuals who exhibit challenging behaviors as well as co-occurring mental disorders or neurocognitive disorder.

(b) In addition, a behavior specialist must:

(1) have received a minimum of four hours of training in functional assessment;

(2) have received 20 hours of instruction in the understanding of the function of behavior;

(3) have received ten hours of instruction on design of positive practices behavioral support strategies;

(4) be determined by a behavior professional to have the training and prerequisite skills required to provide positive practices strategies as well as behavior reduction approved intervention to the person who receives behavioral support; and

(5) be under the direct supervision of a behavior professional.

Sec. 43. Minnesota Statutes 2013 Supplement, section 245D.10, subdivision 3, is amended to read:

Subd. 3. **Service suspension and service termination.** (a) The license holder must establish policies and procedures for temporary service suspension and service termination that promote continuity of care and service coordination with the person and the case manager and with other licensed caregivers, if any, who also provide support to the person.

(b) The policy must include the following requirements:

(1) the license holder must notify the person or the person's legal representative and case manager in writing of the intended termination or temporary service suspension, and the person's right to seek a temporary order staying the termination of service according to the procedures in section 256.045, subdivision 4a, or 6, paragraph (c);

(2) notice of the proposed termination of services, including those situations that began with a temporary service suspension, must be given at least 60 days before the proposed termination is to become effective when a license holder is providing intensive

supports and services identified in section 245D.03, subdivision 1, paragraph (c), and 30 days prior to termination for all other services licensed under this chapter. This notice may be given in conjunction with a notice of temporary service suspension;

(3) notice of temporary service suspension must be given on the first day of the service suspension;

~~(3)~~ (4) the license holder must provide information requested by the person or case manager when services are temporarily suspended or upon notice of termination;

~~(4)~~ (5) prior to giving notice of service termination or temporary service suspension, the license holder must document actions taken to minimize or eliminate the need for service suspension or termination;

~~(5)~~ (6) during the temporary service suspension or service termination notice period, the license holder ~~will~~ must work with the ~~appropriate county agency~~ support team or expanded support team to develop reasonable alternatives to protect the person and others;

~~(6)~~ (7) the license holder must maintain information about the service suspension or termination, including the written termination notice, in the service recipient record; and

~~(7)~~ (8) the license holder must restrict temporary service suspension to situations in which the person's conduct poses an imminent risk of physical harm to self or others and less restrictive or positive support strategies would not achieve and maintain safety.

Sec. 44. Minnesota Statutes 2013 Supplement, section 245D.10, subdivision 4, is amended to read:

Subd. 4. **Availability of current written policies and procedures.** (a) The license holder must review and update, as needed, the written policies and procedures required under this chapter.

(b) (1) The license holder must inform the person and case manager of the policies and procedures affecting a person's rights under section 245D.04, and provide copies of those policies and procedures, within five working days of service initiation.

(2) If a license holder only provides basic services and supports, this includes the:

(i) grievance policy and procedure required under subdivision 2; and

(ii) service suspension and termination policy and procedure required under subdivision 3.

(3) For all other license holders this includes the:

(i) policies and procedures in clause (2);

(ii) emergency use of manual restraints policy and procedure required under section 245D.061, subdivision 10, or successor provisions; and

(iii) data privacy requirements under section 245D.11, subdivision 3.

(c) The license holder must provide a written notice to all persons or their legal representatives and case managers at least 30 days before implementing any procedural revisions to policies affecting a person's service-related or protection-related rights under section 245D.04 and maltreatment reporting policies and procedures. The notice must explain the revision that was made and include a copy of the revised policy and procedure. The license holder must document the reasonable cause for not providing the notice at least 30 days before implementing the revisions.

(d) Before implementing revisions to required policies and procedures, the license holder must inform all employees of the revisions and provide training on implementation of the revised policies and procedures.

(e) The license holder must annually notify all persons, or their legal representatives, and case managers of any procedural revisions to policies required under this chapter, other than those in paragraph (c). Upon request, the license holder must provide the person, or the person's legal representative, and case manager with copies of the revised policies and procedures.

Sec. 45. Minnesota Statutes 2013 Supplement, section 245D.11, subdivision 2, is amended to read:

Subd. 2. **Health and safety.** The license holder must establish policies and procedures that promote health and safety by ensuring:

(1) use of universal precautions and sanitary practices in compliance with section 245D.06, subdivision 2, clause (5);

(2) if the license holder operates a residential program, health service coordination and care according to the requirements in section 245D.05, subdivision 1;

(3) safe medication assistance and administration according to the requirements in sections 245D.05, subdivisions 1a, 2, and 5, and 245D.051, that are established in consultation with a registered nurse, nurse practitioner, physician's assistant, or medical doctor and require completion of medication administration training according to the requirements in section 245D.09, subdivision 4a, paragraph (d). Medication assistance and administration includes, but is not limited to:

(i) providing medication-related services for a person;

(ii) medication setup;

(iii) medication administration;

(iv) medication storage and security;

(v) medication documentation and charting;

(vi) verification and monitoring of effectiveness of systems to ensure safe medication handling and administration;

(vii) coordination of medication refills;

(viii) handling changes to prescriptions and implementation of those changes;

(ix) communicating with the pharmacy; and

(x) coordination and communication with prescriber;

(4) safe transportation, when the license holder is responsible for transportation of persons, with provisions for handling emergency situations according to the requirements in section 245D.06, subdivision 2, clauses (2) to (4);

(5) a plan for ensuring the safety of persons served by the program in emergencies as defined in section 245D.02, subdivision 8, and procedures for staff to report emergencies to the license holder. A license holder with a community residential setting or a day service facility license must ensure the policy and procedures comply with the requirements in section 245D.22, subdivision 4;

(6) a plan for responding to all incidents as defined in section 245D.02, subdivision 11; and reporting all incidents required to be reported according to section 245D.06, subdivision 1. The plan must:

(i) provide the contact information of a source of emergency medical care and transportation; and

(ii) require staff to first call 911 when the staff believes a medical emergency may be life threatening, or to call the mental health crisis intervention team or similar mental health response team or service when such a team is available and appropriate when the person is experiencing a mental health crisis; and

(7) a procedure for the review of incidents and emergencies to identify trends or patterns, and corrective action if needed. The license holder must establish and maintain a record-keeping system for the incident and emergency reports. Each incident and emergency report file must contain a written summary of the incident. The license holder must conduct a review of incident reports for identification of incident patterns, and implementation of corrective action as necessary to reduce occurrences. Each incident report must include:

(i) the name of the person or persons involved in the incident. It is not necessary to identify all persons affected by or involved in an emergency unless the emergency resulted in an incident;

(ii) the date, time, and location of the incident or emergency;

(iii) a description of the incident or emergency;

(iv) a description of the response to the incident or emergency and whether a person's coordinated service and support plan addendum or program policies and procedures were implemented as applicable;

(v) the name of the staff person or persons who responded to the incident or emergency; and

(vi) the determination of whether corrective action is necessary based on the results of the review.

Sec. 46. Minnesota Statutes 2012, section 252.451, subdivision 2, is amended to read:

Subd. 2. **Vendor participation and reimbursement.** Notwithstanding requirements in ~~chapter~~ chapters 245A and 245D, and sections 252.28, 252.40 to 252.46, and 256B.501, vendors of day training and habilitation services may enter into written agreements with qualified businesses to provide additional training and supervision needed by individuals to maintain their employment.

Sec. 47. Minnesota Statutes 2012, section 256.9752, subdivision 2, is amended to read:

Subd. 2. **Authority.** The Minnesota Board on Aging shall allocate to area agencies on aging the state and federal funds which are received for the senior nutrition programs of congregate dining and home-delivered meals in a manner consistent with federal requirements.

Sec. 48. Minnesota Statutes 2013 Supplement, section 256B.0949, subdivision 4, is amended to read:

Subd. 4. **Diagnosis.** (a) A diagnosis must:

(1) be based upon current DSM criteria including direct observations of the child and reports from parents or primary caregivers; and

(2) be completed by ~~both~~ either (i) a licensed physician or advanced practice registered nurse ~~and~~ or (ii) a mental health professional.

(b) Additional diagnostic assessment information may be considered including from special education evaluations and licensed school personnel, and from professionals licensed in the fields of medicine, speech and language, psychology, occupational therapy, and physical therapy.

~~(c) If the commissioner determines there are access problems or delays in diagnosis for a geographic area due to the lack of qualified professionals, the commissioner shall waive the requirement in paragraph (a), clause (2), for two professionals and allow a diagnosis to be made by one professional for that geographic area. This exception must be~~

~~limited to a specific period of time until, with stakeholder input as described in subdivision 8, there is a determination of an adequate number of professionals available to require two professionals for each diagnosis.~~

Sec. 49. Minnesota Statutes 2013 Supplement, section 256B.439, subdivision 1, is amended to read:

Subdivision 1. **Development and implementation of quality profiles.** (a) The commissioner of human services, in cooperation with the commissioner of health, shall develop and implement quality profiles for nursing facilities and, beginning not later than July 1, 2014, for home and community-based services providers, except when the quality profile system would duplicate requirements under section 256B.5011, 256B.5012, or 256B.5013. For purposes of this section, home and community-based services providers are defined as providers of home and community-based services under sections 256B.0625, subdivisions 6a, 7, and 19a; 256B.0913~~,~~; 256B.0915~~,~~; 256B.092~~, and~~; 256B.49~~,~~; and 256B.85, and intermediate care facilities for persons with developmental disabilities providers under section 256B.5013. To the extent possible, quality profiles must be developed for providers of services to older adults and people with disabilities, regardless of payor source, for the purposes of providing information to consumers. The quality profiles must be developed using existing data sets maintained by the commissioners of health and human services to the extent possible. The profiles must incorporate or be coordinated with information on quality maintained by area agencies on aging, long-term care trade associations, the ombudsman offices, counties, tribes, health plans, and other entities and the long-term care database maintained under section 256.975, subdivision 7. The profiles must be designed to provide information on quality to:

(1) consumers and their families to facilitate informed choices of service providers;

(2) providers to enable them to measure the results of their quality improvement efforts and compare quality achievements with other service providers; and

(3) public and private purchasers of long-term care services to enable them to purchase high-quality care.

(b) The profiles must be developed in consultation with the long-term care task force, area agencies on aging, and representatives of consumers, providers, and labor unions. Within the limits of available appropriations, the commissioners may employ consultants to assist with this project.

EFFECTIVE DATE. This section is effective retroactively from February 1, 2014.

Sec. 50. Minnesota Statutes 2013 Supplement, section 256B.439, subdivision 7, is amended to read:

Subd. 7. **Calculation of home and community-based services quality add-on.** ~~Effective~~ On July 1, 2015, the commissioner shall determine the quality add-on rate change and adjust payment rates for ~~participating~~ all home and community-based services providers for services rendered on or after that date. The adjustment to a provider payment rate determined under this subdivision shall become part of the ongoing rate paid to that provider. The payment rate for the quality add-on shall be a variable amount based on each provider's quality score as determined in subdivisions 1 and 2a. All home and community-based services providers shall receive a minimum rate increase under this subdivision. In addition to a minimum rate increase, a home and community-based services provider shall receive a quality add-on payment. The commissioner shall limit the types of home and community-based services providers that may receive the quality add-on ~~and~~ based on availability of quality measures and outcome data. The commissioner shall limit the amount of the minimum rate increase and quality add-on payments to ~~operate the quality add-on within funds appropriated for this purpose and based on the availability of the quality measures~~ the equivalent of a one percent rate increase for all home and community-based services providers.

Sec. 51. Minnesota Statutes 2013 Supplement, section 256B.441, subdivision 53, is amended to read:

Subd. 53. **Calculation of payment rate for external fixed costs.** The commissioner shall calculate a payment rate for external fixed costs.

(a) For a facility licensed as a nursing home, the portion related to section 256.9657 shall be equal to $8.86. For a facility licensed as both a nursing home and a boarding care home, the portion related to section 256.9657 shall be equal to $8.86 multiplied by the result of its number of nursing home beds divided by its total number of licensed beds.

(b) The portion related to the licensure fee under section 144.122, paragraph (d), shall be the amount of the fee divided by actual resident days.

(c) The portion related to scholarships shall be determined under section 256B.431, subdivision 36.

(d) Until September 30, 2013, the portion related to long-term care consultation shall be determined according to section 256B.0911, subdivision 6.

(e) The portion related to development and education of resident and family advisory councils under section 144A.33 shall be $5 divided by 365.

(f) The portion related to planned closure rate adjustments shall be as determined under section 256B.437, subdivision 6, and Minnesota Statutes 2010, section 256B.436. Planned closure rate adjustments that take effect before October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning October 1, 2016. Planned closure rate adjustments that take effect on or after October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning on October 1 of the first year not less than two years after their effective date.

(g) The portions related to property insurance, real estate taxes, special assessments, and payments made in lieu of real estate taxes directly identified or allocated to the nursing facility shall be the actual amounts divided by actual resident days.

(h) The portion related to the Public Employees Retirement Association shall be actual costs divided by resident days.

(i) The single bed room incentives shall be as determined under section 256B.431, subdivision 42. Single bed room incentives that take effect before October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning October 1, 2016. Single bed room incentives that take effect on or after October 1, 2014, shall no longer be included in the payment rate for external fixed costs beginning on October 1 of the first year not less than two years after their effective date.

(j) The portion related to the rate adjustment as provided in subdivision 64.

(k) The payment rate for external fixed costs shall be the sum of the amounts in paragraphs (a) to ~~(i)~~ (j).

Sec. 52. Minnesota Statutes 2012, section 256B.441, is amended by adding a subdivision to read:

Subd. 64. **Rate adjustment for compensation-related costs.** (a) Total payment rates of all nursing facilities that are reimbursed under this section or section 256B.434 shall be increased effective October 1, 2014, to address compensation costs for nursing facility employees paid less than $14.00 per hour.

(b) Based on the application in paragraph (d), the commissioner shall calculate the annualized compensation costs by adding the totals of clauses (1), (2), and (3). The result must be divided by the resident days from the most recently available cost report to determine a per diem amount, which must be included in the external fixed cost portion of the total payment rate under subdivision 53:

(1) the sum of the difference between $9.50 and any hourly wage rate of less than $9.50, multiplied by the number of compensated hours at that wage rate;

(2) the sum of items (i) to (viii):

(i) for all compensated hours from $8.00 to $8.49 per hour, the number of compensated hours is multiplied by $0.13;

(ii) for all compensated hours from $8.50 to $8.99 per hour, the number of compensated hours is multiplied by $0.25;

(iii) for all compensated hours from $9.00 to $9.49 per hour, the number of compensated hours is multiplied by $0.38;

(iv) for all compensated hours from $9.50 to $10.49 per hour, the number of compensated hours is multiplied by $0.50;

(v) for all compensated hours from $10.50 to $10.99 per hour, the number of compensated hours is multiplied by $0.40;

(vi) for all compensated hours from $11.00 to $11.49 per hour, the number of compensated hours is multiplied by $0.30;

(vii) for all compensated hours from $11.50 to $11.99 per hour, the number of compensated hours is multiplied by $0.20; and

(viii) for all compensated hours from $12.00 to $13.00 per hour, the number of compensated hours is multiplied by $0.10; and

(3) the sum of the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, pensions, and contributions to employee retirement accounts attributable to the amounts in clauses (1) and (2).

(c) For the rate year beginning October 1, 2014, nursing facilities that receive approval of the application in paragraph (d) must receive a rate adjustment according to paragraph (b). The rate adjustment must be used to pay compensation costs for nursing facility employees paid less than $14.00 per hour. The rate adjustment must continue to be included in the total payment rate in subsequent years.

(d) To receive a rate adjustment, nursing facilities must submit an application to the commissioner in a form and manner determined by the commissioner. The application shall include data for a period beginning with the first pay period after January 1, 2014, including at least three months of employee compensated hours by wage rate, and a spending plan that describes how the funds from the rate adjustment will be allocated for compensation to employees paid less than $14.00 per hour. The application must be submitted by December 31, 2014. The commissioner may request any additional information needed to determine the rate adjustment within three weeks of receiving a complete application. The nursing facility must provide any additional information requested by the commissioner by March 31, 2015. The commissioner may waive the deadlines in this subdivision under extraordinary circumstances.

(e) For nursing facilities in which employees are represented by an exclusive bargaining representative, the commissioner shall approve the application submitted under this subdivision only upon receipt of a letter of acceptance of the spending plan in regard to members of the bargaining unit, signed by the exclusive bargaining agent and dated after May 31, 2014. Upon receipt of the letter of acceptance, the commissioner shall deem all requirements of this subdivision as having been met in regard to the members of the bargaining unit.

Sec. 53. Minnesota Statutes 2013 Supplement, section 256B.4912, subdivision 1, is amended to read:

Subdivision 1. **Provider qualifications.** (a) For the home and community-based waivers providing services to seniors and individuals with disabilities under sections 256B.0913, 256B.0915, 256B.092, and 256B.49, the commissioner shall establish:

(1) agreements with enrolled waiver service providers to ensure providers meet Minnesota health care program requirements;

(2) regular reviews of provider qualifications, and including requests of proof of documentation; and

(3) processes to gather the necessary information to determine provider qualifications.

(b) Beginning July 1, 2012, staff that provide direct contact, as defined in section 245C.02, subdivision 11, for services specified in the federally approved waiver plans must meet the requirements of chapter 245C prior to providing waiver services and as part of ongoing enrollment. Upon federal approval, this requirement must also apply to consumer-directed community supports.

(c) Beginning January 1, 2014, service owners and managerial officials overseeing the management or policies of services that provide direct contact as specified in the federally approved waiver plans must meet the requirements of chapter 245C prior to reenrollment or revalidation or, for new providers, prior to initial enrollment if they have not already done so as a part of service licensure requirements.

Sec. 54. Minnesota Statutes 2013 Supplement, section 256B.492, is amended to read:

256B.492 HOME AND COMMUNITY-BASED SETTINGS FOR PEOPLE WITH DISABILITIES.

Subdivision 1. **Home and community-based waivers.** (a) Individuals receiving services under a home and community-based waiver under section 256B.092 or 256B.49 may receive services in the following settings:

(1) an individual's own home or family home;

(2) a licensed adult foster care or child foster care setting of up to five people; and

(3) community living settings as defined in section 256B.49, subdivision 23, where individuals with disabilities who are receiving services under a home and community-based waiver may reside in all of the units in a building of four or fewer units, and no more than the greater of four or 25 percent of the units in a multifamily building of more than four units, unless required by the Housing Opportunities for Persons with AIDS Program.

(b) The settings in paragraph (a) must not:

(1) be located in a building that is a publicly or privately operated facility that provides institutional treatment or custodial care;

(2) be located in a building on the grounds of or adjacent to a public or private institution;

(3) be a housing complex designed expressly around an individual's diagnosis or disability, unless required by the Housing Opportunities for Persons with AIDS Program;

(4) be segregated based on a disability, either physically or because of setting characteristics, from the larger community; and

(5) have the qualities of an institution which include, but are not limited to: regimented meal and sleep times, limitations on visitors, and lack of privacy. Restrictions agreed to and documented in the person's individual service plan shall not result in a residence having the qualities of an institution as long as the restrictions for the person are not imposed upon others in the same residence and are the least restrictive alternative, imposed for the shortest possible time to meet the person's needs.

(c) The provisions of paragraphs (a) and (b) do not apply to any setting in which individuals receive services under a home and community-based waiver as of July 1, 2012, and the setting does not meet the criteria of this section.

(d) Notwithstanding paragraph (c), a program in Hennepin County established as part of a Hennepin County demonstration project is qualified for the exception allowed under paragraph (c).

(e) The commissioner shall submit an amendment to the waiver plan no later than December 31, 2012.

Subd. 2. **Exceptions for home and community-based waiver housing programs.** (a) Beginning no later than January 2015, based on the consultation with interested stakeholders as specified in subdivision 3, the commissioner shall accept and process applications for exceptions to subdivision 1 based on the criteria in this subdivision.

(b) An owner, operator, or developer of a community living setting may apply to the commissioner for the granting of an exception from the requirement in subdivision 1, paragraph (a), clause (3), that individuals receiving services under a home and

community-based waiver under section 256B.092 or 256B.49 may only reside in all of the units in a building of four or fewer units, and no more than the greater of four or 25 percent of the units in a multifamily building of more than four units and from the requirement in subdivision 1, paragraph (b), clause (3), that a setting cannot be a housing complex designed expressly around an individual's diagnosis or disability. Such an exception from the requirements in subdivision 1, paragraphs (a), clause (3), and (b), clause (3), may be granted when the organization requesting the exception submits to the commissioner an application providing the information requested in paragraph (c). The exception shall require that housing costs be separated from service costs and allow the client to choose the vendor who provides personal services under the client's waiver.

(c) A community living setting application for an exemption must provide the following information and affirmations:

(1) affirms the community living setting materially meets all the requirements for home and community-based settings in subdivision 1, paragraph (b), other than clause (3);

(2) explains the scope and necessity of the exception, including documentation of the characteristics of the population to be served and the demand for the number of units the applicant anticipates will be occupied by individuals receiving services under a home and community-based waiver in the proposed setting;

(3) explains how the community living setting supports all individuals receiving services under a home and community-based waiver in choosing the setting from among other options and the availability of those other options in the community for the specific population the program proposes to serve, and outlines the proposed rents and service costs, if any, of services to be provided by the applicant and addresses the cost-effectiveness of the model proposed; and

(4) includes a quality assurance plan affirming that the organization requesting the exception:

(i) supports or develops scattered-site alternatives to the setting for which the exception is requested;

(ii) supports the transition of individuals receiving services under a home and community-based waiver to the most integrated setting appropriate to the individual's needs;

(iii) has a history of meeting recognized quality standards for the population it serves or is targeting, or that it will meet recognized quality standards;

(iv) provides and facilitates for tenants receiving services under a home and community-based waiver unlimited access to the community, including opportunities to interact with nonstaff people without disabilities, appropriate to the individual's needs; and

(v) supports a safe and healthy environment for all individuals living in the setting.

(d) In assessing whether to grant the applicant's exception request, the commissioner shall:

(1) evaluate all of the assertions in the application, verify the assertions are accurate, and ensure that the application is complete;

(2) consult with all divisions in the Department of Human Services relevant to the specific populations being served by the applicant and the Minnesota Housing Finance Agency;

(3) within 30 days of receiving the application notify the city, county, and local press of the 14-day public comment period to consider community input on the application, including input from tenants, potential tenants, and other interested stakeholders;

(4) within 60 days of receiving the application issue an approval, conditional approval, or denial of the exception sought; and

(5) accept and process applications from settings throughout the calendar year.

If conditional approval is granted under this section, the commissioner must specify the reasons for conditional approval of the exception and allow the applicant 30 days to amend the application and issue a renewed decision within 15 days of receiving the amended application. If the commissioner denies an exception under this section, the commissioner must specify reasons for denial of the exception.

(e) After an applicant's exception is approved, any material change in the population to be served or the services to be offered must be submitted to the commissioner who shall decide if it is consistent with the basis on which the exception was granted or if another exception request needs to be submitted.

(f) If an exception is approved and later revoked, no tenant shall be displaced as a result of this revocation until a relocation plan has been implemented that provides for an acceptable alternative placement.

(g) Notwithstanding the above provision, no organization that meets the requirements under subdivision 1 shall be required to apply for an exception described in this subdivision.

Subd. 3. **Public input on exception process.** The commissioner shall consult with interested stakeholders to develop a plan for implementing the exceptions process described in subdivision 2. The implementation plan for the applications shall be based upon the criteria in subdivision 2 and any other information necessary to manage the exceptions process. The commissioner must consult with representatives from each relevant division of the Department of Human Services, The Coalition for Choice in Housing, NAMI, The Arc Minnesota, Mental Health Association of Minnesota, Minnesota Disability Law

Center, and other provider organizations, counties, municipalities, disability advocates, and individuals with disabilities or family members of an individual with disabilities.

Sec. 55. Minnesota Statutes 2012, section 256B.5012, is amended by adding a subdivision to read:

Subd. 16. **ICF/DD rate increases effective July 1, 2014.** (a) For each facility reimbursed under this section, for the rate period beginning July 1, 2014, the commissioner shall increase operating payments equal to four percent of the operating payment rates in effect on July 1, 2014. For each facility, the commissioner shall apply the rate increase based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate in effect on the preceding date.

(b) To receive the rate increase under paragraph (a), each facility reimbursed under this section must submit to the commissioner documentation that identifies a quality improvement project the facility will implement by June 30, 2015. Documentation must be provided in a format specified by the commissioner. Projects must:

(1) improve the quality of life of intermediate care facility residents in a meaningful way;

(2) improve the quality of services in a measurable way; or

(3) deliver good quality service more efficiently while using the savings to enhance services for the participants served.

(c) For a facility that fails to submit the documentation described in paragraph (b) by a date or in a format specified by the commissioner, the commissioner shall reduce the facility's rate by one percent effective January 1, 2015.

(d) Facilities that receive a rate increase under this subdivision shall use 75 percent of the rate increase to increase compensation-related costs for employees directly employed by the facility on or after the effective date of the rate adjustments, except:

(1) persons employed in the central office of a corporation or entity that has an ownership interest in the facility or exercises control over the facility; and

(2) persons paid by the facility under a management contract.

This requirement is subject to audit by the commissioner.

(e) Compensation-related costs include:

(1) wages and salaries;

(2) the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, and mileage reimbursement;

(3) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, pensions, and contributions to employee retirement accounts; and

(4) other benefits provided and workforce needs, including the recruiting and training of employees as specified in the distribution plan required under paragraph (f).

(f) A facility that receives a rate adjustment under paragraph (a) that is subject to paragraphs (d) and (e) shall prepare and produce for the commissioner, upon request, a plan that specifies the amount of money the provider expects to receive that is subject to the requirements of paragraphs (d) and (e), as well as how that money will be distributed to increase compensation for employees. The commissioner may recover funds from a facility that fails to comply with this requirement.

(g) Within six months after the effective date of the rate adjustment, the facility shall post the distribution plan required under paragraph (f) for a period of at least six weeks in an area of the facility's operation to which all eligible employees have access, and shall provide instructions for employees who believe they have not received the wage and other compensation-related increases specified in the distribution plan. These instructions must include a mailing address, e-mail address, and telephone number that an employee may use to contact the commissioner or the commissioner's representative. Facilities shall make assurances to the commissioner of compliance with this subdivision using forms prescribed by the commissioner.

(h) For public employees, the increase for wages and benefits for certain staff is available and pay rates must be increased only to the extent that the increases comply with laws governing public employees' collective bargaining. Money received by a provider for pay increases for public employees under this subdivision may be used only for increases implemented within one month of the effective date of the rate increase and must not be used for increases implemented prior to that date.

(i) For a provider that has employees that are represented by an exclusive bargaining representative, the provider shall obtain a letter of acceptance of the distribution plan, in regard to the members of the bargaining unit, signed by the exclusive bargaining agent. Upon receipt of the letter of acceptance, the provider shall be deemed to have met all the requirements of this subdivision in regard to the members of the bargaining unit. The provider shall produce the letter of acceptance for the commissioner upon request.

Sec. 56. Laws 2013, chapter 108, article 7, section 14, the effective date, is amended to read:

EFFECTIVE DATE. Subdivisions 1 to 7 and 9~~,~~ are effective upon federal approval consistent with subdivision 11, but no earlier than ~~March~~ July 1, 2014. Subdivisions 8, 10, and 11 are effective July 1, 2013.

Sec. 57. **PROVIDER RATE AND GRANT INCREASES EFFECTIVE JULY 1, 2014.**

(a) The commissioner of human services shall increase reimbursement rates, grants, allocations, individual limits, and rate limits, as applicable, by four percent for the rate period beginning July 1, 2014, for services rendered on or after that date. County or tribal contracts for services specified in this section must be amended to pass through these rate increases within 60 days of the effective date.

(b) The rate changes described in this section must be provided to:

(1) home and community-based waiver services for persons with developmental disabilities, including consumer-directed community supports, under Minnesota Statutes, section 256B.092;

(2) waiver services under community alternatives for disabled individuals, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(3) community alternative care waiver services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(4) brain injury waiver services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(5) home and community-based waiver services for the elderly under Minnesota Statutes, section 256B.0915;

(6) nursing services and home health services under Minnesota Statutes, section 256B.0625, subdivision 6a;

(7) personal care services and qualified professional supervision of personal care services under Minnesota Statutes, section 256B.0625, subdivisions 6a and 19a;

(8) private duty nursing services under Minnesota Statutes, section 256B.0625, subdivision 7;

(9) community first services and supports under Minnesota Statutes, section 256B.85;

(10) essential community supports under Minnesota Statutes, section 256B.0922;

(11) day training and habilitation services for adults with developmental disabilities or related conditions under Minnesota Statutes, sections 252.41 to 252.46, including the additional cost to counties for rate adjustments to day training and habilitation services provided as a social service;

(12) alternative care services under Minnesota Statutes, section 256B.0913;

(13) living skills training programs for persons with intractable epilepsy who need assistance in the transition to independent living under Laws 1988, chapter 689;

(14) consumer support grants under Minnesota Statutes, section 256.476;

(15) semi-independent living services under Minnesota Statutes, section 252.275;

(16) family support grants under Minnesota Statutes, section 252.32;

(17) housing access grants under Minnesota Statutes, section 256B.0658;

(18) self-advocacy grants under Laws 2009, chapter 101;

(19) technology grants under Laws 2009, chapter 79;

(20) aging grants under Minnesota Statutes, sections 256.975 to 256.977 and 256B.0917;

(21) deaf and hard-of-hearing grants, including community support services for deaf and hard-of-hearing adults with mental illness who use or wish to use sign language as their primary means of communication under Minnesota Statutes, section 256.01, subdivision 2;

(22) deaf and hard-of-hearing grants under Minnesota Statutes, sections 256C.233, 256C.25, and 256C.261;

(23) Disability Linkage Line grants under Minnesota Statutes, section 256.01, subdivision 24;

(24) transition initiative grants under Minnesota Statutes, section 256.478;

(25) employment support grants under Minnesota Statutes, section 256B.021, subdivision 6; and

(26) grants provided to people who are eligible for the Housing Opportunities for Persons with AIDS program under Minnesota Statutes, section 256B.492.

(c) A managed care plan receiving state payments for the services in paragraph (b) must include the increases in paragraph (a) in payments to providers. To implement the rate increase in this section, capitation rates paid by the commissioner to managed care organizations under Minnesota Statutes, section 256B.69, shall reflect a four percent increase for the specified services for the period beginning July 1, 2014.

(d) Counties shall increase the budget for each recipient of consumer-directed community supports by the amounts in paragraph (a) on the effective dates in paragraph (a).

(e) To implement this section, the commissioner shall increase service rates in the disability waiver payment system authorized in Minnesota Statutes, sections 256B.4913 and 256B.4914.

(f) To receive the rate increase described in this section, providers under paragraphs (a) and (b) must submit to the commissioner documentation that identifies a quality improvement project that the provider will implement by June 30, 2015. Documentation must be provided in a format specified by the commissioner. Projects must:

(1) improve the quality of life of home and community-based services recipients in a meaningful way;

(2) improve the quality of services in a measurable way; or

(3) deliver good quality service more efficiently while using the savings to enhance services for the participants served.

Providers listed in paragraph (b), clauses (7), (9), (10), and (13) to (26), are not subject to this requirement.

(g) For a provider that fails to submit documentation described in paragraph (f) by a date or in a format specified by the commissioner, the commissioner shall reduce the provider's rate by one percent effective January 1, 2015.

(h) Providers that receive a rate increase under this subdivision shall use 75 percent of the rate increase to increase compensation-related costs for employees directly employed by the facility on or after the effective date of the rate adjustments, except:

(1) persons employed in the central office of a corporation or entity that has an ownership interest in the facility or exercises control over the facility; and

(2) persons paid by the facility under a management contract.

This requirement is subject to audit by the commissioner.

(i) Compensation-related costs include:

(1) wages and salaries;

(2) the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, and mileage reimbursement;

(3) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, pensions, and contributions to employee retirement accounts; and

(4) other benefits provided and workforce needs, including the recruiting and training of employees as specified in the distribution plan required under paragraph (l).

(j) For public employees, the increase for wages and benefits for certain staff is available and pay rates must be increased only to the extent that the increases comply with laws governing public employees' collective bargaining. Money received by a provider for pay increases for public employees under this section may be used only for increases implemented within one month of the effective date of the rate increase and must not be used for increases implemented prior to that date.

(k) For a provider that has employees that are represented by an exclusive bargaining representative, the provider shall obtain a letter of acceptance of the distribution plan, in regard to the members of the bargaining unit, signed by the exclusive bargaining agent. Upon receipt of the letter of acceptance, the provider shall be deemed to have met all the

requirements of this section in regard to the members of the bargaining unit. The provider shall produce the letter of acceptance for the commissioner upon request.

(l) A provider that receives a rate adjustment under paragraph (b) that is subject to paragraphs (h) and (i) shall prepare and produce for the commissioner, upon request, a plan that specifies the amount of money the provider expects to receive that is subject to the requirements of paragraphs (h) and (i), as well as how that money will be distributed to increase compensation for employees. The commissioner may recover funds from a facility that fails to comply with this requirement.

(m) Within six months after the effective date of the rate adjustment, the provider shall post the distribution plan required under paragraph (l) for a period of at least six weeks in an area of the provider's operation to which all eligible employees have access, and shall provide instructions for employees who believe they have not received the wage and other compensation-related increases specified in the distribution plan. These instructions must include a mailing address, e-mail address, and telephone number that an employee may use to contact the commissioner or the commissioner's representative. Providers shall make assurances to the commissioner of compliance with this section using forms prescribed by the commissioner.

Sec. 58. **REVISOR'S INSTRUCTION.**

(a) In each section of Minnesota Statutes or part of Minnesota Rules referred to in column A, the revisor of statutes shall delete the word or phrase in column B and insert the phrase in column C. The revisor shall also make related grammatical changes and changes in headnotes.

Column A	Column B	Column C
section 158.13	defective persons	persons with developmental disabilities
section 158.14	defective persons	persons with developmental disabilities
section 158.17	defective persons	persons with developmental disabilities
section 158.18	persons not defective	persons without developmental disabilities
	defective person	person with developmental disabilities
	defective persons	persons with developmental disabilities
section 158.19	defective	person with developmental disabilities
section 256.94	defective	children with developmental disabilities and

			children with developmental
section 257.175	defective		disabilities and
part 2911.1350	retardation		developmental disability

(b) The revisor of statutes shall change the term "health and safety" to "health and welfare" in the following statutes: Minnesota Statutes, sections 245D.03, 245D.061, 245D.071, 245D.10, 245D.11, 245D.31, 256B.0915, and 256B.092.

ARTICLE 6

MISCELLANEOUS

Section 1. Minnesota Statutes 2013 Supplement, section 16A.724, subdivision 2, is amended to read:

Subd. 2. **Transfers.** (a) Notwithstanding section 295.581, to the extent available resources in the health care access fund exceed expenditures in that fund, effective for the biennium beginning July 1, 2007, the commissioner of management and budget shall transfer the excess funds from the health care access fund to the general fund on June 30 of each year, provided that the amount transferred in any fiscal biennium shall not exceed $96,000,000. The purpose of this transfer is to meet the rate increase required under Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision 6.

(b) For fiscal ~~years 2006 to 2011~~ year 2018 and thereafter, MinnesotaCare shall be a forecasted program, and, if necessary, the commissioner shall reduce these transfers from the health care access fund to the general fund to meet annual MinnesotaCare expenditures or, if necessary, transfer sufficient funds from the general fund to the health care access fund to meet annual MinnesotaCare expenditures.

(c) Notwithstanding section 295.581, to the extent available resources in the health care access fund exceed expenditures in that fund after the transfer required in paragraph (a), effective for the biennium beginning July 1, 2013, the commissioner of management and budget shall transfer $1,000,000 each fiscal year from the health access fund to the medical education and research costs fund established under section 62J.692, for distribution under section 62J.692, subdivision 4, paragraph (c).

Sec. 2. Minnesota Statutes 2012, section 254B.12, is amended to read:

254B.12 RATE METHODOLOGY.

Subdivision 1. **CCDTF rate methodology established.** The commissioner shall establish a new rate methodology for the consolidated chemical dependency treatment fund. The new methodology must replace county-negotiated rates with a uniform

statewide methodology that must include a graduated reimbursement scale based on the patients' level of acuity and complexity. At least biennially, the commissioner shall review the financial information provided by vendors to determine the need for rate adjustments.

Subd. 2. **Payment methodology for highly specialized vendors.** (a) Notwithstanding subdivision 1, the commissioner shall seek federal authority to develop a separate payment methodology for chemical dependency treatment services provided under the consolidated chemical dependency treatment fund for persons who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community. This payment methodology is effective for services provided on or after October 1, 2015, or on or after the receipt of federal approval, whichever is later.

(b) Before implementing an approved payment methodology under paragraph (a), the commissioner must also receive any necessary legislative approval of required changes to state law or funding.

Sec. 3. Minnesota Statutes 2012, section 256I.04, subdivision 2b, is amended to read:

Subd. 2b. **Group residential housing agreements.** (a) Agreements between county agencies and providers of group residential housing must be in writing and must specify the name and address under which the establishment subject to the agreement does business and under which the establishment, or service provider, if different from the group residential housing establishment, is licensed by the Department of Health or the Department of Human Services; the specific license or registration from the Department of Health or the Department of Human Services held by the provider and the number of beds subject to that license; the address of the location or locations at which group residential housing is provided under this agreement; the per diem and monthly rates that are to be paid from group residential housing funds for each eligible resident at each location; the number of beds at each location which are subject to the group residential housing agreement; whether the license holder is a not-for-profit corporation under section 501(c)(3) of the Internal Revenue Code; and a statement that the agreement is subject to the provisions of sections 256I.01 to 256I.06 and subject to any changes to those sections. Group residential housing agreements may be terminated with or without cause by either the county or the provider with two calendar months prior notice.

(b) The commissioner may enter directly into an agreement with a provider serving veterans who meet the eligibility criteria of this section and reside in a setting according to subdivision 2a, located in Stearns County. Responsibility for monitoring and oversight of this setting shall remain with Stearns County. This agreement may be terminated with

or without cause by either the commissioner or the provider with two calendar months prior notice. This agreement shall be subject to the requirements of county agreements and negotiated rates in subdivisions 1, paragraphs (a) and (b), and 2, and sections 256I.05, subdivisions 1 and 1c, and 256I.06, subdivision 7.

EFFECTIVE DATE. This section is effective July 1, 2015.

Sec. 4. Minnesota Statutes 2012, section 256I.05, subdivision 2, is amended to read:

Subd. 2. **Monthly rates; exemptions.** ~~The maximum group residential housing rate does not apply~~ This subdivision applies to a residence that on August 1, 1984, was licensed by the commissioner of health only as a boarding care home, certified by the commissioner of health as an intermediate care facility, and licensed by the commissioner of human services under Minnesota Rules, parts 9520.0500 to 9520.0690. Notwithstanding the provisions of subdivision 1c, the rate paid to a facility reimbursed under this subdivision shall be determined under section 256B.431, or under section 256B.434 if the facility is accepted by the commissioner for participation in the alternative payment demonstration project. The rate paid to this facility shall also include adjustments to the group residential housing rate according to subdivision 1, and any adjustments applicable to supplemental service rates statewide.

Sec. 5. Minnesota Statutes 2012, section 256J.49, subdivision 13, is amended to read:

Subd. 13. **Work activity.** (a) "Work activity" means any activity in a participant's approved employment plan that leads to employment. For purposes of the MFIP program, this includes activities that meet the definition of work activity under the participation requirements of TANF. Work activity includes:

(1) unsubsidized employment, including work study and paid apprenticeships or internships;

(2) subsidized private sector or public sector employment, including grant diversion as specified in section 256J.69, on-the-job training as specified in section 256J.66, paid work experience, and supported work when a wage subsidy is provided;

(3) unpaid work experience, including community service, volunteer work, the community work experience program as specified in section 256J.67, unpaid apprenticeships or internships, and supported work when a wage subsidy is not provided. Unpaid work experience is only an option if the participant has been unable to obtain or maintain paid employment in the competitive labor market, and no paid work experience programs are available to the participant. Prior to placing a participant in unpaid work, the county must inform the participant that the participant will be notified if a paid work

experience or supported work position becomes available. Unless a participant consents in writing to participate in unpaid work experience, the participant's employment plan may only include unpaid work experience if including the unpaid work experience in the plan will meet the following criteria:

(i) the unpaid work experience will provide the participant specific skills or experience that cannot be obtained through other work activity options where the participant resides or is willing to reside; and

(ii) the skills or experience gained through the unpaid work experience will result in higher wages for the participant than the participant could earn without the unpaid work experience;

(4) job search including job readiness assistance, job clubs, job placement, job-related counseling, and job retention services;

(5) job readiness education, including English as a second language (ESL) or functional work literacy classes ~~as limited by the provisions of section 256J.531, subdivision 2~~, general educational development (GED) or Minnesota adult diploma course work, high school completion, and adult basic education ~~as limited by the provisions of section 256J.531, subdivision 1~~;

(6) job skills training directly related to employment, including postsecondary education and training that can reasonably be expected to lead to employment~~, as limited by the provisions of section 256J.53~~;

(7) providing child care services to a participant who is working in a community service program;

(8) activities included in the employment plan that is developed under section 256J.521, subdivision 3; and

(9) preemployment activities including chemical and mental health assessments, treatment, and services; learning disabilities services; child protective services; family stabilization services; or other programs designed to enhance employability.

(b) "Work activity" does not include activities done for political purposes as defined in section 211B.01, subdivision 6.

Sec. 6. Minnesota Statutes 2012, section 256J.53, subdivision 1, is amended to read:

Subdivision 1. **Length of program.** (a) In order for a postsecondary education or training program to be an approved work activity as defined in section 256J.49, subdivision 13, clause (6), it must be a program lasting ~~24 months~~ four years or less, and the participant must meet the requirements of subdivisions 2, 3, and 5.

(b) Participants with a high school diploma, general educational development (GED) credential, or Minnesota adult diploma must be informed of the opportunity to participate in postsecondary education or training while in the Minnesota family investment program.

Sec. 7. Minnesota Statutes 2012, section 256J.53, subdivision 2, is amended to read:

Subd. 2. **Approval of postsecondary education or training.** (a) ~~In order for a postsecondary education or training program to be an approved activity in an employment plan, the plan must include additional work activities if the education and training activities do not meet the minimum hours required to meet the federal work participation rate under Code of Federal Regulations, title 45, sections 261.31 and 261.35.~~

~~(b)~~ Participants ~~seeking approval of a~~ who are interested in participating in postsecondary education or training ~~plan~~ as part of their employment plan must ~~provide documentation that~~ discuss their education plans with their job counselor. Job counselors must work with participants to evaluate options by:

(1) ~~the employment goal can only be met with the additional education or training;~~

~~(2)~~ advising whether there are suitable employment opportunities that require the specific education or training in the area in which the participant resides or is willing to reside;

~~(3) the education or training will result in significantly higher wages for the participant than the participant could earn without the education or training;~~

~~(4)~~ (2) assisting the participant in exploring whether the participant can meet the requirements for admission into the program; and

~~(5)~~ (3) ~~there is a reasonable expectation that the participant will complete the training program~~ discussing the participant's strengths and challenges based on ~~such factors as~~ the participant's MFIP assessment, previous education, training, and work history~~; current motivation; and changes in previous circumstances~~.

(b) The requirements of this subdivision do not apply to participants who are in:

(1) a recognized career pathway program that leads to stackable credentials;

(2) a training program lasting 12 weeks or less; or

(3) the final year of a multi-year postsecondary education or training program.

Sec. 8. Minnesota Statutes 2012, section 256J.53, subdivision 5, is amended to read:

Subd. 5. **Requirements after postsecondary education or training.** Upon completion of an approved education or training program, a participant who does not meet the participation requirements in section 256J.55, subdivision 1, through unsubsidized employment must participate in job search. If, after ~~six~~ 12 weeks of job search, the

participant does not find a full-time job consistent with the employment goal, the participant must accept any offer of full-time suitable employment, or meet with the job counselor to revise the employment plan to include additional work activities necessary to meet hourly requirements.

Sec. 9. Minnesota Statutes 2012, section 256J.531, is amended to read:

256J.531 BASIC EDUCATION; ENGLISH AS A SECOND LANGUAGE.

Subdivision 1. **Approval of adult basic education.** ~~With the exception of classes related to obtaining a general educational development credential (GED), a participant must have reading or mathematics proficiency below a ninth grade level in order for adult basic education classes to be an~~ A participant who lacks a high school diploma, general educational development (GED) credential, or Minnesota adult diploma must be allowed to pursue these credentials as an approved work activity, provided that the participant is making satisfactory progress. Participants eligible to pursue a general educational development (GED) credential or Minnesota adult diploma under this subdivision must be informed of the opportunity to participate while in the Minnesota family investment program. ~~The employment plan must also specify that the participant fulfill no more than one-half of the participation requirements in section 256J.55, subdivision 1, through attending adult basic education or general educational development classes.~~

Subd. 2. **Approval of English as a second language.** In order for English as a second language (ESL) classes to be an approved work activity in an employment plan, a participant must be below a spoken language proficiency level of SPL6 or its equivalent, as measured by a nationally recognized test. In approving ESL as a work activity, the job counselor must give preference to enrollment in a functional work literacy program, if one is available, over a regular ESL program. ~~A participant may not be approved for more than a combined total of 24 months of ESL classes while participating in the diversionary work program and the employment and training services component of MFIP. The employment plan must also specify that the participant fulfill no more than one-half of the participation requirements in section 256J.55, subdivision 1, through attending ESL classes. For participants enrolled in functional work literacy classes, no more than two-thirds of the participation requirements in section 256J.55, subdivision 1, may be met through attending functional work literacy classes.~~

Sec. 10. Laws 2013, chapter 108, article 3, section 48, is amended to read:

Sec. 48. **REPEALER.**

(a) Minnesota Statutes 2012, section 256J.24, subdivision 6, is repealed ~~January~~ July 1, ~~2015~~ 2014.

(b) Minnesota Statutes 2012, section 609.093, is repealed effective the day following final enactment.

EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 11. **PARENT AWARE QUALITY RATING AND IMPROVEMENT SYSTEM ACCESSIBILITY REPORT.**

Subdivision 1. **Recommendations.** The commissioner of human services, in consultation with representatives from the child care and early childhood advocacy community, child care provider organizations, child care providers, organizations administering Parent Aware, the Departments of Education and Health, counties, and parents, shall make recommendations to the legislature on increasing statewide accessibility for child care providers to the Parent Aware quality rating and improvement system and for increasing access to Parent Aware-rated programs for families with children. The recommendations must address the following factors impacting accessibility:

(1) availability of rated and nonrated programs by child care provider type, within rural and underserved areas, and for different cultural and non-English-speaking groups;

(2) time and resources necessary for child care providers to participate in Parent Aware at various rating levels, including cultural and linguistic considerations;

(3) federal child care development fund regulations; and

(4) other factors as determined by the commissioner.

Subd. 2. **Report.** By February 15, 2015, the commissioner of human services shall report to the legislative committees with jurisdiction over the child care assistance programs and the Parent Aware quality rating and improvement system with recommendations to increase access for families and child care providers to Parent Aware, including benchmarks for achieving the maximum participation in Parent Aware-rated child care programs by families receiving child care assistance.

The recommendations may also include, but are not limited to, potential modifications to Minnesota Statutes, sections 119B.09, subdivision 5; and 119B.125, subdivision 1, if necessary, which may include a delayed effective date, different phase-in process, or repealer.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 12. **DIRECTION TO COMMISSIONER.**

The commissioner of human services shall implement the repeal of the MFIP family cap July 1, 2014. The commissioner shall make every effort to complete systems modifications by that date. If systems modifications cannot be completed in time, the commissioner shall implement a manual procedure to implement the change.

Sec. 13. **CIVIL COMMITMENT TRAINING PROGRAM.**

The commissioner of human services shall develop an online training program for interested individuals and personnel, specifically county and hospital staff and mental health providers, to understand, clarify, and interpret the Civil Commitment Act under Minnesota Statutes, chapter 253B, as it pertains to persons with mental illnesses. The training must be developed in collaboration with the ombudsman for mental health and developmental disabilities, Minnesota County Attorneys Association, National Alliance on Mental Illness of Minnesota, Mental Health Consumer/Survivor Network of Minnesota, State Advisory Council on Mental Health, Mental Health Association, Minnesota Psychiatric Society, Hennepin Commitment Defense Panel, Minnesota Disability Law Center, Minnesota Association of Community Mental Health Programs, Minnesota Hospital Association, and Minnesota Board of Public Defense. The purpose of the training is to promote better clarity and interpretation of the civil commitment laws.

Sec. 14. **DIRECTION TO COMMISSIONER; REPORT ON PROGRAM WAITING LISTS.**

In preparing background materials for the 2016-2017 biennium, the commissioner of human services shall prepare a listing of all of the waiting lists for services that the department oversees and directs. The listing shall identify the number of persons on those waiting lists as of October 1, 2014, an estimate of the cost of serving them based on current average costs, and an estimate of the number of jobs that would be created given current average levels of staffing if the waiting list were eliminated. The commissioner is encouraged to engage postsecondary students in the assembly, analysis, and reporting of this information. The information shall be provided to the governor, the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, and the Legislative Reference Library in electronic form by December 1, 2014.

Sec. 15. **MENTALLY ILL OFFENDERS ARRESTED OR SUBJECT TO ARREST; WORKING GROUP.**

Subdivision 1. **Working group established; study and draft legislation required.** The commissioner of human services may convene a working group to address issues related to offenders with mental illness who are arrested or subject to arrest. The working group shall consider the special needs of these offenders and determine how best to provide for these needs. Specifically, the group shall consider the efficacy of a facility that would serve as a central point for accepting, assessing, and addressing the needs of offenders with mental illness brought in by law enforcement as an alternative to arrest or following arrest. The facility would consolidate and coordinate existing resources as well as offer new resources that would provide a continuum of care addressing the immediate, short-term, and long-term needs of these offenders. The facility would do the following for these offenders: perform timely, credible, and useful mental health assessments; identify community placement opportunities; coordinate community care; make recommendations concerning pretrial release when appropriate; and, in some cases, provide direct services to offenders at the facility or in nearby jails. The working group shall establish criteria to determine which offenders may be admitted to the facility. The facility would be located in the metropolitan region and serve the needs of nearby counties. The facility would represent a partnership between the state, local units of government, and the private sector. In addition, the working group may consider how similar facilities could function in outstate areas. When studying this issue, the working group shall examine what other states have done in this area to determine what programs have been successful and use those programs as models in developing the program in Minnesota. The working group may also study and make recommendations on other ways to improve the process for addressing and assisting these offenders. The commissioner shall enter into an agreement with NAMI Minnesota to carry out the work of the working group.

Subd. 2. **Membership.** The commissioner shall ensure that the working group has expertise and a broad range of interests represented, including, but not limited to: prosecutors; law enforcement, including jail staff; correctional officials; probation officials; criminal defense attorneys; judges; county and city officials; mental health advocates; mental health professionals; and hospital and health care officials.

Subd. 3. **Administrative issues.** (a) The commissioner shall convene the first meeting of the working group by September 1, 2014. NAMI Minnesota shall provide meeting space and administrative support to the working group. The working group shall select a chair from among its members.

(b) The commissioner may solicit in-kind support from work group member agencies to accomplish its assigned duties.

Subd. 4. **Report required.** By January 1, 2015, the working group shall submit a report to the chairs and ranking minority members of the senate and house of representatives committees and divisions having jurisdiction over human services and public safety. The report must summarize the working group's activities and include its recommendations and draft legislation. The recommendations must be specific and include estimates of the costs involved in implementing the recommendations, including the funding sources that might be used to pay for it. The working group shall explore potential funding sources at the federal, local, and private levels, and provide this information in the report. In addition, the report must include draft legislation to implement the recommendations.

Sec. 16. **DETOXIFICATION SERVICES; INSTRUCTIONS TO THE COMMISSIONER.**

The commissioner of human services shall develop a plan to include detoxification services as a covered medical assistance benefit and present the plan to the legislature by December 15, 2014.

ARTICLE 7

HEALTH AND HUMAN SERVICES APPROPRIATIONS

Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are added to or, if shown in parentheses, subtracted from the appropriations in Laws 2013, chapter 108, articles 14 and 15, to the agencies and for the purposes specified in this article. The appropriations are from the general fund and are available for the fiscal years indicated for each purpose. The figures "2014" and "2015" used in this article mean that the addition to or subtraction from the appropriation listed under them is available for the fiscal year ending June 30, 2014, or June 30, 2015, respectively. Supplemental appropriations and reductions to appropriations for the fiscal year ending June 30, 2014, are effective the day following final enactment unless a different effective date is explicit.

	APPROPRIATIONS Available for the Year Ending June 30	
	2014	**2015**
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**		
Subdivision 1. **Total Appropriation**	**785,000**	**73,849,000**

	Appropriations by Fund		
General	785,000	71,502,000	
Federal TANF	-0-	2,347,000	

The appropriation modifications for each purpose are shown in the following subdivisions.

Subd. 2. **Central Office Operations**

(a) **Operations**	-0-	63,000

Base adjustment. The general fund base is decreased by $6,000 in fiscal years 2016 and 2017.

(b) **Health Care**	-0-	113,000

Base adjustment. The general fund base is increased by $108,000 in fiscal years 2016 and 2017.

(c) **Continuing Care**	-0-	1,084,000

Base adjustment. The general fund base is increased by $156,000 in fiscal year 2016 and $19,000 in fiscal year 2017.

(d) **Chemical and Mental Health**	-0-	115,000

Subd. 3. **Forecasted Programs**

(a) **MFIP/DWP**

Appropriations by Fund		
General	-0-	122,000
Federal TANF	-0-	1,995,000

(b) **Group Residential Housing**	-0-	681,000
(c) **Medical Assistance**	800,000	63,744,000
(d) **Alternative Care**	-0-	772,000

Subd. 4. **Grant Programs**

(a) **Children's Services Grants** -0- (3,000)

Base adjustment. The general fund base is increased by $9,000 in fiscal year 2017.

(b) **Child and Economic Support Grants** -0- 1,669,000

Safe harbor. $569,000 in fiscal year 2015 from the general fund is for housing and supportive services for sexually exploited youth.

Homeless youth. $1,100,000 in fiscal year 2015 is for purposes of Minnesota Statutes, section 256K.45.

(c) **Aging and Adult Services Grants** (15,000) 1,180,000

Senior nutrition. $425,000 in fiscal year 2015 from the general fund is for congregate dining services under Minnesota Statutes, section 256.9752.

Base adjustment. The general fund base is decreased by $429,000 in fiscal year 2016 and $419,000 in fiscal year 2017.

(d) **Deaf and Hard-of-Hearing Grants** -0- 66,000

Base adjustment. The general fund base is increased by $6,000 in fiscal years 2016 and 2017.

(e) **Disabilities Grants** -0- 1,015,000

Base adjustment. The general fund base is increased by $224,000 in fiscal year 2016 and $233,000 in fiscal year 2017.

Subd. 5. **State-Operated Services**

(a) **SOS Mental Health** -0- 881,000

Civil commitments. $35,000 in fiscal year 2015 is for developing an online training

program to help interested parties understand the civil commitment process.

Base adjustment. The general fund base is increased by $213,000 in fiscal years 2016 and 2017.

(b) **SOS Enterprise Services** -0- -0-

Community Addiction Recovery Enterprise deficiency funding.

Notwithstanding Minnesota Statutes, section 254B.06, subdivision 1, $4,000,000 is transferred in fiscal years 2014 and 2015 from the consolidated chemical dependency treatment fund administrative account in the special revenue fund and deposited into the enterprise fund for the Community Addiction Recovery Enterprise. This clause is effective the day following final enactment.

Subd. 6. **Technical Activities**

MFIP Child Care Assistance

	Appropriations by Fund	
Federal TANF	-0-	352,000

Sec. 3. **COMMISSIONER OF HEALTH.**

Subdivision 1. **Total Appropriation** **$ 967,000 $ 1,801,000**

	Appropriations by Fund	
	2014	2015
General	1,150,000	1,994,000
State Government Special Revenue	817,000	807,000
Health Care Access	(1,000,000)	(1,000,000)

Subd. 2. **Health Improvement**

	Appropriations by Fund	
General	75,000	1,819,000

Poison information centers. $750,000 in fiscal year 2015 from the general fund

is for regional poison information centers under Minnesota Statutes, section 145.93, and is added to the base. The appropriation is (1) to enhance staffing to meet national accreditation standards; (2) for health care provider education and training; (3) for surveillance of emerging toxicology and poison issues; and (4) to cooperate with local public health officials on outreach efforts.

Minority health disparity grants. $100,000 in fiscal year 2014 and $475,000 in fiscal year 2015 are for the commissioner of health to begin implementing recommendations of the health equity report under Laws 2013, chapter 108, article 12, section 102. This funding is onetime and shall not become part of base funding. Funds must be distributed as follows:

(1) $100,000 in fiscal year 2014 and $100,000 in fiscal year 2015 are for dementia outreach education and training grants targeting minority communities under article 1, section 7;

(2) $75,000 in fiscal year 2015 is for planning and conducting a training conference on immigrant and refugee mental health issues. The conference shall include an emphasis on mental health concerns in the Somali community. Conference planning shall include input from the Somali community and other stakeholders. This is a onetime appropriation;

(3) up to $150,000 in fiscal year 2015 is for additional grants, including but not limited to a grant to a Somali women-led

health care agency. Grantees must use community-based, participatory research to address health inequities and provide services through culturally specific, minority-centered programs; and

(4) remaining funds shall be used for redesigning agency grant making to advance health equity, ensuring that health equity and the analysis of structural inequities become integral aspects of all agency divisions and programs, and awarding additional grants to address health equity issues.

Safe harbor. $569,000 in fiscal year 2015 from the general fund is for grants for comprehensive services, including trauma-informed, culturally specific services, for sexually exploited youth. The commissioner shall use no more than 6.67 percent of these funds for administration of the grants.

Base level adjustment. The general fund base for fiscal year 2016 is $47,619,000. The general fund base for fiscal year 2017 is $47,669,000.

Subd. 3. **Policy Quality and Compliance**

	Appropriations by Fund	
General	-0-	75,000
State Government Special Revenue	-0-	143,000
Health Care Access	(1,000,000)	(1,000,000)

Legislative health care workforce commission. $75,000 in fiscal year 2015 is for the health care workforce commission in article 1, section 6. This is a onetime appropriation.

Spoken language health care interpreters. $81,000 in fiscal year 2015 from the state government special revenue fund is to develop a proposal to promote health equity and quality health outcomes through changes to laws governing spoken language health care interpreters. The commissioner shall consult with spoken language health care interpreters, organizations that employ these interpreters, organizations that pay for interpreter services, health care providers who use interpreters, clients who use interpreters, and community organizations serving non-English speaking populations. The commissioner shall draft legislation and submit a report that documents the process followed and the rationale for the recommendations to the committees with jurisdiction over health and human services by January 15, 2015. In drafting the legislation and report, the commissioner must consider input received from individuals and organizations consulted and must address issues related to:

(1) qualifications for spoken language health care interpreters that assure quality service to health care providers and their patients;

(2) methods to support the education and skills development of spoken language health care interpreters serving Minnesotans;

(3) the role of an advisory council in maintaining a quality system for spoken language health care interpreting in Minnesota;

(4) management of complaints regarding spoken language health care interpreters, including investigation and enforcement actions;

(5) an appropriate structure for oversight of spoken language health care interpreters, including administrative and technology requirements; and

(6) other issues that address qualifications, quality, access, and affordability of spoken language interpreter services.

This is a onetime appropriation.

Base level adjustment. The state government special revenue fund base for fiscal years 2016 and 2017 shall be $16,529,000.

Subd. 4. **Health Protection**

	Appropriations by Fund	
General	100,000	100,000
State Government Special Revenue	817,000	648,000

Healthy housing. $100,000 in fiscal years 2014 and 2015 from the general fund are for education and training grants under Minnesota Statutes, section 144.9513, subdivision 3, and are added to the base.

Subd. 5. **Administrative Support Services** 975,000 16,000

	Appropriations by Fund	
General	975,000	-0-
State Government Special Revenue	-0-	16,000

Lawsuit settlement. In fiscal year 2014, $975,000 from the general fund is a onetime appropriation for the cost of settling the lawsuit Bearder v. State.

Sec. 4. **OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES** **$ 100,000 $ 100,000**

Sec. 5. Laws 2013, chapter 1, section 6, as amended by Laws 2013, chapter 108, article 6, section 32, is amended to read:

Sec. 6. **TRANSFER.**

(a) The commissioner of management and budget shall transfer from the health care access fund to the general fund up to $21,319,000 in fiscal year 2014; up to $42,314,000 in fiscal year 2015; up to $56,147,000 in fiscal year 2016; and up to $64,683,000 in fiscal year 2017.

(b) The commissioner of human services shall determine the difference between the actual or forecasted cost to the medical assistance program of adding 19- and 20-year-olds and parents and relative caretaker populations with income between 100 and 138 percent of the federal poverty guidelines and the cost of adding those populations that was estimated during the 2013 legislative session based on the data from the February 2013 forecast.

(c) For each fiscal year from 2014 to 2017, the commissioner of human services shall certify and report to the commissioner of management and budget the actual or ~~forecasted~~ estimated cost difference of adding 19- and 20-year-olds and parents and relative caretaker populations with income between 100 and 138 percent of the federal poverty guidelines, as determined under paragraph (b), to the commissioner of management and budget at least four weeks prior to the release of a forecast under Minnesota Statutes, section 16A.103, of each fiscal year.

(d) ~~No later than three weeks before the release of the forecast~~ For fiscal years 2014 to 2017, forecasts under Minnesota Statutes, section 16A.103, prepared by the commissioner of management and budget shall ~~reduce the~~ include actual or estimated adjustments to health care access fund ~~transfer~~ transfers in paragraph (a), ~~by the cumulative differences in costs reported by the commissioner of human services under~~ according to paragraph ~~(c)~~ (e). ~~If, for any fiscal year, the amount of the cumulative cost differences determined under paragraph (b) is positive, no change is made to the appropriation. If, for any fiscal year, the amount of the cumulative cost differences determined under paragraph (b) is less than the amount of the original appropriation, the appropriation for that year must be zero.~~

(e) For each fiscal year from 2014 to 2017, the commissioner of management and budget must adjust the transfer amounts in paragraph (a) by the cumulative difference in costs reported by the commissioner of human services under paragraph (c). If, for any fiscal year, the amount of the cumulative difference in costs reported under paragraph (c) is positive, no adjustment shall be made.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2013.

Sec. 6. Laws 2013, chapter 108, article 14, section 2, subdivision 5, is amended to read:

Subd. 5. **Forecasted Programs**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) MFIP/DWP

	Appropriations by Fund	
General	72,583,000	76,927,000
Federal TANF	80,342,000	76,851,000

(b) MFIP Child Care Assistance	61,701,000	69,294,000
(c) General Assistance	54,787,000	56,068,000

General Assistance Standard. The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from parents or a legal guardian at $203. The commissioner may reduce this amount according to Laws 1997, chapter 85, article 3, section 54.

Emergency General Assistance. The amount appropriated for emergency general assistance funds is limited to no more than $6,729,812 in fiscal year 2014 and $6,729,812 in fiscal year 2015. Funds to counties shall be allocated by the commissioner using the allocation method in Minnesota Statutes, section 256D.06.

(d) MN Supplemental Assistance	38,646,000	39,821,000
(e) Group Residential Housing	141,138,000	150,988,000
(f) MinnesotaCare	297,707,000	247,284,000

This appropriation is from the health care access fund.

(g) Medical Assistance

	Appropriations by Fund	
General	4,443,768,000	4,431,612,000
Health Care Access	179,550,000	226,081,000

Base Adjustment. The health care access fund base is $221,035,000 in fiscal year 2016 and $221,035,000 in fiscal year 2017.

Spending to be apportioned. The commissioner shall apportion expenditures under this paragraph consistent with the requirements of section 12.

Support Services for Deaf and Hard-of-Hearing. $121,000 in fiscal year 2014 and $141,000 in fiscal year 2015; and $10,000 in fiscal year 2014 and $13,000 in fiscal year 2015 are from the health care access fund for the hospital reimbursement increase in Minnesota Statutes, section 256.969, subdivision 29, paragraph (b).

Disproportionate Share Payments. Effective for services provided on or after July 1, 2011, through June 30, 2015, the commissioner of human services shall deposit, in the health care access fund, additional federal matching funds received under Minnesota Statutes, section 256B.199, paragraph (e), as disproportionate share hospital payments for inpatient hospital services provided under MinnesotaCare to lawfully present noncitizens who are not eligible for MinnesotaCare with federal financial participation due to immigration

status. The amount deposited shall not exceed $2,200,000 for the time period specified.

Funding for Services Provided to EMA Recipients. $2,200,000 in fiscal year 2014 is from the health care access fund to provide services to emergency medical assistance recipients under Minnesota Statutes, section 256B.06, subdivision 4, paragraph (l). This is a onetime appropriation and is available in either year of the biennium.

(h) Alternative Care 50,776,000 54,922,000

Alternative Care Transfer. Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but shall be transferred to the medical assistance account.

(i) CD Treatment Fund 81,440,000 74,875,000

Balance Transfer. The commissioner must transfer $18,188,000 from the consolidated chemical dependency treatment fund to the general fund by September 30, 2013.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2013.

Sec. 7. Laws 2013, chapter 108, article 14, section 2, subdivision 6, as amended by Laws 2013, chapter 144, section 25, is amended to read:

Subd. 6. **Grant Programs**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Support Services Grants

	Appropriations by Fund	
General	8,915,000	13,333,000
Federal TANF	94,611,000	94,611,000

Paid Work Experience. $2,168,000 each year in fiscal years 2015 and 2016 is from the general fund for paid work experience for long-term MFIP recipients. Paid work includes full and partial wage subsidies and other related services such as job development, marketing, preworksite training, job coaching, and postplacement services. These are onetime appropriations. Unexpended funds for fiscal year 2015 do not cancel, but are available to the commissioner for this purpose in fiscal year 2016.

Work Study Funding for MFIP Participants. $250,000 each year in fiscal years 2015 and 2016 is from the general fund to pilot work study jobs for MFIP recipients in approved postsecondary education programs. This is a onetime appropriation. Unexpended funds for fiscal year 2015 do not cancel, but are available for this purpose in fiscal year 2016.

Local Strategies to Reduce Disparities. $2,000,000 each year in fiscal years 2015 and 2016 is from the general fund for local projects that focus on services for subgroups within the MFIP caseload who are experiencing poor employment outcomes. These are onetime appropriations. Unexpended funds for fiscal year 2015 do not cancel, but are available to the commissioner for this purpose in fiscal year 2016.

Home Visiting Collaborations for MFIP Teen Parents. $200,000 per year in fiscal years 2014 and 2015 is from the general fund and $200,000 in fiscal year 2016 is from the

federal TANF fund for technical assistance and training to support local collaborations that provide home visiting services for MFIP teen parents. The general fund appropriation is onetime. The federal TANF fund appropriation is added to the base.

Performance Bonus Funds for Counties. The TANF fund base is increased by $1,500,000 each year in fiscal years 2016 and 2017. The commissioner must allocate this amount each year to counties that exceed their expected range of performance on the annualized three-year self-support index as defined in Minnesota Statutes, section 256J.751, subdivision 2, clause (6). This is a permanent base adjustment. Notwithstanding any contrary provisions in this article, this provision expires June 30, 2016.

Base Adjustment. The general fund base is decreased by $200,000 in fiscal year 2016 and $4,618,000 in fiscal year 2017. The TANF fund base is increased by $1,700,000 in fiscal years 2016 and 2017.

(b) Basic Sliding Fee Child Care Assistance Grants	36,836,000	42,318,000

Base Adjustment. The general fund base is increased by $3,778,000 in fiscal year 2016 and by $3,849,000 in fiscal year 2017.

(c) Child Care Development Grants	1,612,000	1,737,000
(d) Child Support Enforcement Grants	50,000	50,000

Federal Child Support Demonstration Grants. Federal administrative reimbursement resulting from the federal child support grant expenditures authorized under United States Code, title 42, section

1315, is appropriated to the commissioner for this activity.

(e) Children's Services Grants

	Appropriations by Fund	
General	49,760,000	52,961,000
Federal TANF	140,000	140,000

Adoption Assistance and Relative Custody Assistance. ~~$37,453,000~~ $36,456,000 in fiscal year 2014 and ~~$37,453,000~~ $36,855,000 in fiscal year 2015 is for the adoption assistance and relative custody assistance programs. The commissioner shall determine with the commissioner of Minnesota Management and Budget the appropriation for Northstar Care for Children effective January 1, 2015. The commissioner may transfer appropriations for adoption assistance, relative custody assistance, and Northstar Care for Children between fiscal years and among programs to adjust for transfers across the programs.

Title IV-E Adoption Assistance. Additional federal reimbursements to the state as a result of the Fostering Connections to Success and Increasing Adoptions Act's expanded eligibility for Title IV-E adoption assistance are appropriated for postadoption services, including a parent-to-parent support network.

Privatized Adoption Grants. Federal reimbursement for privatized adoption grant and foster care recruitment grant expenditures is appropriated to the commissioner for adoption grants and foster care and adoption administrative purposes.

Adoption Assistance Incentive Grants. Federal funds available during fiscal years 2014 and 2015 for adoption incentive grants are appropriated for postadoption services, including a parent-to-parent support network.

Base Adjustment. The general fund base is increased by $5,913,000 in fiscal year 2016 and by $10,297,000 in fiscal year 2017.

(f) Child and Community Service Grants	53,301,000	53,301,000
(g) Child and Economic Support Grants	21,047,000	20,848,000

Minnesota Food Assistance Program. Unexpended funds for the Minnesota food assistance program for fiscal year 2014 do not cancel but are available for this purpose in fiscal year 2015.

Transitional Housing. $250,000 each year is for the transitional housing programs under Minnesota Statutes, section 256E.33.

Emergency Services. $250,000 each year is for emergency services grants under Minnesota Statutes, section 256E.36.

Family Assets for Independence. $250,000 each year is for the Family Assets for Independence Minnesota program. This appropriation is available in either year of the biennium and may be transferred between fiscal years.

Food Shelf Programs. $375,000 in fiscal year 2014 and $375,000 in fiscal year 2015 are for food shelf programs under Minnesota Statutes, section 256E.34. If the appropriation for either year is insufficient, the appropriation for the other year is available for it. Notwithstanding Minnesota

Statutes, section 256E.34, subdivision 4, no portion of this appropriation may be used by Hunger Solutions for its administrative expenses, including but not limited to rent and salaries.

Homeless Youth Act. $2,000,000 in fiscal year 2014 and $2,000,000 in fiscal year 2015 is for purposes of Minnesota Statutes, section 256K.45.

Safe Harbor Shelter and Housing. $500,000 in fiscal year 2014 and $500,000 in fiscal year 2015 is for a safe harbor shelter and housing fund for housing and supportive services for youth who are sexually exploited.

High-risk adults. $200,000 in fiscal year 2014 is for a grant to the nonprofit organization selected to administer the demonstration project for high-risk adults under Laws 2007, chapter 54, article 1, section 19, in order to complete the project. This is a onetime appropriation.

(h) Health Care Grants

	Appropriations by Fund	
General	190,000	190,000
Health Care Access	190,000	190,000

Emergency Medical Assistance Referral and Assistance Grants. (a) The commissioner of human services shall award grants to nonprofit programs that provide immigration legal services based on indigency to provide legal services for immigration assistance to individuals with emergency medical conditions or complex and chronic health conditions who are not currently eligible for medical assistance

or other public health care programs, but who may meet eligibility requirements with immigration assistance.

(b) The grantees, in collaboration with hospitals and safety net providers, shall provide referral assistance to connect individuals identified in paragraph (a) with alternative resources and services to assist in meeting their health care needs. $100,000 is appropriated in fiscal year 2014 and $100,000 in fiscal year 2015. This is a onetime appropriation.

Base Adjustment. The general fund is decreased by $100,000 in fiscal year 2016 and $100,000 in fiscal year 2017.

(i) Aging and Adult Services Grants	14,827,000	15,010,000

Base Adjustment. The general fund is increased by $1,150,000 in fiscal year 2016 and $1,151,000 in fiscal year 2017.

Community Service Development Grants and Community Services Grants. Community service development grants and community services grants are reduced by $1,150,000 each year. This is a onetime reduction.

(j) Deaf and Hard-of-Hearing Grants	1,771,000	1,785,000
(k) Disabilities Grants	18,605,000	18,823,000

Advocating Change Together. $310,000 in fiscal year 2014 is for a grant to Advocating Change Together (ACT) to maintain and promote services for persons with intellectual and developmental disabilities throughout the state. This appropriation is onetime. Of this appropriation:

(1) $120,000 is for direct costs associated with the delivery and evaluation of peer-to-peer training programs administered throughout the state, focusing on education, employment, housing, transportation, and voting;

(2) $100,000 is for delivery of statewide conferences focusing on leadership and skill development within the disability community; and

(3) $90,000 is for administrative and general operating costs associated with managing or maintaining facilities, program delivery, staff, and technology.

Base Adjustment. The general fund base is increased by $535,000 in fiscal year 2016 and by $709,000 in fiscal year 2017.

(l) Adult Mental Health Grants

Appropriations by Fund		
General	71,199,000	69,530,000
Health Care Access	750,000	750,000
Lottery Prize	1,733,000	1,733,000

Compulsive Gambling Treatment. Of the general fund appropriation, $602,000 in fiscal year 2014 and $747,000 in fiscal year 2015 are for compulsive gambling treatment under Minnesota Statutes, section 297E.02, subdivision 3, paragraph (c).

Problem Gambling. $225,000 in fiscal year 2014 and $225,000 in fiscal year 2015 is appropriated from the lottery prize fund for a grant to the state affiliate recognized by the National Council on Problem Gambling. The affiliate must provide services to increase public awareness of problem gambling,

education and training for individuals and organizations providing effective treatment services to problem gamblers and their families, and research relating to problem gambling.

Funding Usage. Up to 75 percent of a fiscal year's appropriations for adult mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

Base Adjustment. The general fund base is decreased by $4,427,000 in fiscal years 2016 and 2017.

Mental Health Pilot Project. $230,000 each year is for a grant to the Zumbro Valley Mental Health Center. The grant shall be used to implement a pilot project to test an integrated behavioral health care coordination model. The grant recipient must report measurable outcomes and savings to the commissioner of human services by January 15, 2016. This is a onetime appropriation.

~~**High-risk adults.** $200,000 in fiscal year 2014 is for a grant to the nonprofit organization selected to administer the demonstration project for high-risk adults under Laws 2007, chapter 54, article 1, section 19, in order to complete the project. This is a onetime appropriation.~~

(m) Child Mental Health Grants 18,246,000 20,636,000

Text Message Suicide Prevention Program. $625,000 in fiscal year 2014 and $625,000 in fiscal year 2015 is for a grant to a nonprofit organization to establish and

implement a statewide text message suicide prevention program. The program shall implement a suicide prevention counseling text line designed to use text messaging to connect with crisis counselors and to obtain emergency information and referrals to local resources in the local community. The program shall include training within schools and communities to encourage the use of the program.

Mental Health First Aid Training. $22,000 in fiscal year 2014 and $23,000 in fiscal year 2015 is to train teachers, social service personnel, law enforcement, and others who come into contact with children with mental illnesses, in children and adolescents mental health first aid training.

Funding Usage. Up to 75 percent of a fiscal year's appropriation for child mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

(n) CD Treatment Support Grants 1,816,000 1,816,000

SBIRT Training. (1) $300,000 each year is for grants to train primary care clinicians to provide substance abuse brief intervention and referral to treatment (SBIRT). This is a onetime appropriation. The commissioner of human services shall apply to SAMHSA for an SBIRT professional training grant.

(2) If the commissioner of human services receives a grant under clause (1) funds appropriated under this clause, equal to the grant amount, up to the available appropriation, shall be transferred to the

Minnesota Organization on Fetal Alcohol Syndrome (MOFAS). MOFAS must use the funds for grants. Grant recipients must be selected from communities that are not currently served by federal Substance Abuse Prevention and Treatment Block Grant funds. Grant money must be used to reduce the rates of fetal alcohol syndrome and fetal alcohol effects, and the number of drug-exposed infants. Grant money may be used for prevention and intervention services and programs, including, but not limited to, community grants, professional eduction, public awareness, and diagnosis.

Fetal Alcohol Syndrome Grant. $180,000 each year from the general fund is for a grant to the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS) to support nonprofit Fetal Alcohol Spectrum Disorders (FASD) outreach prevention programs in Olmsted County. This is a onetime appropriation.

Base Adjustment. The general fund base is decreased by $480,000 in fiscal year 2016 and $480,000 in fiscal year 2017.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2013.

Sec. 8. Laws 2013, chapter 108, article 14, section 3, subdivision 1, is amended to read:

			~~**169,326,000**~~		~~**165,531,000**~~
Subdivision 1.	**Total Appropriation**	**$**	169,026,000	**$**	165,231,000

Appropriations by Fund

	2014	2015
General	79,476,000	74,256,000
State Government Special Revenue	48,094,000	50,119,000
Health Care Access	29,743,000	29,143,000

Federal TANF	11,713,000	11,713,000
~~Special Revenue~~	~~300,000~~	~~300,000~~

The amounts that may be spent for each purpose are specified in the following subdivisions.

Sec. 9. Laws 2013, chapter 108, article 14, section 3, subdivision 4, is amended to read:

Subd. 4. **Health Protection**

Appropriations by Fund		
General	9,201,000	9,201,000
State Government Special Revenue	32,633,000	32,636,000
~~Special Revenue~~	~~300,000~~	~~300,000~~

Infectious Disease Laboratory. Of the general fund appropriation, $200,000 in fiscal year 2014 and $200,000 in fiscal year 2015 are to monitor infectious disease trends and investigate infectious disease outbreaks.

Surveillance for Elevated Blood Lead Levels. Of the general fund appropriation, $100,000 in fiscal year 2014 and $100,000 in fiscal year 2015 are for the blood lead surveillance system under Minnesota Statutes, section 144.9502.

Base Level Adjustment. The state government special revenue base is increased by $6,000 in fiscal year 2016 and by $13,000 in fiscal year 2017.

Sec. 10. Laws 2013, chapter 108, article 14, section 4, subdivision 8, is amended to read:

Subd. 8. **Board of Nursing Home Administrators**	3,742,000	2,252,000

Administrative Services Unit - Operating Costs. Of this appropriation, $676,000 in fiscal year 2014 and $626,000 in

fiscal year 2015 are for operating costs of the administrative services unit. The administrative services unit may receive and expend reimbursements for services performed by other agencies.

Administrative Services Unit - Volunteer Health Care Provider Program. Of this appropriation, $150,000 in fiscal year 2014 and $150,000 in fiscal year 2015 are to pay for medical professional liability coverage required under Minnesota Statutes, section 214.40.

Administrative Services Unit - Contested Cases and Other Legal Proceedings. Of this appropriation, $200,000 in fiscal year 2014 and $200,000 in fiscal year 2015 are for costs of contested case hearings and other unanticipated costs of legal proceedings involving health-related boards funded under this section. Upon certification of a health-related board to the administrative services unit that the costs will be incurred and that there is insufficient money available to pay for the costs out of money currently available to that board, the administrative services unit is authorized to transfer money from this appropriation to the board for payment of those costs with the approval of the commissioner of management and budget. This appropriation does not cancel and is available until expended.

This appropriation includes $44,000 in fiscal year 2014 for rulemaking. This is a onetime appropriation. $1,441,000 in fiscal year 2014 and $420,000 in fiscal year

2015 are for the development of a shared disciplinary, regulatory, licensing, and information management system. $391,000 in fiscal year 2014 is a onetime appropriation for retirement costs in the health-related boards. This funding may be transferred to the health boards incurring retirement costs. These funds are available either year of the biennium.

This appropriation includes $16,000 in fiscal years 2014 and 2015 for evening security, $2,000 in fiscal years 2014 and 2015 for a state vehicle lease, and $18,000 in fiscal years 2014 and 2015 for shared office space and administrative support. $205,000 in fiscal year 2014 and $221,000 in fiscal year 2015 are for shared information technology services, equipment, and maintenance.

The remaining balance of the state government special revenue fund appropriation in Laws 2011, First Special Session chapter 9, article 10, section 8, subdivision 8, for Board of Nursing Home Administrators rulemaking, estimated to be $44,000, is canceled, and the remaining balance of the state government special revenue fund appropriation in Laws 2011, First Special Session chapter 9, article 10, section 8, subdivision 8, for electronic licensing system adaptors, estimated to be $761,000, and for the development and implementation of a disciplinary, regulatory, licensing, and information management system, estimated to be $1,100,000, are canceled. This paragraph is effective the day following final enactment.

Base Adjustment. The base is decreased by $370,000 in fiscal years 2016 and 2017.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2013.

Sec. 11. Laws 2013, chapter 108, article 14, section 12, is amended to read:

Sec. 12. **APPROPRIATION ADJUSTMENTS.**

(a) The general fund appropriation in section 2, subdivision 5, paragraph (g), includes up to $53,391,000 in fiscal year 2014; $216,637,000 in fiscal year 2015; $261,660,000 in fiscal year 2016; and $279,984,000 in fiscal year 2017, for medical assistance eligibility and administration changes related to:

(1) eligibility for children age two to 18 with income up to 275 percent of the federal poverty guidelines;

(2) eligibility for pregnant women with income up to 275 percent of the federal poverty guidelines;

(3) Affordable Care Act enrollment and renewal processes, including elimination of six-month renewals, ex parte eligibility reviews, preprinted renewal forms, changes in verification requirements, and other changes in the eligibility determination and enrollment and renewal process;

(4) automatic eligibility for children who turn 18 in foster care until they reach age 26;

(5) eligibility related to spousal impoverishment provisions for waiver recipients; and

(6) presumptive eligibility determinations by hospitals.

(b) the commissioner of human services shall determine the difference between the actual or ~~forecasted~~ estimated costs to the medical assistance program attributable to the program changes in paragraph (a), clauses (1) to (6), and the costs of paragraph (a), clauses (1) to (6), that were estimated during the 2013 legislative session based on data from the 2013 February forecast. ~~The costs in this paragraph must be calculated between January 1, 2014, and June 30, 2017.~~

(c) For each fiscal year from 2014 to 2017, the commissioner of human services shall certify the actual or ~~forecasted~~ estimated cost differences to the medical assistance program determined under paragraph (b), and report the difference in costs to the commissioner of management and budget at least four weeks prior to a forecast under Minnesota Statutes, section 16A.103. ~~No later than three weeks before the release of the forecast~~ For fiscal years 2014 to 2017, forecasts under Minnesota Statutes, section 16A.103, prepared by the commissioner of management and budget shall ~~reduce~~ include actual or estimated adjustments to the health care access fund appropriation in section 2, subdivision 5, paragraph (g), ~~by the cumulative difference in costs determined in~~

according to paragraph ~~(b)~~ (d). ~~If for any fiscal year, the amount of the cumulative cost differences determined under paragraph (b) is positive, no adjustment shall be made to the health care access fund appropriation. If for any fiscal year, the amount of the cumulative cost differences determined under paragraph (b) is less than the original appropriation, the appropriation for that fiscal year is zero.~~

(d) For each fiscal year from 2014 to 2017, the commissioner of management and budget must adjust the health care access fund appropriation by the cumulative difference in costs reported by the commissioner of human services under paragraph (b). If, for any fiscal year, the amount of the cumulative difference in costs determined under paragraph (b) is positive, no adjustment shall be made to the health care access fund appropriation.

(e) This section expires on January 1, 2018.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2013.

Sec. 12. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language in this article expires on June 30, 2015, unless a different expiration date is specified.

ARTICLE 8

HUMAN SERVICES FORECAST ADJUSTMENT

Section 1. **HUMAN SERVICES APPROPRIATION.**

The sums shown in the columns marked "Appropriations" are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2013, chapter 108, article 14, from the general fund or any fund named to the Department of Human Services for the purposes specified in this article, to be available for the fiscal year indicated for each purpose. The figures "2014" and "2015" used in this article mean that the appropriations listed under them are available for the fiscal years ending June 30, 2014, or June 30, 2015, respectively. "The first year" is fiscal year 2014. "The second year" is fiscal year 2015. "The biennium" is fiscal years 2014 and 2015.

	APPROPRIATIONS Available for the Year Ending June 30	
	2014	**2015**
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**		
Subdivision 1. **Total Appropriation**	**$ (196,927)**	**$ 64,288**

	Appropriations by Fund			
General Fund	(153,497)	(25,282)		
Health Care Access Fund	(36,533)	91,294		
Federal TANF	(6,897)	(1,724)		

Subd. 2. **Forecasted Programs**

(a) **MFIP/DWP**

	Appropriations by Fund			
General Fund	3,571	173		
Federal TANF	(6,475)	(1,298)		

(b) **MFIP Child Care Assistance** (684) 11,114

(c) **General Assistance** (2,569) (1,940)

(d) **Minnesota Supplemental Aid** (690) (614)

(e) **Group Residential Housing** 250 (1,740)

(f) **MinnesotaCare** (34,838) 96,340

These appropriations are from the health care access fund.

(g) **Medical Assistance**

	Appropriations by Fund			
General Fund	(149,494)	(27,075)		
Health Care Access Fund	(1,695)	(5,046)		

(h) **Alternative Care Program** (6,936) (13,260)

(i) **CCDTF Entitlements** 3,055 8,060

Subd. 3. **Technical Activities** (422) (426)

These appropriations are from the federal TANF fund.

Sec. 3. Laws 2013, chapter 108, article 14, section 2, subdivision 1, is amended to read:

			~~6,438,485,000~~		~~6,457,117,000~~
Subdivision 1. **Total Appropriation**		**$**	6,437,815,000	**$**	6,456,311,000
	Appropriations by Fund				
	2014	2015			

	~~5,654,765,000~~	~~5,677,458,000~~
General	5,654,095,000	5,676,652,000
State Government Special Revenue	4,099,000	4,510,000
Health Care Access	519,816,000	518,446,000
Federal TANF	257,915,000	254,813,000
Lottery Prize Fund	1,890,000	1,890,000

Receipts for Systems Projects. Appropriations and federal receipts for information systems projects for MAXIS, PRISM, MMIS, and SSIS must be deposited in the state system account authorized in Minnesota Statutes, section 256.014. Money appropriated for computer projects approved by the commissioner of Minnesota information technology services, funded by the legislature, and approved by the commissioner of management and budget, may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary. Any unexpended balance in the appropriation for these projects does not cancel but is available for ongoing development and operations.

Nonfederal Share Transfers. The nonfederal share of activities for which federal administrative reimbursement is appropriated to the commissioner may be transferred to the special revenue fund.

ARRA Supplemental Nutrition Assistance Benefit Increases. The funds provided for food support benefit increases under the Supplemental Nutrition Assistance Program provisions of the American Recovery and Reinvestment Act (ARRA) of 2009 must be

used for benefit increases beginning July 1, 2009.

Supplemental Nutrition Assistance Program Employment and Training. (1) Notwithstanding Minnesota Statutes, sections 256D.051, subdivisions 1a, 6b, and 6c, and 256J.626, federal Supplemental Nutrition Assistance employment and training funds received as reimbursement of MFIP consolidated fund grant expenditures for diversionary work program participants and child care assistance program expenditures must be deposited in the general fund. The amount of funds must be limited to $4,900,000 per year in fiscal years 2014 and 2015, and to $4,400,000 per year in fiscal years 2016 and 2017, contingent on approval by the federal Food and Nutrition Service.

(2) Consistent with the receipt of the federal funds, the commissioner may adjust the level of working family credit expenditures claimed as TANF maintenance of effort. Notwithstanding any contrary provision in this article, this rider expires June 30, 2017.

TANF Maintenance of Effort. (a) In order to meet the basic maintenance of effort (MOE) requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1, the commissioner may only report nonfederal money expended for allowable activities listed in the following clauses as TANF/MOE expenditures:

(1) MFIP cash, diversionary work program, and food assistance benefits under Minnesota Statutes, chapter 256J;

(2) the child care assistance programs under Minnesota Statutes, sections 119B.03 and 119B.05, and county child care administrative costs under Minnesota Statutes, section 119B.15;

(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 256J and 256K;

(4) state, county, and tribal MFIP employment services under Minnesota Statutes, chapters 256J and 256K;

(5) expenditures made on behalf of legal noncitizen MFIP recipients who qualify for the MinnesotaCare program under Minnesota Statutes, chapter 256L;

(6) qualifying working family credit expenditures under Minnesota Statutes, section 290.0671;

(7) qualifying Minnesota education credit expenditures under Minnesota Statutes, section 290.0674; and

(8) qualifying Head Start expenditures under Minnesota Statutes, section 119A.50.

(b) The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's TANF/MOE requirements. For the activities listed in paragraph (a), clauses (2) to (8), the commissioner may only report expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

(c) For fiscal years beginning with state fiscal year 2003, the commissioner shall ensure

that the maintenance of effort used by the commissioner of management and budget for the February and November forecasts required under Minnesota Statutes, section 16A.103, contains expenditures under paragraph (a), clause (1), equal to at least 16 percent of the total required under Code of Federal Regulations, title 45, section 263.1.

(d) The requirement in Minnesota Statutes, section 256.011, subdivision 3, that federal grants or aids secured or obtained under that subdivision be used to reduce any direct appropriations provided by law, do not apply if the grants or aids are federal TANF funds.

(e) For the federal fiscal years beginning on or after October 1, 2007, the commissioner may not claim an amount of TANF/MOE in excess of the 75 percent standard in Code of Federal Regulations, title 45, section 263.1(a)(2), except:

(1) to the extent necessary to meet the 80 percent standard under Code of Federal Regulations, title 45, section 263.1(a)(1), if it is determined by the commissioner that the state will not meet the TANF work participation target rate for the current year;

(2) to provide any additional amounts under Code of Federal Regulations, title 45, section 264.5, that relate to replacement of TANF funds due to the operation of TANF penalties; and

(3) to provide any additional amounts that may contribute to avoiding or reducing TANF work participation penalties through the operation of the excess MOE provisions

of Code of Federal Regulations, title 45, section 261.43 (a)(2).

For the purposes of clauses (1) to (3), the commissioner may supplement the MOE claim with working family credit expenditures or other qualified expenditures to the extent such expenditures are otherwise available after considering the expenditures allowed in this subdivision and subdivisions 2 and 3.

(f) Notwithstanding any contrary provision in this article, paragraphs (a) to (e) expire June 30, 2017.

Working Family Credit Expenditures as TANF/MOE. The commissioner may claim as TANF maintenance of effort up to $6,707,000 per year of working family credit expenditures in each fiscal year.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2013.

Sec. 4. Laws 2013, chapter 108, article 14, section 2, subdivision 4, as amended by Laws 2013, chapter 144, section 24, is amended to read:

Subd. 4. **Central Office**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Operations

	Appropriations by Fund	
General	101,979,000	96,858,000
State Government Special Revenue	3,974,000	4,385,000
Health Care Access	13,177,000	13,004,000
Federal TANF	100,000	100,000

DHS Receipt Center Accounting. The commissioner is authorized to transfer appropriations to, and account for DHS

receipt center operations in, the special revenue fund.

Administrative Recovery; Set-Aside. The commissioner may invoice local entities through the SWIFT accounting system as an alternative means to recover the actual cost of administering the following provisions:

(1) Minnesota Statutes, section 125A.744, subdivision 3;

(2) Minnesota Statutes, section 245.495, paragraph (b);

(3) Minnesota Statutes, section 256B.0625, subdivision 20, paragraph (k);

(4) Minnesota Statutes, section 256B.0924, subdivision 6, paragraph (g);

(5) Minnesota Statutes, section 256B.0945, subdivision 4, paragraph (d); and

(6) Minnesota Statutes, section 256F.10, subdivision 6, paragraph (b).

Systems Modernization. The following amounts are appropriated for transfer to the state systems account authorized in Minnesota Statutes, section 256.014:

(1) $1,825,000 in fiscal year 2014 and $2,502,000 in fiscal year 2015 is for the state share of Medicaid-allocated costs of the health insurance exchange information technology and operational structure. The funding base is $3,222,000 in fiscal year 2016 and $3,037,000 in fiscal year 2017 but shall not be included in the base thereafter; and

(2) $9,344,000 in fiscal year 2014 and $3,660,000 in fiscal year 2015 are for the modernization and streamlining of agency

eligibility and child support systems. The funding base is $5,921,000 in fiscal year 2016 and $1,792,000 in fiscal year 2017 but shall not be included in the base thereafter.

The unexpended balance of the $9,344,000 appropriation in fiscal year 2014 and the $3,660,000 appropriation in fiscal year 2015 must be transferred from the Department of Human Services state systems account to the Office of Enterprise Technology when the Office of Enterprise Technology has negotiated a federally approved internal service fund rates and billing process with sufficient internal accounting controls to properly maximize federal reimbursement to Minnesota for human services system modernization projects, but not later than June 30, 2015.

If contingent funding is fully or partially disbursed under article 15, section 3, and transferred to the state systems account, the unexpended balance of that appropriation must be transferred to the Office of Enterprise Technology in accordance with this clause. Contingent funding must not exceed $11,598,000 for the biennium.

Base Adjustment. The general fund base is increased by $2,868,000 in fiscal year 2016 and decreased by $1,206,000 in fiscal year 2017. The health access fund base is decreased by $551,000 in fiscal years 2016 and 2017. The state government special revenue fund base is increased by $4,000 in fiscal year 2016 and decreased by $236,000 in fiscal year 2017.

(b) Children and Families

	Appropriations by Fund	
General	8,023,000	8,015,000
Federal TANF	2,282,000	2,282,000

Financial Institution Data Match and Payment of Fees. The commissioner is authorized to allocate up to $310,000 each year in fiscal years 2014 and 2015 from the PRISM special revenue account to make payments to financial institutions in exchange for performing data matches between account information held by financial institutions and the public authority's database of child support obligors as authorized by Minnesota Statutes, section 13B.06, subdivision 7.

Base Adjustment. The general fund base is decreased by $300,000 in fiscal years 2016 and 2017. The TANF fund base is increased by $300,000 in fiscal years 2016 and 2017.

(c) Health Care

	Appropriations by Fund	
General	14,028,000	13,826,000
Health Care Access	28,442,000	31,137,000

Base Adjustment. The general fund base is decreased by $86,000 in fiscal year 2016 and by $86,000 in fiscal year 2017. The health care access fund base is increased by $6,954,000 in fiscal year 2016 and by $5,489,000 in fiscal year 2017.

(d) Continuing Care

	Appropriations by Fund	
General	20,993,000	22,359,000
State Government Special Revenue	125,000	125,000

Base Adjustment. The general fund base is increased by $1,690,000 in fiscal year 2016 and by $798,000 in fiscal year 2017.

(e) Chemical and Mental Health

Appropriations by Fund		
	~~4,639,000~~	~~4,490,000~~
General	4,571,000	4,431,000
Lottery Prize Fund	157,000	157,000

~~Of the general fund appropriation, $68,000 in fiscal year 2014 and $59,000 in fiscal year 2015 are for compulsive gambling treatment under Minnesota Statutes, section 297E.02, subdivision 3, paragraph (c).~~

EFFECTIVE DATE. This section is effective retroactively from July 1, 2013.

Sec. 5. Laws 2013, chapter 108, article 14, section 2, subdivision 6, as amended by Laws 2013, chapter 144, section 25, is amended to read:

Subd. 6. **Grant Programs**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Support Services Grants

Appropriations by Fund		
General	8,915,000	13,333,000
Federal TANF	94,611,000	94,611,000

Paid Work Experience. $2,168,000 each year in fiscal years 2015 and 2016 is from the general fund for paid work experience for long-term MFIP recipients. Paid work includes full and partial wage subsidies and other related services such as job development, marketing, preworksite training, job coaching, and postplacement services. These are onetime appropriations. Unexpended funds for fiscal year 2015 do not

cancel, but are available to the commissioner for this purpose in fiscal year 2016.

Work Study Funding for MFIP Participants. $250,000 each year in fiscal years 2015 and 2016 is from the general fund to pilot work study jobs for MFIP recipients in approved postsecondary education programs. This is a onetime appropriation. Unexpended funds for fiscal year 2015 do not cancel, but are available for this purpose in fiscal year 2016.

Local Strategies to Reduce Disparities. $2,000,000 each year in fiscal years 2015 and 2016 is from the general fund for local projects that focus on services for subgroups within the MFIP caseload who are experiencing poor employment outcomes. These are onetime appropriations. Unexpended funds for fiscal year 2015 do not cancel, but are available to the commissioner for this purpose in fiscal year 2016.

Home Visiting Collaborations for MFIP Teen Parents. $200,000 per year in fiscal years 2014 and 2015 is from the general fund and $200,000 in fiscal year 2016 is from the federal TANF fund for technical assistance and training to support local collaborations that provide home visiting services for MFIP teen parents. The general fund appropriation is onetime. The federal TANF fund appropriation is added to the base.

Performance Bonus Funds for Counties. The TANF fund base is increased by $1,500,000 each year in fiscal years 2016 and 2017. The commissioner must allocate

this amount each year to counties that exceed their expected range of performance on the annualized three-year self-support index as defined in Minnesota Statutes, section 256J.751, subdivision 2, clause (6). This is a permanent base adjustment. Notwithstanding any contrary provisions in this article, this provision expires June 30, 2016.

Base Adjustment. The general fund base is decreased by $200,000 in fiscal year 2016 and $4,618,000 in fiscal year 2017. The TANF fund base is increased by $1,700,000 in fiscal years 2016 and 2017.

(b) Basic Sliding Fee Child Care Assistance Grants	36,836,000	42,318,000

Base Adjustment. The general fund base is increased by $3,778,000 in fiscal year 2016 and by $3,849,000 in fiscal year 2017.

(c) Child Care Development Grants	1,612,000	1,737,000
(d) Child Support Enforcement Grants	50,000	50,000

Federal Child Support Demonstration Grants. Federal administrative reimbursement resulting from the federal child support grant expenditures authorized under United States Code, title 42, section 1315, is appropriated to the commissioner for this activity.

(e) Children's Services Grants

	Appropriations by Fund	
General	49,760,000	52,961,000
Federal TANF	140,000	140,000

Adoption Assistance and Relative Custody Assistance. $37,453,000 in fiscal year 2014 and $37,453,000 in fiscal year 2015 is for

the adoption assistance and relative custody assistance programs. The commissioner shall determine with the commissioner of Minnesota Management and Budget the appropriation for Northstar Care for Children effective January 1, 2015. The commissioner may transfer appropriations for adoption assistance, relative custody assistance, and Northstar Care for Children between fiscal years and among programs to adjust for transfers across the programs.

Title IV-E Adoption Assistance. Additional federal reimbursements to the state as a result of the Fostering Connections to Success and Increasing Adoptions Act's expanded eligibility for Title IV-E adoption assistance are appropriated for postadoption services, including a parent-to-parent support network.

Privatized Adoption Grants. Federal reimbursement for privatized adoption grant and foster care recruitment grant expenditures is appropriated to the commissioner for adoption grants and foster care and adoption administrative purposes.

Adoption Assistance Incentive Grants. Federal funds available during fiscal years 2014 and 2015 for adoption incentive grants are appropriated for postadoption services, including a parent-to-parent support network.

Base Adjustment. The general fund base is increased by $5,913,000 in fiscal year 2016 and by $10,297,000 in fiscal year 2017.

(f) Child and Community Service Grants	53,301,000	53,301,000
(g) Child and Economic Support Grants	21,047,000	20,848,000

Minnesota Food Assistance Program. Unexpended funds for the Minnesota food assistance program for fiscal year 2014 do not cancel but are available for this purpose in fiscal year 2015.

Transitional Housing. $250,000 each year is for the transitional housing programs under Minnesota Statutes, section 256E.33.

Emergency Services. $250,000 each year is for emergency services grants under Minnesota Statutes, section 256E.36.

Family Assets for Independence. $250,000 each year is for the Family Assets for Independence Minnesota program. This appropriation is available in either year of the biennium and may be transferred between fiscal years.

Food Shelf Programs. $375,000 in fiscal year 2014 and $375,000 in fiscal year 2015 are for food shelf programs under Minnesota Statutes, section 256E.34. If the appropriation for either year is insufficient, the appropriation for the other year is available for it. Notwithstanding Minnesota Statutes, section 256E.34, subdivision 4, no portion of this appropriation may be used by Hunger Solutions for its administrative expenses, including but not limited to rent and salaries.

Homeless Youth Act. $2,000,000 in fiscal year 2014 and $2,000,000 in fiscal year 2015 is for purposes of Minnesota Statutes, section 256K.45.

Safe Harbor Shelter and Housing. $500,000 in fiscal year 2014 and $500,000 in

fiscal year 2015 is for a safe harbor shelter and housing fund for housing and supportive services for youth who are sexually exploited.

(h) Health Care Grants

	Appropriations by Fund	
General	190,000	190,000
Health Care Access	190,000	190,000

Emergency Medical Assistance Referral and Assistance Grants. (a) The commissioner of human services shall award grants to nonprofit programs that provide immigration legal services based on indigency to provide legal services for immigration assistance to individuals with emergency medical conditions or complex and chronic health conditions who are not currently eligible for medical assistance or other public health care programs, but who may meet eligibility requirements with immigration assistance.

(b) The grantees, in collaboration with hospitals and safety net providers, shall provide referral assistance to connect individuals identified in paragraph (a) with alternative resources and services to assist in meeting their health care needs. $100,000 is appropriated in fiscal year 2014 and $100,000 in fiscal year 2015. This is a onetime appropriation.

Base Adjustment. The general fund is decreased by $100,000 in fiscal year 2016 and $100,000 in fiscal year 2017.

(i) Aging and Adult Services Grants 14,827,000 15,010,000

Base Adjustment. The general fund is increased by $1,150,000 in fiscal year 2016 and $1,151,000 in fiscal year 2017.

Community Service Development Grants and Community Services Grants. Community service development grants and community services grants are reduced by $1,150,000 each year. This is a onetime reduction.

(j) Deaf and Hard-of-Hearing Grants	1,771,000	1,785,000
(k) Disabilities Grants	18,605,000	18,823,000

Advocating Change Together. $310,000 in fiscal year 2014 is for a grant to Advocating Change Together (ACT) to maintain and promote services for persons with intellectual and developmental disabilities throughout the state. This appropriation is onetime. Of this appropriation:

(1) $120,000 is for direct costs associated with the delivery and evaluation of peer-to-peer training programs administered throughout the state, focusing on education, employment, housing, transportation, and voting;

(2) $100,000 is for delivery of statewide conferences focusing on leadership and skill development within the disability community; and

(3) $90,000 is for administrative and general operating costs associated with managing or maintaining facilities, program delivery, staff, and technology.

Base Adjustment. The general fund base is increased by $535,000 in fiscal year 2016 and by $709,000 in fiscal year 2017.

(l) Adult Mental Health Grants

Appropriations by Fund		
	~~71,199,000~~	~~69,530,000~~
General	70,597,000	68,783,000
Health Care Access	750,000	750,000
Lottery Prize	1,733,000	1,733,000

~~**Compulsive Gambling Treatment.** Of the general fund appropriation, $602,000 in fiscal year 2014 and $747,000 in fiscal year 2015 are for compulsive gambling treatment under Minnesota Statutes, section 297E.02, subdivision 3, paragraph (c).~~

Problem Gambling. $225,000 in fiscal year 2014 and $225,000 in fiscal year 2015 is appropriated from the lottery prize fund for a grant to the state affiliate recognized by the National Council on Problem Gambling. The affiliate must provide services to increase public awareness of problem gambling, education and training for individuals and organizations providing effective treatment services to problem gamblers and their families, and research relating to problem gambling.

Funding Usage. Up to 75 percent of a fiscal year's appropriations for adult mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

Base Adjustment. The general fund base is decreased by ~~$4,427,000~~ $4,441,000 in fiscal years 2016 and 2017.

Mental Health Pilot Project. $230,000 each year is for a grant to the Zumbro Valley Mental Health Center. The grant shall be used to implement a pilot project to test an integrated behavioral health care coordination model. The grant recipient must report measurable outcomes and savings to the commissioner of human services by January 15, 2016. This is a onetime appropriation.

High-risk adults. $200,000 in fiscal year 2014 is for a grant to the nonprofit organization selected to administer the demonstration project for high-risk adults under Laws 2007, chapter 54, article 1, section 19, in order to complete the project. This is a onetime appropriation.

(m) Child Mental Health Grants	18,246,000	20,636,000

Text Message Suicide Prevention Program. $625,000 in fiscal year 2014 and $625,000 in fiscal year 2015 is for a grant to a nonprofit organization to establish and implement a statewide text message suicide prevention program. The program shall implement a suicide prevention counseling text line designed to use text messaging to connect with crisis counselors and to obtain emergency information and referrals to local resources in the local community. The program shall include training within schools and communities to encourage the use of the program.

Mental Health First Aid Training. $22,000 in fiscal year 2014 and $23,000 in fiscal year 2015 is to train teachers, social service

personnel, law enforcement, and others who come into contact with children with mental illnesses, in children and adolescents mental health first aid training.

Funding Usage. Up to 75 percent of a fiscal year's appropriation for child mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

(n) CD Treatment Support Grants	1,816,000	1,816,000

SBIRT Training. (1) $300,000 each year is for grants to train primary care clinicians to provide substance abuse brief intervention and referral to treatment (SBIRT). This is a onetime appropriation. The commissioner of human services shall apply to SAMHSA for an SBIRT professional training grant.

(2) If the commissioner of human services receives a grant under clause (1) funds appropriated under this clause, equal to the grant amount, up to the available appropriation, shall be transferred to the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS). MOFAS must use the funds for grants. Grant recipients must be selected from communities that are not currently served by federal Substance Abuse Prevention and Treatment Block Grant funds. Grant money must be used to reduce the rates of fetal alcohol syndrome and fetal alcohol effects, and the number of drug-exposed infants. Grant money may be used for prevention and intervention services and programs, including, but not limited to,

community grants, professional eduction, public awareness, and diagnosis.

Fetal Alcohol Syndrome Grant. $180,000 each year from the general fund is for a grant to the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS) to support nonprofit Fetal Alcohol Spectrum Disorders (FASD) outreach prevention programs in Olmsted County. This is a onetime appropriation.

Base Adjustment. The general fund base is decreased by $480,000 in fiscal year 2016 and $480,000 in fiscal year 2017.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2013.

Sec. 6. **EFFECTIVE DATE.**

Sections 1 and 2 are effective the day following final enactment.

APPENDIX
Article locations in H2150-1

256.969 PAYMENT RATES.

Subd. 8b. **Admissions for persons who apply during hospitalization.** For admissions for individuals under section 256D.03, subdivision 3, paragraph (a), clause (2), that occur before the date of eligibility, payment for the days that the patient is eligible shall be established according to the methods of subdivision 14.

Subd. 9a. **Disproportionate population adjustments until July 1, 1993.** For admissions occurring between January 1, 1993 and June 30, 1993, the adjustment under this subdivision shall be paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of one standard deviation above the arithmetic mean. The adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service, and the result must be multiplied by 1.1.

The provisions of this paragraph are effective only if federal matching funds are not available for all adjustments under this subdivision and it is necessary to implement ratable reductions under subdivision 9.

Subd. 9b. **Implementation of ratable reductions.** Notwithstanding the provisions in subdivision 9, any ratable reductions required under that subdivision or subdivision 9a for fiscal year 1993 shall be implemented as follows:

(1) no ratable reductions shall be applied to admissions occurring between October 1, 1992, and December 31, 1992; and

(2) sufficient ratable reductions shall be taken from hospitals receiving a payment under subdivision 9a for admissions occurring between January 1, 1993, and June 30, 1993, to ensure that all state payments under subdivisions 9 and 9a during federal fiscal year 1993 qualify for federal match.

Subd. 11. **Special rates.** The commissioner may establish special rate-setting methodologies, including a per day operating and property payment system, for hospice, ventilator dependent, and other services on a hospital and recipient specific basis taking into consideration such variables as federal designation, program size, and admission from a medical assistance waiver or home care program. The data and rate calculation method shall conform to the requirements of subdivision 13, except that rates shall not be standardized by the case mix index or adjusted by relative values and hospice rates shall not exceed the amount allowed under federal law. Rates and payments established under this subdivision must meet the requirements of section 256.9685, subdivisions 1 and 2. The cost and charges used to establish rates shall only reflect inpatient medical assistance covered services. Hospital and claims data that are used to establish rates under this subdivision shall not be used to establish payments or relative values under subdivisions 2, 2b, 2c, 3a, 4a, 5a, and 7 to 14.

Subd. 13. **Neonatal transfers.** For admissions occurring on or after July 1, 1989, neonatal diagnostic category transfers shall have operating and property payment rates established at receiving hospitals which have neonatal intensive care units on a per day payment system that is based on the cost finding methods and allowable costs of the Medicare program during the base year. Other neonatal diagnostic category transfers shall have rates established according to subdivision 14. The rate per day for the neonatal service setting within the hospital shall be determined by dividing base year neonatal allowable costs by neonatal patient days. The operating payment rate portion of the rate shall be adjusted by the hospital cost index and the disproportionate population adjustment. For admissions occurring after the transition period specified in section 256.9695, subdivision 3, the operating payment rate portion of the rate shall be standardized by the case mix index and adjusted by relative values. The cost and charges used to establish rates shall only reflect inpatient services covered by medical assistance. Hospital and claims data used to establish rates under this subdivision shall not be used to establish rates under subdivisions 2, 2b, 2c, 3a, 4a, 5a, and 7 to 14.

Subd. 20. **Increases in medical assistance inpatient payments; conditions.** (a) Medical assistance inpatient payments shall increase 20 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occurred between July 1, 1988 and December 31, 1990, if:

(1) the hospital had 100 or fewer Minnesota medical assistance annualized paid admissions, excluding Medicare crossovers, that were paid by March 1, 1988, for the period January 1, 1987 to June 30, 1987;

(2) the hospital had 100 or fewer licensed beds on March 1, 1988;

(3) the hospital is located in Minnesota; and

(4) the hospital is not located in a city of the first class as defined in section 410.01.

For purposes of this paragraph, medical assistance does not include general assistance medical care.

(b) Medical assistance inpatient payments shall increase 15 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occurred between July 1, 1988 and December 31, 1990, if:

(1) the hospital had more than 100 but fewer than 250 Minnesota medical assistance annualized paid admissions, excluding Medicare crossovers, that were paid by March 1, 1988, for the period January 1, 1987 to June 30, 1987;

(2) the hospital had 100 or fewer licensed beds on March 1, 1988;

(3) the hospital is located in Minnesota; and

(4) the hospital is not located in a city of the first class as defined in section 410.01.

For purposes of this paragraph, medical assistance does not include general assistance medical care.

(c) Medical assistance inpatient payment rates shall increase 20 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occur on or after October 1, 1992, if:

(1) the hospital had 100 or fewer Minnesota medical assistance annualized paid admissions, excluding Medicare crossovers, that were paid by March 1, 1988, for the period January 1, 1987 to June 30, 1987;

(2) the hospital had 100 or fewer licensed beds on March 1, 1988;

(3) the hospital is located in Minnesota; and

(4) the hospital is not located in a city of the first class as defined in section 410.01.

For a hospital that qualifies for an adjustment under this paragraph and under subdivision 9 or 23, the hospital must be paid the adjustment under subdivisions 9 and 23, as applicable, plus any amount by which the adjustment under this paragraph exceeds the adjustment under those subdivisions. For this paragraph, medical assistance does not include general assistance medical care.

(d) Medical assistance inpatient payment rates shall increase 15 percent for inpatient hospital originally paid admissions, excluding Medicare crossovers, that occur after September 30, 1992, if:

(1) the hospital had more than 100 but fewer than 250 Minnesota medical assistance annualized paid admissions, excluding Medicare crossovers, that were paid by March 1, 1988, for the period January 1, 1987 to June 30, 1987;

(2) the hospital had 100 or fewer licensed beds on March 1, 1988;

(3) the hospital is located in Minnesota; and

(4) the hospital is not located in a city of the first class as defined in section 410.01.

For a hospital that qualifies for an adjustment under this paragraph and under subdivision 9 or 23, the hospital must be paid the adjustment under subdivisions 9 and 23, as applicable, plus any amount by which the adjustment under this paragraph exceeds the adjustment under those subdivisions. For purposes of this paragraph, medical assistance does not include general assistance medical care.

Subd. 21. **Mental health or chemical dependency admissions; rates.** Admissions under the general assistance medical care program occurring on or after July 1, 1990, and admissions under medical assistance, excluding general assistance medical care, occurring on or after July 1, 1990, and on or before September 30, 1992, that are classified to a diagnostic category of mental health or chemical dependency shall have rates established according to the methods of subdivision 14, except the per day rate shall be multiplied by a factor of 2, provided that the total of the per day rates shall not exceed the per admission rate. This methodology shall also apply when a hold or commitment is ordered by the court for the days that inpatient hospital services are medically necessary. Stays which are medically necessary for inpatient hospital services and covered by medical assistance shall not be billable to any other governmental entity. Medical necessity shall be determined under criteria established to meet the requirements of section 256B.04, subdivision 15, or 256D.03, subdivision 7, paragraph (b).

Subd. 22. **Hospital payment adjustment.** For admissions occurring from January 1, 1993 until June 30, 1993, the commissioner shall adjust the medical assistance payment paid to a hospital, excluding regional treatment centers and facilities of the federal Indian Health Service, with a medical assistance inpatient utilization rate in excess of the arithmetic mean. The adjustment must be determined as follows:

(1) for a hospital with a medical assistance inpatient utilization rate above the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service, the adjustment must be determined by multiplying the total of the operating and property payment rates by the difference between the hospital's actual medical assistance inpatient

utilization rate and the arithmetic mean for all hospitals excluding regional treatment centers and facilities of the federal Indian Health Service; and

(2) for a hospital with a medical assistance inpatient utilization rate above one standard deviation above the mean, the adjustment must be determined by multiplying the adjustment under clause (1) for that hospital by 1.1. Any payment under this clause must be reduced by the amount of any payment received under subdivision 9a. For purposes of this subdivision, medical assistance does not include general assistance medical care.

This subdivision is effective only if federal matching funds are not available for all adjustments under this subdivision and it is necessary to implement ratable reductions under subdivision 9.

Subd. 25. **Long-term hospital rates.** For admissions occurring on or after April 1, 1995, a long-term hospital as designated by Medicare that does not have admissions in the base year shall have inpatient rates established at the average of other hospitals with the same designation. For subsequent rate-setting periods in which base years are updated, the hospital's base year shall be the first Medicare cost report filed with the long-term hospital designation and shall remain in effect until it falls within the same period as other hospitals.

Subd. 26. **Greater Minnesota payment adjustment after June 30, 2001.** (a) For admissions occurring after June 30, 2001, the commissioner shall pay fee-for-service inpatient admissions for the diagnosis-related groups specified in paragraph (b) at hospitals located outside of the seven-county metropolitan area at the higher of:

(1) the hospital's current payment rate for the diagnostic category to which the diagnosis-related group belongs, exclusive of disproportionate population adjustments received under subdivision 9 and hospital payment adjustments received under subdivision 23; or

(2) 90 percent of the average payment rate for that diagnostic category for hospitals located within the seven-county metropolitan area, exclusive of disproportionate population adjustments received under subdivision 9 and hospital payment adjustments received under subdivisions 20 and 23.

(b) The payment increases provided in paragraph (a) apply to the following diagnosis-related groups, as they fall within the diagnostic categories:

(1) 370 cesarean section with complicating diagnosis;
(2) 371 cesarean section without complicating diagnosis;
(3) 372 vaginal delivery with complicating diagnosis;
(4) 373 vaginal delivery without complicating diagnosis;
(5) 386 extreme immaturity and respiratory distress syndrome, neonate;
(6) 388 full-term neonates with other problems;
(7) 390 prematurity without major problems;
(8) 391 normal newborn;
(9) 385 neonate, died or transferred to another acute care facility;
(10) 425 acute adjustment reaction and psychosocial dysfunction;
(11) 430 psychoses;
(12) 431 childhood mental disorders; and
(13) 164-167 appendectomy.

Subd. 27. **Quarterly payment adjustment.** (a) In addition to any other payment under this section, the commissioner shall make the following payments effective July 1, 2007:

(1) for a hospital located in Minnesota and not eligible for payments under subdivision 20, with a medical assistance inpatient utilization rate greater than 17.8 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to 13 percent of the total of the operating and property payment rates;

(2) for a hospital located in Minnesota in a specified urban area outside of the seven-county metropolitan area and not eligible for payments under subdivision 20, with a medical assistance inpatient utilization rate less than or equal to 17.8 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to ten percent of the total of the operating and property payment rates. For purposes of this clause, the following cities are specified urban areas: Detroit Lakes, Rochester, Willmar, Alexandria, Austin, Cambridge, Brainerd, Hibbing, Mankato, Duluth, St. Cloud, Grand Rapids, Wyoming, Fergus Falls, Albert Lea, Winona, Virginia, Thief River Falls, and Wadena;

(3) for a hospital located in Minnesota but not located in a specified urban area under clause (2), with a medical assistance inpatient utilization rate less than or equal to 17.8 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to four percent of the total of the operating and property payment rates. A hospital located in Woodbury and not in existence during the base year shall be reimbursed under this clause; and

(4) in addition to any payments under clauses (1) to (3), for a hospital located in Minnesota and not eligible for payments under subdivision 20 with a medical assistance inpatient utilization rate of 17.9 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to eight percent of the total of the operating and property payment rates, and for a hospital located in Minnesota and not eligible for payments under subdivision 20 with a medical assistance inpatient utilization rate of 59.6 percent of total patient days as of the base year in effect on July 1, 2005, a payment equal to nine percent of the total of the operating and property payment rates. After making any ratable adjustments required under paragraph (b), the commissioner shall proportionately reduce payments under clauses (2) and (3) by an amount needed to make payments under this clause.

(b) The state share of payments under paragraph (a) shall be equal to federal reimbursements to the commissioner to reimburse expenditures reported under section 256B.199, paragraphs (a) to (d). The commissioner shall ratably reduce or increase payments under this subdivision in order to ensure that these payments equal the amount of reimbursement received by the commissioner under section 256B.199, paragraphs (a) to (d), except that payments shall be ratably reduced by an amount equivalent to the state share of a four percent reduction in MinnesotaCare and medical assistance payments for inpatient hospital services. Effective July 1, 2009, the ratable reduction shall be equivalent to the state share of a three percent reduction in these payments. Effective for federal disproportionate share hospital funds earned on payments reported under section 256B.199, paragraphs (a) to (d), for services rendered on or after April 1, 2010, payments shall not be made under this subdivision or subdivision 28.

(c) The payments under paragraph (a) shall be paid quarterly based on each hospital's operating and property payments from the second previous quarter, beginning on July 15, 2007, or upon federal approval of federal reimbursements under section 256B.199, paragraphs (a) to (d), whichever occurs later.

(d) The commissioner shall not adjust rates paid to a prepaid health plan under contract with the commissioner to reflect payments provided in paragraph (a).

(e) The commissioner shall maximize the use of available federal money for disproportionate share hospital payments and shall maximize payments to qualifying hospitals. In order to accomplish these purposes, the commissioner may, in consultation with the nonstate entities identified in section 256B.199, paragraphs (a) to (d), adjust, on a pro rata basis if feasible, the amounts reported by nonstate entities under section 256B.199, paragraphs (a) to (d), when application for reimbursement is made to the federal government, and otherwise adjust the provisions of this subdivision. The commissioner shall utilize a settlement process based on finalized data to maximize revenue under section 256B.199, paragraphs (a) to (d), and payments under this section.

(f) For purposes of this subdivision, medical assistance does not include general assistance medical care.

Subd. 28. **Temporary rate increase for qualifying hospitals.** For the period from April 1, 2009, to September 30, 2010, for each hospital with a medical assistance utilization rate equal to or greater than 25 percent during the base year, the commissioner shall provide an equal percentage rate increase for each medical assistance admission. The commissioner shall estimate the percentage rate increase using as the state share of the increase the amount available under section 256B.199, paragraph (d). The commissioner shall settle up payments to qualifying hospitals based on actual payments under that section and actual hospital admissions.

256.9695 APPEALS OF RATES; PROHIBITED PRACTICES FOR HOSPITALS; TRANSITION RATES.

Subd. 3. **Transition.** Except as provided in section 256.969, subdivision 8, the commissioner shall establish a transition period for the calculation of payment rates from July 1, 1989, to the implementation date of the upgrade to the Medicaid management information system or July 1, 1992, whichever is earlier.

During the transition period:

(a) Changes resulting from section 256.969, subdivisions 7, 9, 10, 11, and 13, shall not be implemented, except as provided in section 256.969, subdivisions 12 and 20.

(b) The beginning of the 1991 rate year shall be delayed and the rates notification requirement shall not be applicable.

(c) Operating payment rates shall be indexed from the hospital's most recent fiscal year ending prior to January 1, 1991, by prorating the hospital cost index methodology in effect on January 1, 1989. For payments made for admissions occurring on or after June 1, 1990, until the implementation date of the upgrade to the Medicaid management information system the hospital

cost index excluding the technology factor shall not exceed five percent. This hospital cost index limitation shall not apply to hospitals that meet the requirements of section 256.969, subdivision 20, paragraphs (a) and (b).

(d) Property and pass-through payment rates shall be maintained at the most recent payment rate effective for June 1, 1990. However, all hospitals are subject to the hospital cost index limitation of subdivision 2c, for two complete fiscal years. Property and pass-through costs shall be retroactively settled through the transition period. The laws in effect on the day before July 1, 1989, apply to the retroactive settlement.

(e) If the upgrade to the Medicaid management information system has not been completed by July 1, 1992, the commissioner shall make adjustments for admissions occurring on or after that date as follows:

(1) provide a ten percent increase to hospitals that meet the requirements of section 256.969, subdivision 20, or, upon written request from the hospital to the commissioner, 50 percent of the rate change that the commissioner estimates will occur after the upgrade to the Medicaid management information system; and

(2) adjust the Minnesota and local trade area rebased payment rates that are established after the upgrade to the Medicaid management information system to compensate for a rebasing effective date of July 1, 1992. The adjustment shall be determined using claim specific payment changes that result from the rebased rates and revised methodology in effect after the systems upgrade. Any adjustment that is greater than zero shall be ratably reduced by 20 percent. In addition, every adjustment shall be reduced for payments under clause (1), and differences in the hospital cost index. Hospitals shall revise claims so that services provided by rehabilitation units of hospitals are reported separately. The adjustment shall be in effect until the amount due to or owed by the hospital is fully paid over a number of admissions that is equal to the number of admissions under adjustment multiplied by 1.5. The adjustment for admissions occurring from July 1, 1992 to December 31, 1992, shall be based on claims paid as of August 1, 1993, and the adjustment shall begin with the effective date of rules governing rebasing. The adjustment for admissions occurring from January 1, 1993, to the effective date of the rules shall be based on claims paid as of February 1, 1994, and shall begin after the first adjustment period is fully paid. For purposes of appeals under subdivision 1, the adjustment shall be considered payment at the time of admission.

Subd. 4. **Study.** The commissioner shall contract for an evaluation of the inpatient and outpatient hospital payment systems. The study shall include recommendations concerning:

(1) more effective methods of assigning operating and property payment rates to specific services or diagnoses;

(2) effective methods of cost control and containment;

(3) fiscal impacts of alternative payment systems;

(4) the relationships of the use of and payment for inpatient and outpatient hospital services;

(5) methods to relate reimbursement levels to the efficient provision of services; and

(6) methods to adjust reimbursement levels to reflect cost differences between geographic areas.

The commissioner shall report the findings to the legislature by January 15, 1991, along with recommendations for implementation.

256N.26 BENEFITS AND PAYMENTS.

Subd. 7. **Special at-risk monthly payment for at-risk children in guardianship assistance and adoption assistance.** A child eligible for guardianship assistance under section 256N.22 or adoption assistance under section 256N.23 who is determined to be an at-risk child shall receive a special at-risk monthly payment of $1 per month basic, unless and until the potential disability manifests itself and the agreement is renegotiated to include reimbursement. Such an at-risk child shall receive neither a supplemental difficulty of care monthly rate under subdivision 4 nor home and vehicle modifications under subdivision 10, but must be considered for medical assistance under subdivision 2.