

SENATE
STATE OF MINNESOTA
EIGHTY-EIGHTH LEGISLATURE

S.F. No. 1034

(SENATE AUTHORS: LOUREY)

DATE	D-PG	OFFICIAL STATUS
03/04/2013	482	Introduction and first reading Joint rule 2.03, referred to Rules and Administration
03/13/2013	906	Comm report: Re-referred to Finance
04/19/2013	2011	Committee report, request to divide out
	2012a	Comm report: To pass as amended and re-refer to Taxes
	2492	Motion did not prevail To reject committee report
04/20/2013		Comm report: To pass as amended Second reading

A bill for an act

1.1 relating to state government; establishing the health and human services budget;
1.2 modifying provisions related to health care, continuing care, nursing facility
1.3 admission, children and family services, human services licensing, chemical
1.4 and mental health, program integrity, managed care organizations, waiver
1.5 provider standards, home care, and the Department of Health; redesigning
1.6 home and community-based services; establishing community first services and
1.7 supports and Northstar Care for Children; providing for fraud investigations
1.8 in the child care assistance program; establishing autism early intensive
1.9 intervention benefits; creating a human services performance council; making
1.10 technical changes; requiring a study; requiring reports; appropriating money;
1.11 repealing MinnesotaCare; amending Minnesota Statutes 2012, sections 13.381,
1.12 subdivisions 2, 10; 13.411, subdivision 7; 13.461, by adding subdivisions;
1.13 16A.724, subdivision 3; 16C.10, subdivision 5; 16C.155, subdivision 1; 62J.692,
1.14 subdivisions 1, 3, 4, 5, 7a, 9, by adding a subdivision; 62Q.19, subdivision 1;
1.15 103I.005, by adding a subdivision; 103I.521; 119B.05, subdivision 1; 119B.13,
1.16 subdivisions 1, 7; 144.051, by adding subdivisions; 144.0724, subdivisions
1.17 4, 6; 144.123, subdivision 1; 144.125, subdivision 1; 144.212; 144.213;
1.18 144.215, subdivisions 3, 4; 144.216, subdivision 1; 144.217, subdivision 2;
1.19 144.218, subdivision 5; 144.225, subdivisions 1, 4, 7, 8; 144.226; 144.966,
1.20 subdivisions 2, 3a; 144.98, subdivisions 3, 5, by adding subdivisions; 144.99,
1.21 subdivision 4; 144A.351; 144A.43; 144A.44; 144A.45; 144D.01, subdivision 4;
1.22 145.906; 145.986; 145A.17, subdivision 1; 145C.01, subdivision 7; 148B.17,
1.23 subdivision 2; 148E.065, subdivision 4a; 149A.02, subdivisions 1a, 2, 3, 4, 5,
1.24 16, 23, 27, 34, 35, 37, by adding subdivisions; 149A.03; 149A.65, by adding
1.25 subdivisions; 149A.70, subdivisions 1, 2, 3, 5; 149A.71, subdivisions 2, 4;
1.26 149A.72, subdivisions 3, 9, by adding a subdivision; 149A.73, subdivisions 1,
1.27 2, 4; 149A.74; 149A.91, subdivision 9; 149A.93, subdivisions 3, 6; 149A.94;
1.28 149A.96, subdivision 9; 151.01, subdivision 27; 151.19, subdivisions 1, 3;
1.29 151.26, subdivision 1; 151.37, subdivision 4; 151.47, subdivision 1, by adding
1.30 a subdivision; 151.49; 152.126; 174.30, subdivision 1; 214.12, by adding
1.31 a subdivision; 214.40, subdivision 1; 243.166, subdivisions 4b, 7; 245.03,
1.32 subdivision 1; 245.462, subdivision 20; 245.4661, subdivisions 5, 6; 245.4682,
1.33 subdivision 2; 245.4875, subdivision 8; 245.4881, subdivision 1; 245A.02,
1.34 subdivisions 1, 9, 10, 14; 245A.03, subdivisions 7, 8, 9; 245A.04, subdivision
1.35 13; 245A.042, subdivision 3; 245A.07, subdivisions 2a, 3; 245A.08, subdivision
1.36 2a; 245A.10; 245A.11, subdivisions 2a, 7, 7a, 7b, 8; 245A.1435; 245A.144;
1.37 245A.1444; 245A.16, subdivision 1; 245A.40, subdivision 5; 245A.50; 245C.04,
1.38 by adding a subdivision; 245C.08, subdivision 1; 245C.32, subdivision 2;
1.39

2.1 245D.02; 245D.03; 245D.04; 245D.05; 245D.06; 245D.07; 245D.09; 245D.10;
 2.2 246.18, subdivision 8, by adding a subdivision; 252.27, subdivision 2a; 252.291,
 2.3 by adding a subdivision; 253B.10, subdivision 1; 254B.04, subdivision 1;
 2.4 254B.13; 256.01, subdivisions 2, 24, 34, by adding subdivisions; 256.82,
 2.5 subdivision 3; 256.9657, subdivisions 1, 3, 3a; 256.969, subdivisions 3a, 29;
 2.6 256.975, subdivision 7, by adding subdivisions; 256.9754, subdivision 5, by
 2.7 adding subdivisions; 256B.02, by adding subdivisions; 256B.021, by adding
 2.8 subdivisions; 256B.04, subdivisions 18, 21, by adding a subdivision; 256B.055,
 2.9 subdivisions 3a, 6, 10, 14, 15, by adding a subdivision; 256B.056, subdivisions
 2.10 1, 1c, 3, 4, as amended, 5c, 10, by adding a subdivision; 256B.057, subdivisions
 2.11 1, 10, by adding a subdivision; 256B.059, subdivision 1; 256B.06, subdivision 4;
 2.12 256B.0623, subdivision 2; 256B.0625, subdivisions 13e, 19c, 31, 39, 48, 56, 58,
 2.13 by adding subdivisions; 256B.0631, subdivision 1; 256B.064, subdivisions 1a, 1b,
 2.14 2; 256B.0659, subdivision 21; 256B.0755, subdivision 3; 256B.0756; 256B.0911,
 2.15 subdivisions 1, 1a, 3a, 4d, 6, 7, by adding a subdivision; 256B.0913, subdivision
 2.16 4, by adding a subdivision; 256B.0915, subdivisions 3a, 5, by adding a
 2.17 subdivision; 256B.0916, by adding a subdivision; 256B.0917, subdivisions 6, 13,
 2.18 by adding subdivisions; 256B.092, subdivisions 11, 12, by adding a subdivision;
 2.19 256B.0943, subdivisions 1, 2, 7, by adding a subdivision; 256B.0946; 256B.095;
 2.20 256B.0951, subdivisions 1, 4; 256B.0952, subdivisions 1, 5; 256B.0955;
 2.21 256B.097, subdivisions 1, 3; 256B.196, subdivision 2; 256B.431, subdivision
 2.22 44; 256B.434, subdivision 4; 256B.437, subdivision 6; 256B.439, subdivisions
 2.23 1, 2, 3, 4, by adding a subdivision; 256B.441, subdivisions 13, 53, 55, 56, 62;
 2.24 256B.49, subdivisions 11a, 12, 14, 15, by adding subdivisions; 256B.4912,
 2.25 subdivisions 1, 2, 3, 7, by adding subdivisions; 256B.4913, subdivisions 5, 6, by
 2.26 adding a subdivision; 256B.492; 256B.493, subdivision 2; 256B.501, by adding
 2.27 a subdivision; 256B.5011, subdivision 2; 256B.5012, by adding subdivisions;
 2.28 256B.69, subdivisions 5c, 31, by adding a subdivision; 256B.694; 256B.76,
 2.29 subdivisions 1, 4, by adding a subdivision; 256B.761; 256B.764; 256B.766;
 2.30 256D.44, subdivision 5; 256I.05, subdivision 1e, by adding a subdivision;
 2.31 256J.08, subdivision 24; 256J.21, subdivision 3; 256J.24, subdivisions 5, 5a, 7;
 2.32 256J.621; 256J.626, subdivision 7; 256K.45; 256L.01, subdivisions 3a, 5, by
 2.33 adding subdivisions; 256L.02, subdivision 2, by adding subdivisions; 256L.03,
 2.34 subdivisions 1, 1a, 3, 5, 6, by adding a subdivision; 256L.04, subdivisions
 2.35 1, 7, 8, 10, 12, by adding subdivisions; 256L.05, subdivisions 1, 2, 3, 3c;
 2.36 256L.06, subdivision 3; 256L.07, subdivisions 1, 2, 3; 256L.09, subdivision
 2.37 2; 256L.11, subdivisions 1, 3, by adding a subdivision; 256L.15, subdivisions
 2.38 1, 2; 256M.40, subdivision 1; 257.75, subdivision 7; 257.85, subdivision 11;
 2.39 259A.05, subdivision 5; 259A.20, subdivision 4; 260B.007, subdivisions 6, 16;
 2.40 260C.007, subdivisions 6, 31; 260C.635, subdivision 1; 295.52, subdivision 8;
 2.41 299C.093; 471.59, subdivision 1; 517.001; 518A.60; 524.5-118, subdivision 1,
 2.42 by adding a subdivision; 524.5-303; 524.5-316; 524.5-403; 524.5-420; 626.556,
 2.43 subdivisions 2, 3, 10d; 626.557, subdivisions 4, 9, 9a, 9e; 626.5572, subdivision
 2.44 13; Laws 1998, chapter 407, article 6, section 116; Laws 2011, First Special
 2.45 Session chapter 9, article 7, section 39, subdivision 14; Laws 2012, chapter
 2.46 247, article 1, section 28; article 6, section 4; Laws 2013, chapter 1, sections 1;
 2.47 6; proposing coding for new law in Minnesota Statutes, chapters 144; 144A;
 2.48 145; 149A; 151; 214; 245; 245A; 245D; 254B; 256B; 256J; 256L; proposing
 2.49 coding for new law as Minnesota Statutes, chapter 245E; repealing Minnesota
 2.50 Statutes 2012, sections 62J.693; 103I.005, subdivision 20; 144.123, subdivision
 2.51 2; 144A.46; 144A.461; 149A.025; 149A.20, subdivision 8; 149A.30, subdivision
 2.52 2; 149A.40, subdivision 8; 149A.45, subdivision 6; 149A.50, subdivision 6;
 2.53 149A.51, subdivision 7; 149A.52, subdivision 5a; 149A.53, subdivision 9;
 2.54 151.19, subdivision 2; 151.25; 151.45; 151.47, subdivision 2; 151.48; 245A.655;
 2.55 245B.01; 245B.02; 245B.03; 245B.031; 245B.04; 245B.05, subdivisions 1,
 2.56 2, 3, 5, 6, 7; 245B.055; 245B.06; 245B.07; 245B.08; 245D.08; 256B.055,
 2.57 subdivisions 3, 5, 10b; 256B.056, subdivision 5b; 256B.057, subdivisions
 2.58 1c, 2; 256B.0911, subdivisions 4a, 4b, 4c; 256B.0917, subdivisions 1, 2,

3.1 3, 4, 5, 7, 8, 9, 10, 11, 12, 14; 256B.096, subdivisions 1, 2, 3, 4; 256B.49,
 3.2 subdivision 16a; 256B.4913, subdivisions 1, 2, 3, 4; 256B.5012, subdivision
 3.3 13; 256J.24, subdivision 6; 256L.01, subdivisions 3, 4a; 256L.02, subdivision
 3.4 3; 256L.03, subdivision 4; 256L.031; 256L.04, subdivisions 1b, 2a, 7a, 9;
 3.5 256L.07, subdivisions 1, 4, 5, 8, 9; 256L.09, subdivisions 1, 4, 5, 6, 7; 256L.11,
 3.6 subdivisions 2a, 5, 6; 256L.12, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9a, 9b;
 3.7 256L.17, subdivisions 1, 2, 3, 4, 5; 485.14; 609.093; Laws 2011, First Special
 3.8 Session chapter 9, article 6, section 97, subdivision 6; article 7, section 54, as
 3.9 amended; Minnesota Rules, parts 4668.0002; 4668.0003; 4668.0005; 4668.0008;
 3.10 4668.0012; 4668.0016; 4668.0017; 4668.0019; 4668.0030; 4668.0035;
 3.11 4668.0040; 4668.0050; 4668.0060; 4668.0065; 4668.0070; 4668.0075;
 3.12 4668.0080; 4668.0100; 4668.0110; 4668.0120; 4668.0130; 4668.0140;
 3.13 4668.0150; 4668.0160; 4668.0170; 4668.0180; 4668.0190; 4668.0200;
 3.14 4668.0218; 4668.0220; 4668.0230; 4668.0240; 4668.0800; 4668.0805;
 3.15 4668.0810; 4668.0815; 4668.0820; 4668.0825; 4668.0830; 4668.0835;
 3.16 4668.0840; 4668.0845; 4668.0855; 4668.0860; 4668.0865; 4668.0870;
 3.17 4669.0001; 4669.0010; 4669.0020; 4669.0030; 4669.0040; 4669.0050.

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

3.19 **ARTICLE 1**

3.20 **AFFORDABLE CARE ACT IMPLEMENTATION; BETTER HEALTH**
 3.21 **CARE FOR MORE MINNESOTANS**

3.22 Section 1. Minnesota Statutes 2012, section 16A.724, subdivision 3, is amended to read:

3.23 Subd. 3. **MinnesotaCare federal receipts.** ~~Receipts received as a result of federal~~
 3.24 ~~participation pertaining to administrative costs of the Minnesota health care reform waiver~~
 3.25 ~~shall be deposited as nondedicated revenue in the health care access fund. Receipts~~
 3.26 ~~received as a result of federal participation pertaining to grants shall be deposited in the~~
 3.27 ~~federal fund and shall offset health care access funds for payments to providers. All federal~~
 3.28 funding received by Minnesota for implementation and administration of MinnesotaCare
 3.29 as a basic health program, as authorized in section 1331 of the Affordable Care Act,
 3.30 Public Law 111-148, as amended by Public Law 111-152, is dedicated to that program and
 3.31 shall be deposited into the health care access fund. Federal funding that is received for
 3.32 implementing and administering MinnesotaCare as a basic health program and deposited in
 3.33 the fund shall be used only for that program to purchase health care coverage for enrollees
 3.34 and reduce enrollee premiums and cost-sharing or provide additional enrollee benefits.

3.35 **EFFECTIVE DATE.** This section is effective January 1, 2015.

3.36 Sec. 2. Minnesota Statutes 2012, section 254B.04, subdivision 1, is amended to read:

3.37 Subdivision 1. **Eligibility.** (a) Persons eligible for benefits under Code of Federal
 3.38 Regulations, title 25, part 20, persons eligible for medical assistance benefits under
 3.39 sections 256B.055, 256B.056, and 256B.057, subdivisions 1, 2, 5, and 6, or who meet
 3.40 the income standards of section 256B.056, subdivision 4, and persons eligible for general

4.1 assistance medical care under section 256D.03, subdivision 3, are entitled to chemical
4.2 dependency fund services. State money appropriated for this paragraph must be placed in
4.3 a separate account established for this purpose.

4.4 Persons with dependent children who are determined to be in need of chemical
4.5 dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or
4.6 a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the
4.7 local agency to access needed treatment services. Treatment services must be appropriate
4.8 for the individual or family, which may include long-term care treatment or treatment in a
4.9 facility that allows the dependent children to stay in the treatment facility. The county
4.10 shall pay for out-of-home placement costs, if applicable.

4.11 (b) A person not entitled to services under paragraph (a), but with family income
4.12 that is less than 215 percent of the federal poverty guidelines for the applicable family
4.13 size, shall be eligible to receive chemical dependency fund services within the limit
4.14 of funds appropriated for this group for the fiscal year. If notified by the state agency
4.15 of limited funds, a county must give preferential treatment to persons with dependent
4.16 children who are in need of chemical dependency treatment pursuant to an assessment
4.17 under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision
4.18 6, or 260C.212. A county may spend money from its own sources to serve persons under
4.19 this paragraph. State money appropriated for this paragraph must be placed in a separate
4.20 account established for this purpose.

4.21 (c) Persons whose income is between 215 percent and 412 percent of the federal
4.22 poverty guidelines for the applicable family size shall be eligible for chemical dependency
4.23 services on a sliding fee basis, within the limit of funds appropriated for this group for the
4.24 fiscal year. Persons eligible under this paragraph must contribute to the cost of services
4.25 according to the sliding fee scale established under subdivision 3. A county may spend
4.26 money from its own sources to provide services to persons under this paragraph. State
4.27 money appropriated for this paragraph must be placed in a separate account established
4.28 for this purpose.

4.29 Sec. 3. Minnesota Statutes 2012, section 256.01, is amended by adding a subdivision
4.30 to read:

4.31 Subd. 35. **Federal approval.** (a) The commissioner shall seek federal authority
4.32 from the U.S. Department of Health and Human Services necessary to operate a health
4.33 coverage program for Minnesotans with incomes up to 275 percent of the federal poverty
4.34 guidelines (FPG). The proposal shall seek to secure all federal funding available from at
4.35 least the following services:

5.1 (1) all premium tax credits and cost sharing subsidies available under United States
5.2 Code, title 26, section 36B, and United States Code, title 42, section 18071, for individuals
5.3 with incomes above 133 percent and at or below 275 percent of the federal poverty
5.4 guidelines who would otherwise be enrolled in the Minnesota Insurance Marketplace as
5.5 defined in section 62V.02;

5.6 (2) Medicaid funding; and

5.7 (3) other funding sources identified by the commissioner that support coverage or
5.8 care redesign in Minnesota.

5.9 (b) Funding received shall be used to design and implement a health coverage
5.10 program that creates a single streamlined program and meets the needs of Minnesotans with
5.11 incomes up to 275 percent of the federal poverty guidelines. The program must incorporate:

5.12 (1) payment reform characteristics included in the health care delivery system and
5.13 accountable care organization payment models;

5.14 (2) flexibility in benefit set design such that benefits can be targeted to meet enrollee
5.15 needs in different income and health status situations and can provide a more seamless
5.16 transition from public to private health care coverage;

5.17 (3) flexibility in co-payment or premium structures to incent patients to seek
5.18 high-quality, low-cost care settings; and

5.19 (4) flexibility in premium structures to ease the transition from public to private
5.20 health care coverage.

5.21 (c) The commissioner shall develop and submit a proposal consistent with the above
5.22 criteria and shall seek all federal authority necessary to implement the health coverage
5.23 program. In developing the request, the commissioner shall consult with appropriate
5.24 stakeholder groups and consumers.

5.25 (d) The commissioner is authorized to seek any available waivers or federal
5.26 approvals to accomplish the goals under paragraph (b) prior to 2017.

5.27 (e) The commissioner shall report to the chairs and ranking minority members of
5.28 the legislative committees with jurisdiction over health and human services policy and
5.29 financing by January 15, 2015, on the progress of receiving a federal waiver and shall
5.30 make recommendations on any legislative changes necessary to accomplish the project
5.31 in this subdivision. Any implementation of the waiver that requires a state financial
5.32 contribution shall be contingent on legislative action approving the contribution.

5.33 (f) The commissioner is authorized to accept and expend federal funds that support
5.34 the purposes of this subdivision.

6.1 Sec. 4. Minnesota Statutes 2012, section 256B.02, is amended by adding a subdivision
6.2 to read:

6.3 Subd. 18. **Caretaker relative.** "Caretaker relative" means a relative, by blood,
6.4 adoption, or marriage, of a child under age 19 with whom the child is living and who
6.5 assumes primary responsibility for the child's care.

6.6 **EFFECTIVE DATE.** This section is effective January 1, 2014.

6.7 Sec. 5. Minnesota Statutes 2012, section 256B.02, is amended by adding a subdivision
6.8 to read:

6.9 Subd. 19. **Insurance affordability program.** "Insurance affordability program"
6.10 means one of the following programs:

6.11 (1) medical assistance under this chapter;

6.12 (2) a program that provides advance payments of the premium tax credits established
6.13 under section 36B of the Internal Revenue Code or cost-sharing reductions established
6.14 under section 1402 of the Affordable Care Act;

6.15 (3) MinnesotaCare as defined in chapter 256L; and

6.16 (4) a Basic Health Plan as defined in section 1331 of the Affordable Care Act.

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

6.18 Sec. 6. Minnesota Statutes 2012, section 256B.04, subdivision 18, is amended to read:

6.19 Subd. 18. **Applications for medical assistance.** (a) The state agency ~~may take~~
6.20 ~~shall accept~~ applications for medical assistance ~~and conduct eligibility determinations for~~
6.21 ~~MinnesotaCare enrollees~~ by telephone, via mail, in-person, online via an Internet Web
6.22 site, and through other commonly available electronic means.

6.23 (b) The commissioner of human services shall modify the Minnesota health care
6.24 programs application form to add a question asking applicants whether they have ever
6.25 served in the United States military.

6.26 (c) For each individual who submits an application or whose eligibility is subject to
6.27 renewal or whose eligibility is being redetermined pursuant to a change in circumstances,
6.28 if the agency determines the individual is not eligible for medical assistance, the agency
6.29 shall determine potential eligibility for other insurance affordability programs.

6.30 **EFFECTIVE DATE.** This section is effective January 1, 2014.

6.31 Sec. 7. Minnesota Statutes 2012, section 256B.055, subdivision 3a, is amended to read:

7.1 Subd. 3a. **Families with children.** ~~Beginning July 1, 2002,~~ Medical assistance may
 7.2 be paid for a person who is a child under the age of 18, ~~or age 18 if a full-time student~~
 7.3 ~~in a secondary school, or in the equivalent level of vocational or technical training, and~~
 7.4 ~~reasonably expected to complete the program before reaching age 19;~~ the parent or
 7.5 stepparent of a dependent child under the age of 19, including a pregnant woman; or a
 7.6 caretaker relative of a dependent child under the age of 19.

7.7 **EFFECTIVE DATE.** This section is effective January 1, 2014, or upon federal
 7.8 approval, whichever is later. The commissioner of human services shall notify the revisor
 7.9 of statutes when federal approval is obtained.

7.10 Sec. 8. Minnesota Statutes 2012, section 256B.055, subdivision 6, is amended to read:

7.11 Subd. 6. **Pregnant women; needy unborn child.** Medical assistance may be paid
 7.12 for a pregnant woman who ~~has written verification of a positive pregnancy test from a~~
 7.13 ~~physician or licensed registered nurse, who~~ meets the other eligibility criteria of this
 7.14 section and whose unborn child would be eligible as a needy child under subdivision 10 if
 7.15 born and living with the woman. In accordance with Code of Federal Regulations, title
 7.16 42, section 435.956, the commissioner must accept self-attestation of pregnancy unless
 7.17 the agency has information that is not reasonably compatible with such attestation. For
 7.18 purposes of this subdivision, a woman is considered pregnant for 60 days postpartum.

7.19 **EFFECTIVE DATE.** This section is effective January 1, 2014.

7.20 Sec. 9. Minnesota Statutes 2012, section 256B.055, subdivision 10, is amended to read:

7.21 Subd. 10. **Infants.** Medical assistance may be paid for an infant less than one year
 7.22 of age, whose mother was eligible for and receiving medical assistance at the time of birth
 7.23 or who is less than two years of age and is in a family with countable income that is equal
 7.24 to or less than the income standard established under section 256B.057, subdivision 1.

7.25 **EFFECTIVE DATE.** This section is effective January 1, 2014.

7.26 Sec. 10. Minnesota Statutes 2012, section 256B.055, subdivision 15, is amended to read:

7.27 Subd. 15. **Adults without children.** Medical assistance may be paid for a person
 7.28 who is:

7.29 (1) at least age 21 and under age 65;

7.30 (2) not pregnant;

7.31 (3) not entitled to Medicare Part A or enrolled in Medicare Part B under Title XVIII
 7.32 of the Social Security Act;

8.1 (4) ~~not an adult in a family with children as defined in section 256L.01, subdivision~~
 8.2 ~~3a; and~~ not otherwise eligible under subdivision 7 as a person who meets the categorical
 8.3 eligibility requirements of the supplemental security income program;

8.4 (5) not enrolled under subdivision 7 as a person who would meet the categorical
 8.5 eligibility requirements of the supplemental security income program except for excess
 8.6 income or assets; and

8.7 ~~(5)~~ (6) not described in another subdivision of this section.

8.8 **EFFECTIVE DATE.** This section is effective January 1, 2014.

8.9 Sec. 11. Minnesota Statutes 2012, section 256B.055, is amended by adding a
 8.10 subdivision to read:

8.11 Subd. 17. **Adults who were in foster care at the age of 18.** Medical assistance may
 8.12 be paid for a person under 26 years of age who was in foster care under the commissioner's
 8.13 responsibility on the date of attaining 18 years of age, and who was enrolled in medical
 8.14 assistance under the state plan or a waiver of the plan while in foster care, in accordance
 8.15 with section 2004 of the Affordable Care Act.

8.16 **EFFECTIVE DATE.** This section is effective January 1, 2014.

8.17 Sec. 12. Minnesota Statutes 2012, section 256B.056, subdivision 1, is amended to read:

8.18 Subdivision 1. **Residency.** To be eligible for medical assistance, a person must
 8.19 reside in Minnesota, or, if absent from the state, be deemed to be a resident of Minnesota,₂
 8.20 in accordance with ~~the rules of the state agency~~ Code of Federal Regulations, title 42,
 8.21 section 435.403.

8.22 **EFFECTIVE DATE.** This section is effective January 1, 2014.

8.23 Sec. 13. Minnesota Statutes 2012, section 256B.056, subdivision 1c, is amended to read:

8.24 Subd. 1c. **Families with children income methodology.** (a)(1) [Expired, 1Sp2003
 8.25 c 14 art 12 s 17]

8.26 (2) ~~For applications processed within one calendar month prior to July 1, 2003,~~
 8.27 ~~eligibility shall be determined by applying the income standards and methodologies in~~
 8.28 ~~effect prior to July 1, 2003, for any months in the six-month budget period before July~~
 8.29 ~~1, 2003, and the income standards and methodologies in effect on July 1, 2003, for any~~
 8.30 ~~months in the six-month budget period on or after that date. The income standards for~~
 8.31 ~~each month shall be added together and compared to the applicant's total countable income~~
 8.32 ~~for the six-month budget period to determine eligibility.~~

9.1 ~~(3) For children ages one through 18 whose eligibility is determined under section~~
9.2 ~~256B.057, subdivision 2, the following deductions shall be applied to income counted~~
9.3 ~~toward the child's eligibility as allowed under the state's AFDC plan in effect as of July~~
9.4 ~~16, 1996: \$90 work expense, dependent care, and child support paid under court order.~~
9.5 ~~This clause is effective October 1, 2003.~~

9.6 ~~(b) For families with children whose eligibility is determined using the standard~~
9.7 ~~specified in section 256B.056, subdivision 4, paragraph (c), 17 percent of countable~~
9.8 ~~earned income shall be disregarded for up to four months and the following deductions~~
9.9 ~~shall be applied to each individual's income counted toward eligibility as allowed under~~
9.10 ~~the state's AFDC plan in effect as of July 16, 1996: dependent care and child support paid~~
9.11 ~~under court order.~~

9.12 ~~(c) If the four-month disregard in paragraph (b) has been applied to the wage~~
9.13 ~~earner's income for four months, the disregard shall not be applied again until the wage~~
9.14 ~~earner's income has not been considered in determining medical assistance eligibility for~~
9.15 ~~12 consecutive months.~~

9.16 ~~(d)~~(b) The commissioner shall adjust the income standards under this section each
9.17 July 1 by the annual update of the federal poverty guidelines following publication by the
9.18 United States Department of Health and Human Services except that the income standards
9.19 shall not go below those in effect on July 1, 2009.

9.20 ~~(e)~~(c) For children age 18 or under, annual gifts of \$2,000 or less by a tax-exempt
9.21 organization to or for the benefit of the child with a life-threatening illness must be
9.22 disregarded from income.

9.23 Sec. 14. Minnesota Statutes 2012, section 256B.056, subdivision 3, is amended to read:

9.24 Subd. 3. **Asset limitations for certain individuals and families.** ~~(a)~~ To be
9.25 eligible for medical assistance, a person must not individually own more than \$3,000 in
9.26 assets, or if a member of a household with two family members, husband and wife, or
9.27 parent and child, the household must not own more than \$6,000 in assets, plus \$200 for
9.28 each additional legal dependent. In addition to these maximum amounts, an eligible
9.29 individual or family may accrue interest on these amounts, but they must be reduced to the
9.30 maximum at the time of an eligibility redetermination. The accumulation of the clothing
9.31 and personal needs allowance according to section 256B.35 must also be reduced to the
9.32 maximum at the time of the eligibility redetermination. The value of assets that are not
9.33 considered in determining eligibility for medical assistance is the value of those assets
9.34 excluded under the supplemental security income program for aged, blind, and disabled
9.35 persons, with the following exceptions:

- 10.1 (1) household goods and personal effects are not considered;
- 10.2 (2) capital and operating assets of a trade or business that the local agency determines
10.3 are necessary to the person's ability to earn an income are not considered;
- 10.4 (3) motor vehicles are excluded to the same extent excluded by the supplemental
10.5 security income program;
- 10.6 (4) assets designated as burial expenses are excluded to the same extent excluded by
10.7 the supplemental security income program. Burial expenses funded by annuity contracts
10.8 or life insurance policies must irrevocably designate the individual's estate as contingent
10.9 beneficiary to the extent proceeds are not used for payment of selected burial expenses;
- 10.10 (5) for a person who no longer qualifies as an employed person with a disability due
10.11 to loss of earnings, assets allowed while eligible for medical assistance under section
10.12 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month
10.13 of ineligibility as an employed person with a disability, to the extent that the person's total
10.14 assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (d);
- 10.15 (6) when a person enrolled in medical assistance under section 256B.057, subdivision
10.16 9, is age 65 or older and has been enrolled during each of the 24 consecutive months
10.17 before the person's 65th birthday, the assets owned by the person and the person's spouse
10.18 must be disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (d),
10.19 when determining eligibility for medical assistance under section 256B.055, subdivision
10.20 7. The income of a spouse of a person enrolled in medical assistance under section
10.21 256B.057, subdivision 9, during each of the 24 consecutive months before the person's
10.22 65th birthday must be disregarded when determining eligibility for medical assistance
10.23 under section 256B.055, subdivision 7. Persons eligible under this clause are not subject to
10.24 the provisions in section 256B.059. A person whose 65th birthday occurs in 2012 or 2013
10.25 is required to have qualified for medical assistance under section 256B.057, subdivision 9,
10.26 prior to age 65 for at least 20 months in the 24 months prior to reaching age 65; and
- 10.27 (7) effective July 1, 2009, certain assets owned by American Indians are excluded as
10.28 required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public
10.29 Law 111-5. For purposes of this clause, an American Indian is any person who meets the
10.30 definition of Indian according to Code of Federal Regulations, title 42, section 447.50.
- 10.31 ~~(b) No asset limit shall apply to persons eligible under section 256B.055, subdivision~~
10.32 ~~15.~~

10.33 **EFFECTIVE DATE.** This section is effective January 1, 2014.

10.34 Sec. 15. Minnesota Statutes 2012, section 256B.056, subdivision 4, as amended by
10.35 Laws 2013, chapter 1, section 5, is amended to read:

11.1 Subd. 4. **Income.** (a) To be eligible for medical assistance, a person eligible under
 11.2 section 256B.055, subdivisions 7, 7a, and 12, may have income up to 100 percent of
 11.3 the federal poverty guidelines. Effective January 1, 2000, and each successive January,
 11.4 recipients of supplemental security income may have an income up to the supplemental
 11.5 security income standard in effect on that date.

11.6 ~~(b) To be eligible for medical assistance, families and children may have an income~~
 11.7 ~~up to 133-1/3 percent of the AFDC income standard in effect under the July 16, 1996,~~
 11.8 ~~AFDC state plan. Effective July 1, 2000, the base AFDC standard in effect on July 16,~~
 11.9 ~~1996, shall be increased by three percent.~~

11.10 ~~(e)~~ (b) Effective January 1, 2014, to be eligible for medical assistance, under section
 11.11 256B.055, subdivision 3a, a parent or caretaker relative may have an income up to 133
 11.12 percent of the federal poverty guidelines for the household size.

11.13 ~~(d)~~ (c) To be eligible for medical assistance under section 256B.055, subdivision
 11.14 15, a person may have an income up to 133 percent of federal poverty guidelines for
 11.15 the household size.

11.16 ~~(e)~~ (d) To be eligible for medical assistance under section 256B.055, subdivision
 11.17 16, a child age 19 to 20 may have an income up to 133 percent of the federal poverty
 11.18 guidelines for the household size.

11.19 ~~(f)~~ (e) To be eligible for medical assistance under section 256B.055, subdivision 3a,
 11.20 a child under age 19 may have income up to 275 percent of the federal poverty guidelines
 11.21 for the household size or an equivalent standard when converted using modified adjusted
 11.22 gross income methodology as required under the Affordable Care Act. Children who are
 11.23 enrolled in medical assistance as of December 31, 2013, and are determined ineligible
 11.24 for medical assistance because of the elimination of income disregards under modified
 11.25 adjusted gross income methodology as defined in subdivision 1a remain eligible for
 11.26 medical assistance under the Children's Health Insurance Program Reauthorization Act
 11.27 of 2009, Public Law 111-3, until the date of their next regularly scheduled eligibility
 11.28 redetermination as required in section 256B.056, subdivision 7a.

11.29 (f) In computing income to determine eligibility of persons under paragraphs (a) to
 11.30 (e) who are not residents of long-term care facilities, the commissioner shall disregard
 11.31 increases in income as required by Public Laws 94-566, section 503; 99-272; and 99-509.
 11.32 For persons eligible under paragraph (a), veteran aid and attendance benefits and Veterans
 11.33 Administration unusual medical expense payments are considered income to the recipient.

11.34 **EFFECTIVE DATE.** This section is effective January 1, 2014.

11.35 Sec. 16. Minnesota Statutes 2012, section 256B.056, subdivision 5c, is amended to read:

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

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

12.8 **EFFECTIVE DATE.** This section is effective January 1, 2014.

12.9 Sec. 17. Minnesota Statutes 2012, section 256B.056, is amended by adding a
12.10 subdivision to read:

12.11 **Subd. 7a. Periodic renewal of eligibility.** (a) The commissioner shall make an
12.12 annual redetermination of eligibility based on information contained in the enrollee's case
12.13 file and other information available to the agency, including but not limited to information
12.14 accessed through an electronic database, without requiring the enrollee to submit any
12.15 information when sufficient data is available for the agency to renew eligibility.

12.16 (b) If the commissioner cannot renew eligibility in accordance with paragraph (a),
12.17 the commissioner must provide the enrollee with a prepopulated renewal form containing
12.18 eligibility information available to the agency and permit the enrollee to submit the form
12.19 with any corrections or additional information to the agency and sign the renewal form via
12.20 any of the modes of submission specified in section 256B.04, subdivision 18.

12.21 (c) An enrollee who is terminated for failure to complete the renewal process may
12.22 subsequently submit the renewal form and required information within four months after
12.23 the date of termination and have coverage reinstated without a lapse, if otherwise eligible
12.24 under this chapter.

12.25 (d) Notwithstanding paragraph (a), individuals eligible under subdivision 5 shall be
12.26 required to renew eligibility every six months.

12.27 **EFFECTIVE DATE.** This section is effective January 1, 2014.

12.28 Sec. 18. Minnesota Statutes 2012, section 256B.056, subdivision 10, is amended to read:

12.29 Subd. 10. **Eligibility verification.** (a) The commissioner shall require women who
12.30 are applying for the continuation of medical assistance coverage following the end of the
12.31 60-day postpartum period to update their income and asset information and to submit
12.32 any required income or asset verification.

13.1 (b) The commissioner shall determine the eligibility of private-sector health care
 13.2 coverage for infants less than one year of age eligible under section 256B.055, subdivision
 13.3 10, or 256B.057, subdivision 1, paragraph (d), and shall pay for private-sector coverage
 13.4 if this is determined to be cost-effective.

13.5 (c) The commissioner shall verify assets and income for all applicants, and for all
 13.6 recipients upon renewal.

13.7 (d) The commissioner shall utilize information obtained through the electronic
 13.8 service established by the secretary of the United States Department of Health and Human
 13.9 Services and other available electronic data sources in Code of Federal Regulations, title
 13.10 42, sections 435.940 to 435.956, to verify eligibility requirements. The commissioner
 13.11 shall establish standards to define when information obtained electronically is reasonably
 13.12 compatible with information provided by applicants and enrollees, including use of
 13.13 self-attestation, to accomplish real-time eligibility determinations and maintain program
 13.14 integrity.

13.15 **EFFECTIVE DATE.** This section is effective January 1, 2014.

13.16 Sec. 19. Minnesota Statutes 2012, section 256B.057, subdivision 1, is amended to read:

13.17 Subdivision 1. **Infants and pregnant women.** (a)(1) An infant less than one year
 13.18 two years of age or a pregnant woman ~~who has written verification of a positive pregnancy~~
 13.19 ~~test from a physician or licensed registered nurse~~ is eligible for medical assistance if the
 13.20 individual's countable family household income is equal to or less than 275 percent of the
 13.21 federal poverty guideline for the same family household size or an equivalent standard
 13.22 when converted using modified adjusted gross income methodology as required under
 13.23 the Affordable Care Act. For purposes of this subdivision, "countable family income"
 13.24 ~~means the amount of income considered available using the methodology of the AFDC~~
 13.25 ~~program under the state's AFDC plan as of July 16, 1996, as required by the Personal~~
 13.26 ~~Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public~~
 13.27 ~~Law 104-193, except for the earned income disregard and employment deductions.~~

13.28 (2) ~~For applications processed within one calendar month prior to the effective date,~~
 13.29 ~~eligibility shall be determined by applying the income standards and methodologies in~~
 13.30 ~~effect prior to the effective date for any months in the six-month budget period before~~
 13.31 ~~that date and the income standards and methodologies in effect on the effective date for~~
 13.32 ~~any months in the six-month budget period on or after that date. The income standards~~
 13.33 ~~for each month shall be added together and compared to the applicant's total countable~~
 13.34 ~~income for the six-month budget period to determine eligibility.~~

13.35 (b)(1) [Expired, 1Sp2003 c 14 art 12 s 19]

14.1 ~~(2) For applications processed within one calendar month prior to July 1, 2003,~~
 14.2 ~~eligibility shall be determined by applying the income standards and methodologies in~~
 14.3 ~~effect prior to July 1, 2003, for any months in the six-month budget period before July 1,~~
 14.4 ~~2003, and the income standards and methodologies in effect on the expiration date for any~~
 14.5 ~~months in the six-month budget period on or after July 1, 2003. The income standards~~
 14.6 ~~for each month shall be added together and compared to the applicant's total countable~~
 14.7 ~~income for the six-month budget period to determine eligibility.~~

14.8 ~~(3) An amount equal to the amount of earned income exceeding 275 percent of~~
 14.9 ~~the federal poverty guideline, up to a maximum of the amount by which the combined~~
 14.10 ~~total of 185 percent of the federal poverty guideline plus the earned income disregards~~
 14.11 ~~and deductions allowed under the state's AFDC plan as of July 16, 1996, as required~~
 14.12 ~~by the Personal Responsibility and Work Opportunity Act of 1996 (PRWORA), Public~~
 14.13 ~~Law 104-193, exceeds 275 percent of the federal poverty guideline will be deducted for~~
 14.14 ~~pregnant women and infants less than one year of age.~~

14.15 ~~(e) Dependent care and child support paid under court order shall be deducted from~~
 14.16 ~~the countable income of pregnant women.~~

14.17 ~~(d)~~ (b) An infant born to a woman who was eligible for and receiving medical
 14.18 assistance on the date of the child's birth shall continue to be eligible for medical assistance
 14.19 without redetermination until the child's first birthday.

14.20 **EFFECTIVE DATE.** This section is effective January 1, 2014.

14.21 Sec. 20. Minnesota Statutes 2012, section 256B.057, subdivision 10, is amended to read:

14.22 Subd. 10. **Certain persons needing treatment for breast or cervical cancer.** (a)
 14.23 Medical assistance may be paid for a person who:

14.24 (1) has been screened for breast or cervical cancer by the Minnesota breast and
 14.25 cervical cancer control program, and program funds have been used to pay for the person's
 14.26 screening;

14.27 (2) according to the person's treating health professional, needs treatment, including
 14.28 diagnostic services necessary to determine the extent and proper course of treatment, for
 14.29 breast or cervical cancer, including precancerous conditions and early stage cancer;

14.30 (3) meets the income eligibility guidelines for the Minnesota breast and cervical
 14.31 cancer control program;

14.32 (4) is under age 65;

14.33 (5) is not otherwise eligible for medical assistance under United States Code, title
 14.34 42, section 1396a(a)(10)(A)(i); and

15.1 (6) is not otherwise covered under creditable coverage, as defined under United
15.2 States Code, title 42, section 1396a(aa).

15.3 (b) Medical assistance provided for an eligible person under this subdivision shall
15.4 be limited to services provided during the period that the person receives treatment for
15.5 breast or cervical cancer.

15.6 (c) A person meeting the criteria in paragraph (a) is eligible for medical assistance
15.7 without meeting the eligibility criteria relating to income and assets in section 256B.056,
15.8 subdivisions 1a to ~~5b~~ 5a.

15.9 **EFFECTIVE DATE.** This section is effective January 1, 2014.

15.10 Sec. 21. Minnesota Statutes 2012, section 256B.057, is amended by adding a
15.11 subdivision to read:

15.12 **Subd. 12. Presumptive eligibility determinations made by qualified hospitals.**

15.13 The commissioner shall establish a process to qualify hospitals that are participating
15.14 providers under the medical assistance program to determine presumptive eligibility for
15.15 medical assistance for applicants who may have a basis of eligibility using the modified
15.16 adjusted gross income methodology as defined in section 256B.056, subdivision 1a,
15.17 paragraph (b), clause (1).

15.18 **EFFECTIVE DATE.** This section is effective January 1, 2014.

15.19 Sec. 22. Minnesota Statutes 2012, section 256B.059, subdivision 1, is amended to read:

15.20 Subdivision 1. **Definitions.** (a) For purposes of this section and sections 256B.058
15.21 and 256B.0595, the terms defined in this subdivision have the meanings given them.

15.22 (b) "Community spouse" means the spouse of an institutionalized spouse.

15.23 (c) "Spousal share" means one-half of the total value of all assets, to the extent that
15.24 either the institutionalized spouse or the community spouse had an ownership interest at
15.25 the time of the first continuous period of institutionalization.

15.26 (d) "Assets otherwise available to the community spouse" means assets individually
15.27 or jointly owned by the community spouse, other than assets excluded by subdivision 5,
15.28 paragraph (c).

15.29 (e) "Community spouse asset allowance" is the value of assets that can be transferred
15.30 under subdivision 3.

15.31 (f) "Institutionalized spouse" means a person who is:

15.32 (1) in a hospital, nursing facility, or intermediate care facility for persons with
15.33 developmental disabilities, or receiving home and community-based services under section

16.1 256B.0915, 256B.092, or 256B.49 and is expected to remain in the facility or institution
 16.2 or receive the home and community-based services for at least 30 consecutive days; and

16.3 (2) married to a person who is not in a hospital, nursing facility, or intermediate
 16.4 care facility for persons with developmental disabilities, and is not receiving home and
 16.5 community-based services under section 256B.0915, 256B.092, or 256B.49.

16.6 (g) "For the sole benefit of" means no other individual or entity can benefit in any
 16.7 way from the assets or income at the time of a transfer or at any time in the future.

16.8 (h) "Continuous period of institutionalization" means a 30-consecutive-day period
 16.9 of time in which a person is expected to stay in a medical or long-term care facility, or
 16.10 receive home and community-based services that would qualify for coverage under ~~the~~
 16.11 ~~elderly waiver (EW) or alternative care (AC) programs~~ section 256B.0913, 256B.0915,
 16.12 256B.092, or 256B.49. For a stay in a facility, the 30-consecutive-day period begins
 16.13 on the date of entry into a medical or long-term care facility. For receipt of home and
 16.14 community-based services, the 30-consecutive-day period begins on the date that the
 16.15 following conditions are met:

16.16 (1) the person is receiving services that meet the nursing facility level of care
 16.17 determined by a long-term care consultation;

16.18 (2) the person has received the long-term care consultation within the past 60 days;

16.19 (3) the services are paid ~~by the EW program~~ under section ~~256B.0915 or the AC~~
 16.20 ~~program under section~~ 256B.0913, 256B.0915, 256B.092, or 256B.49 or would qualify
 16.21 for payment under ~~the EW or AC programs~~ those sections if the person were otherwise
 16.22 eligible for either program, and but for the receipt of such services the person would have
 16.23 resided in a nursing facility; and

16.24 (4) the services are provided by a licensed provider qualified to provide home and
 16.25 community-based services.

16.26 **EFFECTIVE DATE.** This section is effective January 1, 2014.

16.27 Sec. 23. Minnesota Statutes 2012, section 256B.06, subdivision 4, is amended to read:

16.28 Subd. 4. **Citizenship requirements.** (a) Eligibility for medical assistance is limited
 16.29 to citizens of the United States, qualified noncitizens as defined in this subdivision, and
 16.30 other persons residing lawfully in the United States. Citizens or nationals of the United
 16.31 States must cooperate in obtaining satisfactory documentary evidence of citizenship or
 16.32 nationality according to the requirements of the federal Deficit Reduction Act of 2005,
 16.33 Public Law 109-171.

16.34 (b) "Qualified noncitizen" means a person who meets one of the following
 16.35 immigration criteria:

- 17.1 (1) admitted for lawful permanent residence according to United States Code, title 8;
17.2 (2) admitted to the United States as a refugee according to United States Code,
17.3 title 8, section 1157;
- 17.4 (3) granted asylum according to United States Code, title 8, section 1158;
17.5 (4) granted withholding of deportation according to United States Code, title 8,
17.6 section 1253(h);
- 17.7 (5) paroled for a period of at least one year according to United States Code, title 8,
17.8 section 1182(d)(5);
- 17.9 (6) granted conditional entrant status according to United States Code, title 8,
17.10 section 1153(a)(7);
- 17.11 (7) determined to be a battered noncitizen by the United States Attorney General
17.12 according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996,
17.13 title V of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;
- 17.14 (8) is a child of a noncitizen determined to be a battered noncitizen by the United
17.15 States Attorney General according to the Illegal Immigration Reform and Immigrant
17.16 Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill,
17.17 Public Law 104-200; or
- 17.18 (9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public
17.19 Law 96-422, the Refugee Education Assistance Act of 1980.
- 17.20 (c) All qualified noncitizens who were residing in the United States before August
17.21 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for
17.22 medical assistance with federal financial participation.
- 17.23 (d) Beginning December 1, 1996, qualified noncitizens who entered the United
17.24 States on or after August 22, 1996, and who otherwise meet the eligibility requirements
17.25 of this chapter are eligible for medical assistance with federal participation for five years
17.26 if they meet one of the following criteria:
- 17.27 (1) refugees admitted to the United States according to United States Code, title 8,
17.28 section 1157;
- 17.29 (2) persons granted asylum according to United States Code, title 8, section 1158;
- 17.30 (3) persons granted withholding of deportation according to United States Code,
17.31 title 8, section 1253(h);
- 17.32 (4) veterans of the United States armed forces with an honorable discharge for
17.33 a reason other than noncitizen status, their spouses and unmarried minor dependent
17.34 children; or
- 17.35 (5) persons on active duty in the United States armed forces, other than for training,
17.36 their spouses and unmarried minor dependent children.

18.1 Beginning July 1, 2010, children and pregnant women who are noncitizens
18.2 described in paragraph (b) or who are lawfully present in the United States as defined
18.3 in Code of Federal Regulations, title 8, section 103.12, and who otherwise meet
18.4 eligibility requirements of this chapter, are eligible for medical assistance with federal
18.5 financial participation as provided by the federal Children's Health Insurance Program
18.6 Reauthorization Act of 2009, Public Law 111-3.

18.7 (e) Nonimmigrants who otherwise meet the eligibility requirements of this chapter
18.8 are eligible for the benefits as provided in paragraphs (f) to (h). For purposes of this
18.9 subdivision, a "nonimmigrant" is a person in one of the classes listed in United States
18.10 Code, title 8, section 1101(a)(15).

18.11 (f) Payment shall also be made for care and services that are furnished to noncitizens,
18.12 regardless of immigration status, who otherwise meet the eligibility requirements of
18.13 this chapter, if such care and services are necessary for the treatment of an emergency
18.14 medical condition.

18.15 (g) For purposes of this subdivision, the term "emergency medical condition" means
18.16 a medical condition that meets the requirements of United States Code, title 42, section
18.17 1396b(v).

18.18 (h)(1) Notwithstanding paragraph (g), services that are necessary for the treatment
18.19 of an emergency medical condition are limited to the following:

18.20 (i) services delivered in an emergency room or by an ambulance service licensed
18.21 under chapter 144E that are directly related to the treatment of an emergency medical
18.22 condition;

18.23 (ii) services delivered in an inpatient hospital setting following admission from an
18.24 emergency room or clinic for an acute emergency condition; and

18.25 (iii) follow-up services that are directly related to the original service provided
18.26 to treat the emergency medical condition and are covered by the global payment made
18.27 to the provider.

18.28 (2) Services for the treatment of emergency medical conditions do not include:

18.29 (i) services delivered in an emergency room or inpatient setting to treat a
18.30 nonemergency condition;

18.31 (ii) organ transplants, stem cell transplants, and related care;

18.32 (iii) services for routine prenatal care;

18.33 (iv) continuing care, including long-term care, nursing facility services, home health
18.34 care, adult day care, day training, or supportive living services;

18.35 (v) elective surgery;

- 19.1 (vi) outpatient prescription drugs, unless the drugs are administered or dispensed as
 19.2 part of an emergency room visit;
- 19.3 (vii) preventative health care and family planning services;
- 19.4 (viii) dialysis;
- 19.5 (ix) chemotherapy or therapeutic radiation services;
- 19.6 (x) rehabilitation services;
- 19.7 (xi) physical, occupational, or speech therapy;
- 19.8 (xii) transportation services;
- 19.9 (xiii) case management;
- 19.10 (xiv) prosthetics, orthotics, durable medical equipment, or medical supplies;
- 19.11 (xv) dental services;
- 19.12 (xvi) hospice care;
- 19.13 (xvii) audiology services and hearing aids;
- 19.14 (xviii) podiatry services;
- 19.15 (xix) chiropractic services;
- 19.16 (xx) immunizations;
- 19.17 (xxi) vision services and eyeglasses;
- 19.18 (xxii) waiver services;
- 19.19 (xxiii) individualized education programs; or
- 19.20 (xxiv) chemical dependency treatment.

19.21 (i) ~~Beginning July 1, 2009, Pregnant noncitizens who are undocumented,~~
 19.22 ~~nonimmigrants, or lawfully present in the United States as defined in Code of Federal~~
 19.23 ~~Regulations, title 8, section 103.12, ineligible for federally funded medical assistance~~
 19.24 ~~because of immigration status are not covered by a group health plan or health insurance~~
 19.25 ~~coverage according to Code of Federal Regulations, title 42, section 457.310, and who~~
 19.26 ~~otherwise meet the eligibility requirements of this chapter, are eligible for medical~~
 19.27 ~~assistance through the period of pregnancy, including labor and delivery, and 60 days~~
 19.28 ~~postpartum, to the extent federal funds are available under title XXI of the Social Security~~
 19.29 ~~Act, and the state children's health insurance program.~~

19.30 (j) Beginning October 1, 2003, persons who are receiving care and rehabilitation
 19.31 services from a nonprofit center established to serve victims of torture and are otherwise
 19.32 ineligible for medical assistance under this chapter are eligible for medical assistance
 19.33 without federal financial participation. These individuals are eligible only for the period
 19.34 during which they are receiving services from the center. Individuals eligible under this
 19.35 paragraph shall not be required to participate in prepaid medical assistance.

19.36 **EFFECTIVE DATE.** This section is effective January 1, 2014.

20.1 Sec. 24. Minnesota Statutes 2012, section 256B.0755, subdivision 3, is amended to read:

20.2 Subd. 3. **Accountability.** (a) Health care delivery systems must accept responsibility
20.3 for the quality of care based on standards established under subdivision 1, paragraph (b),
20.4 clause (10), and the cost of care or utilization of services provided to its enrollees under
20.5 subdivision 1, paragraph (b), clause (1).

20.6 (b) A health care delivery system may contract and coordinate with providers and
20.7 clinics for the delivery of services and shall contract with community health clinics,
20.8 federally qualified health centers, community mental health centers or programs, county
20.9 agencies, and rural clinics to the extent practicable.

20.10 (c) A health care delivery system must demonstrate how its services will be
20.11 coordinated with other services affecting its attributed patients' health, quality of care, and
20.12 cost of care that are provided by other providers and county agencies in the local service
20.13 area. The health care delivery system must document how other providers and counties,
20.14 including county-based purchasing plans, will provide services to attributed patients of
20.15 the health care delivery system, and how it will address applicable local needs, priorities,
20.16 and public health goals. As part of this documentation, the health care delivery system
20.17 must describe the involvement of local providers and counties, including county-based
20.18 purchasing plans, in developing the application to participate in the demonstration project.

20.19 **EFFECTIVE DATE.** This section is effective July 1, 2013, and applies to health
20.20 care delivery system contracts entered into on or after that date.

20.21 Sec. 25. Minnesota Statutes 2012, section 256B.694, is amended to read:

20.22 **256B.694 SOLE-SOURCE OR SINGLE-PLAN MANAGED CARE**
20.23 **CONTRACT.**

20.24 (a) MS 2010 [Expired, 2008 c 364 s 10]

20.25 (b) The commissioner shall consider, and may approve, contracting on a
20.26 single-health plan basis with ~~other~~ county-based purchasing plans, or with other qualified
20.27 health plans that have coordination arrangements with counties, to serve persons ~~with a~~
20.28 ~~disability who voluntarily enroll~~ enrolled in state public health care programs, in order
20.29 to promote better coordination or integration of health care services, social services and
20.30 other community-based services, provided that all requirements applicable to health plan
20.31 purchasing, including those in section 256B.69, subdivision 23, are satisfied. ~~Nothing in~~
20.32 ~~this paragraph supersedes or modifies the requirements in paragraph (a).~~

21.1 Sec. 26. Minnesota Statutes 2012, section 256L.01, is amended by adding a subdivision
21.2 to read:

21.3 Subd. 1b. **Affordable Care Act.** "Affordable Care Act" means Public Law 111-148,
21.4 as amended by the federal Health Care and Education Reconciliation Act of 2010, Public
21.5 Law 111-152, and any amendments to, or regulations or guidance issued under, those acts.

21.6 Sec. 27. Minnesota Statutes 2012, section 256L.01, subdivision 3a, is amended to read:

21.7 Subd. 3a. **Family with children.** (a) "~~Family with children~~" means:

21.8 (1) ~~parents and their children residing in the same household; or~~

21.9 (2) ~~grandparents, foster parents, relative caretakers as defined in the medical~~
21.10 ~~assistance program, or legal guardians; and their wards who are children residing in the~~
21.11 ~~same household. "Family" has the meaning given for family and family size as defined~~
21.12 ~~in Code of Federal Regulations, title 26, section 1.36B-1.~~

21.13 (b) The term includes children who are temporarily absent from the household in
21.14 settings such as schools, camps, or parenting time with noncustodial parents.

21.15 **EFFECTIVE DATE.** This section is effective January 1, 2014, or upon federal
21.16 approval, whichever is later. The commissioner of human services shall notify the revisor
21.17 of statutes when federal approval is obtained.

21.18 Sec. 28. Minnesota Statutes 2012, section 256L.01, subdivision 5, is amended to read:

21.19 Subd. 5. **Income.** (a) "~~Income~~" has the meaning given for ~~earned and unearned~~
21.20 ~~income for families and children in the medical assistance program, according to the~~
21.21 ~~state's aid to families with dependent children plan in effect as of July 16, 1996. The~~
21.22 ~~definition does not include medical assistance income methodologies and deeming~~
21.23 ~~requirements. The earned income of full-time and part-time students under age 19 is~~
21.24 ~~not counted as income. Public assistance payments and supplemental security income~~
21.25 ~~are not excluded income~~ modified adjusted gross income, as defined in Code of Federal
21.26 Regulations, title 26, section 1.36B-1.

21.27 (b) ~~For purposes of this subdivision, and unless otherwise specified in this section,~~
21.28 ~~the commissioner shall use reasonable methods to calculate gross earned and unearned~~
21.29 ~~income including, but not limited to, projecting income based on income received within~~
21.30 ~~the past 30 days, the last 90 days, or the last 12 months.~~

21.31 **EFFECTIVE DATE.** This section is effective January 1, 2014, or upon federal
21.32 approval, whichever is later. The commissioner of human services shall notify the revisor
21.33 of statutes when federal approval is obtained.

22.1 Sec. 29. Minnesota Statutes 2012, section 256L.01, is amended by adding a subdivision
22.2 to read:

22.3 Subd. 6. **Minnesota Insurance Marketplace.** "Minnesota Insurance Marketplace"
22.4 means the Minnesota Insurance Marketplace as defined in section 62V.02.

22.5 Sec. 30. Minnesota Statutes 2012, section 256L.01, is amended by adding a subdivision
22.6 to read:

22.7 Subd. 7. **Participating entity.** "Participating entity" means a health carrier as
22.8 defined in section 62A.01, subdivision 2; a county-based purchasing plan established
22.9 under section 256B.692; an accountable care organization or other entity operating a
22.10 health care delivery systems demonstration project authorized under section 256B.0755;
22.11 an entity operating a county integrated health care delivery network pilot project
22.12 authorized under section 256B.0756; or a network of health care providers established to
22.13 offer services under MinnesotaCare.

22.14 **EFFECTIVE DATE.** This section is effective January 1, 2015.

22.15 Sec. 31. Minnesota Statutes 2012, section 256L.02, subdivision 2, is amended to read:

22.16 Subd. 2. **Commissioner's duties.** (a) The commissioner shall establish an office
22.17 for the state administration of this plan. The plan shall be used to provide covered health
22.18 services for eligible persons. Payment for these services shall be made to all eligible
22.19 providers participating entities under contract with the commissioner. The commissioner
22.20 shall adopt rules to administer the MinnesotaCare program. The commissioner shall
22.21 establish marketing efforts to encourage potentially eligible persons to receive information
22.22 about the program and about other medical care programs administered or supervised by
22.23 the Department of Human Services.

22.24 (b) A toll-free telephone number and Web site must be used to provide information
22.25 about medical programs and to promote access to the covered services.

22.26 **EFFECTIVE DATE.** Paragraph (a) is effective January 1, 2015. Paragraph (b) is
22.27 effective January 1, 2014.

22.28 Sec. 32. Minnesota Statutes 2012, section 256L.02, is amended by adding a subdivision
22.29 to read:

22.30 Subd. 6. **Federal approval.** (a) The commissioner of human services shall seek
22.31 federal approval to implement the MinnesotaCare program under this chapter as a basic
22.32 health program. In any agreement with the Centers for Medicare and Medicaid Services

23.1 to operate MinnesotaCare as a basic health program, the commissioner shall seek to
 23.2 include procedures to ensure that federal funding is predictable, stable, and sufficient
 23.3 to sustain ongoing operation of MinnesotaCare. These procedures must address issues
 23.4 related to the timing of federal payments, payment reconciliation, enrollee risk adjustment,
 23.5 and minimization of state financial risk. The commissioner shall consult with the
 23.6 commissioner of management and budget, when developing the proposal for establishing
 23.7 MinnesotaCare as a basic health program to be submitted to the Centers for Medicare
 23.8 and Medicaid Services.

23.9 (b) The commissioner of human services, in consultation with the commissioner
 23.10 of management and budget, shall work with the Centers for Medicare and Medicaid
 23.11 Services to establish a process for reconciliation and adjustment of federal payments that
 23.12 balances state and federal liability over time. The commissioner of human services shall
 23.13 request that the United States secretary of health and human services hold the state, and
 23.14 enrollees, harmless in the reconciliation process for the first three years, to allow the state
 23.15 to develop a statistically valid methodology for predicting enrollment trends and their
 23.16 net effect on federal payments.

23.17 (c) The commissioner of human services, through December 31, 2015, may modify
 23.18 the MinnesotaCare program as specified in this chapter, if it is necessary to enhance
 23.19 health benefits, expand provider access, or reduce cost-sharing and premiums in order
 23.20 to comply with the terms and conditions of federal approval as a basic health program.
 23.21 The commissioner may not reduce benefits, impose greater limits on access to providers,
 23.22 or increase cost-sharing and premiums by enrollees under the authority granted by this
 23.23 paragraph. If the commissioner modifies the terms and requirements for MinnesotaCare
 23.24 under this paragraph, the commissioner shall provide the legislature with notice of
 23.25 implementation of the modifications at least ten working days before notifying enrollees
 23.26 and participating entities. The costs of any changes to the program necessary to comply
 23.27 with federal approval shall not become part of the program's base funding for purposes of
 23.28 future budget forecasts.

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

23.30 Sec. 33. Minnesota Statutes 2012, section 256L.02, is amended by adding a subdivision
 23.31 to read:

23.32 Subd. 7. **Coordination with Minnesota Insurance Marketplace.** MinnesotaCare
 23.33 shall be considered a public health care program for purposes of chapter 62V.

23.34 **EFFECTIVE DATE.** This section is effective January 1, 2014.

24.1 Sec. 34. Minnesota Statutes 2012, section 256L.03, subdivision 1, is amended to read:

24.2 Subdivision 1. **Covered health services.** (a) "Covered health services" means the
 24.3 health services reimbursed under chapter 256B, with the exception of ~~inpatient hospital~~
 24.4 ~~services~~, special education services, private duty nursing services, adult dental care
 24.5 services other than services covered under section 256B.0625, subdivision 9, orthodontic
 24.6 services, ~~nonemergency medical transportation services~~, personal care assistance and case
 24.7 management services, and nursing home or intermediate care facilities services, ~~inpatient~~
 24.8 ~~mental health services~~, and ~~chemical dependency services~~.

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

24.13 (c) Covered health services shall be expanded as provided in this section.

24.14 **EFFECTIVE DATE.** This section is effective January 1, 2014, or upon federal
 24.15 approval, whichever is later. The commissioner of human services shall notify the revisor
 24.16 of statutes when federal approval is obtained.

24.17 Sec. 35. Minnesota Statutes 2012, section 256L.03, subdivision 1a, is amended to read:

24.18 Subd. 1a. **~~Pregnant women and Children; MinnesotaCare health care reform~~**
 24.19 **~~waiver.~~** ~~Beginning January 1, 1999,~~ Children and pregnant women are eligible for coverage
 24.20 of all services that are eligible for reimbursement under the medical assistance program
 24.21 according to chapter 256B, except that abortion services under MinnesotaCare shall be
 24.22 limited as provided under subdivision 1. ~~Pregnant women and Children~~ are exempt from
 24.23 the provisions of subdivision 5, regarding co-payments. ~~Pregnant women and Children~~
 24.24 who are lawfully residing in the United States but who are not "qualified noncitizens" under
 24.25 title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996,
 24.26 Public Law 104-193, Statutes at Large, volume 110, page 2105, are eligible for coverage
 24.27 of all services provided under the medical assistance program according to chapter 256B.

24.28 **EFFECTIVE DATE.** This section is effective January 1, 2014, or upon federal
 24.29 approval, whichever is later. The commissioner of human services shall notify the revisor
 24.30 of statutes when federal approval is obtained.

24.31 Sec. 36. Minnesota Statutes 2012, section 256L.03, subdivision 3, is amended to read:

24.32 Subd. 3. **Inpatient hospital services.** (a) Covered health services shall include
 24.33 inpatient hospital services, including inpatient hospital mental health services and inpatient

25.1 hospital and residential chemical dependency treatment, subject to those limitations
 25.2 necessary to coordinate the provision of these services with eligibility under the medical
 25.3 assistance spenddown. ~~The inpatient hospital benefit for adult enrollees who qualify under~~
 25.4 ~~section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and~~
 25.5 ~~2, with family gross income that exceeds 200 percent of the federal poverty guidelines or~~
 25.6 ~~215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not~~
 25.7 ~~pregnant, is subject to an annual limit of \$10,000.~~

25.8 (b) Admissions for inpatient hospital services paid for under section 256L.11,
 25.9 subdivision 3, must be certified as medically necessary in accordance with Minnesota
 25.10 Rules, parts 9505.0500 to 9505.0540, except as provided in clauses (1) and (2):

25.11 (1) all admissions must be certified, except those authorized under rules established
 25.12 under section 254A.03, subdivision 3, or approved under Medicare; and

25.13 (2) payment under section 256L.11, subdivision 3, shall be reduced by five percent
 25.14 for admissions for which certification is requested more than 30 days after the day of
 25.15 admission. The hospital may not seek payment from the enrollee for the amount of the
 25.16 payment reduction under this clause.

25.17 **EFFECTIVE DATE.** This section is effective January 1, 2014, or upon federal
 25.18 approval, whichever is later. The commissioner of human services shall notify the revisor
 25.19 of statutes when federal approval is obtained.

25.20 Sec. 37. Minnesota Statutes 2012, section 256L.03, is amended by adding a subdivision
 25.21 to read:

25.22 Subd. 4a. **Loss ratio.** Health coverage provided through the MinnesotaCare
 25.23 program must have a medical loss ratio of at least 85 percent, as defined using the loss
 25.24 ratio methodology described in section 1001 of the Affordable Care Act.

25.25 **EFFECTIVE DATE.** This section is effective January 1, 2015.

25.26 Sec. 38. Minnesota Statutes 2012, section 256L.03, subdivision 5, is amended to read:

25.27 Subd. 5. **Cost-sharing.** (a) Except as otherwise provided in paragraphs (b) and (c)
 25.28 this subdivision, the MinnesotaCare benefit plan shall include the following cost-sharing
 25.29 requirements for all enrollees:

25.30 (1) ~~ten percent of the paid charges for inpatient hospital services for adult enrollees,~~
 25.31 ~~subject to an annual inpatient out-of-pocket maximum of \$1,000 per individual;~~

25.32 (2) ~~(1)~~ \$3 per prescription for adult enrollees;

25.33 (3) ~~(2)~~ \$25 for eyeglasses for adult enrollees;

26.1 ~~(4)~~ (3) \$3 per nonpreventive visit. For purposes of this subdivision, a "visit" means
26.2 an episode of service which is required because of a recipient's symptoms, diagnosis, or
26.3 established illness, and which is delivered in an ambulatory setting by a physician or
26.4 physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse,
26.5 audiologist, optician, or optometrist;

26.6 ~~(5)~~ (4) \$6 for nonemergency visits to a hospital-based emergency room for services
26.7 provided through December 31, 2010, and \$3.50 effective January 1, 2011; and

26.8 ~~(6)~~ (5) a family deductible equal to the maximum amount allowed under Code of
26.9 Federal Regulations, title 42, part 447.54.

26.10 ~~(b) Paragraph (a), clause (1), does not apply to parents and relative caretakers of~~
26.11 ~~children under the age of 21.~~

26.12 ~~(e) (b) Paragraph (a) does not apply to pregnant women and children under the~~
26.13 ~~age of 21.~~

26.14 ~~(d) (c) Paragraph (a), clause (4) (3), does not apply to mental health services.~~

26.15 ~~(e) Adult enrollees with family gross income that exceeds 200 percent of the federal~~
26.16 ~~poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009,~~
26.17 ~~and who are not pregnant shall be financially responsible for the coinsurance amount, if~~
26.18 ~~applicable, and amounts which exceed the \$10,000 inpatient hospital benefit limit.~~

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

26.24 ~~(g) (d) MinnesotaCare reimbursements to fee-for-service providers and payments to~~
26.25 ~~managed care plans or county-based purchasing plans shall not be increased as a result of~~
26.26 ~~the reduction of the co-payments in paragraph (a), clause (5) (4), effective January 1, 2011.~~

26.27 ~~(h) (e) The commissioner, through the contracting process under section 256L.12,~~
26.28 ~~may allow managed care plans and county-based purchasing plans to waive the family~~
26.29 ~~deductible under paragraph (a), clause (6) (5). The value of the family deductible shall not~~
26.30 ~~be included in the capitation payment to managed care plans and county-based purchasing~~
26.31 ~~plans. Managed care plans and county-based purchasing plans shall certify annually to the~~
26.32 ~~commissioner the dollar value of the family deductible.~~

26.33 **EFFECTIVE DATE.** This section is effective January 1, 2014, or upon federal
26.34 approval, whichever is later. The commissioner of human services shall notify the revisor
26.35 of statutes when federal approval is obtained.

27.1 Sec. 39. Minnesota Statutes 2012, section 256L.03, subdivision 6, is amended to read:

27.2 Subd. 6. **Lien.** When the state agency provides, pays for, or becomes liable for
 27.3 covered health services, the agency shall have a lien for the cost of the covered health
 27.4 services upon any and all causes of action accruing to the enrollee, or to the enrollee's
 27.5 legal representatives, as a result of the occurrence that necessitated the payment for the
 27.6 covered health services. All liens under this section shall be subject to the provisions
 27.7 of section 256.015. For purposes of this subdivision, "state agency" includes ~~prepaid~~
 27.8 ~~health plans participating entities,~~ under contract with the commissioner according to
 27.9 sections ~~256B.69, 256D.03, subdivision 4, paragraph (e), and 256L.12;~~ and county-based
 27.10 ~~purchasing entities under section 256B.692~~ section 256L.121.

27.11 **EFFECTIVE DATE.** This section is effective January 1, 2015.

27.12 Sec. 40. Minnesota Statutes 2012, section 256L.04, subdivision 1, is amended to read:

27.13 Subdivision 1. **Families with children.** ~~(a)~~ Families with children with family
 27.14 income above 133 percent of the federal poverty guidelines and equal to or less than
 27.15 ~~275~~ 200 percent of the federal poverty guidelines for the applicable family size shall be
 27.16 eligible for MinnesotaCare according to this section. All other provisions of sections
 27.17 256L.01 to 256L.18, ~~including the insurance-related barriers to enrollment under section~~
 27.18 ~~256L.07,~~ shall apply unless otherwise specified.

27.19 ~~(b) Parents who enroll in the MinnesotaCare program must also enroll their children,~~
 27.20 ~~if the children are eligible. Children may be enrolled separately without enrollment by~~
 27.21 ~~parents. However, if one parent in the household enrolls, both parents must enroll, unless~~
 27.22 ~~other insurance is available. If one child from a family is enrolled, all children must~~
 27.23 ~~be enrolled, unless other insurance is available. If one spouse in a household enrolls,~~
 27.24 ~~the other spouse in the household must also enroll, unless other insurance is available.~~
 27.25 ~~Families cannot choose to enroll only certain uninsured members.~~

27.26 ~~(c) Beginning October 1, 2003, the dependent sibling definition no longer applies~~
 27.27 ~~to the MinnesotaCare program. These persons are no longer counted in the parental~~
 27.28 ~~household and may apply as a separate household.~~

27.29 ~~(d) Parents are not eligible for MinnesotaCare if their gross income exceeds \$57,500.~~

27.30 ~~(e) Children deemed eligible for MinnesotaCare under section 256L.07, subdivision~~
 27.31 ~~8, are exempt from the eligibility requirements of this subdivision.~~

27.32 **EFFECTIVE DATE.** This section is effective January 1, 2014, or upon federal
 27.33 approval, whichever is later. The commissioner of human services shall notify the revisor
 27.34 of statutes when federal approval is obtained.

28.1 Sec. 41. Minnesota Statutes 2012, section 256L.04, is amended by adding a subdivision
28.2 to read:

28.3 Subd. 1c. **General requirements.** To be eligible for coverage under MinnesotaCare,
28.4 a person must meet the eligibility requirements of this section. A person eligible for
28.5 MinnesotaCare shall not be considered a qualified individual under section 1312 of the
28.6 Affordable Care Act, and is not eligible for enrollment in a qualified health plan offered
28.7 through the Minnesota Insurance Marketplace under chapter 62V.

28.8 **EFFECTIVE DATE.** This section is effective January 1, 2014.

28.9 Sec. 42. Minnesota Statutes 2012, section 256L.04, subdivision 7, is amended to read:

28.10 Subd. 7. **Single adults and households with no children.** (a) The definition of
28.11 eligible persons includes all individuals and ~~households~~ families with no children who
28.12 have ~~gross family~~ incomes that are above 133 percent and equal to or less than 200 percent
28.13 of the federal poverty guidelines for the applicable family size.

28.14 ~~(b) Effective July 1, 2009, the definition of eligible persons includes all individuals~~
28.15 ~~and households with no children who have gross family incomes that are equal to or less~~
28.16 ~~than 250 percent of the federal poverty guidelines.~~

28.17 **EFFECTIVE DATE.** This section is effective January 1, 2014, or upon federal
28.18 approval, whichever is later. The commissioner of human services shall notify the revisor
28.19 of statutes when federal approval is obtained.

28.20 Sec. 43. Minnesota Statutes 2012, section 256L.04, subdivision 8, is amended to read:

28.21 Subd. 8. **Applicants potentially eligible for medical assistance.** (a) Individuals
28.22 who receive supplemental security income or retirement, survivors, or disability benefits
28.23 due to a disability, or other disability-based pension, who qualify under subdivision 7, but
28.24 who are potentially eligible for medical assistance without a spenddown shall be allowed
28.25 to enroll in MinnesotaCare ~~for a period of 60 days~~, so long as the applicant meets all other
28.26 conditions of eligibility. The commissioner shall identify and refer the applications of
28.27 such individuals to their county social service agency. The county and the commissioner
28.28 shall cooperate to ensure that the individuals obtain medical assistance coverage for any
28.29 months for which they are eligible.

28.30 (b) The enrollee must cooperate with the county social service agency in determining
28.31 medical assistance eligibility ~~within the 60-day enrollment period~~. Enrollees who do not
28.32 cooperate with medical assistance ~~within the 60-day enrollment period~~ shall be disenrolled
28.33 from the plan within one calendar month. Persons disenrolled for nonapplication for

29.1 medical assistance may not reenroll until they have obtained a medical assistance
 29.2 eligibility determination. Persons disenrolled for noncooperation with medical assistance
 29.3 may not reenroll until they have cooperated with the county agency and have obtained a
 29.4 medical assistance eligibility determination.

29.5 (c) ~~Beginning January 1, 2000,~~ Counties that choose to become MinnesotaCare
 29.6 enrollment sites shall consider MinnesotaCare applications to also be applications for
 29.7 medical assistance. ~~Applicants who are potentially eligible for medical assistance, except~~
 29.8 ~~for those described in paragraph (a), may choose to enroll in either MinnesotaCare or~~
 29.9 ~~medical assistance.~~

29.10 (d) The commissioner shall redetermine provider payments made under
 29.11 MinnesotaCare to the appropriate medical assistance payments for those enrollees who
 29.12 subsequently become eligible for medical assistance.

29.13 **EFFECTIVE DATE.** This section is effective January 1, 2014, or upon federal
 29.14 approval, whichever is later. The commissioner of human services shall notify the revisor
 29.15 of statutes when federal approval is obtained.

29.16 Sec. 44. Minnesota Statutes 2012, section 256L.04, subdivision 10, is amended to read:

29.17 Subd. 10. **Citizenship requirements.** (a) Eligibility for MinnesotaCare is limited to
 29.18 citizens or nationals of the United States, ~~qualified noncitizens, and other persons residing~~
 29.19 ~~lawfully in the United States present noncitizens~~ as defined in Code of Federal Regulations,
 29.20 title 8, section 103.12. Undocumented noncitizens ~~and nonimmigrants~~ are ineligible for
 29.21 MinnesotaCare. For purposes of this subdivision, ~~a nonimmigrant is an individual in one~~
 29.22 ~~or more of the classes listed in United States Code, title 8, section 1101(a)(15), and an~~
 29.23 undocumented noncitizen is an individual who resides in the United States without the
 29.24 approval or acquiescence of the United States Citizenship and Immigration Services.
 29.25 Families with children who are citizens or nationals of the United States must cooperate in
 29.26 obtaining satisfactory documentary evidence of citizenship or nationality according to the
 29.27 requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

29.28 (b) Notwithstanding subdivisions 1 and 7, eligible persons include families and
 29.29 individuals who are lawfully present and ineligible for medical assistance by reason of
 29.30 immigration status and who have incomes equal to or less than 200 percent of federal
 29.31 poverty guidelines.

29.32 **EFFECTIVE DATE.** This section is effective January 1, 2014, or upon federal
 29.33 approval, whichever is later. The commissioner of human services shall notify the revisor
 29.34 of statutes when federal approval is obtained.

30.1 Sec. 45. Minnesota Statutes 2012, section 256L.04, subdivision 12, is amended to read:

30.2 Subd. 12. **Persons in detention.** ~~Beginning January 1, 1999, An applicant or~~
30.3 ~~enrollee residing in a correctional or detention facility is not eligible for MinnesotaCare,~~
30.4 ~~unless the applicant or enrollee is awaiting disposition of charges. An enrollee residing in~~
30.5 ~~a correctional or detention facility is not eligible at renewal of eligibility under section~~
30.6 ~~256L.05, subdivision 3a.~~

30.7 **EFFECTIVE DATE.** This section is effective January 1, 2014.

30.8 Sec. 46. Minnesota Statutes 2012, section 256L.04, is amended by adding a subdivision
30.9 to read:

30.10 Subd. 14. **Coordination with medical assistance.** (a) Individuals eligible for
30.11 medical assistance under chapter 256B are not eligible for MinnesotaCare under this
30.12 section.

30.13 (b) The commissioner shall coordinate eligibility and coverage to ensure that
30.14 individuals transitioning between medical assistance and MinnesotaCare have seamless
30.15 eligibility and access to health care services.

30.16 **EFFECTIVE DATE.** This section is effective January 1, 2014, or upon federal
30.17 approval, whichever is later. The commissioner of human services shall notify the revisor
30.18 of statutes when federal approval is obtained.

30.19 Sec. 47. Minnesota Statutes 2012, section 256L.05, subdivision 1, is amended to read:

30.20 Subdivision 1. **Application assistance and information availability.** (a) Applicants
30.21 may submit applications online, in person, by mail, or by phone in accordance with the
30.22 Affordable Care Act, and by any other means by which medical assistance applications
30.23 may be submitted. Applicants may submit applications through the Minnesota Insurance
30.24 Marketplace or through the MinnesotaCare program. Applications and application
30.25 assistance must be made available at provider offices, local human services agencies,
30.26 school districts, public and private elementary schools in which 25 percent or more of
30.27 the students receive free or reduced price lunches, community health offices, Women,
30.28 Infants and Children (WIC) program sites, Head Start program sites, public housing
30.29 councils, crisis nurseries, child care centers, early childhood education and preschool
30.30 program sites, legal aid offices, and libraries, and at any other locations at which medical
30.31 assistance applications must be made available. These sites may accept applications and
30.32 forward the forms to the commissioner or local county human services agencies that

31.1 choose to participate as an enrollment site. Otherwise, applicants may apply directly to the
31.2 commissioner or to participating local county human services agencies.

31.3 (b) Application assistance must be available for applicants choosing to file an online
31.4 application through the Minnesota Insurance Marketplace.

31.5 **EFFECTIVE DATE.** This section is effective January 1, 2014.

31.6 Sec. 48. Minnesota Statutes 2012, section 256L.05, subdivision 2, is amended to read:

31.7 Subd. 2. **Commissioner's duties.** The commissioner or county agency shall use
31.8 electronic verification through the Minnesota Insurance Marketplace as the primary
31.9 method of income verification. If there is a discrepancy between reported income
31.10 and electronically verified income, an individual may be required to submit additional
31.11 verification to the extent permitted under the Affordable Care Act. In addition, the
31.12 commissioner shall perform random audits to verify reported income and eligibility. The
31.13 commissioner may execute data sharing arrangements with the Department of Revenue
31.14 and any other governmental agency in order to perform income verification related to
31.15 eligibility and ~~premium payment under the MinnesotaCare program~~.

31.16 **EFFECTIVE DATE.** This section is effective January 1, 2014.

31.17 Sec. 49. Minnesota Statutes 2012, section 256L.05, subdivision 3, is amended to read:

31.18 Subd. 3. **Effective date of coverage.** (a) The effective date of coverage is the
31.19 first day of the month following the month in which eligibility is approved and the first
31.20 premium payment has been received. ~~As provided in section 256B.057, coverage for~~
31.21 ~~newborns is automatic from the date of birth and must be coordinated with other health~~
31.22 ~~coverage. The effective date of coverage for eligible newly adoptive children added to a~~
31.23 ~~family receiving covered health services is the month of placement. The effective date~~
31.24 ~~of coverage for other new members added to the family is the first day of the month~~
31.25 ~~following the month in which the change is reported. All eligibility criteria must be met~~
31.26 ~~by the family at the time the new family member is added. The income of the new family~~
31.27 ~~member is included with the family's modified adjusted gross income and the adjusted~~
31.28 ~~premium begins in the month the new family member is added.~~

31.29 (b) The initial premium must be received by the last working day of the month for
31.30 coverage to begin the first day of the following month.

31.31 (c) ~~Benefits are not available until the day following discharge if an enrollee is~~
31.32 ~~hospitalized on the first day of coverage.~~

32.1 ~~(d)~~ (c) Notwithstanding any other law to the contrary, benefits under sections
 32.2 256L.01 to 256L.18 are secondary to a plan of insurance or benefit program under which
 32.3 an eligible person may have coverage and the commissioner shall use cost avoidance
 32.4 techniques to ensure coordination of any other health coverage for eligible persons. The
 32.5 commissioner shall identify eligible persons who may have coverage or benefits under
 32.6 other plans of insurance or who become eligible for medical assistance.

32.7 ~~(e)~~ (d) The effective date of coverage for individuals or families who are exempt
 32.8 from paying premiums under section 256L.15, subdivision 1, paragraph (d), is the first
 32.9 day of the month following the month in which verification of American Indian status
 32.10 is received or eligibility is approved, whichever is later.

32.11 ~~(f)~~ (e) The effective date of coverage for children eligible under section 256L.07,
 32.12 subdivision 8, is the first day of the month following the date of termination from foster
 32.13 care or release from a juvenile residential correctional facility.

32.14 **EFFECTIVE DATE.** This section is effective January 1, 2014, or upon federal
 32.15 approval, whichever is later. The commissioner of human services shall notify the revisor
 32.16 of statutes when federal approval is obtained.

32.17 Sec. 50. Minnesota Statutes 2012, section 256L.05, subdivision 3c, is amended to read:

32.18 Subd. 3c. **Retroactive coverage.** Notwithstanding subdivision 3, the effective
 32.19 date of coverage shall be the first day of the month following termination from medical
 32.20 assistance for families and individuals who are eligible for MinnesotaCare and who
 32.21 submitted a written request for retroactive MinnesotaCare coverage with a completed
 32.22 application within 30 days of the mailing of notification of termination from medical
 32.23 assistance. The applicant must provide all required verifications within 30 days of the
 32.24 written request for verification. For retroactive coverage, premiums must be paid in full
 32.25 for any retroactive month, current month, and next month within 30 days of the premium
 32.26 billing. ~~General assistance medical care recipients may qualify for retroactive coverage~~
 32.27 ~~under this subdivision at six-month renewal.~~

32.28 **EFFECTIVE DATE.** This section is effective January 1, 2014.

32.29 Sec. 51. Minnesota Statutes 2012, section 256L.06, subdivision 3, is amended to read:

32.30 Subd. 3. **Commissioner's duties and payment.** (a) Premiums are dedicated to the
 32.31 commissioner for MinnesotaCare.

32.32 (b) The commissioner shall develop and implement procedures to: (1) require
 32.33 enrollees to report changes in income; (2) adjust sliding scale premium payments, based

33.1 upon both increases and decreases in enrollee income, at the time the change in income
33.2 is reported; and (3) disenroll enrollees from MinnesotaCare for failure to pay required
33.3 premiums. Failure to pay includes payment with a dishonored check, a returned automatic
33.4 bank withdrawal, or a refused credit card or debit card payment. The commissioner may
33.5 demand a guaranteed form of payment, including a cashier's check or a money order, as
33.6 the only means to replace a dishonored, returned, or refused payment.

33.7 (c) Premiums are calculated on a calendar month basis and may be paid on a
33.8 monthly, quarterly, or semiannual basis, with the first payment due upon notice from the
33.9 commissioner of the premium amount required. The commissioner shall inform applicants
33.10 and enrollees of these premium payment options. Premium payment is required before
33.11 enrollment is complete and to maintain eligibility in MinnesotaCare. Premium payments
33.12 received before noon are credited the same day. Premium payments received after noon
33.13 are credited on the next working day.

33.14 (d) Nonpayment of the premium will result in disenrollment from the plan effective
33.15 for the calendar month for which the premium was due. ~~Persons disenrolled for~~
33.16 ~~nonpayment or who voluntarily terminate coverage from the program may not reenroll~~
33.17 ~~until four calendar months have elapsed.~~ Persons disenrolled for nonpayment who pay
33.18 all past due premiums as well as current premiums due, including premiums due for the
33.19 period of disenrollment, within 20 days of disenrollment, shall be reenrolled retroactively
33.20 to the first day of disenrollment. ~~Persons disenrolled for nonpayment or who voluntarily~~
33.21 ~~terminate coverage from the program may not reenroll for four calendar months unless~~
33.22 ~~the person demonstrates good cause for nonpayment. Good cause does not exist if a~~
33.23 ~~person chooses to pay other family expenses instead of the premium. The commissioner~~
33.24 ~~shall define good cause in rule.~~

33.25 **EFFECTIVE DATE.** This section is effective January 1, 2014, or upon federal
33.26 approval, whichever is later. The commissioner of human services shall notify the revisor
33.27 of statutes when federal approval is obtained.

33.28 Sec. 52. Minnesota Statutes 2012, section 256L.07, subdivision 1, is amended to read:

33.29 Subdivision 1. **General requirements.** ~~(a) Children enrolled in the original~~
33.30 ~~children's health plan as of September 30, 1992, children who enrolled in the~~
33.31 ~~MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549,~~
33.32 ~~article 4, section 17, and children who have family gross incomes that are equal to or~~
33.33 ~~less than 200 percent of the federal poverty guidelines are eligible without meeting the~~
33.34 ~~requirements of subdivision 2 and the four-month requirement in subdivision 3, as long as~~
33.35 ~~they maintain continuous coverage in the MinnesotaCare program or medical assistance.~~

34.1 ~~Parents~~ Families and individuals enrolled in MinnesotaCare under section 256L.04,
 34.2 subdivision 1, whose income increases above ~~275~~ 200 percent of the federal poverty
 34.3 guidelines, are no longer eligible for the program and shall be disenrolled by the
 34.4 commissioner. ~~Beginning January 1, 2008, Individuals enrolled in MinnesotaCare under~~
 34.5 ~~section 256L.04, subdivision 7, whose income increases above 200 percent of the federal~~
 34.6 ~~poverty guidelines or 250 percent of the federal poverty guidelines on or after July 1,~~
 34.7 ~~2009, are no longer eligible for the program and shall be disenrolled by the commissioner.~~
 34.8 For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the
 34.9 last day of the calendar month following the month in which the commissioner determines
 34.10 that the income of a family or individual exceeds program income limits.

34.11 ~~(b) Children may remain enrolled in MinnesotaCare if their gross family income as~~
 34.12 ~~defined in section 256L.01, subdivision 4, is greater than 275 percent of federal poverty~~
 34.13 ~~guidelines. The premium for children remaining eligible under this paragraph shall be the~~
 34.14 ~~maximum premium determined under section 256L.15, subdivision 2, paragraph (b).~~

34.15 ~~(c) Notwithstanding paragraph (a), parents are not eligible for MinnesotaCare if~~
 34.16 ~~gross household income exceeds \$57,500 for the 12-month period of eligibility.~~

34.17 **EFFECTIVE DATE.** This section is effective January 1, 2014, or upon federal
 34.18 approval, whichever is later. The commissioner of human services shall notify the revisor
 34.19 of statutes when federal approval is obtained.

34.20 Sec. 53. Minnesota Statutes 2012, section 256L.07, subdivision 2, is amended to read:

34.21 Subd. 2. **Must not have access to employer-subsidized minimum essential**
 34.22 **coverage.** (a) To be eligible, a family or individual must not have access to subsidized
 34.23 health coverage through an employer and must not have had access to employer-subsidized
 34.24 coverage through a current employer for 18 months prior to application or reapplication.
 34.25 ~~A family or individual whose employer-subsidized coverage is lost due to an employer~~
 34.26 ~~terminating health care coverage as an employee benefit during the previous 18 months is~~
 34.27 ~~not eligible that is affordable and provides minimum value as defined in Code of Federal~~
 34.28 ~~Regulations, title 26, section 1.36B-2.~~

34.29 (b) This subdivision does not apply to a family or individual ~~who was enrolled~~
 34.30 ~~in MinnesotaCare within six months or less of reapplication and who no longer has~~
 34.31 ~~employer-subsidized coverage due to the employer terminating health care coverage as an~~
 34.32 ~~employee benefit. This subdivision does not apply to children with family gross incomes~~
 34.33 ~~that are equal to or less than 200 percent of federal poverty guidelines.~~

34.34 (c) For purposes of this requirement, subsidized health coverage means health
 34.35 coverage for which the employer pays at least 50 percent of the cost of coverage for

35.1 ~~the employee or dependent, or a higher percentage as specified by the commissioner.~~
 35.2 ~~Children are eligible for employer-subsidized coverage through either parent, including~~
 35.3 ~~the noncustodial parent. The commissioner must treat employer contributions to Internal~~
 35.4 ~~Revenue Code Section 125 plans and any other employer benefits intended to pay~~
 35.5 ~~health care costs as qualified employer subsidies toward the cost of health coverage for~~
 35.6 ~~employees for purposes of this subdivision.~~

35.7 **EFFECTIVE DATE.** This section is effective January 1, 2014, or upon federal
 35.8 approval, whichever is later. The commissioner of human services shall notify the revisor
 35.9 of statutes when federal approval is obtained.

35.10 Sec. 54. Minnesota Statutes 2012, section 256L.07, subdivision 3, is amended to read:

35.11 Subd. 3. **Other health coverage.** ~~(a) Families and individuals enrolled in the~~
 35.12 ~~MinnesotaCare program must have no~~ To be eligible, a family or individual must not have
 35.13 minimum essential health coverage while enrolled, as defined by section 5000A of the
 35.14 Internal Revenue Code. Children with family gross incomes equal to or greater than 200
 35.15 percent of federal poverty guidelines, and adults, must have had no health coverage for
 35.16 at least four months prior to application and renewal. Children enrolled in the original
 35.17 children's health plan and children in families with income equal to or less than 200
 35.18 percent of the federal poverty guidelines, who have other health insurance, are eligible if
 35.19 the coverage:

35.20 (1) ~~lacks two or more of the following:~~

35.21 (i) ~~basic hospital insurance;~~

35.22 (ii) ~~medical-surgical insurance;~~

35.23 (iii) ~~prescription drug coverage;~~

35.24 (iv) ~~dental coverage; or~~

35.25 (v) ~~vision coverage;~~

35.26 (2) ~~requires a deductible of \$100 or more per person per year; or~~

35.27 (3) ~~lacks coverage because the child has exceeded the maximum coverage for a~~
 35.28 ~~particular diagnosis or the policy excludes a particular diagnosis.~~

35.29 ~~The commissioner may change this eligibility criterion for sliding scale premiums~~
 35.30 ~~in order to remain within the limits of available appropriations. The requirement of no~~
 35.31 ~~health coverage does not apply to newborns.~~

35.32 (b) ~~Coverage purchased as provided under section 256L.031, subdivision 2, medical~~
 35.33 ~~assistance, and the Civilian Health and Medical Program of the Uniformed Service,~~
 35.34 ~~CHAMPUS, or other coverage provided under United States Code, title 10, subtitle A,~~

36.1 ~~part II, chapter 55, are not considered insurance or health coverage for purposes of the~~
 36.2 ~~four-month requirement described in this subdivision.~~

36.3 (e) ~~(b)~~ For purposes of this subdivision, an applicant or enrollee who is entitled to
 36.4 Medicare Part A or enrolled in Medicare Part B coverage under title XVIII of the Social
 36.5 Security Act, United States Code, title 42, sections 1395c to 1395w-152, is considered
 36.6 to have minimum essential health coverage. An applicant or enrollee who is entitled to
 36.7 premium-free Medicare Part A may not refuse to apply for or enroll in Medicare coverage
 36.8 to establish eligibility for MinnesotaCare.

36.9 (d) ~~Applicants who were recipients of medical assistance within one month of~~
 36.10 ~~application must meet the provisions of this subdivision and subdivision 2.~~

36.11 (e) ~~Cost-effective health insurance that was paid for by medical assistance is not~~
 36.12 ~~considered health coverage for purposes of the four-month requirement under this~~
 36.13 ~~section, except if the insurance continued after medical assistance no longer considered it~~
 36.14 ~~cost-effective or after medical assistance closed.~~

36.15 **EFFECTIVE DATE.** This section is effective January 1, 2014, or upon federal
 36.16 approval, whichever is later. The commissioner of human services shall notify the revisor
 36.17 of statutes when federal approval is obtained.

36.18 Sec. 55. Minnesota Statutes 2012, section 256L.09, subdivision 2, is amended to read:

36.19 Subd. 2. **Residency requirement.** To be eligible for health coverage under the
 36.20 MinnesotaCare program, ~~pregnant women,~~ individuals, and families with children must
 36.21 meet the residency requirements as provided by Code of Federal Regulations, title 42,
 36.22 section 435.403, ~~except that the provisions of section 256B.056, subdivision 1, shall apply~~
 36.23 ~~upon receipt of federal approval.~~

36.24 **EFFECTIVE DATE.** This section is effective January 1, 2014, or upon federal
 36.25 approval, whichever is later. The commissioner of human services shall notify the revisor
 36.26 of statutes when federal approval is obtained.

36.27 Sec. 56. Minnesota Statutes 2012, section 256L.11, subdivision 1, is amended to read:

36.28 Subdivision 1. **Medical assistance rate to be used.** (a) Payment to providers
 36.29 under ~~sections 256L.01 to 256L.11~~ this chapter shall be at the same rates and conditions
 36.30 established for medical assistance, except as provided in ~~subdivisions 2 to 6~~ this section.

36.31 (b) ~~Effective for services provided on or after July 1, 2009, total payments for basic~~
 36.32 ~~care services shall be reduced by three percent, in accordance with section 256B.766.~~

37.1 ~~Payments made to managed care and county-based purchasing plans shall be reduced for~~
 37.2 ~~services provided on or after October 1, 2009, to reflect this reduction.~~

37.3 ~~(e) Effective for services provided on or after July 1, 2009, payment rates for~~
 37.4 ~~physician and professional services shall be reduced as described under section 256B.76,~~
 37.5 ~~subdivision 1, paragraph (e). Payments made to managed care and county-based~~
 37.6 ~~purchasing plans shall be reduced for services provided on or after October 1, 2009,~~
 37.7 ~~to reflect this reduction.~~

37.8 **EFFECTIVE DATE.** This section is effective January 1, 2014.

37.9 Sec. 57. Minnesota Statutes 2012, section 256L.11, is amended by adding a subdivision
 37.10 to read:

37.11 Subd. 1a. **Rate increases.** Notwithstanding subdivision 1, effective for services
 37.12 provided on or after January 1, 2015, the commissioner shall increase payments for
 37.13 basic care services, physician and professional services, and dental services by three
 37.14 percent from the rates in effect for the MinnesotaCare program on December 31, 2014.
 37.15 Payments to participating entities established through the competitive process under
 37.16 section 256L.121 must reflect this increase.

37.17 Sec. 58. Minnesota Statutes 2012, section 256L.11, subdivision 3, is amended to read:

37.18 Subd. 3. **Inpatient hospital services.** Inpatient hospital services provided under
 37.19 section 256L.03, subdivision 3, shall be paid for as provided in subdivisions 4 to 6 at the
 37.20 medical assistance rate.

37.21 **EFFECTIVE DATE.** This section is effective January 1, 2014.

37.22 Sec. 59. **[256L.121] SERVICE DELIVERY.**

37.23 Subdivision 1. **Competitive process.** The commissioner of human services shall
 37.24 establish a competitive process for entering into contracts with participating entities for
 37.25 the offering of standard health plans through MinnesotaCare. Coverage through standard
 37.26 health plans must be available to enrollees beginning January 1, 2015. Each standard health
 37.27 plan must cover the health services listed in, and meet the requirements of, section 256L.03.
 37.28 The competitive process must meet the requirements of section 1331 of the Affordable
 37.29 Care Act and be designed to ensure enrollee access to high-quality health care coverage
 37.30 options. The commissioner, to the extent feasible, shall seek to ensure that enrollees have
 37.31 a choice of coverage from more than one participating entity within a geographic area.

38.1 Subd. 2. **Other requirements for participating entities.** The commissioner shall
 38.2 require participating entities, as a condition of contract, to document to the commissioner:

38.3 (1) the provision of culturally and linguistically appropriate services, including
 38.4 marketing materials, to MinnesotaCare enrollees; and

38.5 (2) the inclusion in provider networks of providers designated as essential
 38.6 community providers under section 62Q.19.

38.7 Subd. 3. **Coordination with state-administered health programs.** The
 38.8 commissioner shall coordinate the administration of the MinnesotaCare program with
 38.9 medical assistance to maximize efficiency and improve the continuity of care. This
 38.10 includes, but is not limited to:

38.11 (1) establishing geographic areas for MinnesotaCare that are consistent with the
 38.12 geographic areas of the medical assistance program, within which participating entities
 38.13 may offer health plans;

38.14 (2) requiring, as a condition of participation in MinnesotaCare, participating entities
 38.15 to also participate in the medical assistance program;

38.16 (3) complying with sections 256B.69, subdivision 3a; 256B.692, subdivision 1; and
 38.17 256B.694 when contracting with MinnesotaCare participating entities;

38.18 (4) providing MinnesotaCare enrollees, to the extent possible, with the option to
 38.19 remain in the same health plan and provider network, if they later become eligible for
 38.20 medical assistance or coverage through the Minnesota Insurance Marketplace and if, in
 38.21 the case of becoming eligible for medical assistance, the enrollee's MinnesotaCare health
 38.22 plan is also a medical assistance health plan in the enrollee's county of residence; and

38.23 (5) establishing requirements and criteria for selection that ensure that covered
 38.24 health care services will be coordinated with local public health, social services, long-term
 38.25 care services, mental health services, and other local services affecting enrollees' health,
 38.26 access, and quality of care.

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

38.28 Sec. 60. Minnesota Statutes 2012, section 256L.15, subdivision 1, is amended to read:

38.29 Subdivision 1. **Premium determination.** (a) Families with children and individuals
 38.30 shall pay a premium determined according to subdivision 2.

38.31 ~~(b) Pregnant women and children under age two are exempt from the provisions~~
 38.32 ~~of section 256L.06, subdivision 3, paragraph (b), clause (3), requiring disenrollment~~
 38.33 ~~for failure to pay premiums. For pregnant women, this exemption continues until the~~
 38.34 ~~first day of the month following the 60th day postpartum. Women who remain enrolled~~
 38.35 ~~during pregnancy or the postpartum period, despite nonpayment of premiums, shall be~~

39.1 ~~disenrolled on the first of the month following the 60th day postpartum for the penalty~~
 39.2 ~~period that otherwise applies under section 256L.06, unless they begin paying premiums.~~

39.3 (e) (b) Members of the military and their families who meet the eligibility criteria
 39.4 for MinnesotaCare upon eligibility approval made within 24 months following the end
 39.5 of the member's tour of active duty shall have their premiums paid by the commissioner.
 39.6 The effective date of coverage for an individual or family who meets the criteria of this
 39.7 paragraph shall be the first day of the month following the month in which eligibility is
 39.8 approved. This exemption applies for 12 months.

39.9 (d) (c) Beginning July 1, 2009, American Indians enrolled in MinnesotaCare and
 39.10 their families shall have their premiums waived by the commissioner in accordance with
 39.11 section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5.
 39.12 An individual must document status as an American Indian, as defined under Code of
 39.13 Federal Regulations, title 42, section 447.50, to qualify for the waiver of premiums.

39.14 **EFFECTIVE DATE.** This section is effective January 1, 2014, or upon federal
 39.15 approval, whichever is later. The commissioner of human services shall notify the revisor
 39.16 of statutes when federal approval is obtained.

39.17 Sec. 61. Minnesota Statutes 2012, section 256L.15, subdivision 2, is amended to read:

39.18 Subd. 2. **Sliding fee scale; monthly gross individual or family income.** (a) The
 39.19 commissioner shall establish a sliding fee scale to determine the percentage of ~~monthly~~
 39.20 ~~gross~~ individual or family income that households at different income levels must pay to
 39.21 obtain coverage through the MinnesotaCare program. The sliding fee scale must be based
 39.22 on the enrollee's monthly ~~gross~~ individual or family income. The sliding fee scale must
 39.23 contain separate tables based on enrollment of one, two, or three or more persons. ~~Until~~
 39.24 ~~June 30, 2009, the sliding fee scale begins with a premium of 1.5 percent of monthly gross~~
 39.25 ~~individual or family income for individuals or families with incomes below the limits for~~
 39.26 ~~the medical assistance program for families and children in effect on January 1, 1999, and~~
 39.27 ~~proceeds through the following evenly spaced steps: 1.8, 2.3, 3.1, 3.8, 4.8, 5.9, 7.4, and~~
 39.28 ~~8.8 percent.~~ These percentages are matched to evenly spaced income steps ranging from
 39.29 the medical assistance income limit for families and children in effect on January 1, 1999,
 39.30 to ~~275~~ 200 percent of the federal poverty guidelines for the applicable family size, up to a
 39.31 family size of five. The sliding fee scale for a family of five must be used for families of
 39.32 more than five. The sliding fee scale and percentages are not subject to the provisions of
 39.33 chapter 14. If a family or individual reports increased income after enrollment, premiums
 39.34 shall be adjusted at the time the change in income is reported.

40.1 ~~(b) Children in families whose gross income is above 275 percent of the federal~~
 40.2 ~~poverty guidelines shall pay the maximum premium. The maximum premium is defined~~
 40.3 ~~as a base charge for one, two, or three or more enrollees so that if all MinnesotaCare~~
 40.4 ~~cases paid the maximum premium, the total revenue would equal the total cost of~~
 40.5 ~~MinnesotaCare medical coverage and administration. In this calculation, administrative~~
 40.6 ~~costs shall be assumed to equal ten percent of the total. The costs of medical coverage~~
 40.7 ~~for pregnant women and children under age two and the enrollees in these groups shall~~
 40.8 ~~be excluded from the total. The maximum premium for two enrollees shall be twice the~~
 40.9 ~~maximum premium for one, and the maximum premium for three or more enrollees shall~~
 40.10 ~~be three times the maximum premium for one.~~

40.11 ~~(e) Beginning July 1, 2009, (b) MinnesotaCare enrollees shall pay premiums~~
 40.12 ~~according to the premium scale specified in paragraph (d) (c), with the exception that~~
 40.13 ~~children in families with income at or below 200 percent of the federal poverty guidelines~~
 40.14 ~~shall pay no premiums. For purposes of paragraph (d) (c), "minimum" means a monthly~~
 40.15 ~~premium of \$4.~~

40.16 ~~(d) the following premium scale is established for individuals and families with~~
 40.17 ~~gross family incomes of 275 percent of the federal poverty guidelines or less:~~

40.18 Federal Poverty Guideline Range	40.18 Percent of Average Gross Monthly Income
40.19 0-45%	40.19 minimum
40.20 46-54%	40.20 \$4 or 1.1% of family income, whichever is
40.21 	40.21 greater
40.22 55-81%	40.22 1.6%
40.23 82-109%	40.23 2.2%
40.24 110-136%	40.24 2.9%
40.25 137-164%	40.25 3.6%
40.26 165-191%	40.26 4.6%
40.27 192-219%	40.27 5.6%
40.28 220-248%	40.28 6.5%
40.29 249-275%	40.29 7.2%

40.30 ~~(c) Effective January 1, 2014, the following premium scale is established for~~
 40.31 ~~individuals and families with incomes of 200 percent of federal poverty guidelines or less:~~

40.32 Federal Poverty Guideline Range	40.32 Percent of Average Income
40.33 0-45%	40.33 minimum
40.34 46-54%	40.34 \$4 or .25% of family income, whichever is
40.35 	40.35 greater
40.36 55-81%	40.36 .5%
40.37 82-109%	40.37 1.0%
40.38 110-136%	40.38 1.5%
40.39 137-164%	40.39 2.0%

41.1 165-191% 2.5%
 41.2 192-200% 3.0%

41.3 **EFFECTIVE DATE.** This section is effective January 1, 2014, or upon federal
 41.4 approval, whichever is later. The commissioner of human services shall notify the revisor
 41.5 of statutes when federal approval is obtained.

41.6 Sec. 62. Laws 2013, chapter 1, section 1, the effective date, is amended to read:

41.7 **EFFECTIVE DATE.** This section is effective ~~January 1, 2014~~ July 1, 2013.

41.8 Sec. 63. **DETERMINATION OF FUNDING ADEQUACY FOR**
 41.9 **MINNESOTACARE.**

41.10 The commissioners of revenue and management and budget, in consultation with
 41.11 the commissioner of human services, shall conduct an assessment of health care taxes,
 41.12 including the gross premiums tax, the provider tax, and Medicaid surcharges, and their
 41.13 relationship to the long-term solvency of the health care access fund, as part of the state
 41.14 revenue and expenditure forecast in November 2013. The commissioners shall determine
 41.15 the amount of state funding that will be required after December 31, 2019, in addition
 41.16 to the federal payments made available under section 1331 of the Affordable Care Act,
 41.17 for the MinnesotaCare program. The commissioners shall evaluate the stability and
 41.18 likelihood of long-term federal funding for the MinnesotaCare program under section
 41.19 1331. The commissioners shall report the results of this assessment to the chairs and
 41.20 ranking minority members of the legislative committees with jurisdiction over human
 41.21 services, finances, and taxes by January 15, 2014, along with recommendations for
 41.22 changes to state revenue for the health care access fund, if state funding continues to
 41.23 be required beyond December 31, 2019.

41.24 Sec. 64. **REVISOR'S INSTRUCTION.**

41.25 The revisor shall remove cross-references to the sections repealed in this act
 41.26 wherever they appear in Minnesota Statutes and Minnesota Rules and make changes
 41.27 necessary to correct the punctuation, grammar, or structure of the remaining text and
 41.28 preserve its meaning.

41.29 Sec. 65. **REPEALER.**

42.1 (a) Minnesota Statutes 2012, sections 256L.01, subdivision 4a; 256L.02, subdivision
 42.2 3; 256L.031; 256L.04, subdivisions 1b, 7a, and 9; and 256L.11, subdivisions 2a, 5, and
 42.3 6, are repealed, effective January 1, 2014.

42.4 (b) Minnesota Statutes 2012, sections 256L.01, subdivision 3; 256L.03, subdivision
 42.5 4; 256L.04, subdivision 2a; 256L.07, subdivisions 1, 4, 5, 8, and 9; 256L.09, subdivisions
 42.6 1, 4, 5, 6, and 7; 256L.12, subdivisions 1, 2, 3, 4, 5, 6, 7, 8, 9a, and 9b; and 256L.17,
 42.7 subdivisions 1, 2, 3, 4, and 5, are repealed effective January 1, 2015.

42.8 (c) Minnesota Statutes 2012, sections 256B.055, subdivisions 3, 5, and 10b;
 42.9 256B.056, subdivision 5b; and 256B.057, subdivisions 1c and 2, are repealed.

42.10 **ARTICLE 2**

42.11 **CONTINGENT REFORM 2020; REDESIGNING HOME AND** 42.12 **COMMUNITY-BASED SERVICES**

42.13 Section 1. Minnesota Statutes 2012, section 144.0724, subdivision 4, is amended to read:

42.14 Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and
 42.15 electronically submit to the commissioner of health case mix assessments that conform
 42.16 with the assessment schedule defined by Code of Federal Regulations, title 42, section
 42.17 483.20, and published by the United States Department of Health and Human Services,
 42.18 Centers for Medicare and Medicaid Services, in the Long Term Care Assessment
 42.19 Instrument User's Manual, version 3.0, and subsequent updates when issued by the
 42.20 Centers for Medicare and Medicaid Services. The commissioner of health may substitute
 42.21 successor manuals or question and answer documents published by the United States
 42.22 Department of Health and Human Services, Centers for Medicare and Medicaid Services,
 42.23 to replace or supplement the current version of the manual or document.

42.24 (b) The assessments used to determine a case mix classification for reimbursement
 42.25 include the following:

42.26 (1) a new admission assessment must be completed by day 14 following admission;

42.27 (2) an annual assessment which must have an assessment reference date (ARD)
 42.28 within 366 days of the ARD of the last comprehensive assessment;

42.29 (3) a significant change assessment must be completed within 14 days of the
 42.30 identification of a significant change; and

42.31 (4) all quarterly assessments must have an assessment reference date (ARD) within
 42.32 92 days of the ARD of the previous assessment.

42.33 (c) In addition to the assessments listed in paragraph (b), the assessments used to
 42.34 determine nursing facility level of care include the following:

43.1 (1) preadmission screening completed under section ~~256B.0911, subdivision 4a, by a~~
 43.2 ~~county, tribe, or managed care organization under contract with the Department of Human~~
 43.3 ~~Services 256.975, subdivision 7a, by the Senior LinkAge Line or Disability Linkage Line~~
 43.4 ~~or other organization under contract with the Minnesota Board on Aging; and~~

43.5 (2) a nursing facility level of care determination as provided for under section
 43.6 256B.0911, subdivision 4e, as part of a face-to-face long-term care consultation assessment
 43.7 completed under section 256B.0911, subdivision 3a, 3b, or 4d, by a county, tribe, or
 43.8 managed care organization under contract with the Department of Human Services.

43.9 Sec. 2. Minnesota Statutes 2012, section 144A.351, is amended to read:

43.10 **144A.351 BALANCING LONG-TERM CARE SERVICES AND SUPPORTS:**
 43.11 **REPORT AND STUDY REQUIRED.**

43.12 Subdivision 1. Report requirements. The commissioners of health and human
 43.13 services, with the cooperation of counties and in consultation with stakeholders, including
 43.14 persons who need or are using long-term care services and supports, lead agencies,
 43.15 regional entities, senior, disability, and mental health organization representatives, service
 43.16 providers, and community members shall prepare a report to the legislature by August 15,
 43.17 2013, and biennially thereafter, regarding the status of the full range of long-term care
 43.18 services and supports for the elderly and children and adults with disabilities and mental
 43.19 illnesses in Minnesota. The report shall address:

43.20 (1) demographics and need for long-term care services and supports in Minnesota;

43.21 (2) summary of county and regional reports on long-term care gaps, surpluses,
 43.22 imbalances, and corrective action plans;

43.23 (3) status of long-term care services and related mental health services, housing
 43.24 options, and supports by county and region including:

43.25 (i) changes in availability of the range of long-term care services and housing options;

43.26 (ii) access problems, including access to the least restrictive and most integrated
 43.27 services and settings, regarding long-term care services; and

43.28 (iii) comparative measures of long-term care services availability, including serving
 43.29 people in their home areas near family, and changes over time; and

43.30 (4) recommendations regarding goals for the future of long-term care services and
 43.31 supports, policy and fiscal changes, and resource development and transition needs.

43.32 Subd. 2. Critical access study. The commissioner shall conduct a onetime study to
 43.33 assess local capacity and availability of home and community-based services for older
 43.34 adults, people with disabilities, and people with mental illnesses. The study must assess
 43.35 critical access at the community level and identify potential strategies to build home and

44.1 community-based service capacity in critical access areas. The report shall be submitted
44.2 to the legislature no later than August 15, 2015.

44.3 Sec. 3. Minnesota Statutes 2012, section 148E.065, subdivision 4a, is amended to read:

44.4 Subd. 4a. **City, county, and state social workers.** (a) Beginning July 1, 2016, the
44.5 licensure of city, county, and state agency social workers is voluntary, except an individual
44.6 who is newly employed by a city or state agency after July 1, 2016, must be licensed
44.7 if the individual who provides social work services, as those services are defined in
44.8 section 148E.010, subdivision 11, paragraph (b), is presented to the public by any title
44.9 incorporating the words "social work" or "social worker."

44.10 (b) City, county, and state agencies employing social workers and staff who are
44.11 designated to perform mandated duties under sections 256.975, subdivisions 7 to 7c and
44.12 256.01, subdivision 24, are not required to employ licensed social workers.

44.13 Sec. 4. Minnesota Statutes 2012, section 256.01, subdivision 2, is amended to read:

44.14 Subd. 2. **Specific powers.** Subject to the provisions of section 241.021, subdivision
44.15 2, the commissioner of human services shall carry out the specific duties in paragraphs (a)
44.16 through ~~(ee)~~ (dd):

44.17 (a) Administer and supervise all forms of public assistance provided for by state law
44.18 and other welfare activities or services as are vested in the commissioner. Administration
44.19 and supervision of human services activities or services includes, but is not limited to,
44.20 assuring timely and accurate distribution of benefits, completeness of service, and quality
44.21 program management. In addition to administering and supervising human services
44.22 activities vested by law in the department, the commissioner shall have the authority to:

44.23 (1) require county agency participation in training and technical assistance programs
44.24 to promote compliance with statutes, rules, federal laws, regulations, and policies
44.25 governing human services;

44.26 (2) monitor, on an ongoing basis, the performance of county agencies in the
44.27 operation and administration of human services, enforce compliance with statutes, rules,
44.28 federal laws, regulations, and policies governing welfare services and promote excellence
44.29 of administration and program operation;

44.30 (3) develop a quality control program or other monitoring program to review county
44.31 performance and accuracy of benefit determinations;

44.32 (4) require county agencies to make an adjustment to the public assistance benefits
44.33 issued to any individual consistent with federal law and regulation and state law and rule
44.34 and to issue or recover benefits as appropriate;

45.1 (5) delay or deny payment of all or part of the state and federal share of benefits and
45.2 administrative reimbursement according to the procedures set forth in section 256.017;

45.3 (6) make contracts with and grants to public and private agencies and organizations,
45.4 both profit and nonprofit, and individuals, using appropriated funds; and

45.5 (7) enter into contractual agreements with federally recognized Indian tribes with
45.6 a reservation in Minnesota to the extent necessary for the tribe to operate a federally
45.7 approved family assistance program or any other program under the supervision of the
45.8 commissioner. The commissioner shall consult with the affected county or counties in
45.9 the contractual agreement negotiations, if the county or counties wish to be included,
45.10 in order to avoid the duplication of county and tribal assistance program services. The
45.11 commissioner may establish necessary accounts for the purposes of receiving and
45.12 disbursing funds as necessary for the operation of the programs.

45.13 (b) Inform county agencies, on a timely basis, of changes in statute, rule, federal law,
45.14 regulation, and policy necessary to county agency administration of the programs.

45.15 (c) Administer and supervise all child welfare activities; promote the enforcement of
45.16 laws protecting disabled, dependent, neglected and delinquent children, and children born
45.17 to mothers who were not married to the children's fathers at the times of the conception
45.18 nor at the births of the children; license and supervise child-caring and child-placing
45.19 agencies and institutions; supervise the care of children in boarding and foster homes or
45.20 in private institutions; and generally perform all functions relating to the field of child
45.21 welfare now vested in the State Board of Control.

45.22 (d) Administer and supervise all noninstitutional service to disabled persons,
45.23 including those who are visually impaired, hearing impaired, or physically impaired
45.24 or otherwise disabled. The commissioner may provide and contract for the care and
45.25 treatment of qualified indigent children in facilities other than those located and available
45.26 at state hospitals when it is not feasible to provide the service in state hospitals.

45.27 (e) Assist and actively cooperate with other departments, agencies and institutions,
45.28 local, state, and federal, by performing services in conformity with the purposes of Laws
45.29 1939, chapter 431.

45.30 (f) Act as the agent of and cooperate with the federal government in matters of
45.31 mutual concern relative to and in conformity with the provisions of Laws 1939, chapter
45.32 431, including the administration of any federal funds granted to the state to aid in the
45.33 performance of any functions of the commissioner as specified in Laws 1939, chapter 431,
45.34 and including the promulgation of rules making uniformly available medical care benefits
45.35 to all recipients of public assistance, at such times as the federal government increases its

46.1 participation in assistance expenditures for medical care to recipients of public assistance,
46.2 the cost thereof to be borne in the same proportion as are grants of aid to said recipients.

46.3 (g) Establish and maintain any administrative units reasonably necessary for the
46.4 performance of administrative functions common to all divisions of the department.

46.5 (h) Act as designated guardian of both the estate and the person of all the wards of
46.6 the state of Minnesota, whether by operation of law or by an order of court, without any
46.7 further act or proceeding whatever, except as to persons committed as developmentally
46.8 disabled. For children under the guardianship of the commissioner or a tribe in Minnesota
46.9 recognized by the Secretary of the Interior whose interests would be best served by
46.10 adoptive placement, the commissioner may contract with a licensed child-placing agency
46.11 or a Minnesota tribal social services agency to provide adoption services. A contract
46.12 with a licensed child-placing agency must be designed to supplement existing county
46.13 efforts and may not replace existing county programs or tribal social services, unless the
46.14 replacement is agreed to by the county board and the appropriate exclusive bargaining
46.15 representative, tribal governing body, or the commissioner has evidence that child
46.16 placements of the county continue to be substantially below that of other counties. Funds
46.17 encumbered and obligated under an agreement for a specific child shall remain available
46.18 until the terms of the agreement are fulfilled or the agreement is terminated.

46.19 (i) Act as coordinating referral and informational center on requests for service for
46.20 newly arrived immigrants coming to Minnesota.

46.21 (j) The specific enumeration of powers and duties as hereinabove set forth shall in no
46.22 way be construed to be a limitation upon the general transfer of powers herein contained.

46.23 (k) Establish county, regional, or statewide schedules of maximum fees and charges
46.24 which may be paid by county agencies for medical, dental, surgical, hospital, nursing and
46.25 nursing home care and medicine and medical supplies under all programs of medical
46.26 care provided by the state and for congregate living care under the income maintenance
46.27 programs.

46.28 (l) Have the authority to conduct and administer experimental projects to test methods
46.29 and procedures of administering assistance and services to recipients or potential recipients
46.30 of public welfare. To carry out such experimental projects, it is further provided that the
46.31 commissioner of human services is authorized to waive the enforcement of existing specific
46.32 statutory program requirements, rules, and standards in one or more counties. The order
46.33 establishing the waiver shall provide alternative methods and procedures of administration,
46.34 shall not be in conflict with the basic purposes, coverage, or benefits provided by law, and
46.35 in no event shall the duration of a project exceed four years. It is further provided that no

47.1 order establishing an experimental project as authorized by the provisions of this section
47.2 shall become effective until the following conditions have been met:

47.3 (1) the secretary of health and human services of the United States has agreed, for
47.4 the same project, to waive state plan requirements relative to statewide uniformity; and

47.5 (2) a comprehensive plan, including estimated project costs, shall be approved by
47.6 the Legislative Advisory Commission and filed with the commissioner of administration.

47.7 (m) According to federal requirements, establish procedures to be followed by
47.8 local welfare boards in creating citizen advisory committees, including procedures for
47.9 selection of committee members.

47.10 (n) Allocate federal fiscal disallowances or sanctions which are based on quality
47.11 control error rates for the aid to families with dependent children program formerly
47.12 codified in sections 256.72 to 256.87, medical assistance, or food stamp program in the
47.13 following manner:

47.14 (1) one-half of the total amount of the disallowance shall be borne by the county
47.15 boards responsible for administering the programs. For the medical assistance and the
47.16 AFDC program formerly codified in sections 256.72 to 256.87, disallowances shall be
47.17 shared by each county board in the same proportion as that county's expenditures for the
47.18 sanctioned program are to the total of all counties' expenditures for the AFDC program
47.19 formerly codified in sections 256.72 to 256.87, and medical assistance programs. For the
47.20 food stamp program, sanctions shall be shared by each county board, with 50 percent of
47.21 the sanction being distributed to each county in the same proportion as that county's
47.22 administrative costs for food stamps are to the total of all food stamp administrative costs
47.23 for all counties, and 50 percent of the sanctions being distributed to each county in the
47.24 same proportion as that county's value of food stamp benefits issued are to the total of
47.25 all benefits issued for all counties. Each county shall pay its share of the disallowance
47.26 to the state of Minnesota. When a county fails to pay the amount due hereunder, the
47.27 commissioner may deduct the amount from reimbursement otherwise due the county, or
47.28 the attorney general, upon the request of the commissioner, may institute civil action
47.29 to recover the amount due; and

47.30 (2) notwithstanding the provisions of clause (1), if the disallowance results from
47.31 knowing noncompliance by one or more counties with a specific program instruction, and
47.32 that knowing noncompliance is a matter of official county board record, the commissioner
47.33 may require payment or recover from the county or counties, in the manner prescribed in
47.34 clause (1), an amount equal to the portion of the total disallowance which resulted from the
47.35 noncompliance, and may distribute the balance of the disallowance according to clause (1).

48.1 (o) Develop and implement special projects that maximize reimbursements and
48.2 result in the recovery of money to the state. For the purpose of recovering state money,
48.3 the commissioner may enter into contracts with third parties. Any recoveries that result
48.4 from projects or contracts entered into under this paragraph shall be deposited in the
48.5 state treasury and credited to a special account until the balance in the account reaches
48.6 \$1,000,000. When the balance in the account exceeds \$1,000,000, the excess shall be
48.7 transferred and credited to the general fund. All money in the account is appropriated to
48.8 the commissioner for the purposes of this paragraph.

48.9 (p) Have the authority to make direct payments to facilities providing shelter
48.10 to women and their children according to section 256D.05, subdivision 3. Upon
48.11 the written request of a shelter facility that has been denied payments under section
48.12 256D.05, subdivision 3, the commissioner shall review all relevant evidence and make
48.13 a determination within 30 days of the request for review regarding issuance of direct
48.14 payments to the shelter facility. Failure to act within 30 days shall be considered a
48.15 determination not to issue direct payments.

48.16 (q) Have the authority to establish and enforce the following county reporting
48.17 requirements:

48.18 (1) the commissioner shall establish fiscal and statistical reporting requirements
48.19 necessary to account for the expenditure of funds allocated to counties for human
48.20 services programs. When establishing financial and statistical reporting requirements, the
48.21 commissioner shall evaluate all reports, in consultation with the counties, to determine if
48.22 the reports can be simplified or the number of reports can be reduced;

48.23 (2) the county board shall submit monthly or quarterly reports to the department
48.24 as required by the commissioner. Monthly reports are due no later than 15 working days
48.25 after the end of the month. Quarterly reports are due no later than 30 calendar days after
48.26 the end of the quarter, unless the commissioner determines that the deadline must be
48.27 shortened to 20 calendar days to avoid jeopardizing compliance with federal deadlines
48.28 or risking a loss of federal funding. Only reports that are complete, legible, and in the
48.29 required format shall be accepted by the commissioner;

48.30 (3) if the required reports are not received by the deadlines established in clause (2),
48.31 the commissioner may delay payments and withhold funds from the county board until
48.32 the next reporting period. When the report is needed to account for the use of federal
48.33 funds and the late report results in a reduction in federal funding, the commissioner shall
48.34 withhold from the county boards with late reports an amount equal to the reduction in
48.35 federal funding until full federal funding is received;

49.1 (4) a county board that submits reports that are late, illegible, incomplete, or not
49.2 in the required format for two out of three consecutive reporting periods is considered
49.3 noncompliant. When a county board is found to be noncompliant, the commissioner
49.4 shall notify the county board of the reason the county board is considered noncompliant
49.5 and request that the county board develop a corrective action plan stating how the
49.6 county board plans to correct the problem. The corrective action plan must be submitted
49.7 to the commissioner within 45 days after the date the county board received notice
49.8 of noncompliance;

49.9 (5) the final deadline for fiscal reports or amendments to fiscal reports is one year
49.10 after the date the report was originally due. If the commissioner does not receive a report
49.11 by the final deadline, the county board forfeits the funding associated with the report for
49.12 that reporting period and the county board must repay any funds associated with the
49.13 report received for that reporting period;

49.14 (6) the commissioner may not delay payments, withhold funds, or require repayment
49.15 under clause (3) or (5) if the county demonstrates that the commissioner failed to
49.16 provide appropriate forms, guidelines, and technical assistance to enable the county to
49.17 comply with the requirements. If the county board disagrees with an action taken by the
49.18 commissioner under clause (3) or (5), the county board may appeal the action according
49.19 to sections 14.57 to 14.69; and

49.20 (7) counties subject to withholding of funds under clause (3) or forfeiture or
49.21 repayment of funds under clause (5) shall not reduce or withhold benefits or services to
49.22 clients to cover costs incurred due to actions taken by the commissioner under clause
49.23 (3) or (5).

49.24 (r) Allocate federal fiscal disallowances or sanctions for audit exceptions when
49.25 federal fiscal disallowances or sanctions are based on a statewide random sample in direct
49.26 proportion to each county's claim for that period.

49.27 (s) Be responsible for ensuring the detection, prevention, investigation, and
49.28 resolution of fraudulent activities or behavior by applicants, recipients, and other
49.29 participants in the human services programs administered by the department.

49.30 (t) Require county agencies to identify overpayments, establish claims, and utilize
49.31 all available and cost-beneficial methodologies to collect and recover these overpayments
49.32 in the human services programs administered by the department.

49.33 (u) Have the authority to administer a drug rebate program for drugs purchased
49.34 pursuant to the prescription drug program established under section 256.955 after the
49.35 beneficiary's satisfaction of any deductible established in the program. The commissioner
49.36 shall require a rebate agreement from all manufacturers of covered drugs as defined in

50.1 section 256B.0625, subdivision 13. Rebate agreements for prescription drugs delivered on
50.2 or after July 1, 2002, must include rebates for individuals covered under the prescription
50.3 drug program who are under 65 years of age. For each drug, the amount of the rebate shall
50.4 be equal to the rebate as defined for purposes of the federal rebate program in United
50.5 States Code, title 42, section 1396r-8. The manufacturers must provide full payment
50.6 within 30 days of receipt of the state invoice for the rebate within the terms and conditions
50.7 used for the federal rebate program established pursuant to section 1927 of title XIX of
50.8 the Social Security Act. The manufacturers must provide the commissioner with any
50.9 information necessary to verify the rebate determined per drug. The rebate program shall
50.10 utilize the terms and conditions used for the federal rebate program established pursuant to
50.11 section 1927 of title XIX of the Social Security Act.

50.12 (v) Have the authority to administer the federal drug rebate program for drugs
50.13 purchased under the medical assistance program as allowed by section 1927 of title XIX
50.14 of the Social Security Act and according to the terms and conditions of section 1927.
50.15 Rebates shall be collected for all drugs that have been dispensed or administered in an
50.16 outpatient setting and that are from manufacturers who have signed a rebate agreement
50.17 with the United States Department of Health and Human Services.

50.18 (w) Have the authority to administer a supplemental drug rebate program for drugs
50.19 purchased under the medical assistance program. The commissioner may enter into
50.20 supplemental rebate contracts with pharmaceutical manufacturers and may require prior
50.21 authorization for drugs that are from manufacturers that have not signed a supplemental
50.22 rebate contract. Prior authorization of drugs shall be subject to the provisions of section
50.23 256B.0625, subdivision 13.

50.24 (x) Operate the department's communication systems account established in Laws
50.25 1993, First Special Session chapter 1, article 1, section 2, subdivision 2, to manage shared
50.26 communication costs necessary for the operation of the programs the commissioner
50.27 supervises. A communications account may also be established for each regional
50.28 treatment center which operates communications systems. Each account must be used
50.29 to manage shared communication costs necessary for the operations of the programs the
50.30 commissioner supervises. The commissioner may distribute the costs of operating and
50.31 maintaining communication systems to participants in a manner that reflects actual usage.
50.32 Costs may include acquisition, licensing, insurance, maintenance, repair, staff time and
50.33 other costs as determined by the commissioner. Nonprofit organizations and state, county,
50.34 and local government agencies involved in the operation of programs the commissioner
50.35 supervises may participate in the use of the department's communications technology and
50.36 share in the cost of operation. The commissioner may accept on behalf of the state any

51.1 gift, bequest, devise or personal property of any kind, or money tendered to the state for
51.2 any lawful purpose pertaining to the communication activities of the department. Any
51.3 money received for this purpose must be deposited in the department's communication
51.4 systems accounts. Money collected by the commissioner for the use of communication
51.5 systems must be deposited in the state communication systems account and is appropriated
51.6 to the commissioner for purposes of this section.

51.7 (y) Receive any federal matching money that is made available through the medical
51.8 assistance program for the consumer satisfaction survey. Any federal money received for
51.9 the survey is appropriated to the commissioner for this purpose. The commissioner may
51.10 expend the federal money received for the consumer satisfaction survey in either year of
51.11 the biennium.

51.12 (z) Designate community information and referral call centers and incorporate
51.13 cost reimbursement claims from the designated community information and referral
51.14 call centers into the federal cost reimbursement claiming processes of the department
51.15 according to federal law, rule, and regulations. Existing information and referral centers
51.16 provided by Greater Twin Cities United Way or existing call centers for which Greater
51.17 Twin Cities United Way has legal authority to represent, shall be included in these
51.18 designations upon review by the commissioner and assurance that these services are
51.19 accredited and in compliance with national standards. Any reimbursement is appropriated
51.20 to the commissioner and all designated information and referral centers shall receive
51.21 payments according to normal department schedules established by the commissioner
51.22 upon final approval of allocation methodologies from the United States Department of
51.23 Health and Human Services Division of Cost Allocation or other appropriate authorities.

51.24 (aa) Develop recommended standards for foster care homes that address the
51.25 components of specialized therapeutic services to be provided by foster care homes with
51.26 those services.

51.27 (bb) Authorize the method of payment to or from the department as part of the
51.28 human services programs administered by the department. This authorization includes the
51.29 receipt or disbursement of funds held by the department in a fiduciary capacity as part of
51.30 the human services programs administered by the department.

51.31 (cc) Have the authority to administer a drug rebate program for drugs purchased for
51.32 persons eligible for general assistance medical care under section 256D.03, subdivision 3.
51.33 For manufacturers that agree to participate in the general assistance medical care rebate
51.34 program, the commissioner shall enter into a rebate agreement for covered drugs as
51.35 defined in section 256B.0625, subdivisions 13 and 13d. For each drug, the amount of the
51.36 rebate shall be equal to the rebate as defined for purposes of the federal rebate program in

52.1 United States Code, title 42, section 1396r-8. The manufacturers must provide payment
 52.2 within the terms and conditions used for the federal rebate program established under
 52.3 section 1927 of title XIX of the Social Security Act. The rebate program shall utilize
 52.4 the terms and conditions used for the federal rebate program established under section
 52.5 1927 of title XIX of the Social Security Act.

52.6 Effective January 1, 2006, drug coverage under general assistance medical care shall
 52.7 be limited to those prescription drugs that:

52.8 (1) are covered under the medical assistance program as described in section
 52.9 256B.0625, subdivisions 13 and 13d; and

52.10 (2) are provided by manufacturers that have fully executed general assistance
 52.11 medical care rebate agreements with the commissioner and comply with such agreements.
 52.12 Prescription drug coverage under general assistance medical care shall conform to
 52.13 coverage under the medical assistance program according to section 256B.0625,
 52.14 subdivisions 13 to 13g.

52.15 The rebate revenues collected under the drug rebate program are deposited in the
 52.16 general fund.

52.17 (dd) Designate the agencies that operate the Senior LinkAge Line under section
 52.18 256.975, subdivision 7, and the Disability Linkage Line under subdivision 24 as the state
 52.19 of Minnesota Aging and the Disability Resource Centers under United States Code, title
 52.20 42, section 3001, the Older Americans Act Amendments of 2006, and incorporate cost
 52.21 reimbursement claims from the designated centers into the federal cost reimbursement
 52.22 claiming processes of the department according to federal law, rule, and regulations. Any
 52.23 reimbursement must be appropriated to the commissioner and all Aging and Disability
 52.24 Resource Center designated agencies shall receive payments of grant funding that supports
 52.25 the activity and generates the federal financial participation according to Board on Aging
 52.26 administrative granting mechanisms.

52.27 Sec. 5. Minnesota Statutes 2012, section 256.01, subdivision 24, is amended to read:

52.28 Subd. 24. **Disability Linkage Line.** The commissioner shall establish the Disability
 52.29 Linkage Line, ~~to~~ which shall serve people with disabilities as the designated Aging and
 52.30 Disability Resource Center under United States Code, title 42, section 3001, the Older
 52.31 Americans Act Amendments of 2006, in partnership with the Senior LinkAge Line and
 52.32 shall serve as Minnesota's neutral access point for statewide disability information and
 52.33 assistance and must be available during business hours through a statewide toll-free
 52.34 number and the Internet. The Disability Linkage Line shall:

52.35 (1) deliver information and assistance based on national and state standards;

- 53.1 (2) provide information about state and federal eligibility requirements, benefits,
 53.2 and service options;
- 53.3 (3) provide benefits and options counseling;
- 53.4 (4) make referrals to appropriate support entities;
- 53.5 (5) educate people on their options so they can make well-informed choices and link
 53.6 them to quality profiles;
- 53.7 (6) help support the timely resolution of service access and benefit issues;
- 53.8 (7) inform people of their long-term community services and supports;
- 53.9 (8) provide necessary resources and supports that can lead to employment and
 53.10 increased economic stability of people with disabilities; ~~and~~
- 53.11 (9) serve as the technical assistance and help center for the Web-based tool,
 53.12 Minnesota's Disability Benefits 101.org; and
- 53.13 (10) provide preadmission screening for individuals under 60 years of age using
 53.14 the procedures as defined in section 256.975, subdivisions 7a to 7c, and 256B.0911,
 53.15 subdivision 4d.

53.16 Sec. 6. Minnesota Statutes 2012, section 256.975, subdivision 7, is amended to read:

53.17 Subd. 7. **Consumer information and assistance and long-term care options**
 53.18 **counseling; Senior LinkAge Line.** (a) The Minnesota Board on Aging shall operate a
 53.19 statewide service to aid older Minnesotans and their families in making informed choices
 53.20 about long-term care options and health care benefits. Language services to persons
 53.21 with limited English language skills may be made available. The service, known as
 53.22 Senior LinkAge Line, shall serve older adults as the designated Aging and Disability
 53.23 Resource Center under United States Code, title 42, section 3001, the Older Americans
 53.24 Act Amendments of 2006, in partnership with the Disability LinkAge Line under section
 53.25 256.01, subdivision 24, and must be available during business hours through a statewide
 53.26 toll-free number and ~~must also be available through~~ the Internet. The Minnesota Board
 53.27 on Aging shall consult with, and when appropriate work through, the area agencies on
 53.28 aging to provide and maintain the telephone infrastructure and related support for the
 53.29 Aging and Disability Resource Center partners that agree by memorandum to access the
 53.30 infrastructure, including the designated providers of the Senior LinkAge Line and the
 53.31 Disability Linkage Line.

53.32 (b) The service must provide long-term care options counseling by assisting older
 53.33 adults, caregivers, and providers in accessing information and options counseling about
 53.34 choices in long-term care services that are purchased through private providers or available
 53.35 through public options. The service must:

- 54.1 (1) develop a comprehensive database that includes detailed listings in both
54.2 consumer- and provider-oriented formats;
- 54.3 (2) make the database accessible on the Internet and through other telecommunication
54.4 and media-related tools;
- 54.5 (3) link callers to interactive long-term care screening tools and make these tools
54.6 available through the Internet by integrating the tools with the database;
- 54.7 (4) develop community education materials with a focus on planning for long-term
54.8 care and evaluating independent living, housing, and service options;
- 54.9 (5) conduct an outreach campaign to assist older adults and their caregivers in
54.10 finding information on the Internet and through other means of communication;
- 54.11 (6) implement a messaging system for overflow callers and respond to these callers
54.12 by the next business day;
- 54.13 (7) link callers with county human services and other providers to receive more
54.14 in-depth assistance and consultation related to long-term care options;
- 54.15 (8) link callers with quality profiles for nursing facilities and other home and
54.16 community-based services providers developed by the ~~commissioner~~ commissioners of
54.17 health and human services;
- 54.18 (9) incorporate information about the availability of housing options, as well as
54.19 registered housing with services and consumer rights within the MinnesotaHelp.info
54.20 network long-term care database to facilitate consumer comparison of services and costs
54.21 among housing with services establishments and with other in-home services and to
54.22 support financial self-sufficiency as long as possible. Housing with services establishments
54.23 and their arranged home care providers shall provide information that will facilitate price
54.24 comparisons, including delineation of charges for rent and for services available. The
54.25 commissioners of health and human services shall align the data elements required by
54.26 section 144G.06, the Uniform Consumer Information Guide, and this section to provide
54.27 consumers standardized information and ease of comparison of long-term care options.
54.28 The commissioner of human services shall provide the data to the Minnesota Board on
54.29 Aging for inclusion in the MinnesotaHelp.info network long-term care database;
- 54.30 (10) provide long-term care options counseling. Long-term care options counselors
54.31 shall:
- 54.32 (i) for individuals not eligible for case management under a public program or public
54.33 funding source, provide interactive decision support under which consumers, family
54.34 members, or other helpers are supported in their deliberations to determine appropriate
54.35 long-term care choices in the context of the consumer's needs, preferences, values, and
54.36 individual circumstances, including implementing a community support plan;

55.1 (ii) provide Web-based educational information and collateral written materials to
 55.2 familiarize consumers, family members, or other helpers with the long-term care basics,
 55.3 issues to be considered, and the range of options available in the community;

55.4 (iii) provide long-term care futures planning, which means providing assistance to
 55.5 individuals who anticipate having long-term care needs to develop a plan for the more
 55.6 distant future; and

55.7 (iv) provide expertise in benefits and financing options for long-term care, including
 55.8 Medicare, long-term care insurance, tax or employer-based incentives, reverse mortgages,
 55.9 private pay options, and ways to access low or no-cost services or benefits through
 55.10 volunteer-based or charitable programs;

55.11 (11) using risk management and support planning protocols, provide long-term care
 55.12 options counseling to current residents of nursing homes deemed appropriate for discharge
 55.13 by the commissioner and older adults who request service after consultation with the
 55.14 Senior LinkAge Line under clause (12). ~~In order to meet this requirement, The Senior~~
 55.15 LinkAge Line shall also receive referrals from the residents or staff of nursing homes. The
 55.16 Senior LinkAge Line shall identify and contact residents deemed appropriate for discharge
 55.17 by developing targeting criteria in consultation with the commissioner who shall provide
 55.18 designated Senior LinkAge Line contact centers with a list of nursing home residents that
 55.19 meet the criteria as being appropriate for discharge planning via a secure Web portal.
 55.20 Senior LinkAge Line shall provide these residents, if they indicate a preference to
 55.21 receive long-term care options counseling, with initial assessment, ~~review of risk factors,~~
 55.22 ~~independent living support consultation, or and, if appropriate, a referral to:~~

55.23 (i) long-term care consultation services under section 256B.0911;

55.24 (ii) designated care coordinators of contracted entities under section 256B.035 for
 55.25 persons who are enrolled in a managed care plan; or

55.26 (iii) the long-term care consultation team for those who are ~~appropriate~~ eligible
 55.27 for relocation service coordination due to high-risk factors or psychological or physical
 55.28 disability; and

55.29 (12) develop referral protocols and processes that will assist certified health care
 55.30 homes and hospitals to identify at-risk older adults and determine when to refer these
 55.31 individuals to the Senior LinkAge Line for long-term care options counseling under this
 55.32 section. The commissioner is directed to work with the commissioner of health to develop
 55.33 protocols that would comply with the health care home designation criteria and protocols
 55.34 available at the time of hospital discharge. The commissioner shall keep a record of the
 55.35 number of people who choose long-term care options counseling as a result of this section.

56.1 Sec. 7. Minnesota Statutes 2012, section 256.975, is amended by adding a subdivision
56.2 to read:

56.3 Subd. 7a. **Preadmission screening activities related to nursing facility**
56.4 **admissions.** (a) All individuals seeking admission to Medicaid certified nursing facilities,
56.5 including certified boarding care facilities, must be screened prior to admission regardless
56.6 of income, assets, or funding sources for nursing facility care, except as described in
56.7 subdivision 7b, paragraphs (a) and (b). The purpose of the screening is to determine the
56.8 need for nursing facility level of care as described in section 256B.0911, subdivision
56.9 4e, and to complete activities required under federal law related to mental illness and
56.10 developmental disability as outlined in paragraph (b).

56.11 (b) A person who has a diagnosis or possible diagnosis of mental illness or
56.12 developmental disability must receive a preadmission screening before admission
56.13 regardless of the exemptions outlined in subdivision 7b, paragraphs (a) and (b), to identify
56.14 the need for further evaluation and specialized services, unless the admission prior to
56.15 screening is authorized by the local mental health authority or the local developmental
56.16 disabilities case manager, or unless authorized by the county agency according to Public
56.17 Law 101-508.

56.18 (c) The following criteria apply to the preadmission screening:

56.19 (1) requests for preadmission screenings must be submitted via an online form
56.20 developed by the commissioner;

56.21 (2) the Senior LinkAge Line must use forms and criteria developed by the
56.22 commissioner to identify persons who require referral for further evaluation and
56.23 determination of the need for specialized services; and

56.24 (3) the evaluation and determination of the need for specialized services must be
56.25 done by:

56.26 (i) a qualified independent mental health professional, for persons with a primary or
56.27 secondary diagnosis of a serious mental illness; or

56.28 (ii) a qualified developmental disability professional, for persons with a primary or
56.29 secondary diagnosis of developmental disability. For purposes of this requirement, a
56.30 qualified developmental disability professional must meet the standards for a qualified
56.31 developmental disability professional under Code of Federal Regulations, title 42, section
56.32 483.430.

56.33 (d) The local county mental health authority or the state developmental disability
56.34 authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a
56.35 nursing facility if the individual does not meet the nursing facility level of care criteria or
56.36 needs specialized services as defined in Public Law Numbers 100-203 and 101-508. For

57.1 purposes of this section, "specialized services" for a person with developmental disability
 57.2 means active treatment as that term is defined under Code of Federal Regulations, title
 57.3 42, section 483.440(a)(1).

57.4 (e) In assessing a person's needs, the screener shall:

57.5 (1) use an automated system designated by the commissioner;

57.6 (2) consult with care transitions coordinators or physician; and

57.7 (3) consider the assessment of the individual's physician.

57.8 Other personnel may be included in the level of care determination as deemed
 57.9 necessary by the screener.

57.10 **EFFECTIVE DATE.** This section is effective October 1, 2013.

57.11 Sec. 8. Minnesota Statutes 2012, section 256.975, is amended by adding a subdivision
 57.12 to read:

57.13 Subd. 7b. **Exemptions and emergency admissions.** (a) Exemptions from the federal
 57.14 screening requirements outlined in subdivision 7a, paragraphs (b) and (c), are limited to:

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

57.17 (2) a person transferring from one certified nursing facility in Minnesota to another
 57.18 certified nursing facility in Minnesota.

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

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

57.22 (2) an individual who has a contractual right to have nursing facility care paid for
 57.23 indefinitely by the Veterans' Administration;

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

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

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

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

58.1 (1) a person is admitted from the community to a certified nursing or certified
 58.2 boarding care facility during Senior LinkAge Line nonworking hours for ages 60 and
 58.3 older and Disability Linkage Line nonworking hours for under age 60;

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

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

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

58.11 (5) the Senior LinkAge Line or Disability Linkage Line is contacted on the first
 58.12 working day following the emergency admission.

58.13 Transfer of a patient from an acute care hospital to a nursing facility is not considered
 58.14 an emergency except for a person who has received hospital services in the following
 58.15 situations: hospital admission for observation, care in an emergency room without hospital
 58.16 admission, or following hospital 24-hour bed care and from whom admission is being
 58.17 sought on a nonworking day.

58.18 (e) A nursing facility must provide written information to all persons admitted
 58.19 regarding the person's right to request and receive long-term care consultation services as
 58.20 defined in section 256B.0911, subdivision 1a. The information must be provided prior to
 58.21 the person's discharge from the facility and in a format specified by the commissioner.

58.22 **EFFECTIVE DATE.** This section is effective October 1, 2013.

58.23 Sec. 9. Minnesota Statutes 2012, section 256.975, is amended by adding a subdivision
 58.24 to read:

58.25 Subd. 7c. **Screening requirements.** (a) A person may be screened for nursing
 58.26 facility admission by telephone or in a face-to-face screening interview. The Senior
 58.27 LinkAge Line shall identify each individual's needs using the following categories:

58.28 (1) the person needs no face-to-face long-term care consultation assessment
 58.29 completed under section 256B.0911, subdivision 3a, 3b, or 4d, by a county, tribe, or
 58.30 managed care organization under contract with the Department of Human Services to
 58.31 determine the need for nursing facility level of care based on information obtained from
 58.32 other health care professionals;

58.33 (2) the person needs an immediate face-to-face long-term care consultation
 58.34 assessment completed under section 256B.0911, subdivision 3a, 3b, or 4d, by a county,
 58.35 tribe, or managed care organization under contract with the Department of Human

59.1 Services to determine the need for nursing facility level of care and complete activities
 59.2 required under subdivision 7a; or

59.3 (3) the person may be exempt from screening requirements as outlined in subdivision
 59.4 7b, but will need transitional assistance after admission or in-person follow-along after
 59.5 a return home.

59.6 (b) Individuals between the ages of 60 and 64 who are admitted to nursing facilities
 59.7 with only a telephone screening must receive a face-to-face assessment from the long-term
 59.8 care consultation team member of the county in which the facility is located or from the
 59.9 recipient's county case manager within 40 calendar days of admission as described in
 59.10 section 256B.0911, subdivision 4d, paragraph (c).

59.11 (c) Persons admitted on a nonemergency basis to a Medicaid-certified nursing
 59.12 facility must be screened prior to admission.

59.13 (d) Screenings provided by the Senior LinkAge Line must include processes
 59.14 to identify persons who may require transition assistance described in subdivision 7,
 59.15 paragraph (b), clause (12), and section 256B.0911, subdivision 3b.

59.16 **EFFECTIVE DATE.** This section is effective October 1, 2013.

59.17 Sec. 10. Minnesota Statutes 2012, section 256.975, is amended by adding a subdivision
 59.18 to read:

59.19 **Subd. 7d. Payment for preadmission screening.** Funding for preadmission
 59.20 screening shall be provided to the Minnesota Board on Aging for the population 60
 59.21 years of age and older by the Department of Human Services to cover screener salaries
 59.22 and expenses to provide the services described in subdivisions 7a to 7c. The Minnesota
 59.23 Board on Aging shall employ, or contract with other agencies to employ, within the limits
 59.24 of available funding, sufficient personnel to provide preadmission screening and level of
 59.25 care determination services and shall seek to maximize federal funding for the service as
 59.26 provided under section 256.01, subdivision 2, paragraph (dd).

59.27 **EFFECTIVE DATE.** This section is effective October 1, 2013.

59.28 Sec. 11. Minnesota Statutes 2012, section 256.9754, is amended by adding a
 59.29 subdivision to read:

59.30 **Subd. 3a. Priority for other grants.** The commissioner of health shall give
 59.31 priority to a grantee selected under subdivision 3 when awarding technology-related
 59.32 grants, if the grantee is using technology as a part of a proposal, unless that priority
 59.33 conflicts with existing state or federal guidance related to grant awards by the Department

60.1 of Health. The commissioner of transportation shall give priority to a grantee selected
60.2 under subdivision 3 when distributing transportation-related funds to create transportation
60.3 options for older adults.

60.4 Sec. 12. Minnesota Statutes 2012, section 256.9754, is amended by adding a
60.5 subdivision to read:

60.6 Subd. 3b. **State waivers.** The commissioner of health may waive applicable state
60.7 laws and rules on a time-limited basis if the commissioner of health determines that a
60.8 participating grantee requires a waiver in order to achieve demonstration project goals.

60.9 Sec. 13. Minnesota Statutes 2012, section 256.9754, subdivision 5, is amended to read:

60.10 Subd. 5. **Grant preference.** The commissioner of human services shall give
60.11 preference when awarding grants under this section to areas where nursing facility
60.12 closures have occurred or are occurring or areas with service needs identified by section
60.13 144A.351. The commissioner may award grants to the extent grant funds are available
60.14 and to the extent applications are approved by the commissioner. Denial of approval of an
60.15 application in one year does not preclude submission of an application in a subsequent
60.16 year. The maximum grant amount is limited to \$750,000.

60.17 Sec. 14. Minnesota Statutes 2012, section 256B.021, is amended by adding a
60.18 subdivision to read:

60.19 Subd. 4a. **Evaluation.** The commissioner shall evaluate the projects contained in
60.20 subdivision 4, paragraphs (f), clauses (2) and (12), and (h). The evaluation must include:

60.21 (1) an impact assessment focusing on program outcomes, especially those
60.22 experienced directly by the person receiving services;

60.23 (2) study samples drawn from the population of interest for each project; and

60.24 (3) a time series analysis to examine aggregate trends in average monthly
60.25 utilization, expenditures, and other outcomes in the targeted populations before and after
60.26 implementation of the initiatives.

60.27 Sec. 15. Minnesota Statutes 2012, section 256B.021, is amended by adding a
60.28 subdivision to read:

60.29 Subd. 6. **Work, empower, and encourage independence.** As provided under
60.30 subdivision 4, paragraph (e), upon federal approval, the commissioner shall establish a
60.31 demonstration project to provide navigation, employment supports, and benefits planning
60.32 services to a targeted group of federally funded Medicaid recipients to begin July 1, 2014.

61.1 This demonstration shall promote economic stability, increase independence, and reduce
61.2 applications for disability benefits while providing a positive impact on the health and
61.3 future of participants.

61.4 Sec. 16. Minnesota Statutes 2012, section 256B.021, is amended by adding a
61.5 subdivision to read:

61.6 Subd. 7. **Housing stabilization.** As provided under subdivision 4, paragraph (e),
61.7 upon federal approval, the commissioner shall establish a demonstration project to provide
61.8 service coordination, outreach, in-reach, tenancy support, and community living assistance
61.9 to a targeted group of federally funded Medicaid recipients to begin January 1, 2014. This
61.10 demonstration shall promote housing stability, reduce costly medical interventions, and
61.11 increase opportunities for independent community living.

61.12 Sec. 17. Minnesota Statutes 2012, section 256B.0911, subdivision 1, is amended to read:

61.13 Subdivision 1. **Purpose and goal.** (a) The purpose of long-term care consultation
61.14 services is to assist persons with long-term or chronic care needs in making care
61.15 decisions and selecting support and service options that meet their needs and reflect
61.16 their preferences. The availability of, and access to, information and other types of
61.17 assistance, including assessment and support planning, is also intended to prevent or delay
61.18 institutional placements and to provide access to transition assistance after admission.
61.19 Further, the goal of these services is to contain costs associated with unnecessary
61.20 institutional admissions. Long-term consultation services must be available to any person
61.21 regardless of public program eligibility. The commissioner of human services shall seek
61.22 to maximize use of available federal and state funds and establish the broadest program
61.23 possible within the funding available.

61.24 (b) These services must be coordinated with long-term care options counseling
61.25 provided under subdivision 4d, section 256.975, ~~subdivision~~ subdivisions 7 to 7c, and
61.26 section 256.01, subdivision 24. The lead agency providing long-term care consultation
61.27 services shall encourage the use of volunteers from families, religious organizations, social
61.28 clubs, and similar civic and service organizations to provide community-based services.

61.29 Sec. 18. Minnesota Statutes 2012, section 256B.0911, subdivision 1a, is amended to
61.30 read:

61.31 Subd. 1a. **Definitions.** For purposes of this section, the following definitions apply:

61.32 (a) Until additional requirements apply under paragraph (b), "long-term care
61.33 consultation services" means:

62.1 (1) intake for and access to assistance in identifying services needed to maintain an
62.2 individual in the most inclusive environment;

62.3 (2) providing recommendations for and referrals to cost-effective community
62.4 services that are available to the individual;

62.5 (3) development of an individual's person-centered community support plan;

62.6 (4) providing information regarding eligibility for Minnesota health care programs;

62.7 (5) face-to-face long-term care consultation assessments, which may be completed
62.8 in a hospital, nursing facility, intermediate care facility for persons with developmental
62.9 disabilities (ICF/DDs), regional treatment centers, or the person's current or planned
62.10 residence;

62.11 ~~(6) federally mandated preadmission screening activities described under~~
62.12 ~~subdivisions 4a and 4b;~~

62.13 ~~(7)~~ (6) determination of home and community-based waiver and other service
62.14 eligibility as required under sections 256B.0913, 256B.0915, and 256B.49, including level
62.15 of care determination for individuals who need an institutional level of care as determined
62.16 under section 256B.0911, subdivision 4a, ~~paragraph (d)~~ 4e, based on assessment and
62.17 community support plan development, appropriate referrals to obtain necessary diagnostic
62.18 information, and including an eligibility determination for consumer-directed community
62.19 supports;

62.20 ~~(8)~~ (7) providing recommendations for institutional placement when there are no
62.21 cost-effective community services available;

62.22 ~~(9)~~ (8) providing access to assistance to transition people back to community settings
62.23 after institutional admission; and

62.24 ~~(10)~~ (9) providing information about competitive employment, with or without
62.25 supports, for school-age youth and working-age adults and referrals to the Disability
62.26 Linkage Line and Disability Benefits 101 to ensure that an informed choice about
62.27 competitive employment can be made. For the purposes of this subdivision, "competitive
62.28 employment" means work in the competitive labor market that is performed on a full-time
62.29 or part-time basis in an integrated setting, and for which an individual is compensated at or
62.30 above the minimum wage, but not less than the customary wage and level of benefits paid
62.31 by the employer for the same or similar work performed by individuals without disabilities.

62.32 (b) Upon statewide implementation of lead agency requirements in subdivisions 2b,
62.33 2c, and 3a, "long-term care consultation services" also means:

62.34 (1) service eligibility determination for state plan home care services identified in:

62.35 (i) section 256B.0625, subdivisions 7, 19a, and 19c;

62.36 (ii) section 256B.0657; or

63.1 (iii) consumer support grants under section 256.476;

63.2 (2) notwithstanding provisions in Minnesota Rules, parts 9525.0004 to 9525.0024,
63.3 determination of eligibility for case management services available under sections
63.4 256B.0621, subdivision 2, paragraph (4), and 256B.0924 and Minnesota Rules, part
63.5 9525.0016;

63.6 (3) determination of institutional level of care, home and community-based service
63.7 waiver, and other service eligibility as required under section 256B.092, determination
63.8 of eligibility for family support grants under section 252.32, semi-independent living
63.9 services under section 252.275, and day training and habilitation services under section
63.10 256B.092; and

63.11 (4) obtaining necessary diagnostic information to determine eligibility under clauses
63.12 (2) and (3).

63.13 (c) "Long-term care options counseling" means the services provided by the linkage
63.14 lines as mandated by sections 256.01, subdivision 24, and 256.975, subdivision 7, and
63.15 also includes telephone assistance and follow up once a long-term care consultation
63.16 assessment has been completed.

63.17 (d) "Minnesota health care programs" means the medical assistance program under
63.18 chapter 256B and the alternative care program under section 256B.0913.

63.19 (e) "Lead agencies" means counties administering or tribes and health plans under
63.20 contract with the commissioner to administer long-term care consultation assessment and
63.21 support planning services.

63.22 Sec. 19. Minnesota Statutes 2012, section 256B.0911, subdivision 3a, is amended to
63.23 read:

63.24 Subd. 3a. **Assessment and support planning.** (a) Persons requesting assessment,
63.25 services planning, or other assistance intended to support community-based living,
63.26 including persons who need assessment in order to determine waiver or alternative care
63.27 program eligibility, must be visited by a long-term care consultation team within 20
63.28 calendar days after the date on which an assessment was requested or recommended.
63.29 Upon statewide implementation of subdivisions 2b, 2c, and 5, this requirement also
63.30 applies to an assessment of a person requesting personal care assistance services and
63.31 private duty nursing. The commissioner shall provide at least a 90-day notice to lead
63.32 agencies prior to the effective date of this requirement. Face-to-face assessments must be
63.33 conducted according to paragraphs (b) to (i).

63.34 (b) The lead agency may utilize a team of either the social worker or public health
63.35 nurse, or both. Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall

64.1 use certified assessors to conduct the assessment. The consultation team members must
64.2 confer regarding the most appropriate care for each individual screened or assessed. For
64.3 a person with complex health care needs, a public health or registered nurse from the
64.4 team must be consulted.

64.5 (c) The assessment must be comprehensive and include a person-centered assessment
64.6 of the health, psychological, functional, environmental, and social needs of referred
64.7 individuals and provide information necessary to develop a community support plan that
64.8 meets the consumers needs, using an assessment form provided by the commissioner.

64.9 (d) The assessment must be conducted in a face-to-face interview with the person
64.10 being assessed and the person's legal representative, and other individuals as requested by
64.11 the person, who can provide information on the needs, strengths, and preferences of the
64.12 person necessary to develop a community support plan that ensures the person's health and
64.13 safety, but who is not a provider of service or has any financial interest in the provision
64.14 of services. For persons who are to be assessed for elderly waiver customized living
64.15 services under section 256B.0915, with the permission of the person being assessed or
64.16 the person's designated or legal representative, the client's current or proposed provider
64.17 of services may submit a copy of the provider's nursing assessment or written report
64.18 outlining its recommendations regarding the client's care needs. The person conducting
64.19 the assessment will notify the provider of the date by which this information is to be
64.20 submitted. This information shall be provided to the person conducting the assessment
64.21 prior to the assessment.

64.22 (e) If the person chooses to use community-based services, the person or the person's
64.23 legal representative must be provided with a written community support plan within 40
64.24 calendar days of the assessment visit, regardless of whether the individual is eligible for
64.25 Minnesota health care programs. The written community support plan must include:

64.26 (1) a summary of assessed needs as defined in paragraphs (c) and (d);

64.27 (2) the individual's options and choices to meet identified needs, including all
64.28 available options for case management services and providers;

64.29 (3) identification of health and safety risks and how those risks will be addressed,
64.30 including personal risk management strategies;

64.31 (4) referral information; and

64.32 (5) informal caregiver supports, if applicable.

64.33 For a person determined eligible for state plan home care under subdivision 1a,
64.34 paragraph (b), clause (1), the person or person's representative must also receive a copy of
64.35 the home care service plan developed by the certified assessor.

65.1 (f) A person may request assistance in identifying community supports without
65.2 participating in a complete assessment. Upon a request for assistance identifying
65.3 community support, the person must be transferred or referred to long-term care options
65.4 counseling services available under sections 256.975, subdivision 7, and 256.01,
65.5 subdivision 24, for telephone assistance and follow up.

65.6 (g) The person has the right to make the final decision between institutional
65.7 placement and community placement after the recommendations have been provided,
65.8 except as provided in section 256.975, subdivision 4a, paragraph (e) 7a, paragraph (d).

65.9 (h) The lead agency must give the person receiving assessment or support planning,
65.10 or the person's legal representative, materials, and forms supplied by the commissioner
65.11 containing the following information:

65.12 (1) written recommendations for community-based services and consumer-directed
65.13 options;

65.14 (2) documentation that the most cost-effective alternatives available were offered to
65.15 the individual. For purposes of this clause, "cost-effective" means community services and
65.16 living arrangements that cost the same as or less than institutional care. For an individual
65.17 found to meet eligibility criteria for home and community-based service programs under
65.18 section 256B.0915 or 256B.49, "cost-effectiveness" has the meaning found in the federally
65.19 approved waiver plan for each program;

65.20 (3) the need for and purpose of preadmission screening conducted by long-term care
65.21 options counselors according to sections 256.975, subdivisions 7a to 7c, and 256.01,
65.22 subdivision 24, if the person selects nursing facility placement. If the individual selects
65.23 nursing facility placement, the lead agency shall forward information needed to complete
65.24 the level of care determinations and screening for developmental disability and mental
65.25 illness collected during the assessment to the long-term care options counselor using forms
65.26 provided by the commissioner;

65.27 (4) the role of long-term care consultation assessment and support planning in
65.28 eligibility determination for waiver and alternative care programs, and state plan home
65.29 care, case management, and other services as defined in subdivision 1a, paragraphs (a),
65.30 clause (7), and (b);

65.31 (5) information about Minnesota health care programs;

65.32 (6) the person's freedom to accept or reject the recommendations of the team;

65.33 (7) the person's right to confidentiality under the Minnesota Government Data
65.34 Practices Act, chapter 13;

65.35 (8) the certified assessor's decision regarding the person's need for institutional level
65.36 of care as determined under criteria established in section 256B.0911, subdivision 4a;

66.1 ~~paragraph (d) 4e~~, and the certified assessor's decision regarding eligibility for all services
 66.2 and programs as defined in subdivision 1a, paragraphs (a), clause (7), and (b); and

66.3 (9) the person's right to appeal the certified assessor's decision regarding eligibility
 66.4 for all services and programs as defined in subdivision 1a, paragraphs (a), clause (7), and
 66.5 (b), and incorporating the decision regarding the need for institutional level of care or the
 66.6 lead agency's final decisions regarding public programs eligibility according to section
 66.7 256.045, subdivision 3.

66.8 (i) Face-to-face assessment completed as part of eligibility determination for
 66.9 the alternative care, elderly waiver, community alternatives for disabled individuals,
 66.10 community alternative care, and brain injury waiver programs under sections 256B.0913,
 66.11 256B.0915, and 256B.49 is valid to establish service eligibility for no more than 60
 66.12 calendar days after the date of assessment.

66.13 (j) The effective eligibility start date for programs in paragraph (i) can never be
 66.14 prior to the date of assessment. If an assessment was completed more than 60 days
 66.15 before the effective waiver or alternative care program eligibility start date, assessment
 66.16 and support plan information must be updated in a face-to-face visit and documented in
 66.17 the department's Medicaid Management Information System (MMIS). Notwithstanding
 66.18 retroactive medical assistance coverage of state plan services, the effective date of
 66.19 eligibility for programs included in paragraph (i) cannot be prior to the date the most
 66.20 recent updated assessment is completed.

66.21 Sec. 20. Minnesota Statutes 2012, section 256B.0911, subdivision 4d, is amended to
 66.22 read:

66.23 Subd. 4d. **Preadmission screening of individuals under 65 60 years of age.** (a)
 66.24 It is the policy of the state of Minnesota to ensure that individuals with disabilities or
 66.25 chronic illness are served in the most integrated setting appropriate to their needs and have
 66.26 the necessary information to make informed choices about home and community-based
 66.27 service options.

66.28 (b) Individuals under 65 60 years of age who are admitted to a Medicaid-certified
 66.29 nursing facility ~~from a hospital~~ must be screened prior to admission ~~as outlined in~~
 66.30 ~~subdivisions 4a through 4e~~ according to the requirements outlined in section 256.975,
 66.31 subdivisions 7a to 7c. This shall be provided by the Disability Linkage Line as required
 66.32 under section 256.01, subdivision 24.

66.33 (c) Individuals under 65 years of age who are admitted to nursing facilities with
 66.34 only a telephone screening must receive a face-to-face assessment from the long-term

67.1 care consultation team member of the county in which the facility is located or from the
67.2 recipient's county case manager within 40 calendar days of admission.

67.3 ~~(d) Individuals under 65 years of age who are admitted to a nursing facility~~
67.4 ~~without preadmission screening according to the exemption described in subdivision 4b,~~
67.5 ~~paragraph (a), clause (3), and who remain in the facility longer than 30 days must receive~~
67.6 ~~a face-to-face assessment within 40 days of admission.~~

67.7 ~~(e)~~ (d) At the face-to-face assessment, the long-term care consultation team member
67.8 or county case manager must perform the activities required under subdivision 3b.

67.9 ~~(f)~~ (e) For individuals under 21 years of age, a screening interview which
67.10 recommends nursing facility admission must be face-to-face and approved by the
67.11 commissioner before the individual is admitted to the nursing facility.

67.12 ~~(g)~~ (f) In the event that an individual under ~~65~~ 60 years of age is admitted to a
67.13 nursing facility on an emergency basis, the ~~county~~ Disability Linkage Line must be
67.14 notified of the admission on the next working day, and a face-to-face assessment as
67.15 described in paragraph (c) must be conducted within 40 calendar days of admission.

67.16 ~~(h)~~ (g) At the face-to-face assessment, the long-term care consultation team member
67.17 or the case manager must present information about home and community-based options,
67.18 including consumer-directed options, so the individual can make informed choices. If the
67.19 individual chooses home and community-based services, the long-term care consultation
67.20 team member or case manager must complete a written relocation plan within 20 working
67.21 days of the visit. The plan shall describe the services needed to move out of the facility
67.22 and a time line for the move which is designed to ensure a smooth transition to the
67.23 individual's home and community.

67.24 ~~(i)~~ (h) An individual under 65 years of age residing in a nursing facility shall receive
67.25 a face-to-face assessment at least every 12 months to review the person's service choices
67.26 and available alternatives unless the individual indicates, in writing, that annual visits are
67.27 not desired. In this case, the individual must receive a face-to-face assessment at least
67.28 once every 36 months for the same purposes.

67.29 ~~(j)~~ (i) Notwithstanding the provisions of subdivision 6, the commissioner may pay
67.30 county agencies directly for face-to-face assessments for individuals under 65 years of age
67.31 who are being considered for placement or residing in a nursing facility.

67.32 (j) Funding for preadmission screening shall be provided to the Disability Linkage
67.33 Line for the under 60 population by the Department of Human Services to cover screener
67.34 salaries and expenses to provide the services described in subdivisions 7a to 7c. The
67.35 Disability Linkage Line shall employ, or contract with other agencies to employ, within
67.36 the limits of available funding, sufficient personnel to provide preadmission screening and

68.1 level of care determination services and shall seek to maximize federal funding for the
68.2 service as provided under section 256.01, subdivision 2, paragraph (dd).

68.3 **EFFECTIVE DATE.** This section is effective October 1, 2013.

68.4 Sec. 21. Minnesota Statutes 2012, section 256B.0911, subdivision 4d, is amended to
68.5 read:

68.6 Subd. 4d. **Preadmission screening of individuals under 65 years of age.** (a)

68.7 It is the policy of the state of Minnesota to ensure that individuals with disabilities or
68.8 chronic illness are served in the most integrated setting appropriate to their needs and have
68.9 the necessary information to make informed choices about home and community-based
68.10 service options.

68.11 (b) Individuals under 65 years of age who are admitted to a nursing facility from a
68.12 hospital must be screened prior to admission as outlined in subdivisions 4a through 4c.

68.13 (c) Individuals under 65 years of age who are admitted to nursing facilities with
68.14 only a telephone screening must receive a face-to-face assessment from the long-term
68.15 care consultation team member of the county in which the facility is located or from the
68.16 recipient's county case manager within 40 calendar days of admission.

68.17 (d) Individuals under 65 years of age who are admitted to a nursing facility
68.18 without preadmission screening according to the exemption described in subdivision 4b,
68.19 paragraph (a), clause (3), and who remain in the facility longer than 30 days must receive
68.20 a face-to-face assessment within 40 days of admission.

68.21 (e) At the face-to-face assessment, the long-term care consultation team member or
68.22 county case manager must perform the activities required under subdivision 3b.

68.23 (f) For individuals under 21 years of age, a screening interview which recommends
68.24 nursing facility admission must be face-to-face and approved by the commissioner before
68.25 the individual is admitted to the nursing facility.

68.26 (g) In the event that an individual under 65 years of age is admitted to a nursing
68.27 facility on an emergency basis, the county must be notified of the admission on the
68.28 next working day, and a face-to-face assessment as described in paragraph (c) must be
68.29 conducted within 40 calendar days of admission.

68.30 (h) At the face-to-face assessment, the long-term care consultation team member or
68.31 the case manager must present information about home and community-based options,
68.32 including consumer-directed options, so the individual can make informed choices. If the
68.33 individual chooses home and community-based services, the long-term care consultation
68.34 team member or case manager must complete a written relocation plan within 20 working
68.35 days of the visit. The plan shall describe the services needed to move out of the facility

69.1 and a time line for the move which is designed to ensure a smooth transition to the
69.2 individual's home and community.

69.3 (i) An individual under 65 years of age residing in a nursing facility shall receive a
69.4 face-to-face assessment at least every 12 months to review the person's service choices
69.5 and available alternatives unless the individual indicates, in writing, that annual visits are
69.6 not desired. In this case, the individual must receive a face-to-face assessment at least
69.7 once every 36 months for the same purposes.

69.8 (j) Notwithstanding the provisions of subdivision 6, the commissioner may pay
69.9 county agencies directly for face-to-face assessments for individuals under 65 years of age
69.10 who are being considered for placement or residing in a nursing facility. Until September
69.11 30, 2013, payments for individuals under 65 years of age shall be made as described
69.12 in this subdivision.

69.13 Sec. 22. Minnesota Statutes 2012, section 256B.0911, is amended by adding a
69.14 subdivision to read:

69.15 Subd. 4e. **Determination of institutional level of care.** The determination of the
69.16 need for nursing facility, hospital, and intermediate care facility levels of care must be
69.17 made according to criteria developed by the commissioner, and in section 256B.092,
69.18 using forms developed by the commissioner. Effective January 1, 2014, for individuals
69.19 age 21 and older, the determination of need for nursing facility level of care shall be
69.20 based on criteria in section 144.0724, subdivision 11. For individuals under age 21, the
69.21 determination of the need for nursing facility level of care must be made according to
69.22 criteria developed by the commissioner until criteria in section 144.0724, subdivision 11,
69.23 becomes effective on or after October 1, 2019.

69.24 Sec. 23. Minnesota Statutes 2012, section 256B.0911, subdivision 6, is amended to read:

69.25 Subd. 6. **Payment for long-term care consultation services.** (a) Until September
69.26 30, 2013, payment for long-term care consultation face-to-face assessment shall be made
69.27 as described in this subdivision.

69.28 (b) The total payment for each county must be paid monthly by certified nursing
69.29 facilities in the county. The monthly amount to be paid by each nursing facility for each
69.30 fiscal year must be determined by dividing the county's annual allocation for long-term
69.31 care consultation services by 12 to determine the monthly payment and allocating the
69.32 monthly payment to each nursing facility based on the number of licensed beds in the
69.33 nursing facility. Payments to counties in which there is no certified nursing facility must be
69.34 made by increasing the payment rate of the two facilities located nearest to the county seat.

70.1 ~~(b)~~ (c) The commissioner shall include the total annual payment determined under
70.2 paragraph (a) for each nursing facility reimbursed under section 256B.431, 256B.434,
70.3 or 256B.441.

70.4 ~~(e)~~ (d) In the event of the layaway, delicensure and decertification, or removal
70.5 from layaway of 25 percent or more of the beds in a facility, the commissioner may
70.6 adjust the per diem payment amount in paragraph ~~(b)~~ (c) and may adjust the monthly
70.7 payment amount in paragraph ~~(a)~~ (b). The effective date of an adjustment made under this
70.8 paragraph shall be on or after the first day of the month following the effective date of the
70.9 layaway, delicensure and decertification, or removal from layaway.

70.10 ~~(d)~~ (e) Payments for long-term care consultation services are available to the county
70.11 or counties to cover staff salaries and expenses to provide the services described in
70.12 subdivision 1a. The county shall employ, or contract with other agencies to employ,
70.13 within the limits of available funding, sufficient personnel to provide long-term care
70.14 consultation services while meeting the state's long-term care outcomes and objectives as
70.15 defined in subdivision 1. The county shall be accountable for meeting local objectives
70.16 as approved by the commissioner in the biennial home and community-based services
70.17 quality assurance plan on a form provided by the commissioner.

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

70.21 ~~(f)~~ (g) The commissioner of human services shall amend the Minnesota medical
70.22 assistance plan to include reimbursement for the local consultation teams.

70.23 ~~(g)~~ (h) Until the alternative payment methodology in paragraph ~~(h)~~ (i) is implemented,
70.24 the county may bill, as case management services, assessments, support planning, and
70.25 follow-along provided to persons determined to be eligible for case management under
70.26 Minnesota health care programs. No individual or family member shall be charged for an
70.27 initial assessment or initial support plan development provided under subdivision 3a or 3b.

70.28 ~~(h)~~ (i) The commissioner shall develop an alternative payment methodology,
70.29 effective on October 1, 2013, for long-term care consultation services that includes
70.30 the funding available under this subdivision, and for assessments authorized under
70.31 sections 256B.092 and 256B.0659. In developing the new payment methodology, the
70.32 commissioner shall consider the maximization of other funding sources, including federal
70.33 administrative reimbursement through federal financial participation funding, for all
70.34 long-term care consultation and ~~preadmission screening~~ activity. The alternative payment
70.35 methodology shall include the use of the appropriate time studies and the state financing
70.36 of nonfederal share as part of the state's medical assistance program.

71.1 Sec. 24. Minnesota Statutes 2012, section 256B.0911, subdivision 7, is amended to read:

71.2 Subd. 7. **Reimbursement for certified nursing facilities.** (a) Medical assistance
71.3 reimbursement for nursing facilities shall be authorized for a medical assistance recipient
71.4 only if a preadmission screening has been conducted prior to admission or the county has
71.5 authorized an exemption. Medical assistance reimbursement for nursing facilities shall
71.6 not be provided for any recipient who the local screener has determined does not meet the
71.7 level of care criteria for nursing facility placement in section 144.0724, subdivision 11, or,
71.8 if indicated, has not had a level II OBRA evaluation as required under the federal Omnibus
71.9 Budget Reconciliation Act of 1987 completed unless an admission for a recipient with
71.10 mental illness is approved by the local mental health authority or an admission for a
71.11 recipient with developmental disability is approved by the state developmental disability
71.12 authority.

71.13 (b) The nursing facility must not bill a person who is not a medical assistance
71.14 recipient for resident days that preceded the date of completion of screening activities
71.15 as required under section 256.975, subdivisions ~~4a, 4b, and 4e~~ 7a to 7c. The nursing
71.16 facility must include unreimbursed resident days in the nursing facility resident day totals
71.17 reported to the commissioner.

71.18 Sec. 25. Minnesota Statutes 2012, section 256B.0913, subdivision 4, is amended to read:

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

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

71.22 (1) the person has been determined by a community assessment under section
71.23 256B.0911 to be a person who would require the level of care provided in a nursing
71.24 facility, as determined under section 256B.0911, subdivision ~~4a~~, ~~paragraph (d)~~ 4e, but for
71.25 the provision of services under the alternative care program;

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

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

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

71.32 (5) the person needs long-term care services that are not funded through other
71.33 state or federal funding, or other health insurance or other third-party insurance such as
71.34 long-term care insurance;

72.1 (6) except for individuals described in clause (7), the monthly cost of the alternative
72.2 care services funded by the program for this person does not exceed 75 percent of the
72.3 monthly limit described under section 256B.0915, subdivision 3a. This monthly limit
72.4 does not prohibit the alternative care client from payment for additional services, but in no
72.5 case may the cost of additional services purchased under this section exceed the difference
72.6 between the client's monthly service limit defined under section 256B.0915, subdivision
72.7 3, and the alternative care program monthly service limit defined in this paragraph. If
72.8 care-related supplies and equipment or environmental modifications and adaptations are or
72.9 will be purchased for an alternative care services recipient, the costs may be prorated on a
72.10 monthly basis for up to 12 consecutive months beginning with the month of purchase.
72.11 If the monthly cost of a recipient's other alternative care services exceeds the monthly
72.12 limit established in this paragraph, the annual cost of the alternative care services shall be
72.13 determined. In this event, the annual cost of alternative care services shall not exceed 12
72.14 times the monthly limit described in this paragraph;

72.15 (7) for individuals assigned a case mix classification A as described under section
72.16 256B.0915, subdivision 3a, paragraph (a), with (i) no dependencies in activities of daily
72.17 living, or (ii) up to two dependencies in bathing, dressing, grooming, walking, and eating
72.18 when the dependency score in eating is three or greater as determined by an assessment
72.19 performed under section 256B.0911, the monthly cost of alternative care services funded
72.20 by the program cannot exceed \$593 per month for all new participants enrolled in
72.21 the program on or after July 1, 2011. This monthly limit shall be applied to all other
72.22 participants who meet this criteria at reassessment. This monthly limit shall be increased
72.23 annually as described in section 256B.0915, subdivision 3a, paragraph (a). This monthly
72.24 limit does not prohibit the alternative care client from payment for additional services, but
72.25 in no case may the cost of additional services purchased exceed the difference between the
72.26 client's monthly service limit defined in this clause and the limit described in clause (6)
72.27 for case mix classification A; and

72.28 (8) the person is making timely payments of the assessed monthly fee.

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

72.31 (i) the appointment of a representative payee;

72.32 (ii) automatic payment from a financial account;

72.33 (iii) the establishment of greater family involvement in the financial management of
72.34 payments; or

72.35 (iv) another method acceptable to the lead agency to ensure prompt fee payments.

73.1 The lead agency may extend the client's eligibility as necessary while making
73.2 arrangements to facilitate payment of past-due amounts and future premium payments.
73.3 Following disenrollment due to nonpayment of a monthly fee, eligibility shall not be
73.4 reinstated for a period of 30 days.

73.5 (b) Alternative care funding under this subdivision is not available for a person who
73.6 is a medical assistance recipient or who would be eligible for medical assistance without a
73.7 spenddown or waiver obligation. A person whose initial application for medical assistance
73.8 and the elderly waiver program is being processed may be served under the alternative care
73.9 program for a period up to 60 days. If the individual is found to be eligible for medical
73.10 assistance, medical assistance must be billed for services payable under the federally
73.11 approved elderly waiver plan and delivered from the date the individual was found eligible
73.12 for the federally approved elderly waiver plan. Notwithstanding this provision, alternative
73.13 care funds may not be used to pay for any service the cost of which: (i) is payable by
73.14 medical assistance; (ii) is used by a recipient to meet a waiver obligation; or (iii) is used to
73.15 pay a medical assistance income spenddown for a person who is eligible to participate in the
73.16 federally approved elderly waiver program under the special income standard provision.

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

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

73.27 Sec. 26. Minnesota Statutes 2012, section 256B.0913, is amended by adding a
73.28 subdivision to read:

73.29 Subd. 17. **Essential community supports grants.** (a) Notwithstanding subdivisions
73.30 1 to 14, the purpose of the essential community supports grant program is to provide
73.31 targeted services to persons age 65 and older who need essential community support, but
73.32 whose needs do not meet the level of care required for nursing facility placement under
73.33 section 144.0724, subdivision 11.

74.1 (b) Essential community supports grants are available not to exceed \$400 per person
74.2 per month. Essential community supports service grants may be used as authorized within
74.3 an authorization period not to exceed 12 months. Grants must be available to a person who:

74.4 (1) is age 65 or older;

74.5 (2) is not eligible for medical assistance;

74.6 (3) would otherwise be financially eligible for the alternative care program under
74.7 subdivision 4;

74.8 (4) has received a community assessment under section 256B.0911, subdivision 3a
74.9 or 3b, and does not require the level of care provided in a nursing facility;

74.10 (5) has a community support plan; and

74.11 (6) has been determined by a community assessment under section 256B.0911,
74.12 subdivision 3a or 3b, to be a person who would require provision of at least one of the
74.13 following services, as defined in the approved elderly waiver plan, in order to maintain
74.14 their community residence:

74.15 (i) caregiver support;

74.16 (ii) homemaker support;

74.17 (iii) chores; or

74.18 (iv) a personal emergency response device or system.

74.19 (c) The person receiving any of the essential community supports in this subdivision
74.20 must also receive service coordination, not to exceed \$600 in a 12-month authorization
74.21 period, as part of their community support plan.

74.22 (d) A person who has been determined to be eligible for an essential community
74.23 supports grant must be reassessed at least annually and continue to meet the criteria in
74.24 paragraph (b) to remain eligible for an essential community supports grant.

74.25 (e) The commissioner is authorized to use federal matching funds for essential
74.26 community supports as necessary and to meet demand for essential community supports
74.27 grants as outlined in paragraphs (f) and (g), and that amount of federal funds is
74.28 appropriated to the commissioner for this purpose.

74.29 (f) Upon federal approval and following a reasonable implementation period
74.30 determined by the commissioner, essential community supports are available to an
74.31 individual who:

74.32 (1) is receiving nursing facility services or home and community-based long-term
74.33 services and supports under section 256B.0915 or 256B.49 on the effective date of
74.34 implementation of the revised nursing facility level of care under section 144.0724,
74.35 subdivision 11;

74.36 (2) meets one of the following criteria:

75.1 (i) due to the implementation of the revised nursing facility level of care, loses
 75.2 eligibility for continuing medical assistance payment of nursing facility services at the
 75.3 first reassessment under section 144.0724, subdivision 11, paragraph (b), that occurs on or
 75.4 after the effective date of the revised nursing facility level of care criteria under section
 75.5 144.0724, subdivision 11; or

75.6 (ii) due to the implementation of the revised nursing facility level of care, loses
 75.7 eligibility for continuing medical assistance payment of home and community-based
 75.8 long-term services and supports under section 256B.0915 or 256B.49 at the first
 75.9 reassessment required under those sections that occurs on or after the effective date of
 75.10 implementation of the revised nursing facility level of care under section 144.0724,
 75.11 subdivision 11;

75.12 (3) is not eligible for personal care attendant services; and

75.13 (4) has an assessed need for one or more of the supportive services offered under
 75.14 essential community supports.

75.15 Individuals eligible under this paragraph includes individuals who continue to be
 75.16 eligible for medical assistance state plan benefits and those who are not or are no longer
 75.17 financially eligible for medical assistance.

75.18 (g) Upon federal approval and following a reasonable implementation period
 75.19 determined by the commissioner, the services available through essential community
 75.20 supports include the services and grants provided in paragraphs (b) and (c), home-delivered
 75.21 meals, and community living assistance as defined by the commissioner. These services
 75.22 are available to all eligible recipients including those outlined in paragraphs (b) and (f).
 75.23 Recipients are eligible if they have a need for any of these services and meet all other
 75.24 eligibility criteria.

75.25 Sec. 27. Minnesota Statutes 2012, section 256B.0915, subdivision 5, is amended to read:

75.26 Subd. 5. **Assessments and reassessments for waiver clients.** (a) Each client
 75.27 shall receive an initial assessment of strengths, informal supports, and need for services
 75.28 in accordance with section 256B.0911, subdivisions 3, 3a, and 3b. A reassessment of a
 75.29 client served under the elderly waiver must be conducted at least every 12 months and at
 75.30 other times when the case manager determines that there has been significant change in
 75.31 the client's functioning. This may include instances where the client is discharged from
 75.32 the hospital. There must be a determination that the client requires nursing facility level
 75.33 of care as defined in section 256B.0911, subdivision 4a, ~~paragraph (d)~~ 4e, at initial and
 75.34 subsequent assessments to initiate and maintain participation in the waiver program.

76.1 (b) Regardless of other assessments identified in section 144.0724, subdivision
 76.2 4, as appropriate to determine nursing facility level of care for purposes of medical
 76.3 assistance payment for nursing facility services, only face-to-face assessments conducted
 76.4 according to section 256B.0911, subdivisions 3a and 3b, that result in a nursing facility
 76.5 level of care determination will be accepted for purposes of initial and ongoing access to
 76.6 waiver service payment.

76.7 Sec. 28. Minnesota Statutes 2012, section 256B.0917, is amended by adding a
 76.8 subdivision to read:

76.9 Subd. 1a. **Home and community-based services for older adults.** (a) The purpose
 76.10 of projects selected by the commissioner of human services under this section is to
 76.11 make strategic changes in the long-term services and supports system for older adults
 76.12 including statewide capacity for local service development and technical assistance, and
 76.13 statewide availability of home and community-based services for older adult services,
 76.14 caregiver support and respite care services, and other supports in the state of Minnesota.
 76.15 These projects are intended to create incentives for new and expanded home and
 76.16 community-based services in Minnesota in order to:

76.17 (1) reach older adults early in the progression of their need for long-term services
 76.18 and supports, providing them with low-cost, high-impact services that will prevent or
 76.19 delay the use of more costly services;

76.20 (2) support older adults to live in the most integrated, least restrictive community
 76.21 setting;

76.22 (3) support the informal caregivers of older adults;

76.23 (4) develop and implement strategies to integrate long-term services and supports
 76.24 with health care services, in order to improve the quality of care and enhance the quality
 76.25 of life of older adults and their informal caregivers;

76.26 (5) ensure cost-effective use of financial and human resources;

76.27 (6) build community-based approaches and community commitment to delivering
 76.28 long-term services and supports for older adults in their own homes;

76.29 (7) achieve a broad awareness and use of lower-cost in-home services as an
 76.30 alternative to nursing homes and other residential services;

76.31 (8) strengthen and develop additional home and community-based services and
 76.32 alternatives to nursing homes and other residential services; and

76.33 (9) strengthen programs that use volunteers.

76.34 (b) The services provided by these projects are available to older adults who are
 76.35 eligible for medical assistance and the elderly waiver under section 256B.0915, the

77.1 alternative care program under section 256B.0913, or essential community supports grant
 77.2 under subdivision 14, paragraph (b), and to persons who have their own funds to pay for
 77.3 services.

77.4 Sec. 29. Minnesota Statutes 2012, section 256B.0917, is amended by adding a
 77.5 subdivision to read:

77.6 Subd. 1b. **Definitions.** (a) For purposes of this section, the following terms have
 77.7 the meanings given.

77.8 (b) "Community" means a town; township; city; or targeted neighborhood within a
 77.9 city; or a consortium of towns, townships, cities, or specific neighborhoods within a city.

77.10 (c) "Core home and community-based services provider" means a Faith in Action,
 77.11 Living at Home Block Nurse, Congregational Nurse, or similar community-based
 77.12 program governed by a board, the majority of whose members reside within the program's
 77.13 service area, that organizes and uses volunteers and paid staff to deliver nonmedical
 77.14 services intended to assist older adults to identify and manage risks and to maintain their
 77.15 community living and integration in the community.

77.16 (d) "Eldercare development partnership" means a team of representatives of county
 77.17 social service and public health agencies, the area agency on aging, local nursing home
 77.18 providers, local home care providers, and other appropriate home and community-based
 77.19 providers in the area agency's planning and service area.

77.20 (e) "Long-term services and supports" means any service available under the
 77.21 elderly waiver program or alternative care grant programs, nursing facility services,
 77.22 transportation services, caregiver support and respite care services, and other home and
 77.23 community-based services identified as necessary either to maintain lifestyle choices for
 77.24 older adults or to support them to remain in their own home.

77.25 (f) "Older adult" refers to an individual who is 65 years of age or older.

77.26 Sec. 30. Minnesota Statutes 2012, section 256B.0917, is amended by adding a
 77.27 subdivision to read:

77.28 Subd. 1c. **Eldercare development partnerships.** The commissioner of human
 77.29 services shall select and contract with eldercare development partnerships sufficient to
 77.30 provide statewide availability of service development and technical assistance using a
 77.31 request for proposals process. Eldercare development partnerships shall:

77.32 (1) develop a local long-term services and supports strategy consistent with state
 77.33 goals and objectives;

78.1 (2) identify and use existing local skills, knowledge, and relationships, and build
 78.2 on these assets;

78.3 (3) coordinate planning for funds to provide services to older adults, including funds
 78.4 received under Title III of the Older Americans Act, Title XX of the Social Security Act,
 78.5 and the Local Public Health Act;

78.6 (4) target service development and technical assistance where nursing facility
 78.7 closures have occurred or are occurring or in areas where service needs have been
 78.8 identified through activities under section 144A.351;

78.9 (5) provide sufficient staff for development and technical support in its designated
 78.10 area; and

78.11 (6) designate a single public or nonprofit member of the eldercare development
 78.12 partnerships to apply grant funding and manage the project.

78.13 Sec. 31. Minnesota Statutes 2012, section 256B.0917, subdivision 6, is amended to read:

78.14 Subd. 6. **Caregiver support and respite care projects.** (a) The commissioner
 78.15 shall establish ~~up to 36~~ projects to expand the ~~respite care network in the state and to~~
 78.16 ~~support caregivers in their responsibilities for care. The purpose of each project shall~~
 78.17 ~~be to~~ availability of caregiver support and respite care services for family and other
 78.18 caregivers. The commissioner shall use a request for proposals to select nonprofit entities
 78.19 to administer the projects. Projects shall:

78.20 (1) establish a local coordinated network of volunteer and paid respite workers;

78.21 (2) coordinate assignment of respite workers care services to ~~clients and care~~
 78.22 ~~receivers and assure the health and safety of the client; and caregivers of older adults;~~

78.23 (3) ~~provide training for caregivers and ensure that support groups are available~~
 78.24 ~~in the community.~~

78.25 (b) ~~The caregiver support and respite care funds shall be available to the four to six~~
 78.26 ~~local long-term care strategy projects designated in subdivisions 1 to 5.~~

78.27 (c) ~~The commissioner shall publish a notice in the State Register to solicit proposals~~
 78.28 ~~from public or private nonprofit agencies for the projects not included in the four to six~~
 78.29 ~~local long-term care strategy projects defined in subdivision 2. A county agency may,~~
 78.30 ~~alone or in combination with other county agencies, apply for caregiver support and~~
 78.31 ~~respite care project funds. A public or nonprofit agency within a designated SAIL project~~
 78.32 ~~area may apply for project funds if the agency has a letter of agreement with the county~~
 78.33 ~~or counties in which services will be developed, stating the intention of the county or~~
 78.34 ~~counties to coordinate their activities with the agency requesting a grant.~~

78.35 (d) The commissioner shall select grantees based on the following criteria:

79.1 ~~(1) the ability of the proposal to demonstrate need in the area served, as evidenced~~
 79.2 ~~by a community needs assessment or other demographic data;~~

79.3 ~~(2) the ability of the proposal to clearly describe how the project~~

79.4 ~~(3) assure the health and safety of the older adults;~~

79.5 ~~(4) identify at-risk caregivers;~~

79.6 ~~(5) provide information, education, and training for caregivers in the designated~~
 79.7 ~~community; and~~

79.8 ~~(6) demonstrate the need in the proposed service area particularly where nursing~~
 79.9 ~~facility closures have occurred or are occurring or areas with service needs identified~~
 79.10 ~~by section 144A.351. Preference must be given for projects that reach underserved~~
 79.11 ~~populations.~~

79.12 ~~(b) Projects must clearly describe:~~

79.13 ~~(1) how they will achieve the their purpose defined in paragraph (b);~~

79.14 ~~(3) the ability of the proposal to reach underserved populations;~~

79.15 ~~(4) the ability of the proposal to demonstrate community commitment to the project,~~
 79.16 ~~as evidenced by letters of support and cooperation as well as formation of a community~~
 79.17 ~~task force;~~

79.18 ~~(5) the ability of the proposal to clearly describe (2) the process for recruiting,~~
 79.19 ~~training, and retraining volunteers; and~~

79.20 ~~(6) the inclusion in the proposal of the (3) a plan to promote the project in the~~
 79.21 ~~designated community, including outreach to persons needing the services.~~

79.22 ~~(e) (c) Funds for all projects under this subdivision may be used to:~~

79.23 ~~(1) hire a coordinator to develop a coordinated network of volunteer and paid respite~~
 79.24 ~~care services and assign workers to clients;~~

79.25 ~~(2) recruit and train volunteer providers;~~

79.26 ~~(3) ~~train~~ provide information, training, and education to caregivers;~~

79.27 ~~(4) ensure the development of support groups for caregivers;~~

79.28 ~~(5) (4) advertise the availability of the caregiver support and respite care project; and~~

79.29 ~~(6) (5) purchase equipment to maintain a system of assigning workers to clients.~~

79.30 ~~(f) (d) Project funds may not be used to supplant existing funding sources.~~

79.31 Sec. 32. Minnesota Statutes 2012, section 256B.0917, is amended by adding a
 79.32 subdivision to read:

79.33 Subd. 7a. Core home and community-based services. The commissioner shall
 79.34 select and contract with core home and community-based services providers for projects

80.1 to provide services and supports to older adults both with and without family and other
 80.2 informal caregivers using a request for proposals process. Projects must:

80.3 (1) have a credible, public, or private nonprofit sponsor providing ongoing financial
 80.4 support;

80.5 (2) have a specific, clearly defined geographic service area;

80.6 (3) use a practice framework designed to identify high-risk older adults and help them
 80.7 take action to better manage their chronic conditions and maintain their community living;

80.8 (4) have a team approach to coordination and care, ensuring that the older adult
 80.9 participants, their families, and the formal and informal providers are all part of planning
 80.10 and providing services;

80.11 (5) provide information, support services, homemaking services, counseling, and
 80.12 training for the older adults and family caregivers;

80.13 (6) encourage service area or neighborhood residents and local organizations to
 80.14 collaborate in meeting the needs of older adults in their geographic service areas;

80.15 (7) recruit, train, and direct the use of volunteers to provide informal services and
 80.16 other appropriate support to older adults and their caregivers; and

80.17 (8) provide coordination and management of formal and informal services to older
 80.18 adults and their families using less expensive alternatives.

80.19 Sec. 33. Minnesota Statutes 2012, section 256B.0917, subdivision 13, is amended to
 80.20 read:

80.21 Subd. 13. **Community service grants.** The commissioner shall award contracts
 80.22 for grants to public and private nonprofit agencies to establish services that strengthen
 80.23 a community's ability to provide a system of home and community-based services
 80.24 for elderly persons. The commissioner shall use a request for proposal process. The
 80.25 commissioner shall give preference when awarding grants under this section to areas
 80.26 where nursing facility closures have occurred or are occurring or to areas with service
 80.27 needs identified under section 144A.351. ~~The commissioner shall consider grants for:~~

80.28 ~~(1) caregiver support and respite care projects under subdivision 6;~~

80.29 ~~(2) the living-at-home/block nurse grant under subdivisions 7 to 10; and~~

80.30 ~~(3) services identified as needed for community transition.~~

80.31 Sec. 34. Minnesota Statutes 2012, section 256B.439, subdivision 1, is amended to read:

80.32 Subdivision 1. **Development and implementation of quality profiles.** (a) The
 80.33 commissioner of human services, in cooperation with the commissioner of health,
 80.34 shall develop and implement a quality profile system profiles for nursing facilities and,

81.1 beginning not later than July 1, ~~2004~~ 2014, other providers of long-term care services,
 81.2 except when the quality profile system would duplicate requirements under section
 81.3 256B.5011, 256B.5012, or 256B.5013. The system quality profiles must be developed
 81.4 ~~and implemented to the extent possible without the collection of significant amounts of~~
 81.5 ~~new data. To the extent possible, the system~~ using existing data sets maintained by the
 81.6 commissioners of health and human services to the extent possible. The profiles must
 81.7 incorporate or be coordinated with information on quality maintained by area agencies on
 81.8 aging, long-term care trade associations, the ombudsman offices, counties, tribes, health
 81.9 plans, and other entities and the long-term care database maintained under section 256.975,
 81.10 subdivision 7. The system profiles must be designed to provide information on quality to:
 81.11 (1) consumers and their families to facilitate informed choices of service providers;
 81.12 (2) providers to enable them to measure the results of their quality improvement
 81.13 efforts and compare quality achievements with other service providers; and
 81.14 (3) public and private purchasers of long-term care services to enable them to
 81.15 purchase high-quality care.
 81.16 (b) The system profiles must be developed in consultation with the long-term care
 81.17 task force, area agencies on aging, and representatives of consumers, providers, and labor
 81.18 unions. Within the limits of available appropriations, the commissioners may employ
 81.19 consultants to assist with this project.

81.20 Sec. 35. Minnesota Statutes 2012, section 256B.439, subdivision 2, is amended to read:

81.21 Subd. 2. **Quality measurement tools.** The commissioners shall identify and apply
 81.22 existing quality measurement tools to:

- 81.23 (1) emphasize quality of care and its relationship to quality of life; and
 81.24 (2) address the needs of various users of long-term care services, including, but not
 81.25 limited to, short-stay residents, persons with behavioral problems, persons with dementia,
 81.26 and persons who are members of minority groups.

81.27 The tools must be identified and applied, to the extent possible, without requiring
 81.28 providers to supply information beyond ~~current~~ state and federal requirements.

81.29 Sec. 36. Minnesota Statutes 2012, section 256B.439, subdivision 3, is amended to read:

81.30 Subd. 3. **Consumer surveys of nursing facilities residents.** Following
 81.31 identification of the quality measurement tool, the commissioners shall conduct surveys
 81.32 of long-term care service consumers of nursing facilities to develop quality profiles
 81.33 of providers. To the extent possible, surveys must be conducted face-to-face by state
 81.34 employees or contractors. At the discretion of the commissioners, surveys may be

82.1 conducted by telephone or by provider staff. Surveys must be conducted periodically to
 82.2 update quality profiles of individual service nursing facilities providers.

82.3 Sec. 37. Minnesota Statutes 2012, section 256B.439, is amended by adding a
 82.4 subdivision to read:

82.5 Subd. 3a. **Home and community-based services report card in cooperation with**
 82.6 **the commissioner of health.** The profiles developed for home and community-based
 82.7 services providers under this section shall be incorporated into a report card and
 82.8 maintained by the Minnesota Board on Aging pursuant to section 256.975, subdivision
 82.9 7, paragraph (b), clause (2), as data becomes available. The commissioner, in
 82.10 cooperation with the commissioner of health, shall use consumer choice, quality of life,
 82.11 care approaches, and cost or flexible purchasing categories to organize the consumer
 82.12 information in the profiles. The final categories used shall include consumer input and
 82.13 survey data to the extent that it is available through the state agencies. The commissioner
 82.14 shall develop and disseminate the qualify profiles for a limited number of provider types
 82.15 initially, and develop quality profiles for additional provider types as measurement tools
 82.16 are developed and data becomes available. This includes providers of services to older
 82.17 adults and people with disabilities, regardless of payor source.

82.18 Sec. 38. Minnesota Statutes 2012, section 256B.439, subdivision 4, is amended to read:

82.19 Subd. 4. **Dissemination of quality profiles.** By July 1, 2003 2014, the
 82.20 commissioners shall implement a system public awareness effort to disseminate the quality
 82.21 profiles developed from consumer surveys using the quality measurement tool. Profiles
 82.22 may be disseminated to through the Senior LinkAge Line and Disability Linkage Line and
 82.23 to consumers, providers, and purchasers of long-term care services ~~through all feasible~~
 82.24 ~~printed and electronic outlets. The commissioners may conduct a public awareness~~
 82.25 ~~campaign to inform potential users regarding profile contents and potential uses.~~

82.26 Sec. 39. Minnesota Statutes 2012, section 256B.441, subdivision 13, is amended to read:

82.27 Subd. 13. **External fixed costs.** "External fixed costs" means costs related to the
 82.28 nursing home surcharge under section 256.9657, subdivision 1; licensure fees under
 82.29 section 144.122; until September 30, 2013, long-term care consultation fees under
 82.30 section 256B.0911, subdivision 6; family advisory council fee under section 144A.33;
 82.31 scholarships under section 256B.431, subdivision 36; planned closure rate adjustments
 82.32 under section 256B.437; or single bed room incentives under section 256B.431,
 82.33 subdivision 42; property taxes and property insurance; and PERA.

83.1 Sec. 40. Minnesota Statutes 2012, section 256B.441, subdivision 53, is amended to read:

83.2 Subd. 53. **Calculation of payment rate for external fixed costs.** The commissioner
83.3 shall calculate a payment rate for external fixed costs.

83.4 (a) For a facility licensed as a nursing home, the portion related to section 256.9657
83.5 shall be equal to \$8.86. For a facility licensed as both a nursing home and a boarding care
83.6 home, the portion related to section 256.9657 shall be equal to \$8.86 multiplied by the
83.7 result of its number of nursing home beds divided by its total number of licensed beds.

83.8 (b) The portion related to the licensure fee under section 144.122, paragraph (d),
83.9 shall be the amount of the fee divided by actual resident days.

83.10 (c) The portion related to scholarships shall be determined under section 256B.431,
83.11 subdivision 36.

83.12 (d) Until September 30, 2013, the portion related to long-term care consultation shall
83.13 be determined according to section 256B.0911, subdivision 6.

83.14 (e) The portion related to development and education of resident and family advisory
83.15 councils under section 144A.33 shall be \$5 divided by 365.

83.16 (f) The portion related to planned closure rate adjustments shall be as determined
83.17 under section 256B.437, subdivision 6, and Minnesota Statutes 2010, section 256B.436.
83.18 Planned closure rate adjustments that take effect before October 1, 2014, shall no longer
83.19 be included in the payment rate for external fixed costs beginning October 1, 2016.
83.20 Planned closure rate adjustments that take effect on or after October 1, 2014, shall no
83.21 longer be included in the payment rate for external fixed costs beginning on October 1 of
83.22 the first year not less than two years after their effective date.

83.23 (g) The portions related to property insurance, real estate taxes, special assessments,
83.24 and payments made in lieu of real estate taxes directly identified or allocated to the nursing
83.25 facility shall be the actual amounts divided by actual resident days.

83.26 (h) The portion related to the Public Employees Retirement Association shall be
83.27 actual costs divided by resident days.

83.28 (i) The single bed room incentives shall be as determined under section 256B.431,
83.29 subdivision 42. Single bed room incentives that take effect before October 1, 2014, shall
83.30 no longer be included in the payment rate for external fixed costs beginning October 1,
83.31 2016. Single bed room incentives that take effect on or after October 1, 2014, shall no
83.32 longer be included in the payment rate for external fixed costs beginning on October 1 of
83.33 the first year not less than two years after their effective date.

83.34 (j) The payment rate for external fixed costs shall be the sum of the amounts in
83.35 paragraphs (a) to (i).

84.1 Sec. 41. Minnesota Statutes 2012, section 256B.49, subdivision 12, is amended to read:

84.2 Subd. 12. **Informed choice.** Persons who are determined likely to require the level
84.3 of care provided in a nursing facility as determined under section 256B.0911, subdivision
84.4 4e, or a hospital shall be informed of the home and community-based support alternatives
84.5 to the provision of inpatient hospital services or nursing facility services. Each person
84.6 must be given the choice of either institutional or home and community-based services
84.7 using the provisions described in section 256B.77, subdivision 2, paragraph (p).

84.8 Sec. 42. Minnesota Statutes 2012, section 256B.49, subdivision 14, is amended to read:

84.9 Subd. 14. **Assessment and reassessment.** (a) Assessments and reassessments
84.10 shall be conducted by certified assessors according to section 256B.0911, subdivision 2b.
84.11 With the permission of the recipient or the recipient's designated legal representative,
84.12 the recipient's current provider of services may submit a written report outlining their
84.13 recommendations regarding the recipient's care needs prepared by a direct service
84.14 employee with at least 20 hours of service to that client. The person conducting the
84.15 assessment or reassessment must notify the provider of the date by which this information
84.16 is to be submitted. This information shall be provided to the person conducting the
84.17 assessment and the person or the person's legal representative and must be considered
84.18 prior to the finalization of the assessment or reassessment.

84.19 (b) There must be a determination that the client requires a hospital level of care or a
84.20 nursing facility level of care as defined in section 256B.0911, subdivision ~~4a~~, ~~paragraph~~
84.21 ~~(d)~~ 4e, at initial and subsequent assessments to initiate and maintain participation in the
84.22 waiver program.

84.23 (c) Regardless of other assessments identified in section 144.0724, subdivision 4, as
84.24 appropriate to determine nursing facility level of care for purposes of medical assistance
84.25 payment for nursing facility services, only face-to-face assessments conducted according
84.26 to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care
84.27 determination or a nursing facility level of care determination must be accepted for
84.28 purposes of initial and ongoing access to waiver services payment.

84.29 (d) Recipients who are found eligible for home and community-based services under
84.30 this section before their 65th birthday may remain eligible for these services after their
84.31 65th birthday if they continue to meet all other eligibility factors.

84.32 (e) The commissioner shall develop criteria to identify recipients whose level of
84.33 functioning is reasonably expected to improve and reassess these recipients to establish
84.34 a baseline assessment. Recipients who meet these criteria must have a comprehensive
84.35 transitional service plan developed under subdivision 15, paragraphs (b) and (c), and be

85.1 reassessed every six months until there has been no significant change in the recipient's
85.2 functioning for at least 12 months. After there has been no significant change in the
85.3 recipient's functioning for at least 12 months, reassessments of the recipient's strengths,
85.4 informal support systems, and need for services shall be conducted at least every 12
85.5 months and at other times when there has been a significant change in the recipient's
85.6 functioning. Counties, case managers, and service providers are responsible for
85.7 conducting these reassessments and shall complete the reassessments out of existing funds.

85.8 **Sec. 43. [256B.85] COMMUNITY FIRST SERVICES AND SUPPORTS.**

85.9 Subdivision 1. **Basis and scope.** (a) Upon federal approval, the commissioner
85.10 shall establish a medical assistance state plan option for the provision of home and
85.11 community-based personal assistance service and supports called "community first
85.12 services and supports (CFSS)."

85.13 (b) CFSS is a participant-controlled method of selecting and providing services
85.14 and supports that allows the participant maximum control of the services and supports.
85.15 Participants may choose the degree to which they direct and manage their supports by
85.16 choosing to have a significant and meaningful role in the management of services and
85.17 supports including by directly employing support workers with the necessary supports
85.18 to perform that function.

85.19 (c) CFSS is available statewide to eligible individuals to assist with accomplishing
85.20 activities of daily living (ADLs), instrumental activities of daily living (IADLs), and
85.21 health-related procedures and tasks through hands-on assistance to accomplish the task
85.22 or constant supervision and cueing to accomplish the task; and to assist with acquiring,
85.23 maintaining, and enhancing the skills necessary to accomplish ADLs, IADLs, and
85.24 health-related procedures and tasks. CFSS allows payment for certain supports and goods
85.25 such as environmental modifications and technology that are intended to replace or
85.26 decrease the need for human assistance.

85.27 (d) Upon federal approval, CFSS will replace the personal care assistance program
85.28 under sections 256.476, 256B.0625, subdivisions 19a and 19c, and 256B.0659.

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

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

85.33 (c) "Agency-provider model" means a method of CFSS under which a qualified
85.34 agency provides services and supports through the agency's own employees and policies.
85.35 The agency must allow the participant to have a significant role in the selection and

86.1 dismissal of support workers of their choice for the delivery of their specific services
86.2 and supports.

86.3 (d) "Behavior" means a description of a need for services and supports used to
86.4 determine the home care rating and additional service units. The presence of Level I
86.5 behavior is used to determine the home care rating. "Level I behavior" means physical
86.6 aggression towards self or others or destruction of property that requires the immediate
86.7 response of another person. If qualified for a home care rating as described in subdivision
86.8 8, additional service units can be added as described in subdivision 8, paragraph (f), for
86.9 the following behaviors:

86.10 (1) Level I behavior;

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

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

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

86.18 (1) tube feedings requiring:

86.19 (i) a gastrojejunostomy tube; or

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

86.21 (2) wounds described as:

86.22 (i) stage III or stage IV;

86.23 (ii) multiple wounds;

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

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

86.27 (3) parenteral therapy described as:

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

86.30 (ii) total parenteral nutrition (TPN) daily;

86.31 (4) respiratory interventions, including:

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

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

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

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

- 87.1 (v) dependence on another to apply respiratory ventilation augmentation devices
87.2 such as BiPAP and CPAP; and
- 87.3 (vi) ventilator dependence under section 256B.0652;
87.4 (5) insertion and maintenance of catheter, including:
87.5 (i) sterile catheter changes more than one time per month;
87.6 (ii) clean intermittent catheterization, and including self-catheterization more than
87.7 six times per day; or
87.8 (iii) bladder irrigations;
87.9 (6) bowel program more than two times per week requiring more than 30 minutes to
87.10 perform each time;
87.11 (7) neurological intervention, including:
87.12 (i) seizures more than two times per week and requiring significant physical
87.13 assistance to maintain safety; or
87.14 (ii) swallowing disorders diagnosed by a physician and requiring specialized
87.15 assistance from another on a daily basis; and
87.16 (8) other congenital or acquired diseases creating a need for significantly increased
87.17 direct hands-on assistance and interventions in six to eight activities of daily living.
- 87.18 (f) "Community first services and supports" or "CFSS" means the assistance and
87.19 supports program under this section needed for accomplishing activities of daily living,
87.20 instrumental activities of daily living, and health-related tasks through hands-on assistance
87.21 to complete the task or supervision and cueing to complete the task, or the purchase of
87.22 goods as defined in subdivision 7, paragraph (a), clause (2), that replace the need for
87.23 human assistance.
- 87.24 (g) "Community first services and supports service delivery plan" or "service delivery
87.25 plan" means a written summary of the services and supports, that is based on the community
87.26 support plan identified in section 256B.0911 and coordinated services and support plan
87.27 and budget identified in section 256B.0915, subdivision 6, if applicable, that is determined
87.28 by the participant to meet the assessed needs, using a person-centered planning process.
- 87.29 (h) "Critical activities of daily living" means transferring, mobility, eating, and
87.30 toileting.
- 87.31 (i) "Dependency" in activities of daily living means a person requires hands-on
87.32 assistance or constant supervision and cueing to accomplish one or more of the activities
87.33 of daily living every day or on the days during the week that the activity is performed;
87.34 however, a child may not be found to be dependent in an activity of daily living if,
87.35 because of the child's age, an adult would either perform the activity for the child or assist

88.1 the child with the activity. Assistance needed is the assistance appropriate for a typical
88.2 child of the same age.

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

88.8 (k) "Financial management services contractor or vendor" means a qualified
88.9 organization having a written contract with the department to provide services necessary to
88.10 use the budget model under subdivision 13, that include but are not limited to: participant
88.11 education and technical assistance; CFSS service delivery planning and budgeting; billing,
88.12 making payments, and monitoring of spending; and assisting the participant in fulfilling
88.13 employer-related requirements in accordance with Section 3504 of the IRS code and
88.14 the IRS Revenue Procedure 70-6.

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

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

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

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

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

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

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

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

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

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

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

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

89.28 (r) "Person-centered planning process" means a process that is driven by the
89.29 participant for discovering and planning services and supports that ensures the participant
89.30 makes informed choices and decisions. The person-centered planning process must:

89.31 (1) include people chosen by the participant;

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

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

89.36 (4) reflect cultural considerations of the participant;

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

90.3 (6) offer choices to the participant regarding the services and supports they receive
 90.4 and from whom;

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

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

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

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

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

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

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

90.21 (u) "Support worker" means an employee of the agency provider or of the participant
 90.22 who has direct contact with the participant and provides services as specified within the
 90.23 participant's service delivery plan.

90.24 (v) "Wages and benefits" means the hourly wages and salaries, the employer's
 90.25 share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers'
 90.26 compensation, mileage reimbursement, health and dental insurance, life insurance,
 90.27 disability insurance, long-term care insurance, uniform allowance, contributions to
 90.28 employee retirement accounts, or other forms of employee compensation and benefits.

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

90.31 (1) is a recipient of medical assistance as determined under section 256B.055,
 90.32 256B.056, or 256B.057, subdivisions 5 and 9;

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

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

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

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

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

91.7 (2) is not a recipient under the family support grant under section 252.32;

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

91.11 Subd. 4. **Eligibility for other services.** Selection of CFSS by a participant must not
91.12 restrict access to other medically necessary care and services furnished under the state
91.13 plan medical assistance benefit or other services available through alternative care.

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

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

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

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

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

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

91.29 (d) The lead agency assessor may request a temporary authorization for CFSS
91.30 services. Authorization for a temporary level of CFSS services is limited to the time
91.31 specified by the commissioner, but shall not exceed 45 days. The level of services
91.32 authorized under this provision shall have no bearing on a future authorization.

91.33 Subd. 6. **Community first services and support service delivery plan.** (a) The
91.34 CFSS service delivery plan must be developed, implemented, and evaluated through a
91.35 person-centered planning process by the participant, or the participant's representative
91.36 or legal representative who may be assisted by a support specialist. The CFSS service

92.1 delivery plan must reflect the services and supports that are important to the participant
92.2 and for the participant to meet the needs assessed by the certified assessor and identified
92.3 in the community support plan under section 256B.0911 or the coordinated services and
92.4 support plan identified in section 256B.0915, subdivision 6, if applicable. The CFSS
92.5 service delivery plan must be reviewed by the participant and the agency-provider or
92.6 financial management services contractor at least annually upon reassessment, or when
92.7 there is a significant change in the participant's condition, or a change in the need for
92.8 services and supports.

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

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

92.12 (1) specify the agency-provider or financial management services contractor selected
92.13 by the participant;

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

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

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

92.18 (5) include individually identified goals and desired outcomes;

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

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

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

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

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

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

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

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

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

93.1 and documented in the community support plan, coordinated services and supports plan,
 93.2 and service delivery plan.

93.3 Subd. 7. **Community first services and supports; covered services.** Services
 93.4 and supports covered under CFSS include:

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

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

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

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

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

93.17 (4) observation and redirection for behavior or symptoms where there is a need for
 93.18 assistance. A recipient qualifies as having a need for assistance due to behaviors if the
 93.19 recipient's behavior requires assistance at least four times per week and shows one or
 93.20 more of the following behaviors:

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

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

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

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

93.29 (6) transition costs, including:

93.30 (i) deposits for rent and utilities;

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

93.32 (iii) bedding;

93.33 (iv) basic kitchen supplies;

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

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

94.5 (7) services by a support specialist defined under subdivision 2 that are chosen
 94.6 by the participant.

94.7 Subd. 8. **Determination of CFSS service methodology.** (a) All community first
 94.8 services and supports must be authorized by the commissioner or the commissioner's
 94.9 designee before services begin, except for the assessments established in section
 94.10 256B.0911. The authorization for CFSS must be completed as soon as possible following
 94.11 an assessment but no later than 40 calendar days from the date of the assessment.

94.12 (b) The amount of CFSS authorized must be based on the recipient's home care
 94.13 rating described in subdivision 8, paragraphs (d) and (e), and any additional service units
 94.14 for which the person qualifies as described in subdivision 8, paragraph (f).

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

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

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

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

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

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

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

94.31 (ii) Q home care rating requires Level 1 behavior and one to three dependencies in
 94.32 ADLs and qualifies one for six service units;

94.33 (iii) R home care rating requires complex health-related needs and one to three
 94.34 dependencies in ADLs and qualifies one for seven service units;

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

95.1 (v) T home care rating requires four to six dependencies in ADLs and Level 1
 95.2 behavior and qualifies one for 11 service units;

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

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

95.7 (viii) W home care rating requires seven to eight dependencies in ADLs and Level 1
 95.8 behavior and qualifies one for 20 service units;

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

95.11 (x) EN home care rating includes ventilator dependency as defined in section
 95.12 256B.0651, subdivision 1, paragraph (g). Recipients who meet the definition of
 95.13 ventilator-dependent and the EN home care rating and utilize a combination of CFSS
 95.14 and other home care services are limited to a total of 96 service units per day for those
 95.15 services in combination. Additional units may be authorized when a recipient's assessment
 95.16 indicates a need for two staff to perform activities. Additional time is limited to 16 service
 95.17 units per day.

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

95.20 (1) 30 additional minutes per day for a dependency in each critical activity of daily
 95.21 living as defined in subdivision 2, paragraph (h);

95.22 (2) 30 additional minutes per day for each complex health-related function as
 95.23 defined in subdivision 2, paragraph (e); and

95.24 (3) 30 additional minutes per day for each behavior issue as defined in subdivision 2,
 95.25 paragraph (d).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

96.19 (8) medical supplies and equipment;

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

96.21 (10) expenses for travel, lodging, or meals related to training the participant, the
96.22 participant's representative, legal representative, or paid or unpaid caregivers that exceed
96.23 \$500 in a 12-month period;

96.24 (11) experimental treatments;

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

96.28 (13) membership dues or costs, except when the service is necessary and appropriate
96.29 to treat a physical condition or to improve or maintain the participant's physical condition.

96.30 The condition must be identified in the participant's CFSS plan and monitored by a
96.31 physician enrolled in a Minnesota health care program;

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

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

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

- 97.1 Subd. 10. **Provider qualifications and general requirements.** (a)
- 97.2 Agency-providers delivering services under the agency-provider model under subdivision
- 97.3 11 or financial management service (FMS) contractors under subdivision 13 shall:
- 97.4 (1) enroll as a medical assistance Minnesota health care programs provider and meet
- 97.5 all applicable provider standards;
- 97.6 (2) comply with medical assistance provider enrollment requirements;
- 97.7 (3) demonstrate compliance with law and policies of CFSS as determined by the
- 97.8 commissioner;
- 97.9 (4) comply with background study requirements under chapter 245C;
- 97.10 (5) verify and maintain records of all services and expenditures by the participant,
- 97.11 including hours worked by support workers and support specialists;
- 97.12 (6) not engage in any agency-initiated direct contact or marketing in person, by
- 97.13 telephone, or other electronic means to potential participants, guardians, family member,
- 97.14 or participants' representatives;
- 97.15 (7) pay support workers and support specialists based upon actual hours of services
- 97.16 provided;
- 97.17 (8) withhold and pay all applicable federal and state payroll taxes;
- 97.18 (9) make arrangements and pay unemployment insurance, taxes, workers'
- 97.19 compensation, liability insurance, and other benefits, if any;
- 97.20 (10) enter into a written agreement with the participant, participant's representative,
- 97.21 or legal representative that assigns roles and responsibilities to be performed before
- 97.22 services, supports, or goods are provided using a format established by the commissioner;
- 97.23 (11) report maltreatment as required under sections 626.556 and 626.557; and
- 97.24 (12) provide the participant with a copy of the service-related rights under
- 97.25 subdivision 19 at the start of services and supports.
- 97.26 (b) The commissioner shall develop policies and procedures designed to ensure
- 97.27 program integrity and fiscal accountability for goods and services provided in this section
- 97.28 in consultation with the implementation council described in subdivision 21.
- 97.29 Subd. 11. **Agency-provider model.** (a) The agency-provider model is limited to
- 97.30 the services provided by support workers and support specialists who are employed by
- 97.31 an agency-provider that is licensed according to chapter 245A or meets other criteria
- 97.32 established by the commissioner, including required training.
- 97.33 (b) The agency-provider shall allow the participant to have a significant role in the
- 97.34 selection and dismissal of the support workers for the delivery of the services and supports
- 97.35 specified in the participant's service delivery plan.

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

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

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

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

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

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

98.22 (2) proof of surety bond coverage in the amount of \$50,000 or ten percent of the
98.23 provider's payments from Medicaid in the previous year, whichever is less;

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

98.25 (4) proof of workers' compensation insurance coverage;

98.26 (5) proof of liability insurance;

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

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

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

- 99.1 (i) a copy of the CFSS provider agency's time sheet if the time sheet varies from
99.2 the standard time sheet for CFSS services approved by the commissioner, and a letter
99.3 requesting approval of the CFSS provider agency's nonstandard time sheet;
- 99.4 (ii) the CFSS provider agency's template for the CFSS care plan; and
99.5 (iii) the CFSS provider agency's template for the written agreement in subdivision
99.6 21 for recipients using the CFSS choice option, if applicable;
- 99.7 (9) a list of all training and classes that the CFSS provider agency requires of its
99.8 staff providing CFSS services;
- 99.9 (10) documentation that the CFSS provider agency and staff have successfully
99.10 completed all the training required by this section;
- 99.11 (11) documentation of the agency's marketing practices;
99.12 (12) disclosure of ownership, leasing, or management of all residential properties
99.13 that is used or could be used for providing home care services;
- 99.14 (13) documentation that the agency will use the following percentages of revenue
99.15 generated from the medical assistance rate paid for CFSS services for employee personal
99.16 care assistant wages and benefits: 72.5 percent of revenue from CFSS providers. The
99.17 revenue generated by the support specialist and the reasonable costs associated with the
99.18 support specialist shall not be used in making this calculation; and
- 99.19 (14) documentation that the agency does not burden recipients' free exercise of their
99.20 right to choose service providers by requiring personal care assistants to sign an agreement
99.21 not to work with any particular CFSS recipient or for another CFSS provider agency after
99.22 leaving the agency and that the agency is not taking action on any such agreements or
99.23 requirements regardless of the date signed.
- 99.24 (b) CFSS provider agencies shall provide to the commissioner the information
99.25 specified in paragraph (a).
- 99.26 (c) All CFSS provider agencies shall require all employees in management and
99.27 supervisory positions and owners of the agency who are active in the day-to-day
99.28 management and operations of the agency to complete mandatory training as determined
99.29 by the commissioner. Employees in management and supervisory positions and owners
99.30 who are active in the day-to-day operations of an agency who have completed the required
99.31 training as an employee with a CFSS provider agency do not need to repeat the required
99.32 training if they are hired by another agency, if they have completed the training within
99.33 the past three years. CFSS provider agency billing staff shall complete training about
99.34 CFSS program financial management. Any new owners or employees in management
99.35 and supervisory positions involved in the day-to-day operations are required to complete
99.36 mandatory training as a requisite of working for the agency. CFSS provider agencies

100.1 certified for participation in Medicare as home health agencies are exempt from the
100.2 training required in this subdivision.

100.3 Subd. 13. **Budget model.** (a) Under the budget model participants can exercise
100.4 more responsibility and control over the services and supports described and budgeted
100.5 within the CFSS service delivery plan. Under this model, participants may use their
100.6 budget allocation to:

100.7 (1) directly employ support workers;

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

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

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

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

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

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

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

100.20 (c) The FMS contractor shall not provide CFSS services and supports under the
100.21 agency-provider service model. The FMS contractor shall provide service functions as
100.22 determined by the commissioner that include but are not limited to:

100.23 (1) information and consultation about CFSS;

100.24 (2) assistance with the development of the service delivery plan and budget model
100.25 as requested by the participant;

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

100.27 (4) assisting participants in fulfilling employer-related requirements according to
100.28 Internal Revenue Code Procedure 70-6, section 3504, Agency Employer Tax Liability,
100.29 regulation 137036-08, which includes assistance with filing and paying payroll taxes, and
100.30 obtaining worker compensation coverage;

100.31 (5) data recording and reporting of participant spending; and

100.32 (6) other duties established in the contract with the department.

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

101.1 (e) The FMS contractor shall:

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

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

101.7 (3) be knowledgeable of state and federal employment regulations under the Fair
101.8 Labor Standards Act of 1938, and comply with the requirements under the Internal
101.9 Revenue Service Revenue Code Procedure 70-6, Section 35-4, Agency Employer Tax
101.10 Liability for vendor or fiscal employer agent, and any requirements necessary to process
101.11 employer and employee deductions, provide appropriate and timely submission of
101.12 employer tax liabilities, and maintain documentation to support medical assistance claims;

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

101.16 (5) assume fiscal accountability for state funds designated for the program; and

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

101.24 (f) The commissioner of human services shall:

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

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

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

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

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

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

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

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

102.11 Subd. 14. **Participant's responsibilities under budget model.** (a) A participant
102.12 using the budget model must use an FMS contractor or vendor that is under contract with
102.13 the department. Upon a determination of eligibility and completion of the assessment and
102.14 community support plan, the participant shall choose a FMS contractor from a list of
102.15 eligible vendors maintained by the department.

102.16 (b) When the participant, participant's representative, or legal representative chooses
102.17 to be the employer of the support worker, they are responsible for the hiring and supervision
102.18 of the support worker, including, but not limited to, recruiting, interviewing, training, and
102.19 discharging the support worker consistent with federal and state laws and regulations.

102.20 (c) In addition to the employer responsibilities in paragraph (b), the participant,
102.21 participant's representative, or legal representative is responsible for:

102.22 (1) tracking the services provided and all expenditures for goods or other supports;

102.23 (2) preparing and submitting time sheets, signed by both the participant and support
102.24 worker, to the FMS contractor on a regular basis and in a timely manner according to
102.25 the FMS contractor's procedures;

102.26 (3) notifying the FMS contractor within ten days of any changes in circumstances
102.27 affecting the CFSS service plan or in the participant's place of residence including, but
102.28 not limited to, any hospitalization of the participant or change in the participant's address,
102.29 telephone number, or employment;

102.30 (4) notifying the FMS contractor of any changes in the employment status of each
102.31 participant support worker; and

102.32 (5) reporting any problems resulting from the quality of services rendered by the
102.33 support worker to the FMS contractor. If the participant is unable to resolve any problems
102.34 resulting from the quality of service rendered by the support worker with the assistance of
102.35 the FMS contractor, the participant shall report the situation to the department.

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

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

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

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

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

103.18 (3) full name of the participant;

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

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

103.22 (6) personal signature of the support worker;

103.23 (7) any shared care provided, if applicable;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

104.33 **Subd. 17. Support specialist requirements and payments.** The commissioner
104.34 shall develop qualifications, scope of functions, and payment rates and service limits for a
104.35 support specialist that may provide additional or specialized assistance necessary to plan,
104.36 implement, arrange, augment, or evaluate services and supports.

105.1 Subd. 18. **Service unit and budget allocation requirements and limits.** (a) For the
105.2 agency-provider model, services will be authorized in units of service. The total service
105.3 unit amount must be established based upon the assessed need for CFSS services, and must
105.4 not exceed the maximum number of units available as determined under subdivision 8.

105.5 (b) For the budget model, the budget allocation allowed for services and supports
105.6 is established by multiplying the number of units authorized under subdivision 8 by the
105.7 payment rate established by the commissioner.

105.8 Subd. 19. **Support system.** (a) The commissioner shall provide information,
105.9 consultation, training, and assistance to ensure the participant is able to manage the
105.10 services and supports and budgets, if applicable. This support shall include individual
105.11 consultation on how to select and employ workers, manage responsibilities under CFSS,
105.12 and evaluate personal outcomes.

105.13 (b) The commissioner shall provide assistance with the development of risk
105.14 management agreements.

105.15 Subd. 20. **Service-related rights.** (a) Participants must be provided with adequate
105.16 information, counseling, training, and assistance, as needed, to ensure that the participant
105.17 is able to choose and manage services, models, and budgets. This support shall include
105.18 information regarding:

- 105.19 (1) person-centered planning;
105.20 (2) the range and scope of individual choices;
105.21 (3) the process for changing plans, services and budgets;
105.22 (4) the grievance process;
105.23 (5) individual rights;
105.24 (6) identifying and assessing appropriate services;
105.25 (7) risks and responsibilities; and
105.26 (8) risk management.

105.27 (b) The commissioner must ensure that the participant has a copy of the most recent
105.28 community support plan and service delivery plan.

105.29 (c) A participant who appeals a reduction in previously authorized CFSS services
105.30 may continue previously authorized services pending an appeal in accordance with section
105.31 256.045.

105.32 (d) If the units of service or budget allocation for CFSS are reduced, denied, or
105.33 terminated, the commissioner must provide notice of the reasons for the reduction in the
105.34 participant's notice of denial, termination, or reduction.

105.35 (e) If all or part of a service delivery plan is denied approval, the commissioner must
105.36 provide a notice that describes the basis of the denial.

106.1 Subd. 21. **Development and Implementation Council.** The commissioner
106.2 shall establish a Development and Implementation Council of which the majority of
106.3 members are individuals with disabilities, elderly individuals, and their representatives.
106.4 The commissioner shall consult and collaborate with the council when developing and
106.5 implementing this section for at least the first five years of operation. The commissioner,
106.6 in consultation with the council, shall provide recommendations on how to improve the
106.7 quality and integrity of CFSS, reduce the paper documentation required in subdivisions
106.8 10, 12, and 15, make use of electronic means of documentation and online reporting in
106.9 order to reduce administrative costs and improve training to the legislative chairs of the
106.10 health and human services policy and finance committees by February 1, 2014.

106.11 Subd. 22. **Quality assurance and risk management system.** (a) The commissioner
106.12 shall establish quality assurance and risk management measures for use in developing and
106.13 implementing CFSS, including those that (1) recognize the roles and responsibilities of
106.14 those involved in obtaining CFSS, and (2) ensure the appropriateness of such plans and
106.15 budgets based upon a recipient's resources and capabilities. Risk management measures
106.16 must include background studies, and backup and emergency plans, including disaster
106.17 planning.

106.18 (b) The commissioner shall provide ongoing technical assistance and resource and
106.19 educational materials for CFSS participants.

106.20 (c) Performance assessment measures, such as a participant's satisfaction with the
106.21 services and supports, and ongoing monitoring of health and well-being shall be identified
106.22 in consultation with the council established in subdivision 21.

106.23 (d) Data reporting requirements will be developed in consultation with the council
106.24 established in subdivision 21.

106.25 Subd. 23. **Commissioner's access.** When the commissioner is investigating a
106.26 possible overpayment of Medicaid funds, the commissioner must be given immediate
106.27 access without prior notice to the agency provider or FMS contractor's office during
106.28 regular business hours and to documentation and records related to services provided and
106.29 submission of claims for services provided. Denying the commissioner access to records
106.30 is cause for immediate suspension of payment and terminating the agency provider's
106.31 enrollment according to section 256B.064 or terminating the FMS contract.

106.32 Subd. 24. **CFSS agency-providers; background studies.** CFSS agency-providers
106.33 enrolled to provide personal care assistance services under the medical assistance program
106.34 shall comply with the following:

106.35 (1) owners who have a five percent interest or more and all managing employees
106.36 are subject to a background study as provided in chapter 245C. This applies to currently

107.1 enrolled CFSS agency-providers and those agencies seeking enrollment as a CFSS
 107.2 agency-provider. "Managing employee" has the same meaning as Code of Federal
 107.3 Regulations, title 42, section 455. An organization is barred from enrollment if:

107.4 (i) the organization has not initiated background studies on owners managing
 107.5 employees; or

107.6 (ii) the organization has initiated background studies on owners and managing
 107.7 employees, but the commissioner has sent the organization a notice that an owner or
 107.8 managing employee of the organization has been disqualified under section 245C.14, and
 107.9 the owner or managing employee has not received a set-aside of the disqualification
 107.10 under section 245C.22;

107.11 (2) a background study must be initiated and completed for all support specialists; and

107.12 (3) a background study must be initiated and completed for all support workers.

107.13 **EFFECTIVE DATE.** This section is effective upon federal approval but no earlier
 107.14 than January 1, 2014. The service will begin 90 days after federal approval or January 1,
 107.15 2014, whichever is later. The commissioner of human services shall notify the revisor of
 107.16 statutes when this occurs.

107.17 Sec. 44. Minnesota Statutes 2012, section 256I.05, is amended by adding a subdivision
 107.18 to read:

107.19 Subd. 1o. **Supplementary service rate; exemptions.** A county agency shall not
 107.20 negotiate a supplementary service rate under this section for any individual that has been
 107.21 determined to be eligible for Housing Stability Services as approved by the Centers
 107.22 for Medicare and Medicaid Services, and who resides in an establishment voluntarily
 107.23 registered under section 144D.025, as a supportive housing establishment or participates
 107.24 in the Minnesota supportive housing demonstration program under section 256I.04,
 107.25 subdivision 3, paragraph (a), clause (4).

107.26 Sec. 45. Minnesota Statutes 2012, section 626.557, subdivision 4, is amended to read:

107.27 Subd. 4. **Reporting.** (a) Except as provided in paragraph (b), a mandated reporter
 107.28 shall immediately make an oral report to the common entry point. The common entry
 107.29 point may accept electronic reports submitted through a Web-based reporting system
 107.30 established by the commissioner. Use of a telecommunications device for the deaf or other
 107.31 similar device shall be considered an oral report. The common entry point may not require
 107.32 written reports. To the extent possible, the report must be of sufficient content to identify
 107.33 the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment,
 107.34 any evidence of previous maltreatment, the name and address of the reporter, the time,

108.1 date, and location of the incident, and any other information that the reporter believes
108.2 might be helpful in investigating the suspected maltreatment. A mandated reporter may
108.3 disclose not public data, as defined in section 13.02, and medical records under sections
108.4 144.291 to 144.298, to the extent necessary to comply with this subdivision.

108.5 (b) A boarding care home that is licensed under sections 144.50 to 144.58 and
108.6 certified under Title 19 of the Social Security Act, a nursing home that is licensed under
108.7 section 144A.02 and certified under Title 18 or Title 19 of the Social Security Act, or a
108.8 hospital that is licensed under sections 144.50 to 144.58 and has swing beds certified under
108.9 Code of Federal Regulations, title 42, section 482.66, may submit a report electronically
108.10 to the common entry point instead of submitting an oral report. The report may be a
108.11 duplicate of the initial report the facility submits electronically to the commissioner of
108.12 health to comply with the reporting requirements under Code of Federal Regulations, title
108.13 42, section 483.13. The commissioner of health may modify these reporting requirements
108.14 to include items required under paragraph (a) that are not currently included in the
108.15 electronic reporting form.

108.16 **EFFECTIVE DATE.** This section is effective July 1, 2014.

108.17 Sec. 46. Minnesota Statutes 2012, section 626.557, subdivision 9, is amended to read:

108.18 Subd. 9. **Common entry point designation.** (a) ~~Each county board shall designate~~
108.19 ~~a common entry point for reports of suspected maltreatment. Two or more county boards~~
108.20 ~~may jointly designate a single~~ The commissioner of human services shall establish a
108.21 common entry point effective July 1, 2014. The common entry point is the unit responsible
108.22 for receiving the report of suspected maltreatment under this section.

108.23 (b) The common entry point must be available 24 hours per day to take calls from
108.24 reporters of suspected maltreatment. The common entry point shall use a standard intake
108.25 form that includes:

- 108.26 (1) the time and date of the report;
- 108.27 (2) the name, address, and telephone number of the person reporting;
- 108.28 (3) the time, date, and location of the incident;
- 108.29 (4) the names of the persons involved, including but not limited to, perpetrators,
108.30 alleged victims, and witnesses;
- 108.31 (5) whether there was a risk of imminent danger to the alleged victim;
- 108.32 (6) a description of the suspected maltreatment;
- 108.33 (7) the disability, if any, of the alleged victim;
- 108.34 (8) the relationship of the alleged perpetrator to the alleged victim;
- 108.35 (9) whether a facility was involved and, if so, which agency licenses the facility;

109.1 (10) any action taken by the common entry point;

109.2 (11) whether law enforcement has been notified;

109.3 (12) whether the reporter wishes to receive notification of the initial and final
109.4 reports; and

109.5 (13) if the report is from a facility with an internal reporting procedure, the name,
109.6 mailing address, and telephone number of the person who initiated the report internally.

109.7 (c) The common entry point is not required to complete each item on the form prior
109.8 to dispatching the report to the appropriate lead investigative agency.

109.9 (d) The common entry point shall immediately report to a law enforcement agency
109.10 any incident in which there is reason to believe a crime has been committed.

109.11 (e) If a report is initially made to a law enforcement agency or a lead investigative
109.12 agency, those agencies shall take the report on the appropriate common entry point intake
109.13 forms and immediately forward a copy to the common entry point.

109.14 (f) The common entry point staff must receive training on how to screen and
109.15 dispatch reports efficiently and in accordance with this section.

109.16 (g) The commissioner of human services shall maintain a centralized database
109.17 for the collection of common entry point data, lead investigative agency data including
109.18 maltreatment report disposition, and appeals data. The common entry point shall
109.19 have access to the centralized database and must log the reports into the database and
109.20 immediately identify and locate prior reports of abuse, neglect, or exploitation.

109.21 (h) When appropriate, the common entry point staff must refer calls that do not
109.22 allege the abuse, neglect, or exploitation of a vulnerable adult to other organizations
109.23 that might resolve the reporter's concerns.

109.24 (i) a common entry point must be operated in a manner that enables the
109.25 commissioner of human services to:

109.26 (1) track critical steps in the reporting, evaluation, referral, response, disposition,
109.27 and investigative process to ensure compliance with all requirements for all reports;

109.28 (2) maintain data to facilitate the production of aggregate statistical reports for
109.29 monitoring patterns of abuse, neglect, or exploitation;

109.30 (3) serve as a resource for the evaluation, management, and planning of preventative
109.31 and remedial services for vulnerable adults who have been subject to abuse, neglect,
109.32 or exploitation;

109.33 (4) set standards, priorities, and policies to maximize the efficiency and effectiveness
109.34 of the common entry point; and

109.35 (5) track and manage consumer complaints related to the common entry point.

110.1 (j) The commissioners of human services and health shall collaborate on the
 110.2 creation of a system for referring reports to the lead investigative agencies. This system
 110.3 shall enable the commissioner of human services to track critical steps in the reporting,
 110.4 evaluation, referral, response, disposition, investigation, notification, determination, and
 110.5 appeal processes.

110.6 Sec. 47. Minnesota Statutes 2012, section 626.557, subdivision 9e, is amended to read:

110.7 Subd. 9e. **Education requirements.** (a) The commissioners of health, human
 110.8 services, and public safety shall cooperate in the development of a joint program for
 110.9 education of lead investigative agency investigators in the appropriate techniques for
 110.10 investigation of complaints of maltreatment. This program must be developed by July
 110.11 1, 1996. The program must include but need not be limited to the following areas: (1)
 110.12 information collection and preservation; (2) analysis of facts; (3) levels of evidence; (4)
 110.13 conclusions based on evidence; (5) interviewing skills, including specialized training to
 110.14 interview people with unique needs; (6) report writing; (7) coordination and referral
 110.15 to other necessary agencies such as law enforcement and judicial agencies; (8) human
 110.16 relations and cultural diversity; (9) the dynamics of adult abuse and neglect within family
 110.17 systems and the appropriate methods for interviewing relatives in the course of the
 110.18 assessment or investigation; (10) the protective social services that are available to protect
 110.19 alleged victims from further abuse, neglect, or financial exploitation; (11) the methods by
 110.20 which lead investigative agency investigators and law enforcement workers cooperate in
 110.21 conducting assessments and investigations in order to avoid duplication of efforts; and
 110.22 (12) data practices laws and procedures, including provisions for sharing data.

110.23 (b) The commissioner of human services shall conduct an outreach campaign to
 110.24 promote the common entry point for reporting vulnerable adult maltreatment. This
 110.25 campaign shall use the Internet and other means of communication.

110.26 ~~(b)~~ (c) The commissioners of health, human services, and public safety shall offer at
 110.27 least annual education to others on the requirements of this section, on how this section is
 110.28 implemented, and investigation techniques.

110.29 ~~(e)~~ (d) The commissioner of human services, in coordination with the commissioner
 110.30 of public safety shall provide training for the common entry point staff as required in this
 110.31 subdivision and the program courses described in this subdivision, at least four times
 110.32 per year. At a minimum, the training shall be held twice annually in the seven-county
 110.33 metropolitan area and twice annually outside the seven-county metropolitan area. The
 110.34 commissioners shall give priority in the program areas cited in paragraph (a) to persons
 110.35 currently performing assessments and investigations pursuant to this section.

111.1 ~~(d)~~ (e) The commissioner of public safety shall notify in writing law enforcement
 111.2 personnel of any new requirements under this section. The commissioner of public
 111.3 safety shall conduct regional training for law enforcement personnel regarding their
 111.4 responsibility under this section.

111.5 ~~(e)~~ (f) Each lead investigative agency investigator must complete the education
 111.6 program specified by this subdivision within the first 12 months of work as a lead
 111.7 investigative agency investigator.

111.8 A lead investigative agency investigator employed when these requirements take
 111.9 effect must complete the program within the first year after training is available or as soon
 111.10 as training is available.

111.11 All lead investigative agency investigators having responsibility for investigation
 111.12 duties under this section must receive a minimum of eight hours of continuing education
 111.13 or in-service training each year specific to their duties under this section.

111.14 Sec. 48. **FEDERAL APPROVAL.**

111.15 This article is contingent on federal approval.

111.16 Sec. 49. **REPEALER.**

111.17 (a) Minnesota Statutes 2012, sections 245A.655; and 256B.0917, subdivisions 1, 2,
 111.18 3, 4, 5, 7, 8, 9, 10, 11, 12, and 14, are repealed.

111.19 (b) Minnesota Statutes 2012, section 256B.0911, subdivisions 4a, 4b, and 4c, are
 111.20 repealed effective October 1, 2013.

111.21 **ARTICLE 3**

111.22 **SAFE AND HEALTHY DEVELOPMENT OF CHILDREN,** 111.23 **YOUTH, AND FAMILIES**

111.24 Section 1. Minnesota Statutes 2012, section 119B.05, subdivision 1, is amended to read:

111.25 Subdivision 1. **Eligible participants.** Families eligible for child care assistance
 111.26 under the MFIP child care program are:

111.27 (1) MFIP participants who are employed or in job search and meet the requirements
 111.28 of section 119B.10;

111.29 (2) persons who are members of transition year families under section 119B.011,
 111.30 subdivision 20, and meet the requirements of section 119B.10;

111.31 (3) families who are participating in employment orientation or job search, or
 111.32 other employment or training activities that are included in an approved employability
 111.33 development plan under section 256J.95;

112.1 (4) MFIP families who are participating in work job search, job support,
 112.2 employment, or training activities as required in their employment plan, or in appeals,
 112.3 hearings, assessments, or orientations according to chapter 256J;

112.4 (5) MFIP families who are participating in social services activities under chapter
 112.5 256J or mental health treatment as required in their employment plan approved according
 112.6 to chapter 256J;

112.7 (6) families who are participating in services or activities that are included in an
 112.8 approved family stabilization plan under section 256J.575;

112.9 (7) MFIP child-only cases under section 256J.88, for up to 20 hours of child care
 112.10 per child per week under the following conditions: (i) child care will be authorized if the
 112.11 child's primary caregiver is receiving SSI for a disability related to depression or other
 112.12 serious mental illness; and (ii) child care will only be authorized for children five years
 112.13 of age or younger. The child's authorized care under this clause is not conditional based
 112.14 on the primary caregiver participating in an authorized activity under section 119B.07 or
 112.15 119B.11. Medical appointments, treatment, or therapy are considered authorized activities
 112.16 for participants in this category;

112.17 (8) families who are participating in programs as required in tribal contracts under
 112.18 section 119B.02, subdivision 2, or 256.01, subdivision 2; and

112.19 ~~(8)~~ (9) families who are participating in the transition year extension under section
 112.20 119B.011, subdivision 20a.

112.21 Sec. 2. Minnesota Statutes 2012, section 119B.13, subdivision 1, is amended to read:

112.22 Subdivision 1. **Subsidy restrictions.** (a) ~~Beginning October 31, 2011~~ July 1, 2014,
 112.23 the maximum rate paid for child care assistance in any county or multicounty region under
 112.24 the child care fund shall be the rate for like-care arrangements in the county effective July
 112.25 1, ~~2006~~ 2012, ~~decreased~~ increased by ~~2.5~~ two percent.

112.26 (b) Biennially, beginning in 2012, the commissioner shall survey rates charged
 112.27 by child care providers in Minnesota to determine the 75th percentile for like-care
 112.28 arrangements in counties. When the commissioner determines that, using the
 112.29 commissioner's established protocol, the number of providers responding to the survey is
 112.30 too small to determine the 75th percentile rate for like-care arrangements in a county or
 112.31 multicounty region, the commissioner may establish the 75th percentile maximum rate
 112.32 based on like-care arrangements in a county, region, or category that the commissioner
 112.33 deems to be similar.

113.1 (c) A rate which includes a special needs rate paid under subdivision 3 or under a
113.2 school readiness service agreement paid under section 119B.231, may be in excess of the
113.3 maximum rate allowed under this subdivision.

113.4 (d) The department shall monitor the effect of this paragraph on provider rates. The
113.5 county shall pay the provider's full charges for every child in care up to the maximum
113.6 established. The commissioner shall determine the maximum rate for each type of care
113.7 on an hourly, full-day, and weekly basis, including special needs and disability care. The
113.8 maximum payment to a provider for one day of care must not exceed the daily rate. The
113.9 maximum payment to a provider for one week of care must not exceed the weekly rate.

113.10 (e) Child care providers receiving reimbursement under this chapter must not be
113.11 paid activity fees or an additional amount above the maximum rates for care provided
113.12 during nonstandard hours for families receiving assistance.

113.13 (f) When the provider charge is greater than the maximum provider rate allowed,
113.14 the parent is responsible for payment of the difference in the rates in addition to any
113.15 family co-payment fee.

113.16 (g) All maximum provider rates changes shall be implemented on the Monday
113.17 following the effective date of the maximum provider rate.

113.18 Sec. 3. Minnesota Statutes 2012, section 119B.13, subdivision 7, is amended to read:

113.19 Subd. 7. **Absent days.** (a) Licensed child care providers and license-exempt centers
113.20 must not be reimbursed for more than ~~ten~~ 25 full-day absent days per child, excluding
113.21 holidays, in a fiscal year, or for more than ten consecutive full-day absent days. Legal
113.22 nonlicensed family child care providers must not be reimbursed for absent days. If a child
113.23 attends for part of the time authorized to be in care in a day, but is absent for part of the
113.24 time authorized to be in care in that same day, the absent time must be reimbursed but the
113.25 time must not count toward the ~~ten~~ 25 absent ~~day~~ days limit. Child care providers must
113.26 only be reimbursed for absent days if the provider has a written policy for child absences
113.27 and charges all other families in care for similar absences.

113.28 (b) Notwithstanding paragraph (a), children in families may exceed the ~~ten~~ 25 absent
113.29 days limit if at least one parent: (1) is under the age of 21; (2) does not have a high school
113.30 or general equivalency diploma; and (3) is a student in a school district or another similar
113.31 program that provides or arranges for child care, parenting support, social services, career
113.32 and employment supports, and academic support to achieve high school graduation, upon
113.33 request of the program and approval of the county. If a child attends part of an authorized
113.34 day, payment to the provider must be for the full amount of care authorized for that day.

114.1 (c) Child care providers must be reimbursed for up to ten federal or state holidays or
114.2 designated holidays per year when the provider charges all families for these days and the
114.3 holiday or designated holiday falls on a day when the child is authorized to be in attendance.
114.4 Parents may substitute other cultural or religious holidays for the ten recognized state and
114.5 federal holidays. Holidays do not count toward the ~~ten~~ 25 absent ~~day~~ days limit.

114.6 (d) A family or child care provider must not be assessed an overpayment for an
114.7 absent day payment unless (1) there was an error in the amount of care authorized for the
114.8 family, (2) all of the allowed full-day absent payments for the child have been paid, or (3)
114.9 the family or provider did not timely report a change as required under law.

114.10 (e) The provider and family shall receive notification of the number of absent days
114.11 used upon initial provider authorization for a family and ongoing notification of the
114.12 number of absent days used as of the date of the notification.

114.13 Sec. 4. Minnesota Statutes 2012, section 245A.07, subdivision 2a, is amended to read:

114.14 Subd. 2a. **Immediate suspension expedited hearing.** (a) Within five working days
114.15 of receipt of the license holder's timely appeal, the commissioner shall request assignment
114.16 of an administrative law judge. The request must include a proposed date, time, and place
114.17 of a hearing. A hearing must be conducted by an administrative law judge within 30
114.18 calendar days of the request for assignment, unless an extension is requested by either
114.19 party and granted by the administrative law judge for good cause. The commissioner shall
114.20 issue a notice of hearing by certified mail or personal service at least ten working days
114.21 before the hearing. The scope of the hearing shall be limited solely to the issue of whether
114.22 the temporary immediate suspension should remain in effect pending the commissioner's
114.23 final order under section 245A.08, regarding a licensing sanction issued under subdivision
114.24 3 following the immediate suspension. The burden of proof in expedited hearings under
114.25 this subdivision shall be limited to the commissioner's demonstration that reasonable
114.26 cause exists to believe that the license holder's actions or failure to comply with applicable
114.27 law or rule poses, or if the actions of other individuals or conditions in the program
114.28 poses an imminent risk of harm to the health, safety, or rights of persons served by the
114.29 program. "Reasonable cause" means there exist specific articulable facts or circumstances
114.30 which provide the commissioner with a reasonable suspicion that there is an imminent
114.31 risk of harm to the health, safety, or rights of persons served by the program. When the
114.32 commissioner has determined there is reasonable cause to order the temporary immediate
114.33 suspension of a license based on a violation of safe sleep requirements, as defined in
114.34 section 245A.1435, the commissioner is not required to demonstrate that an infant died or
114.35 was injured as a result of the safe sleep violations.

115.1 (b) The administrative law judge shall issue findings of fact, conclusions, and a
 115.2 recommendation within ten working days from the date of hearing. The parties shall have
 115.3 ten calendar days to submit exceptions to the administrative law judge's report. The
 115.4 record shall close at the end of the ten-day period for submission of exceptions. The
 115.5 commissioner's final order shall be issued within ten working days from the close of the
 115.6 record. Within 90 calendar days after a final order affirming an immediate suspension, the
 115.7 commissioner shall make a determination regarding whether a final licensing sanction
 115.8 shall be issued under subdivision 3. The license holder shall continue to be prohibited
 115.9 from operation of the program during this 90-day period.

115.10 (c) When the final order under paragraph (b) affirms an immediate suspension, and a
 115.11 final licensing sanction is issued under subdivision 3 and the license holder appeals that
 115.12 sanction, the license holder continues to be prohibited from operation of the program
 115.13 pending a final commissioner's order under section 245A.08, subdivision 5, regarding the
 115.14 final licensing sanction.

115.15 Sec. 5. Minnesota Statutes 2012, section 245A.1435, is amended to read:

115.16 **245A.1435 REDUCTION OF RISK OF SUDDEN UNEXPECTED INFANT**
 115.17 **DEATH SYNDROME IN LICENSED PROGRAMS.**

115.18 (a) When a license holder is placing an infant to sleep, the license holder must
 115.19 place the infant on the infant's back, unless the license holder has documentation from
 115.20 the infant's parent physician directing an alternative sleeping position for the infant. The
 115.21 parent physician directive must be on a form approved by the commissioner and must
 115.22 ~~include a statement that the parent or legal guardian has read the information provided by~~
 115.23 ~~the Minnesota Sudden Infant Death Center, related to the risk of SIDS and the importance~~
 115.24 ~~of placing an infant or child on its back to sleep to reduce the risk of SIDS.~~ remain on file
 115.25 at the licensed location. An infant who independently rolls onto its stomach after being
 115.26 placed to sleep on its back may be allowed to remain sleeping on its stomach if the infant
 115.27 is at least six months of age or the license holder has a signed statement from the parent
 115.28 indicating that the infant regularly rolls over at home.

115.29 (b) ~~The license holder must place the infant in a crib directly on a firm mattress with~~
 115.30 ~~a fitted crib sheet that fits tightly on the mattress and overlaps the mattress so it cannot be~~
 115.31 ~~dislodged by pulling on the corner of the sheet. The license holder must not place pillows,~~
 115.32 ~~quilts, comforters, sheepskin, pillow-like stuffed toys, or other soft products in the crib~~
 115.33 ~~with the infant~~ The license holder must place the infant in a crib directly on a firm mattress
 115.34 with a fitted sheet that is appropriate to the mattress size, that fits tightly on the mattress,
 115.35 and overlaps the underside of the mattress so it cannot be dislodged by pulling on the corner

116.1 of the sheet with reasonable effort. The license holder must not place anything in the crib
 116.2 with the infant except for the infant's pacifier. The requirements of this section apply to
 116.3 license holders serving infants up to and including 12 months younger than one year of age.
 116.4 Licensed child care providers must meet the crib requirements under section 245A.146.

116.5 (c) If an infant falls asleep before being placed in a crib, the license holder must
 116.6 move the infant to a crib as soon as practicable, and must keep the infant within sight of
 116.7 the license holder until the infant is placed in a crib. When an infant falls asleep while
 116.8 being held, the license holder must consider the supervision needs of other children in
 116.9 care when determining how long to hold the infant before placing the infant in a crib to
 116.10 sleep. The sleeping infant must not be in a position where the airway may be blocked or
 116.11 with anything covering the infant's face.

116.12 (d) Placing a swaddled infant down to sleep in a licensed setting is not recommended
 116.13 for an infant of any age and is prohibited for any infant who has begun to roll over
 116.14 independently. However, with the written consent of a parent or guardian according to this
 116.15 paragraph, a license holder may place the infant who has not yet begun to roll over on its
 116.16 own down to sleep in a one-piece sleeper equipped with an attached system that fastens
 116.17 securely only across the upper torso, with no constriction of the hips or legs, to create a
 116.18 swaddle. Prior to any use of swaddling for sleep by a provider licensed under this chapter,
 116.19 the license holder must obtain informed written consent for the use of swaddling from the
 116.20 parent or guardian of the infant on a form provided by the commissioner and prepared in
 116.21 partnership with the Minnesota Sudden Infant Death Center.

116.22 Sec. 6. Minnesota Statutes 2012, section 245A.144, is amended to read:

116.23 **245A.144 TRAINING ON RISK OF SUDDEN UNEXPECTED INFANT**
 116.24 **DEATH AND SHAKEN-BABY SYNDROME ABUSIVE HEAD TRAUMA FOR**
 116.25 **CHILD FOSTER CARE PROVIDERS.**

116.26 (a) Licensed child foster care providers that care for infants or children through five
 116.27 years of age must document that before staff persons and caregivers assist in the care
 116.28 of infants or children through five years of age, they are instructed on the standards in
 116.29 section 245A.1435 and receive training on reducing the risk of sudden unexpected infant
 116.30 death syndrome and shaken-baby syndrome for abusive head trauma from shaking infants
 116.31 and young children. This section does not apply to emergency relative placement under
 116.32 section 245A.035. The training on reducing the risk of sudden unexpected infant death
 116.33 syndrome and shaken-baby syndrome abusive head trauma may be provided as:

116.34 (1) orientation training to child foster care providers, who care for infants or children
 116.35 through five years of age, under Minnesota Rules, part 2960.3070, subpart 1; or

117.1 (2) in-service training to child foster care providers, who care for infants or children
117.2 through five years of age, under Minnesota Rules, part 2960.3070, subpart 2.

117.3 (b) Training required under this section must be at least one hour in length and must
117.4 be completed at least once every five years. At a minimum, the training must address
117.5 the risk factors related to sudden unexpected infant death ~~syndrome~~ and ~~shaken-baby~~
117.6 ~~syndrome~~ abusive head trauma, means of reducing the risk of sudden unexpected infant
117.7 death ~~syndrome~~ and ~~shaken-baby-syndrome~~ abusive head trauma, and license holder
117.8 communication with parents regarding reducing the risk of sudden unexpected infant
117.9 death ~~syndrome~~ and ~~shaken-baby-syndrome~~ abusive head trauma.

117.10 (c) Training for child foster care providers must be approved by the county or
117.11 private licensing agency that is responsible for monitoring the child foster care provider
117.12 under section 245A.16. The approved training fulfills, in part, training required under
117.13 Minnesota Rules, part 2960.3070.

117.14 Sec. 7. Minnesota Statutes 2012, section 245A.1444, is amended to read:

117.15 **245A.1444 TRAINING ON RISK OF SUDDEN UNEXPECTED INFANT**
117.16 **~~DEATH SYNDROME~~ AND ~~SHAKEN-BABY SYNDROME~~ ABUSIVE HEAD**
117.17 **TRAUMA BY OTHER PROGRAMS.**

117.18 A licensed chemical dependency treatment program that serves clients with infants
117.19 or children through five years of age, who sleep at the program and a licensed children's
117.20 residential facility that serves infants or children through five years of age, must document
117.21 that before program staff persons or volunteers assist in the care of infants or children
117.22 through five years of age, they are instructed on the standards in section 245A.1435 and
117.23 receive training on reducing the risk of sudden unexpected infant death ~~syndrome~~ and
117.24 ~~shaken-baby-syndrome~~ abusive head trauma from shaking infants and young children. The
117.25 training conducted under this section may be used to fulfill training requirements under
117.26 Minnesota Rules, parts 2960.0100, subpart 3; and 9530.6490, subpart 4, item B.

117.27 This section does not apply to child care centers or family child care programs
117.28 governed by sections 245A.40 and 245A.50.

117.29 Sec. 8. **[245A.1446] FAMILY CHILD CARE DIAPERING AREA**
117.30 **DISINFECTION.**

117.31 Notwithstanding Minnesota Rules, part 9502.0435, a family child care provider may
117.32 disinfect the diaper changing surface with either a solution of at least two teaspoons
117.33 of chlorine bleach to one quart of water or with a surface disinfectant that meets the
117.34 following criteria:

118.1 (1) the manufacturer's label or instructions state that the product is registered with
 118.2 the United States Environmental Protection Agency;

118.3 (2) the manufacturer's label or instructions state that the disinfectant is effective
 118.4 against Staphylococcus aureus, Salmonella choleraesuis, and Pseudomonas aeruginosa;

118.5 (3) the manufacturer's label or instructions state that the disinfectant is effective with
 118.6 a ten minute or less contact time;

118.7 (4) the disinfectant is clearly labeled by the manufacturer with directions for mixing
 118.8 and use;

118.9 (5) the disinfectant is used only in accordance with the manufacturer's directions; and

118.10 (6) the product does not include triclosan or derivatives of triclosan.

118.11 **Sec. 9. [245A.147] FAMILY CHILD CARE INFANT SLEEP SUPERVISION**
 118.12 **REQUIREMENTS.**

118.13 Subdivision 1. **In-person checks on infants.** (a) License holders that serve infants
 118.14 are encouraged to monitor sleeping infants by conducting in-person checks on each infant
 118.15 in their care every 30 minutes.

118.16 (b) Upon enrollment of an infant in a family child care program, the license holder is
 118.17 encouraged to conduct in-person checks on the sleeping infant every 15 minutes, during
 118.18 the first four months of care.

118.19 (c) When an infant has an upper respiratory infection, the license holder is
 118.20 encouraged to conduct in-person checks on the sleeping infant every 15 minutes
 118.21 throughout the hours of sleep.

118.22 Subd. 2. **Use of audio or visual monitoring devices.** In addition to conducting
 118.23 the in-person checks encouraged under subdivision 1, license holders serving infants are
 118.24 encouraged to use and maintain an audio or visual monitoring device to monitor each
 118.25 sleeping infant in care during all hours of sleep.

118.26 **Sec. 10. [245A.152] CHILD CARE LICENSE HOLDER INSURANCE.**

118.27 (a) A license holder must provide a written notice to all parents or guardians of all
 118.28 children to be accepted for care prior to admission stating whether the license holder has
 118.29 liability insurance. This notice may be incorporated into and provided on the admission
 118.30 form used by the license holder.

118.31 (b) If the license holder has liability insurance:

118.32 (1) the license holder shall inform parents in writing that a current certificate of
 118.33 coverage for insurance is available for inspection to all parents or guardians of children
 118.34 receiving services and to all parents seeking services from the family child care program;

119.1 (2) the notice must provide the parent or guardian with the date of expiration or
 119.2 next renewal of the policy; and

119.3 (3) upon the expiration date of the policy, the license holder must provide a new
 119.4 written notice indicating whether the insurance policy has lapsed or whether the license
 119.5 holder has renewed the policy.

119.6 If the policy was renewed, the license holder must provide the new expiration date of the
 119.7 policy in writing to the parents or guardians.

119.8 (c) If the license holder does not have liability insurance, the license holder must
 119.9 provide an annual notice on a form developed and made available by the commissioner,
 119.10 to the parents or guardians of children in care indicating that the license holder does not
 119.11 carry liability insurance.

119.12 (d) The license holder must notify all parents and guardians in writing immediately
 119.13 of any change in insurance status.

119.14 (e) The license holder must make available upon request the certificate of liability
 119.15 insurance to the parents of children in care, to the commissioner, and to county licensing
 119.16 agents.

119.17 (f) The license holder must document, with the signature of the parent or guardian,
 119.18 that the parent or guardian received the notices required by this section.

119.19 Sec. 11. Minnesota Statutes 2012, section 245A.40, subdivision 5, is amended to read:

119.20 Subd. 5. **Sudden unexpected infant death syndrome and ~~shaken baby syndrome~~**
 119.21 **abusive head trauma training.** (a) License holders must document that before staff
 119.22 persons and volunteers care for infants, they are instructed on the standards in section
 119.23 245A.1435 and receive training on reducing the risk of sudden unexpected infant death
 119.24 ~~syndrome~~. In addition, license holders must document that before staff persons care for
 119.25 infants or children under school age, they receive training on the risk of ~~shaken baby~~
 119.26 ~~syndrome~~ abusive head trauma from shaking infants and young children. The training
 119.27 in this subdivision may be provided as orientation training under subdivision 1 and
 119.28 in-service training under subdivision 7.

119.29 (b) Sudden unexpected infant death ~~syndrome~~ reduction training required under
 119.30 this subdivision must be at least one-half hour in length and must be completed at least
 119.31 once every ~~five years~~ year. At a minimum, the training must address the risk factors
 119.32 related to sudden unexpected infant death ~~syndrome~~, means of reducing the risk of sudden
 119.33 unexpected infant death ~~syndrome~~ in child care, and license holder communication with
 119.34 parents regarding reducing the risk of sudden unexpected infant death ~~syndrome~~.

120.1 (c) ~~Shaken baby syndrome~~ Abusive head trauma training under this subdivision
 120.2 must be at least one-half hour in length and must be completed at least once every ~~five~~
 120.3 ~~years~~ year. At a minimum, the training must address the risk factors related to ~~shaken~~
 120.4 ~~baby syndrome~~ for shaking infants and young children, means to reduce the risk of ~~shaken~~
 120.5 ~~baby syndrome~~ abusive head trauma in child care, and license holder communication with
 120.6 parents regarding reducing the risk of ~~shaken baby syndrome~~ abusive head trauma.

120.7 (d) The commissioner shall make available for viewing a video presentation on the
 120.8 dangers associated with shaking infants and young children. The video presentation must
 120.9 be part of the orientation and annual in-service training of licensed child care center
 120.10 staff persons caring for children under school age. The commissioner shall provide to
 120.11 child care providers and interested individuals, at cost, copies of a video approved by the
 120.12 commissioner of health under section 144.574 on the dangers associated with shaking
 120.13 infants and young children.

120.14 Sec. 12. Minnesota Statutes 2012, section 245A.50, is amended to read:

120.15 **245A.50 FAMILY CHILD CARE TRAINING REQUIREMENTS.**

120.16 Subdivision 1. **Initial training.** (a) License holders, caregivers, and substitutes must
 120.17 comply with the training requirements in this section.

120.18 (b) Helpers who assist with care on a regular basis must complete six hours of
 120.19 training within one year after the date of initial employment.

120.20 Subd. 2. **Child growth and development and behavior guidance training.** (a) For
 120.21 purposes of family and group family child care, the license holder and each adult caregiver
 120.22 who provides care in the licensed setting for more than 30 days in any 12-month period
 120.23 shall complete and document at least ~~two~~ four hours of child growth and development
 120.24 and behavior guidance training within the first year of prior to initial licensure, and before
 120.25 caring for children. For purposes of this subdivision, "child growth and development
 120.26 training" means training in understanding how children acquire language and develop
 120.27 physically, cognitively, emotionally, and socially. "Behavior guidance training" means
 120.28 training in the understanding of the functions of child behavior and strategies for managing
 120.29 challenging situations. Child growth and development and behavior guidance training
 120.30 must be repeated annually. Training curriculum shall be developed or approved by the
 120.31 commissioner of human services by January 1, 2014.

120.32 (b) Notwithstanding paragraph (a), individuals are exempt from this requirement if
 120.33 they:

120.34 (1) have taken a three-credit course on early childhood development within the
 120.35 past five years;

121.1 (2) have received a baccalaureate or master's degree in early childhood education or
 121.2 school-age child care within the past five years;

121.3 (3) are licensed in Minnesota as a prekindergarten teacher, an early childhood
 121.4 educator, a kindergarten to grade 6 teacher with a prekindergarten specialty, an early
 121.5 childhood special education teacher, or an elementary teacher with a kindergarten
 121.6 endorsement; or

121.7 (4) have received a baccalaureate degree with a Montessori certificate within the
 121.8 past five years.

121.9 Subd. 3. **First aid.** (a) When children are present in a family child care home
 121.10 governed by Minnesota Rules, parts 9502.0315 to 9502.0445, at least one staff person
 121.11 must be present in the home who has been trained in first aid. The first aid training must
 121.12 have been provided by an individual approved to provide first aid instruction. First aid
 121.13 training may be less than eight hours and persons qualified to provide first aid training
 121.14 include individuals approved as first aid instructors. First aid training must be repeated
 121.15 every two years.

121.16 (b) A family child care provider is exempt from the first aid training requirements
 121.17 under this subdivision related to any substitute caregiver who provides less than 30 hours
 121.18 of care during any 12-month period.

121.19 (c) Video training reviewed and approved by the county licensing agency satisfies
 121.20 the training requirement of this subdivision.

121.21 Subd. 4. **Cardiopulmonary resuscitation.** (a) When children are present in a family
 121.22 child care home governed by Minnesota Rules, parts 9502.0315 to 9502.0445, at least
 121.23 one staff person must be present in the home who has been trained in cardiopulmonary
 121.24 resuscitation (CPR) and in the treatment of obstructed airways that includes CPR
 121.25 techniques for infants and children. The CPR training must have been provided by an
 121.26 individual approved to provide CPR instruction, must be repeated at least once every ~~three~~
 121.27 two years, and must be documented in the staff person's records.

121.28 (b) A family child care provider is exempt from the CPR training requirement in
 121.29 this subdivision related to any substitute caregiver who provides less than 30 hours of
 121.30 care during any 12-month period.

121.31 ~~(c) Video training reviewed and approved by the county licensing agency satisfies~~
 121.32 ~~the training requirement of this subdivision.~~ Persons providing CPR training must use
 121.33 CPR training that has been developed:

121.34 (1) by the American Heart Association or the American Red Cross and incorporates
 121.35 psychomotor skills to support the instruction; or

122.1 (2) using nationally recognized, evidence-based guidelines for CPR training and
 122.2 incorporates psychomotor skills to support the instruction.

122.3 Subd. 5. **Sudden unexpected infant death syndrome and ~~shaken baby syndrome~~**
 122.4 **abusive head trauma training.** (a) License holders must document that before staff
 122.5 persons, caregivers, and helpers assist in the care of infants, they are instructed on the
 122.6 standards in section 245A.1435 and receive training on reducing the risk of sudden
 122.7 unexpected infant death syndrome. In addition, license holders must document that before
 122.8 staff persons, caregivers, and helpers assist in the care of infants and children under
 122.9 school age, they receive training on reducing the risk of ~~shaken baby syndrome~~ abusive
 122.10 head trauma from shaking infants and young children. The training in this subdivision
 122.11 may be provided as initial training under subdivision 1 or ongoing annual training under
 122.12 subdivision 7.

122.13 (b) Sudden unexpected infant death syndrome reduction training required under this
 122.14 subdivision must be at least one-half hour in length and must be completed in person
 122.15 at least once every five years two years. On the years when the license holder is not
 122.16 receiving the in-person training on sudden unexpected infant death reduction, the license
 122.17 holder must receive sudden unexpected infant death reduction training through a video
 122.18 of no more than one hour in length developed or approved by the commissioner. At a
 122.19 minimum, the training must address the risk factors related to sudden unexpected infant
 122.20 death syndrome, means of reducing the risk of sudden unexpected infant death syndrome
 122.21 in child care, and license holder communication with parents regarding reducing the risk
 122.22 of sudden unexpected infant death syndrome.

122.23 (c) ~~Shaken baby syndrome~~ Abusive head trauma training required under this
 122.24 subdivision must be at least one-half hour in length and must be completed at least once
 122.25 every ~~five years~~ year. At a minimum, the training must address the risk factors related
 122.26 to ~~shaken baby syndrome~~ shaking infants and young children, means of reducing the
 122.27 risk of ~~shaken baby syndrome~~ abusive head trauma in child care, and license holder
 122.28 communication with parents regarding reducing the risk of ~~shaken baby syndrome~~ abusive
 122.29 head trauma.

122.30 (d) Training for family and group family child care providers must be developed
 122.31 by the commissioner in conjunction with the Minnesota Sudden Infant Death Center
 122.32 and approved by the county licensing agency by the Minnesota Center for Professional
 122.33 Development.

122.34 (e) ~~The commissioner shall make available for viewing by all licensed child care~~
 122.35 ~~providers a video presentation on the dangers associated with shaking infants and young~~
 122.36 ~~children. The video presentation shall be part of the initial and ongoing annual training of~~

123.1 ~~licensed child care providers, caregivers, and helpers caring for children under school age.~~
123.2 ~~The commissioner shall provide to child care providers and interested individuals, at cost,~~
123.3 ~~copies of a video approved by the commissioner of health under section 144.574 on the~~
123.4 ~~dangers associated with shaking infants and young children.~~

123.5 Subd. 6. **Child passenger restraint systems; training requirement.** (a) A license
123.6 holder must comply with all seat belt and child passenger restraint system requirements
123.7 under section 169.685.

123.8 (b) Family and group family child care programs licensed by the Department of
123.9 Human Services that serve a child or children under nine years of age must document
123.10 training that fulfills the requirements in this subdivision.

123.11 (1) Before a license holder, staff person, caregiver, or helper transports a child or
123.12 children under age nine in a motor vehicle, the person placing the child or children in a
123.13 passenger restraint must satisfactorily complete training on the proper use and installation
123.14 of child restraint systems in motor vehicles. Training completed under this subdivision may
123.15 be used to meet initial training under subdivision 1 or ongoing training under subdivision 7.

123.16 (2) Training required under this subdivision must be at least one hour in length,
123.17 completed at initial training, and repeated at least once every five years. At a minimum,
123.18 the training must address the proper use of child restraint systems based on the child's
123.19 size, weight, and age, and the proper installation of a car seat or booster seat in the motor
123.20 vehicle used by the license holder to transport the child or children.

123.21 (3) Training under this subdivision must be provided by individuals who are certified
123.22 and approved by the Department of Public Safety, Office of Traffic Safety. License holders
123.23 may obtain a list of certified and approved trainers through the Department of Public
123.24 Safety Web site or by contacting the agency.

123.25 (c) Child care providers that only transport school-age children as defined in section
123.26 245A.02, subdivision 19, paragraph (f), in child care buses as defined in section 169.448,
123.27 subdivision 1, paragraph (e), are exempt from this subdivision.

123.28 Subd. 7. **Training requirements for family and group family child care.** For
123.29 purposes of family and group family child care, the license holder and each primary
123.30 caregiver must complete ~~eight~~ 16 hours of ongoing training each year. For purposes
123.31 of this subdivision, a primary caregiver is an adult caregiver who provides services in
123.32 the licensed setting for more than 30 days in any 12-month period. Repeat of topical
123.33 training requirements in subdivisions 2 to 8 shall count toward the annual 16-hour training
123.34 requirement. Additional ongoing training subjects to meet the annual 16-hour training
123.35 requirement must be selected from the following areas:

124.1 (1) "child growth and development training" ~~has the meaning given in~~ under
 124.2 subdivision 2, paragraph (a);

124.3 (2) "learning environment and curriculum" ~~includes,~~ including training in
 124.4 establishing an environment and providing activities that provide learning experiences to
 124.5 meet each child's needs, capabilities, and interests;

124.6 (3) "assessment and planning for individual needs" ~~includes,~~ including training in
 124.7 observing and assessing what children know and can do in order to provide curriculum
 124.8 and instruction that addresses their developmental and learning needs, including children
 124.9 with special needs and bilingual children or children for whom English is not their
 124.10 primary language;

124.11 (4) "interactions with children" ~~includes,~~ including training in establishing
 124.12 supportive relationships with children, guiding them as individuals and as part of a group;

124.13 (5) "families and communities" ~~includes,~~ including training in working
 124.14 collaboratively with families and agencies or organizations to meet children's needs and to
 124.15 encourage the community's involvement;

124.16 (6) "health, safety, and nutrition" ~~includes,~~ including training in establishing and
 124.17 maintaining an environment that ensures children's health, safety, and nourishment,
 124.18 including child abuse, maltreatment, prevention, and reporting; home and fire safety; child
 124.19 injury prevention; communicable disease prevention and control; first aid; and CPR; ~~and~~

124.20 (7) "program planning and evaluation" ~~includes,~~ including training in establishing,
 124.21 implementing, evaluating, and enhancing program operations; and

124.22 (8) behavior guidance, including training in the understanding of the functions of
 124.23 child behavior and strategies for managing behavior.

124.24 Subd. 8. **Other required training requirements.** (a) The training required of
 124.25 family and group family child care providers and staff must include training in the cultural
 124.26 dynamics of early childhood development and child care. The cultural dynamics and
 124.27 disabilities training and skills development of child care providers must be designed to
 124.28 achieve outcomes for providers of child care that include, but are not limited to:

124.29 (1) an understanding and support of the importance of culture and differences in
 124.30 ability in children's identity development;

124.31 (2) understanding the importance of awareness of cultural differences and
 124.32 similarities in working with children and their families;

124.33 (3) understanding and support of the needs of families and children with differences
 124.34 in ability;

124.35 (4) developing skills to help children develop unbiased attitudes about cultural
 124.36 differences and differences in ability;

125.1 (5) developing skills in culturally appropriate caregiving; and

125.2 (6) developing skills in appropriate caregiving for children of different abilities.

125.3 The commissioner shall approve the curriculum for cultural dynamics and disability
125.4 training.

125.5 (b) The provider must meet the training requirement in section 245A.14, subdivision
125.6 11, paragraph (a), clause (4), to be eligible to allow a child cared for at the family child
125.7 care or group family child care home to use the swimming pool located at the home.

125.8 Subd. 9. **Supervising for safety; training requirement.** Effective July 1, 2014,
125.9 all family child care license holders and each adult caregiver who provides care in the
125.10 licensed family child care home for more than 30 days in any 12-month period shall
125.11 complete and document at least six hours approved training on supervising for safety
125.12 prior to initial licensure, and before caring for children. At least two hours of training
125.13 on supervising for safety must be repeated annually. For purposes of this subdivision,
125.14 "supervising for safety" includes supervision basics, supervision outdoors, equipment and
125.15 materials, illness, injuries, and disaster preparedness. The commissioner shall develop
125.16 the supervising for safety curriculum by January 1, 2014.

125.17 Subd. 10. **Approved training.** (a) County licensing staff must accept training
125.18 approved by the Minnesota Center for Professional Development, including:

125.19 (1) face-to-face or classroom training;

125.20 (2) online training; and

125.21 (3) relationship-based professional development, such as mentoring, coaching,
125.22 and consulting.

125.23 (b) New and increased training requirements under this section must not be imposed
125.24 on providers until the commissioner establishes statewide accessibility to the required
125.25 provider training.

125.26 Sec. 13. Minnesota Statutes 2012, section 252.27, subdivision 2a, is amended to read:

125.27 Subd. 2a. **Contribution amount.** (a) The natural or adoptive parents of a minor
125.28 child, including a child determined eligible for medical assistance without consideration of
125.29 parental income, must contribute to the cost of services used by making monthly payments
125.30 on a sliding scale based on income, unless the child is married or has been married, parental
125.31 rights have been terminated, or the child's adoption is subsidized according to section
125.32 259.67 or through title IV-E of the Social Security Act. The parental contribution is a partial
125.33 or full payment for medical services provided for diagnostic, therapeutic, curing, treating,
125.34 mitigating, rehabilitation, maintenance, and personal care services as defined in United
125.35 States Code, title 26, section 213, needed by the child with a chronic illness or disability.

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

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

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

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

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

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

126.25 If the child lives with the parent, the annual adjusted gross income is reduced by
126.26 \$2,400 prior to calculating the parental contribution. If the child resides in an institution
126.27 specified in section 256B.35, the parent is responsible for the personal needs allowance
126.28 specified under that section in addition to the parental contribution determined under this
126.29 section. The parental contribution is reduced by any amount required to be paid directly to
126.30 the child pursuant to a court order, but only if actually paid.

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

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

127.5 (e) The contribution shall be explained in writing to the parents at the time eligibility
127.6 for services is being determined. The contribution shall be made on a monthly basis
127.7 effective with the first month in which the child receives services. Annually upon
127.8 redetermination or at termination of eligibility, if the contribution exceeded the cost of
127.9 services provided, the local agency or the state shall reimburse that excess amount to
127.10 the parents, either by direct reimbursement if the parent is no longer required to pay a
127.11 contribution, or by a reduction in or waiver of parental fees until the excess amount is
127.12 exhausted. All reimbursements must include a notice that the amount reimbursed may be
127.13 taxable income if the parent paid for the parent's fees through an employer's health care
127.14 flexible spending account under the Internal Revenue Code, section 125, and that the
127.15 parent is responsible for paying the taxes owed on the amount reimbursed.

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

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

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

127.34 Parents who have more than one child receiving services shall not be required
127.35 to pay more than the amount for the child with the highest expenditures. There shall
127.36 be no resource contribution from the parents. The parent shall not be required to pay

128.1 a contribution in excess of the cost of the services provided to the child, not counting
128.2 payments made to school districts for education-related services. Notice of an increase in
128.3 fee payment must be given at least 30 days before the increased fee is due.

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

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

128.7 (2) the insurer denied insurance;

128.8 (3) the parents submitted a complaint or appeal, in writing to the insurer, submitted
128.9 a complaint or appeal, in writing, to the commissioner of health or the commissioner of
128.10 commerce, or litigated the complaint or appeal; and

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

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

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

128.19 ~~(j) Notwithstanding paragraph (b), for the period from July 1, 2010, to June 30,~~
128.20 ~~2015, the parental contribution shall be computed by applying the following contribution~~
128.21 ~~schedule to the adjusted gross income of the natural or adoptive parents:~~

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

128.25 ~~(2) if the adjusted gross income is equal to or greater than 175 percent of federal~~
128.26 ~~poverty guidelines and less than or equal to 525 percent of federal poverty guidelines,~~
128.27 ~~the parental contribution shall be determined using a sliding fee scale established by the~~
128.28 ~~commissioner of human services which begins at one percent of adjusted gross income~~
128.29 ~~at 175 percent of federal poverty guidelines and increases to eight percent of adjusted~~
128.30 ~~gross income for those with adjusted gross income up to 525 percent of federal poverty~~
128.31 ~~guidelines;~~

128.32 ~~(3) if the adjusted gross income is greater than 525 percent of federal poverty~~
128.33 ~~guidelines and less than 675 percent of federal poverty guidelines, the parental~~
128.34 ~~contribution shall be 9.5 percent of adjusted gross income;~~

128.35 ~~(4) if the adjusted gross income is equal to or greater than 675 percent of federal~~
128.36 ~~poverty guidelines and less than 900 percent of federal poverty guidelines, the parental~~

129.1 ~~contribution shall be determined using a sliding fee scale established by the commissioner~~
 129.2 ~~of human services which begins at 9.5 percent of adjusted gross income at 675 percent of~~
 129.3 ~~federal poverty guidelines and increases to 12 percent of adjusted gross income for those~~
 129.4 ~~with adjusted gross income up to 900 percent of federal poverty guidelines; and~~

129.5 (5) ~~if the adjusted gross income is equal to or greater than 900 percent of federal~~
 129.6 ~~poverty guidelines, the parental contribution shall be 13.5 percent of adjusted gross~~
 129.7 ~~income. If the child lives with the parent, the annual adjusted gross income is reduced by~~
 129.8 ~~\$2,400 prior to calculating the parental contribution. If the child resides in an institution~~
 129.9 ~~specified in section 256B.35, the parent is responsible for the personal needs allowance~~
 129.10 ~~specified under that section in addition to the parental contribution determined under this~~
 129.11 ~~section. The parental contribution is reduced by any amount required to be paid directly to~~
 129.12 ~~the child pursuant to a court order, but only if actually paid.~~

129.13 Sec. 14. Minnesota Statutes 2012, section 256.82, subdivision 3, is amended to read:

129.14 Subd. 3. **Setting foster care standard rates.** The commissioner shall annually
 129.15 establish minimum standard maintenance rates for foster care maintenance and difficulty
 129.16 of care payments for all children in foster care. Any increase in rates shall in no case
 129.17 exceed three percent per annum. The foster care rates in effect on January 1, 2013, shall
 129.18 remain in effect until December 13, 2015.

129.19 Sec. 15. Minnesota Statutes 2012, section 256J.08, subdivision 24, is amended to read:

129.20 Subd. 24. **Disregard.** "Disregard" means earned income that is not counted ~~when~~
 129.21 ~~determining initial eligibility in the initial income test in section 256J.21, subdivision 3,~~
 129.22 ~~or income that is not counted when determining ongoing eligibility and calculating the~~
 129.23 ~~amount of the assistance payment for participants. The commissioner shall determine~~
 129.24 ~~the amount of the disregard according to section 256J.24, subdivision 10 for ongoing~~
 129.25 ~~eligibility shall be 50 percent of gross earned income.~~

129.26 **EFFECTIVE DATE.** This section is effective October 1, 2013, or upon approval
 129.27 from the United States Department of Agriculture, whichever is later.

129.28 Sec. 16. Minnesota Statutes 2012, section 256J.21, subdivision 3, is amended to read:

129.29 Subd. 3. **Initial income test.** The county agency shall determine initial eligibility
 129.30 by considering all earned and unearned income that is not excluded under subdivision 2.
 129.31 To be eligible for MFIP, the assistance unit's countable income minus the disregards in
 129.32 paragraphs (a) and (b) must be below the ~~transitional standard of assistance~~ family wage
 129.33 level according to section 256J.24 for that size assistance unit.

130.1 (a) The initial eligibility determination must disregard the following items:

130.2 (1) the employment disregard is 18 percent of the gross earned income whether or
130.3 not the member is working full time or part time;

130.4 (2) dependent care costs must be deducted from gross earned income for the actual
130.5 amount paid for dependent care up to a maximum of \$200 per month for each child less
130.6 than two years of age, and \$175 per month for each child two years of age and older under
130.7 this chapter and chapter 119B;

130.8 (3) all payments made according to a court order for spousal support or the support
130.9 of children not living in the assistance unit's household shall be disregarded from the
130.10 income of the person with the legal obligation to pay support, provided that, if there has
130.11 been a change in the financial circumstances of the person with the legal obligation to pay
130.12 support since the support order was entered, the person with the legal obligation to pay
130.13 support has petitioned for a modification of the support order; and

130.14 (4) an allocation for the unmet need of an ineligible spouse or an ineligible child
130.15 under the age of 21 for whom the caregiver is financially responsible and who lives with
130.16 the caregiver according to section 256J.36.

130.17 (b) Notwithstanding paragraph (a), when determining initial eligibility for applicant
130.18 units when at least one member has received MFIP in this state within four months of
130.19 the most recent application for MFIP, apply the disregard as defined in section 256J.08,
130.20 subdivision 24, for all unit members.

130.21 After initial eligibility is established, the assistance payment calculation is based on
130.22 the monthly income test.

130.23 **EFFECTIVE DATE.** This section is effective October 1, 2013, or upon approval
130.24 from the United States Department of Agriculture, whichever is later.

130.25 Sec. 17. Minnesota Statutes 2012, section 256J.24, subdivision 5, is amended to read:

130.26 Subd. 5. **MFIP transitional standard.** The MFIP transitional standard is based
130.27 on the number of persons in the assistance unit eligible for both food and cash assistance
130.28 ~~unless the restrictions in subdivision 6 on the birth of a child apply.~~ The amount of the
130.29 transitional standard is published annually by the Department of Human Services.

130.30 **EFFECTIVE DATE.** This section is effective July 1, 2014.

130.31 Sec. 18. Minnesota Statutes 2012, section 256J.24, subdivision 5a, is amended to read:

131.1 Subd. 5a. ~~Food portion of~~ Adjustments to the MFIP transitional standard. (a)
 131.2 Effective October 1, 2015, the commissioner shall adjust the MFIP transitional standard as
 131.3 needed to reflect a onetime increase in the cash portion of 16 percent.

131.4 (b) When any adjustments are made in the Supplemental Nutrition Assistance
 131.5 Program, the commissioner shall adjust the food portion of the MFIP transitional standard
 131.6 as needed to reflect adjustments to the Supplemental Nutrition Assistance Program. The
 131.7 commissioner shall publish the transitional standard including a breakdown of the cash
 131.8 and food portions for an assistance unit of sizes one to ten in the State Register whenever
 131.9 an adjustment is made.

131.10 Sec. 19. Minnesota Statutes 2012, section 256J.24, subdivision 7, is amended to read:

131.11 Subd. 7. **Family wage level.** The family wage level is 110 percent of the transitional
 131.12 standard under subdivision 5 or 6, ~~when applicable, and is the standard used when there is~~
 131.13 ~~earned income in the assistance unit. As specified in section 256J.21.~~ If there is earned
 131.14 income in the assistance unit, earned income is subtracted from the family wage level to
 131.15 determine the amount of the assistance payment, as specified in section 256J.21. The
 131.16 assistance payment may not exceed the transitional standard under subdivision 5 or 6,
 131.17 or the shared household standard under subdivision 9, whichever is applicable, for the
 131.18 assistance unit.

131.19 **EFFECTIVE DATE.** This section is effective October 1, 2013, or upon approval
 131.20 from the United States Department of Agriculture, whichever is later.

131.21 Sec. 20. Minnesota Statutes 2012, section 256J.621, is amended to read:

131.22 **256J.621 WORK PARTICIPATION CASH BENEFITS.**

131.23 Subdivision 1. Program characteristics. (a) Effective October 1, 2009, upon
 131.24 exiting the diversionary work program (DWP) or upon terminating the Minnesota family
 131.25 investment program with earnings, a participant who is employed may be eligible for work
 131.26 participation cash benefits of \$25 per month to assist in meeting the family's basic needs
 131.27 as the participant continues to move toward self-sufficiency.

131.28 (b) To be eligible for work participation cash benefits, the participant shall not
 131.29 receive MFIP or diversionary work program assistance during the month and the
 131.30 participant or participants must meet the following work requirements:

131.31 (1) if the participant is a single caregiver and has a child under six years of age, the
 131.32 participant must be employed at least 87 hours per month;

132.1 (2) if the participant is a single caregiver and does not have a child under six years of
 132.2 age, the participant must be employed at least 130 hours per month; or

132.3 (3) if the household is a two-parent family, at least one of the parents must be
 132.4 employed 130 hours per month.

132.5 Whenever a participant exits the diversionary work program or is terminated from
 132.6 MFIP and meets the other criteria in this section, work participation cash benefits are
 132.7 available for up to 24 consecutive months.

132.8 (c) Expenditures on the program are maintenance of effort state funds under
 132.9 a separate state program for participants under paragraph (b), clauses (1) and (2).
 132.10 Expenditures for participants under paragraph (b), clause (3), are nonmaintenance of effort
 132.11 funds. Months in which a participant receives work participation cash benefits under this
 132.12 section do not count toward the participant's MFIP 60-month time limit.

132.13 Subd. 2. **Program suspension.** (a) Effective December 1, 2013, the work
 132.14 participation cash benefits program shall be suspended.

132.15 (b) The commissioner of human services may reinstate the work participation cash
 132.16 benefits program if the United States Department of Human Services determines that the
 132.17 state of Minnesota did not meet the federal TANF work participation rate and sends a
 132.18 notice of penalty to reduce Minnesota's federal TANF block grant authorized under title I
 132.19 of Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation
 132.20 Act of 1996, and under Public Law 109-171, the Deficit Reduction Act of 2005.

132.21 (c) The commissioner shall notify the chairs and ranking minority members of the
 132.22 legislative committees with jurisdiction over human services policy and finance of the
 132.23 potential penalty and the commissioner's plans to reinstate the work participation cash
 132.24 benefit program within 30 days of the date the commissioner receives notification that
 132.25 the state failed to meet the federal work participation rate.

132.26 Sec. 21. Minnesota Statutes 2012, section 256J.626, subdivision 7, is amended to read:

132.27 **Subd. 7. Performance base funds.** ~~(a) For the purpose of this section, the following~~
 132.28 ~~terms have the meanings given:~~

132.29 ~~(1) "Caseload Reduction Credit" (CRC) means the measure of how much Minnesota~~
 132.30 ~~TANF and separate state program caseload has fallen relative to federal fiscal year 2005~~
 132.31 ~~based on caseload data from October 1 to September 30.~~

132.32 ~~(2) "TANF participation rate target" means a 50 percent participation rate reduced by~~
 132.33 ~~the CRC for the previous year.~~

132.34 ~~(b) (a) For calendar year 2010~~ 2016 ~~and yearly thereafter, each county and tribe will~~
 132.35 ~~must be allocated 95 percent of their initial calendar year allocation. Allocations for~~

133.1 counties and tribes ~~will~~ must be allocated additional funds adjusted based on performance
133.2 as follows:

133.3 ~~(1) a county or tribe that achieves the TANF participation rate target or a five~~
133.4 ~~percentage point improvement over the previous year's TANF participation rate under~~
133.5 ~~section 256J.751, subdivision 2, clause (7), as averaged across 12 consecutive months for~~
133.6 ~~the most recent year for which the measurements are available, will receive an additional~~
133.7 ~~allocation equal to 2.5 percent of its initial allocation;~~

133.8 ~~(2) (1) a county or tribe that performs within or above its range of expected~~
133.9 ~~performance on the annualized three-year self-support index under section 256J.751,~~
133.10 ~~subdivision 2, clause (6), will~~ must receive an additional allocation equal to ~~2.5~~ five
133.11 percent of its initial allocation; ~~and~~

133.12 ~~(3) a county or tribe that does not achieve the TANF participation rate target or~~
133.13 ~~a five percentage point improvement over the previous year's TANF participation rate~~
133.14 ~~under section 256J.751, subdivision 2, clause (7), as averaged across 12 consecutive~~
133.15 ~~months for the most recent year for which the measurements are available, will not~~
133.16 ~~receive an additional 2.5 percent of its initial allocation until after negotiating a multiyear~~
133.17 ~~improvement plan with the commissioner; or~~

133.18 ~~(4) (2) a county or tribe that does not perform within or above~~ performs below its
133.19 range of expected performance on the annualized three-year self-support index under
133.20 section 256J.751, subdivision 2, clause (6), ~~will not receive an additional allocation equal~~
133.21 ~~to 2.5 percent of its initial allocation until after negotiating~~ for a single year, may receive
133.22 an additional allocation of up to five percent of its initial allocation. A county or tribe that
133.23 continues to perform below its range of expected performance for two consecutive years
133.24 must negotiate a multiyear improvement plan with the commissioner. If no improvement
133.25 is shown by the end of the multiyear plan, the commissioner may decrease the county's or
133.26 tribe's performance-based funds by up to five percent. The decrease must remain in effect
133.27 until the county or tribe performs within or above its range of expected performance.

133.28 ~~(e) (b) For calendar year 2009~~ 2016 and yearly thereafter, performance-based funds
133.29 for a federally approved tribal TANF program in which the state and tribe have in place a
133.30 contract under section 256.01, addressing consolidated funding, ~~will~~ must be allocated
133.31 as follows:

133.32 ~~(1) a tribe that achieves the participation rate approved in its federal TANF plan~~
133.33 ~~using the average of 12 consecutive months for the most recent year for which the~~
133.34 ~~measurements are available, will receive an additional allocation equal to 2.5 percent of~~
133.35 ~~its initial allocation; and~~

134.1 ~~(2) (1)~~ a tribe that performs ~~within or~~ above its range of expected performance on the
 134.2 annualized three-year self-support index under section 256J.751, subdivision 2, clause (6),
 134.3 ~~will~~ must receive an additional allocation equal to 2.5 percent of its initial allocation; or

134.4 ~~(3) a tribe that does not achieve the participation rate approved in its federal TANF~~
 134.5 ~~plan using the average of 12 consecutive months for the most recent year for which the~~
 134.6 ~~measurements are available, will not receive an additional allocation equal to 2.5 percent~~
 134.7 ~~of its initial allocation until after negotiating a multiyear improvement plan with the~~
 134.8 ~~commissioner; or~~

134.9 ~~(4) (2)~~ a tribe that ~~does not perform within or above~~ performs below its range of
 134.10 expected performance on the annualized three-year self-support index under section
 134.11 256J.751, subdivision 2, clause (6), ~~will not receive an additional allocation equal to 2.5~~
 134.12 ~~percent until after negotiating~~ for a single year may receive an additional allocation of up
 134.13 to five percent of its initial allocation. A county or tribe that continues to perform below
 134.14 its range of expected performance for two consecutive years must negotiate a multiyear
 134.15 improvement plan with the commissioner. If no improvement is shown by the end of the
 134.16 multiyear plan, the commissioner may decrease the tribe's performance-based funds by
 134.17 up to five percent. The decrease must remain in effect until the tribe performs within or
 134.18 above its range of expected performance.

134.19 ~~(d) (c)~~ Funds remaining unallocated after the performance-based allocations in
 134.20 ~~paragraph paragraphs (a) and (b)~~ are available to the commissioner for innovation projects
 134.21 under subdivision 5.

134.22 ~~(1) (d)~~ If available funds are insufficient to meet county and tribal allocations under
 134.23 ~~paragraph paragraphs (a) and (b)~~, the commissioner ~~may make available for allocation~~
 134.24 ~~funds that are unobligated and available from the innovation projects through the end of~~
 134.25 ~~the current biennium~~ shall proportionally prorate funds to counties and tribes that qualify
 134.26 for an additional allocation under paragraphs (a), clause (1), and (b), clause (1).

134.27 ~~(2) If after the application of clause (1) funds remain insufficient to meet county and~~
 134.28 ~~tribal allocations under paragraph (b)~~, the commissioner ~~must proportionally reduce the~~
 134.29 ~~allocation of each county and tribe with respect to their maximum allocation available~~
 134.30 ~~under paragraph (b).~~

134.31 Sec. 22. **[256J.78] TANF DEMONSTRATION PROJECTS OR WAIVER FROM**
 134.32 **FEDERAL RULES AND REGULATIONS.**

134.33 Subdivision 1. Duties of the commissioner. The commissioner of human services
 134.34 may pursue TANF demonstration projects or waivers of TANF requirements from the
 134.35 United States Department of Health and Human Services as needed to allow the state to

135.1 build a more results-oriented Minnesota Family Investment Program to better meet the
 135.2 needs of Minnesota families.

135.3 Subd. 2. Purpose. The purpose of the TANF demonstration projects or waivers is to:

135.4 (1) replace the federal TANF process measure and its complex administrative
 135.5 requirements with state-developed outcomes measures that track adult employment and
 135.6 exits from MFIP cash assistance;

135.7 (2) simplify programmatic and administrative requirements; and

135.8 (3) make other policy or programmatic changes that improve the performance of the
 135.9 program and the outcomes for participants.

135.10 Subd. 3. Report to legislature. The commissioner shall report to the members of
 135.11 the legislative committees having jurisdiction over human services issues by March 1,
 135.12 2014, regarding the progress of this waiver or demonstration project.

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

135.14 Sec. 23. Minnesota Statutes 2012, section 256K.45, is amended to read:

135.15 **256K.45 RUNAWAY AND HOMELESS YOUTH ACT.**

135.16 Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this
 135.17 section.

135.18 (b) "Commissioner" means the commissioner of human services.

135.19 (c) "Homeless youth" means a person 21 years of age or younger who is
 135.20 unaccompanied by a parent or guardian and is without shelter where appropriate care and
 135.21 supervision are available, whose parent or legal guardian is unable or unwilling to provide
 135.22 shelter and care, or who lacks a fixed, regular, and adequate nighttime residence. The
 135.23 following are not fixed, regular, or adequate nighttime residences:

135.24 (1) a supervised publicly or privately operated shelter designed to provide temporary
 135.25 living accommodations;

135.26 (2) an institution or a publicly or privately operated shelter designed to provide
 135.27 temporary living accommodations;

135.28 (3) transitional housing;

135.29 (4) a temporary placement with a peer, friend, or family member that has not offered
 135.30 permanent residence, a residential lease, or temporary lodging for more than 30 days; or

135.31 (5) a public or private place not designed for, nor ordinarily used as, a regular
 135.32 sleeping accommodation for human beings.

135.33 Homeless youth does not include persons incarcerated or otherwise detained under
 135.34 federal or state law.

136.1 (d) "Youth at risk of homelessness" means a person 21 years of age or younger
136.2 whose status or circumstances indicate a significant danger of experiencing homelessness
136.3 in the near future. Status or circumstances that indicate a significant danger may include:
136.4 (1) youth exiting out-of-home placements; (2) youth who previously were homeless; (3)
136.5 youth whose parents or primary caregivers are or were previously homeless; (4) youth
136.6 who are exposed to abuse and neglect in their homes; (5) youth who experience conflict
136.7 with parents due to chemical or alcohol dependency, mental health disabilities, or other
136.8 disabilities; and (6) runaways.

136.9 (e) "Runaway" means an unmarried child under the age of 18 years who is absent
136.10 from the home of a parent or guardian or other lawful placement without the consent of
136.11 the parent, guardian, or lawful custodian.

136.12 Subd. 2. **Homeless and runaway youth report.** The commissioner shall ~~develop a~~
136.13 ~~report for homeless youth, youth at risk of homelessness, and runaways. The report shall~~
136.14 ~~include coordination of services as defined under subdivisions 3 to 5~~ prepare a biennial
136.15 report, beginning in February 2015, which provides meaningful information to the
136.16 legislative committees having jurisdiction over the issue of homeless youth, that includes,
136.17 but is not limited to: (1) a list of the areas of the state with the greatest need for services
136.18 and housing for homeless youth, and the level and nature of the needs identified; (2) details
136.19 about grants made; (3) the distribution of funds throughout the state based on population
136.20 need; (4) follow-up information, if available, on the status of homeless youth and whether
136.21 they have stable housing two years after services are provided; and (5) any other outcomes
136.22 for populations served to determine the effectiveness of the programs and use of funding.

136.23 Subd. 3. **Street and community outreach and drop-in program.** Youth drop-in
136.24 centers must provide walk-in access to crisis intervention and ongoing supportive services
136.25 including one-to-one case management services on a self-referral basis. Street and
136.26 community outreach programs must locate, contact, and provide information, referrals,
136.27 and services to homeless youth, youth at risk of homelessness, and runaways. Information,
136.28 referrals, and services provided may include, but are not limited to:

136.29 (1) family reunification services;
136.30 (2) conflict resolution or mediation counseling;
136.31 (3) assistance in obtaining temporary emergency shelter;
136.32 (4) assistance in obtaining food, clothing, medical care, or mental health counseling;
136.33 (5) counseling regarding violence, prostitution, substance abuse, sexually transmitted
136.34 diseases, and pregnancy;
136.35 (6) referrals to other agencies that provide support services to homeless youth,
136.36 youth at risk of homelessness, and runaways;

- 137.1 (7) assistance with education, employment, and independent living skills;
 137.2 (8) aftercare services;
 137.3 (9) specialized services for highly vulnerable runaways and homeless youth,
 137.4 including teen parents, emotionally disturbed and mentally ill youth, and sexually
 137.5 exploited youth; and
 137.6 (10) homelessness prevention.

137.7 Subd. 4. **Emergency shelter program.** (a) Emergency shelter programs must
 137.8 provide homeless youth and runaways with referral and walk-in access to emergency,
 137.9 short-term residential care. The program shall provide homeless youth and runaways with
 137.10 safe, dignified shelter, including private shower facilities, beds, and at least one meal each
 137.11 day; and shall assist a runaway and homeless youth with reunification with the family or
 137.12 legal guardian when required or appropriate.

137.13 (b) The services provided at emergency shelters may include, but are not limited to:

- 137.14 (1) family reunification services;
 137.15 (2) individual, family, and group counseling;
 137.16 (3) assistance obtaining clothing;
 137.17 (4) access to medical and dental care and mental health counseling;
 137.18 (5) education and employment services;
 137.19 (6) recreational activities;
 137.20 (7) advocacy and referral services;
 137.21 (8) independent living skills training;
 137.22 (9) aftercare and follow-up services;
 137.23 (10) transportation; and
 137.24 (11) homelessness prevention.

137.25 Subd. 5. **Supportive housing and transitional living programs.** Transitional
 137.26 living programs must help homeless youth and youth at risk of homelessness to find and
 137.27 maintain safe, dignified housing. The program may also provide rental assistance and
 137.28 related supportive services, or refer youth to other organizations or agencies that provide
 137.29 such services. Services provided may include, but are not limited to:

- 137.30 (1) educational assessment and referrals to educational programs;
 137.31 (2) career planning, employment, work skill training, and independent living skills
 137.32 training;
 137.33 (3) job placement;
 137.34 (4) budgeting and money management;
 137.35 (5) assistance in securing housing appropriate to needs and income;

- 138.1 (6) counseling regarding violence, prostitution, substance abuse, sexually transmitted
 138.2 diseases, and pregnancy;
- 138.3 (7) referral for medical services or chemical dependency treatment;
- 138.4 (8) parenting skills;
- 138.5 (9) self-sufficiency support services or life skill training;
- 138.6 (10) aftercare and follow-up services; and
- 138.7 (11) homelessness prevention.

138.8 Subd. 6. **Funding.** Any Funds appropriated for this section may be expended on
 138.9 programs described under subdivisions 3 to 5, technical assistance, and capacity building.
 138.10 ~~Up to four percent of funds appropriated may be used for the purpose of monitoring and~~
 138.11 ~~evaluating runaway and homeless youth programs receiving funding under this section.~~
 138.12 ~~Funding shall be directed to meet the greatest need, with a significant share of the funding~~
 138.13 ~~focused on homeless youth providers in greater Minnesota to meet the greatest need~~
 138.14 on a statewide basis.

138.15 Sec. 24. Minnesota Statutes 2012, section 256M.40, subdivision 1, is amended to read:

138.16 Subdivision 1. **Formula.** The commissioner shall allocate state funds appropriated
 138.17 under this chapter to each county board on a calendar year basis in an amount determined
 138.18 according to the formula in paragraphs (a) to (e).

138.19 (a) For calendar years 2011 and 2012, the commissioner shall allocate available
 138.20 funds to each county in proportion to that county's share in calendar year 2010.

138.21 (b) For calendar year 2013 and each calendar year thereafter, the commissioner shall
 138.22 allocate available funds to each county as follows:

138.23 (1) 75 percent must be distributed on the basis of the county share in calendar year
 138.24 2012;

138.25 (2) five percent must be distributed on the basis of the number of persons residing in
 138.26 the county as determined by the most recent data of the state demographer;

138.27 (3) ten percent must be distributed on the basis of the number of vulnerable children
 138.28 that are subjects of reports under chapter 260C and sections 626.556 and 626.5561, and in
 138.29 the county as determined by the most recent data of the commissioner; and

138.30 (4) ten percent must be distributed on the basis of the number of vulnerable adults
 138.31 that are subjects of reports under section 626.557 in the county as determined by the most
 138.32 recent data of the commissioner.

138.33 (c) ~~For calendar year 2014, the commissioner shall allocate available funds to each~~
 138.34 ~~county as follows:~~

139.1 ~~(1) 50 percent must be distributed on the basis of the county share in calendar year~~
 139.2 ~~2012;~~

139.3 ~~(2) Ten percent must be distributed on the basis of the number of persons residing in~~
 139.4 ~~the county as determined by the most recent data of the state demographer;~~

139.5 ~~(3) 20 percent must be distributed on the basis of the number of vulnerable children~~
 139.6 ~~that are subjects of reports under chapter 260C and sections 626.556 and 626.5561, in the~~
 139.7 ~~county as determined by the most recent data of the commissioner; and~~

139.8 ~~(4) 20 percent must be distributed on the basis of the number of vulnerable adults~~
 139.9 ~~that are subjects of reports under section 626.557 in the county as determined by the~~
 139.10 ~~most recent data of the commissioner~~ The commissioner is precluded from changing the
 139.11 formula under this subdivision or recommending a change to the legislature without
 139.12 public review and input.

139.13 ~~(d) For calendar year 2015, the commissioner shall allocate available funds to each~~
 139.14 ~~county as follows:~~

139.15 ~~(1) 25 percent must be distributed on the basis of the county share in calendar year~~
 139.16 ~~2012;~~

139.17 ~~(2) 15 percent must be distributed on the basis of the number of persons residing in~~
 139.18 ~~the county as determined by the most recent data of the state demographer;~~

139.19 ~~(3) 30 percent must be distributed on the basis of the number of vulnerable children~~
 139.20 ~~that are subjects of reports under chapter 260C and sections 626.556 and 626.5561, in the~~
 139.21 ~~county as determined by the most recent data of the commissioner; and~~

139.22 ~~(4) 30 percent must be distributed on the basis of the number of vulnerable adults~~
 139.23 ~~that are subjects of reports under section 626.557 in the county as determined by the most~~
 139.24 ~~recent data of the commissioner.~~

139.25 ~~(e) For calendar year 2016 and each calendar year thereafter, the commissioner shall~~
 139.26 ~~allocate available funds to each county as follows:~~

139.27 ~~(1) 20 percent must be distributed on the basis of the number of persons residing in~~
 139.28 ~~the county as determined by the most recent data of the state demographer;~~

139.29 ~~(2) 40 percent must be distributed on the basis of the number of vulnerable children~~
 139.30 ~~that are subjects of reports under chapter 260C and sections 626.556 and 626.5561, in the~~
 139.31 ~~county as determined by the most recent data of the commissioner; and~~

139.32 ~~(3) 40 percent must be distributed on the basis of the number of vulnerable adults~~
 139.33 ~~that are subjects of reports under section 626.557 in the county as determined by the most~~
 139.34 ~~recent data of the commissioner.~~

139.35 Sec. 25. Minnesota Statutes 2012, section 257.85, subdivision 11, is amended to read:

140.1 Subd. 11. **Financial considerations.** ~~(a) Payment of relative custody assistance~~
140.2 ~~under a relative custody assistance agreement is subject to the availability of state funds~~
140.3 ~~and payments may be reduced or suspended on order of the commissioner if insufficient~~
140.4 ~~funds are available~~ Beginning July 1, 2013, relative custody assistance shall be a forecasted
140.5 program, and the commissioner, with the approval of the commissioner of management
140.6 and budget, may transfer unencumbered appropriation balances within fiscal years of
140.7 each biennium to other forecasted programs of the Department of Human Services. The
140.8 commissioner shall inform the chairs and ranking minority members of the senate Health
140.9 and Human Services Finance Division and the house of representatives Health and Human
140.10 Services Finance Committee quarterly about transfers made under this provision.

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

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

140.19 Sec. 26. Minnesota Statutes 2012, section 259A.05, subdivision 5, is amended to read:

140.20 Subd. 5. **Transfer of funds.** ~~The commissioner of human services may transfer~~
140.21 ~~funds into the adoption assistance account when a deficit in the adoption assistance~~
140.22 ~~program occurs~~ Beginning July 1, 2013, adoption assistance shall be a forecasted program
140.23 and the commissioner, with the approval of the commissioner of management and budget,
140.24 may transfer unencumbered appropriation balances within fiscal years of each biennium to
140.25 other forecasted programs of the Department of Human Services. The commissioner shall
140.26 inform the chairs and ranking minority members of the senate Health and Human Services
140.27 Finance Division and the house of representatives Health and Human Services Finance
140.28 Committee quarterly about transfers made under this provision.

140.29 Sec. 27. Minnesota Statutes 2012, section 259A.20, subdivision 4, is amended to read:

140.30 Subd. 4. **Reimbursement for special nonmedical expenses.** (a) Reimbursement
140.31 for special nonmedical expenses is available to children, except those eligible for adoption
140.32 assistance based on being an at-risk child.

140.33 (b) Reimbursements under this paragraph shall be made only after the adoptive
140.34 parent documents that the requested service was denied by the local social service agency,

141.1 community agencies, the local school district, the local public health department, the
141.2 parent's insurance provider, or the child's program. The denial must be for an eligible
141.3 service or qualified item under the program requirements of the applicable agency or
141.4 organization.

141.5 (c) Reimbursements must be previously authorized, adhere to the requirements and
141.6 procedures prescribed by the commissioner, and be limited to:

141.7 (1) child care for a child age 12 and younger, or for a child age 13 or 14 who has a
141.8 documented disability that requires special instruction for and services by the child care
141.9 provider. Child care reimbursements may be made if all available adult caregivers are
141.10 employed, unemployed due to a disability as defined in section 259A.01, subdivision 14,
141.11 or attending educational or vocational training programs. Documentation from a qualified
141.12 expert that is dated within the last 12 months must be provided to verify the disability. If a
141.13 parent is attending an educational or vocational training program, child care reimbursement
141.14 is limited to no more than the time necessary to complete the credit requirements for an
141.15 associate or baccalaureate degree as determined by the educational institution. Child
141.16 care reimbursement is not limited for an adoptive parent completing basic or remedial
141.17 education programs needed to prepare for postsecondary education or employment;

141.18 (2) respite care provided for the relief of the child's parent up to 504 hours of respite
141.19 care annually;

141.20 (3) camping up to 14 days per state fiscal year for a child to attend a special needs
141.21 camp. The camp must be accredited by the American Camp Association as a special needs
141.22 camp in order to be eligible for camp reimbursement;

141.23 (4) postadoption counseling to promote the child's integration into the adoptive
141.24 family that is provided by the placing agency during the first year following the date of the
141.25 adoption decree. Reimbursement is limited to 12 sessions of postadoption counseling;

141.26 (5) family counseling that is required to meet the child's special needs.
141.27 Reimbursement is limited to the prorated portion of the counseling fees allotted to the
141.28 family when the adoptive parent's health insurance or Medicaid pays for the child's
141.29 counseling but does not cover counseling for the rest of the family members;

141.30 (6) home modifications to accommodate the child's special needs upon which
141.31 eligibility for adoption assistance was approved. Reimbursement is limited to once every
141.32 five years per child;

141.33 (7) vehicle modifications to accommodate the child's special needs upon which
141.34 eligibility for adoption assistance was approved. Reimbursement is limited to once every
141.35 five years per family; and

142.1 (8) burial expenses up to \$1,000, if the special needs, upon which eligibility for
142.2 adoption assistance was approved, resulted in the death of the child.

142.3 (d) The adoptive parent shall submit statements for expenses incurred between July
142.4 1 and June 30 of a given fiscal year to the state adoption assistance unit within 60 days
142.5 after the end of the fiscal year in order for reimbursement to occur.

142.6 Sec. 28. Minnesota Statutes 2012, section 260B.007, subdivision 6, is amended to read:

142.7 Subd. 6. **Delinquent child.** (a) Except as otherwise provided in paragraphs (b)
142.8 and (c), "delinquent child" means a child:

142.9 (1) who has violated any state or local law, except as provided in section 260B.225,
142.10 subdivision 1, and except for juvenile offenders as described in subdivisions 16 to 18;

142.11 (2) who has violated a federal law or a law of another state and whose case has been
142.12 referred to the juvenile court if the violation would be an act of delinquency if committed
142.13 in this state or a crime or offense if committed by an adult;

142.14 (3) who has escaped from confinement to a state juvenile correctional facility after
142.15 being committed to the custody of the commissioner of corrections; or

142.16 (4) who has escaped from confinement to a local juvenile correctional facility after
142.17 being committed to the facility by the court.

142.18 (b) The term delinquent child does not include a child alleged to have committed
142.19 murder in the first degree after becoming 16 years of age, but the term delinquent child
142.20 does include a child alleged to have committed attempted murder in the first degree.

142.21 (c) The term delinquent child does not include a child ~~under the age of 16 years~~
142.22 alleged to have engaged in conduct which would, if committed by an adult, violate any
142.23 federal, state, or local law relating to being hired, offering to be hired, or agreeing to be
142.24 hired by another individual to engage in sexual penetration or sexual conduct.

142.25 **EFFECTIVE DATE.** This section is effective August 1, 2014, and applies to
142.26 offenses committed on or after that date.

142.27 Sec. 29. Minnesota Statutes 2012, section 260B.007, subdivision 16, is amended to read:

142.28 Subd. 16. **Juvenile petty offender; juvenile petty offense.** (a) "Juvenile petty
142.29 offense" includes a juvenile alcohol offense, a juvenile controlled substance offense,
142.30 a violation of section 609.685, or a violation of a local ordinance, which by its terms
142.31 prohibits conduct by a child under the age of 18 years which would be lawful conduct if
142.32 committed by an adult.

142.33 (b) Except as otherwise provided in paragraph (c), "juvenile petty offense" also
142.34 includes an offense that would be a misdemeanor if committed by an adult.

143.1 (c) "Juvenile petty offense" does not include any of the following:

143.2 (1) a misdemeanor-level violation of section 518B.01, 588.20, 609.224, 609.2242,
143.3 609.324, subdivision 2 or 3, 609.5632, 609.576, 609.66, 609.746, 609.748, 609.79,
143.4 or 617.23;

143.5 (2) a major traffic offense or an adult court traffic offense, as described in section
143.6 260B.225;

143.7 (3) a misdemeanor-level offense committed by a child whom the juvenile court
143.8 previously has found to have committed a misdemeanor, gross misdemeanor, or felony
143.9 offense; or

143.10 (4) a misdemeanor-level offense committed by a child whom the juvenile court
143.11 has found to have committed a misdemeanor-level juvenile petty offense on two or
143.12 more prior occasions, unless the county attorney designates the child on the petition
143.13 as a juvenile petty offender notwithstanding this prior record. As used in this clause,
143.14 "misdemeanor-level juvenile petty offense" includes a misdemeanor-level offense that
143.15 would have been a juvenile petty offense if it had been committed on or after July 1, 1995.

143.16 (d) A child who commits a juvenile petty offense is a "juvenile petty offender." The
143.17 term juvenile petty offender does not include a child ~~under the age of 16 years~~ alleged
143.18 to have violated any law relating to being hired, offering to be hired, or agreeing to be
143.19 hired by another individual to engage in sexual penetration or sexual conduct which, if
143.20 committed by an adult, would be a misdemeanor.

143.21 **EFFECTIVE DATE.** This section is effective August 1, 2014, and applies to
143.22 offenses committed on or after that date.

143.23 Sec. 30. Minnesota Statutes 2012, section 260C.007, subdivision 6, is amended to read:

143.24 Subd. 6. **Child in need of protection or services.** "Child in need of protection or
143.25 services" means a child who is in need of protection or services because the child:

143.26 (1) is abandoned or without parent, guardian, or custodian;

143.27 (2)(i) has been a victim of physical or sexual abuse as defined in section 626.556,
143.28 subdivision 2, (ii) resides with or has resided with a victim of child abuse as defined in
143.29 subdivision 5 or domestic child abuse as defined in subdivision 13, (iii) resides with or
143.30 would reside with a perpetrator of domestic child abuse as defined in subdivision 13 or
143.31 child abuse as defined in subdivision 5 or 13, or (iv) is a victim of emotional maltreatment
143.32 as defined in subdivision 15;

143.33 (3) is without necessary food, clothing, shelter, education, or other required care
143.34 for the child's physical or mental health or morals because the child's parent, guardian,
143.35 or custodian is unable or unwilling to provide that care;

144.1 (4) is without the special care made necessary by a physical, mental, or emotional
144.2 condition because the child's parent, guardian, or custodian is unable or unwilling to
144.3 provide that care;

144.4 (5) is medically neglected, which includes, but is not limited to, the withholding of
144.5 medically indicated treatment from a disabled infant with a life-threatening condition. The
144.6 term "withholding of medically indicated treatment" means the failure to respond to the
144.7 infant's life-threatening conditions by providing treatment, including appropriate nutrition,
144.8 hydration, and medication which, in the treating physician's or physicians' reasonable
144.9 medical judgment, will be most likely to be effective in ameliorating or correcting all
144.10 conditions, except that the term does not include the failure to provide treatment other
144.11 than appropriate nutrition, hydration, or medication to an infant when, in the treating
144.12 physician's or physicians' reasonable medical judgment:

144.13 (i) the infant is chronically and irreversibly comatose;

144.14 (ii) the provision of the treatment would merely prolong dying, not be effective in
144.15 ameliorating or correcting all of the infant's life-threatening conditions, or otherwise be
144.16 futile in terms of the survival of the infant; or

144.17 (iii) the provision of the treatment would be virtually futile in terms of the survival
144.18 of the infant and the treatment itself under the circumstances would be inhumane;

144.19 (6) is one whose parent, guardian, or other custodian for good cause desires to be
144.20 relieved of the child's care and custody, including a child who entered foster care under a
144.21 voluntary placement agreement between the parent and the responsible social services
144.22 agency under section 260C.227;

144.23 (7) has been placed for adoption or care in violation of law;

144.24 (8) is without proper parental care because of the emotional, mental, or physical
144.25 disability, or state of immaturity of the child's parent, guardian, or other custodian;

144.26 (9) is one whose behavior, condition, or environment is such as to be injurious or
144.27 dangerous to the child or others. An injurious or dangerous environment may include, but
144.28 is not limited to, the exposure of a child to criminal activity in the child's home;

144.29 (10) is experiencing growth delays, which may be referred to as failure to thrive, that
144.30 have been diagnosed by a physician and are due to parental neglect;

144.31 (11) ~~has engaged in prostitution as defined in section 609.321, subdivision 9~~ is a
144.32 sexually exploited youth;

144.33 (12) has committed a delinquent act or a juvenile petty offense before becoming
144.34 ten years old;

144.35 (13) is a runaway;

144.36 (14) is a habitual truant;

145.1 (15) has been found incompetent to proceed or has been found not guilty by reason
 145.2 of mental illness or mental deficiency in connection with a delinquency proceeding, a
 145.3 certification under section 260B.125, an extended jurisdiction juvenile prosecution, or a
 145.4 proceeding involving a juvenile petty offense; or

145.5 (16) has a parent whose parental rights to one or more other children were
 145.6 involuntarily terminated or whose custodial rights to another child have been involuntarily
 145.7 transferred to a relative and there is a case plan prepared by the responsible social services
 145.8 agency documenting a compelling reason why filing the termination of parental rights
 145.9 petition under section 260C.301, subdivision 3, is not in the best interests of the child; or

145.10 ~~(17) is a sexually exploited youth.~~

145.11 **EFFECTIVE DATE.** This section is effective August 1, 2014.

145.12 Sec. 31. Minnesota Statutes 2012, section 260C.007, subdivision 31, is amended to read:

145.13 Subd. 31. **Sexually exploited youth.** "Sexually exploited youth" means an
 145.14 individual who:

145.15 (1) is alleged to have engaged in conduct which would, if committed by an adult,
 145.16 violate any federal, state, or local law relating to being hired, offering to be hired, or
 145.17 agreeing to be hired by another individual to engage in sexual penetration or sexual conduct;

145.18 (2) is a victim of a crime described in section 609.342, 609.343, 609.344, 609.345,
 145.19 609.3451, 609.3453, 609.352, 617.246, or 617.247;

145.20 (3) is a victim of a crime described in United States Code, title 18, section 2260;
 145.21 2421; 2422; 2423; 2425; 2425A; or 2256; or

145.22 (4) is a sex trafficking victim as defined in section 609.321, subdivision 7b.

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

145.24 Sec. 32. Minnesota Statutes 2012, section 518A.60, is amended to read:

145.25 **518A.60 COLLECTION; ARREARS ONLY.**

145.26 (a) Remedies available for the collection and enforcement of support in this chapter
 145.27 and chapters 256, 257, 518, and 518C also apply to cases in which the child or children
 145.28 for whom support is owed are emancipated and the obligor owes past support or has an
 145.29 accumulated arrearage as of the date of the youngest child's emancipation. Child support
 145.30 arrearages under this section include arrearages for child support, medical support, child
 145.31 care, pregnancy and birth expenses, and unreimbursed medical expenses as defined in
 145.32 section 518A.41, subdivision 1, paragraph (h).

146.1 (b) This section applies retroactively to any support arrearage that accrued on or
146.2 before June 3, 1997, and to all arrearages accruing after June 3, 1997.

146.3 (c) Past support or pregnancy and confinement expenses ordered for which the
146.4 obligor has specific court ordered terms for repayment may not be enforced using
146.5 drivers' and occupational or professional license suspension, credit bureau reporting, and
146.6 additional income withholding under section 518A.53, subdivision 10, paragraph (a),
146.7 unless the obligor fails to comply with the terms of the court order for repayment.

146.8 (d) If an arrearage exists at the time a support order would otherwise terminate
146.9 and section 518A.53, subdivision 10, paragraph (c), does not apply to this section, the
146.10 arrearage shall be repaid in an amount equal to the current support order until all arrears
146.11 have been paid in full, absent a court order to the contrary.

146.12 (e) If an arrearage exists according to a support order which fails to establish a
146.13 monthly support obligation in a specific dollar amount, the public authority, if it provides
146.14 child support services, or the obligee, may establish a payment agreement which shall
146.15 equal what the obligor would pay for current support after application of section 518A.34,
146.16 plus an additional 20 percent of the current support obligation, until all arrears have been
146.17 paid in full. If the obligor fails to enter into or comply with a payment agreement, the
146.18 public authority, if it provides child support services, or the obligee, may move the district
146.19 court or child support magistrate, if section 484.702 applies, for an order establishing
146.20 repayment terms.

146.21 (f) If there is no longer a current support order because all of the children of the
146.22 order are emancipated, the public authority may discontinue child support services and
146.23 close its case under title IV-D of the Social Security Act if:

146.24 (1) the arrearage is under \$500; or

146.25 (2) the arrearage is considered unenforceable by the public authority because there
146.26 have been no collections for three years, and all administrative and legal remedies have
146.27 been attempted or are determined by the public authority to be ineffective because the
146.28 obligor is unable to pay, the obligor has no known income or assets, and there is no
146.29 reasonable prospect that the obligor will be able to pay in the foreseeable future.

146.30 (g) At least 60 calendar days before the discontinuation of services under paragraph
146.31 (f), the public authority must mail a written notice to the obligee and obligor at the
146.32 obligee's and obligor's last known addresses that the public authority intends to close the
146.33 child support enforcement case and explaining each party's rights. Seven calendar days
146.34 after the first notice is mailed, the public authority must mail a second notice under this
146.35 paragraph to the obligee.

147.1 (h) The case must be kept open if the obligee responds before case closure and
 147.2 provides information that could reasonably lead to collection of arrears. If the case is
 147.3 closed, the obligee may later request that the case be reopened by completing a new
 147.4 application for services, if there is a change in circumstances that could reasonably lead to
 147.5 the collection of arrears.

147.6 Sec. 33. Laws 1998, chapter 407, article 6, section 116, is amended to read:

147.7 Sec. 116. **EBT TRANSACTION COSTS; APPROVAL FROM LEGISLATURE.**

147.8 The commissioner of human services shall ~~request and receive approval from the~~
 147.9 ~~legislature before adjusting the payment to~~ discontinue the state subsidy to retailers for
 147.10 electronic benefit transfer transaction costs Supplemental Nutrition Assistance Program
 147.11 transactions when the federal government discontinues the federal subsidy to the same.

147.12 Sec. 34. **DIRECTION TO COMMISSIONERS; INCOME AND ASSET**
 147.13 **EXCLUSION.**

147.14 (a) The commissioner of human services shall not count conditional cash transfers
 147.15 made to families participating in a family independence demonstration as income or
 147.16 assets for purposes of determining or redetermining eligibility for child care assistance
 147.17 programs under Minnesota Statutes, chapter 119B; general assistance under Minnesota
 147.18 Statutes, chapter 256D; group residential housing under Minnesota Statutes, chapter 256I;
 147.19 the Minnesota family investment program, work benefit program, or diversionary work
 147.20 program under Minnesota Statutes, chapter 256J, during the duration of the demonstration.

147.21 (b) The commissioner of human services shall not count conditional cash transfers
 147.22 made to families participating in a family independence demonstration as income or assets
 147.23 for purposes of determining or redetermining eligibility for medical assistance under
 147.24 Minnesota Statutes, chapter 256B, and MinnesotaCare under Minnesota Statutes, chapter
 147.25 256L, except that for enrollees subject to a modified adjusted gross income calculation to
 147.26 determine eligibility, the conditional cash transfer payments shall be counted as income if
 147.27 they are included on the enrollee's federal tax return as income, or if the payments can be
 147.28 taken into account in the month of receipt as a lump sum payment.

147.29 (c) The commissioner of the Minnesota Housing Finance Agency shall not count
 147.30 conditional cash transfers made to families participating in a family independence
 147.31 demonstration as income or assets for purposes of determining or redetermining eligibility
 147.32 for housing assistance programs under Minnesota Statutes, section 462A.201, during
 147.33 the duration of the demonstration.

147.34 (d) For the purposes of this section:

148.1 (1) "conditional cash transfer" means a payment made to a participant in a family
148.2 independence demonstration by a sponsoring organization to incent, support, or facilitate
148.3 participation; and

148.4 (2) "family independence demonstration" means an initiative sponsored or
148.5 cosponsored by a governmental or nongovernmental organization, the goal of which is
148.6 to facilitate individualized goal-setting and peer support for cohorts of no more than 12
148.7 families each toward the development of financial and nonfinancial assets that enable the
148.8 participating families to achieve financial independence.

148.9 (e) The citizens league shall provide a report to the legislative committees having
148.10 jurisdiction over human services issues by July 1, 2016, informing the legislature on the
148.11 progress and outcomes of the demonstration under this section.

148.12 **Sec. 35. UNIFORM BENEFITS FOR CHILDREN IN FOSTER CARE,**
148.13 **PERMANENT RELATIVE CARE, AND ADOPTION ASSISTANCE.**

148.14 Using available resources, the commissioner of human services, in consultation with
148.15 representatives of the judicial branch, county human services, and tribes participating in
148.16 the American Indian child welfare initiative under Minnesota Statutes, section 256.01,
148.17 subdivision 14b, together with other appropriate stakeholders, which might include
148.18 communities of color; youth in foster care or those who have aged out of care; kinship
148.19 caregivers, foster parents, adoptive parents, foster and adoptive agencies; guardians ad
148.20 litem; and experts in permanency, adoption, child development, and the effects of trauma,
148.21 and the use of medical assistance home and community-based waivers for persons with
148.22 disabilities, shall analyze benefits and services available to children in family foster care
148.23 under Minnesota Rules, parts 9560.0650 to 9560.0656, relative custody assistance under
148.24 Minnesota Statutes, section 257.85, and adoption assistance under Minnesota Statutes,
148.25 chapter 259A. The goal of the analysis is to establish a uniform set of benefits available
148.26 to children in foster care, permanent relative care, and adoption so that the benefits
148.27 can follow the child rather than being tied to the child's legal status. Included in the
148.28 analysis is possible accessing of federal title IV-E through guardianship assistance. The
148.29 commissioner shall report findings and conclusions to the chairs and ranking minority
148.30 members of the legislative committees and divisions with jurisdiction over health and
148.31 human services policy and finance by January 15, 2014, and include draft legislation
148.32 establishing uniform benefits.

148.33 **Sec. 36. REPEALER.**

149.1 (a) Minnesota Statutes 2012, section 256J.24, subdivision 6, is repealed effective
 149.2 July 1, 2014.

149.3 (b) Minnesota Statutes 2012, section 609.093, is repealed effective the day following
 149.4 final enactment.

149.5 **ARTICLE 4**

149.6 **STRENGTHENING CHEMICAL AND MENTAL HEALTH SERVICES**

149.7 Section 1. Minnesota Statutes 2012, section 245.462, subdivision 20, is amended to read:

149.8 Subd. 20. **Mental illness.** (a) "Mental illness" means an organic disorder of the brain
 149.9 or a clinically significant disorder of thought, mood, perception, orientation, memory, or
 149.10 behavior that is detailed in a diagnostic codes list published by the commissioner, and that
 149.11 seriously limits a person's capacity to function in primary aspects of daily living such as
 149.12 personal relations, living arrangements, work, and recreation.

149.13 (b) An "adult with acute mental illness" means an adult who has a mental illness that
 149.14 is serious enough to require prompt intervention.

149.15 (c) For purposes of case management and community support services, a "person
 149.16 with serious and persistent mental illness" means an adult who has a mental illness and
 149.17 meets at least one of the following criteria:

149.18 (1) the adult has undergone two or more episodes of inpatient care for a mental
 149.19 illness within the preceding 24 months;

149.20 (2) the adult has experienced a continuous psychiatric hospitalization or residential
 149.21 treatment exceeding six months' duration within the preceding 12 months;

149.22 (3) the adult has been treated by a crisis team two or more times within the preceding
 149.23 24 months;

149.24 (4) the adult:

149.25 (i) has a diagnosis of schizophrenia, bipolar disorder, major depression,
 149.26 schizoaffective disorder, or borderline personality disorder;

149.27 (ii) indicates a significant impairment in functioning; and

149.28 (iii) has a written opinion from a mental health professional, in the last three years,
 149.29 stating that the adult is reasonably likely to have future episodes requiring inpatient or
 149.30 residential treatment, of a frequency described in clause (1) or (2), unless ongoing case
 149.31 management or community support services are provided;

149.32 (5) the adult has, in the last three years, been committed by a court as a person who is
 149.33 mentally ill under chapter 253B, or the adult's commitment has been stayed or continued; ~~or~~

149.34 (6) the adult (i) was eligible under clauses (1) to (5), but the specified time period
 149.35 has expired or the adult was eligible as a child under section 245.4871, subdivision 6; and

150.1 (ii) has a written opinion from a mental health professional, in the last three years, stating
150.2 that the adult is reasonably likely to have future episodes requiring inpatient or residential
150.3 treatment, of a frequency described in clause (1) or (2), unless ongoing case management
150.4 or community support services are provided; or

150.5 (7) the adult was eligible as a child under section 245.4871, subdivision 6, and is
150.6 age 21 or younger.

150.7 Sec. 2. Minnesota Statutes 2012, section 245.4661, subdivision 5, is amended to read:

150.8 Subd. 5. **Planning for pilot projects.** (a) Each local plan for a pilot project, with
150.9 the exception of the placement of a Minnesota specialty treatment facility as defined in
150.10 paragraph (c), must be developed under the direction of the county board, or multiple
150.11 county boards acting jointly, as the local mental health authority. The planning process
150.12 for each pilot shall include, but not be limited to, mental health consumers, families,
150.13 advocates, local mental health advisory councils, local and state providers, representatives
150.14 of state and local public employee bargaining units, and the department of human services.
150.15 As part of the planning process, the county board or boards shall designate a managing
150.16 entity responsible for receipt of funds and management of the pilot project.

150.17 (b) For Minnesota specialty treatment facilities, the commissioner shall issue a
150.18 request for proposal for regions in which a need has been identified for services.

150.19 (c) For purposes of this section, Minnesota specialty treatment facility is defined as
150.20 an intensive rehabilitative mental health service under section 256B.0622, subdivision 2,
150.21 paragraph (b).

150.22 Sec. 3. Minnesota Statutes 2012, section 245.4661, subdivision 6, is amended to read:

150.23 Subd. 6. **Duties of commissioner.** (a) For purposes of the pilot projects, the
150.24 commissioner shall facilitate integration of funds or other resources as needed and
150.25 requested by each project. These resources may include:

150.26 (1) residential services funds administered under Minnesota Rules, parts 9535.2000
150.27 to 9535.3000, in an amount to be determined by mutual agreement between the project's
150.28 managing entity and the commissioner of human services after an examination of the
150.29 county's historical utilization of facilities located both within and outside of the county
150.30 and licensed under Minnesota Rules, parts 9520.0500 to 9520.0690;

150.31 (2) community support services funds administered under Minnesota Rules, parts
150.32 9535.1700 to 9535.1760;

150.33 (3) other mental health special project funds;

151.1 (4) medical assistance, general assistance medical care, MinnesotaCare and group
 151.2 residential housing if requested by the project's managing entity, and if the commissioner
 151.3 determines this would be consistent with the state's overall health care reform efforts; ~~and~~

151.4 (5) regional treatment center resources consistent with section 246.0136, subdivision
 151.5 1.; and

151.6 (6) funds transferred from section 246.18, subdivision 8, for grants to providers to
 151.7 participate in mental health specialty treatment services, awarded to providers through
 151.8 a request for proposal process.

151.9 (b) The commissioner shall consider the following criteria in awarding start-up and
 151.10 implementation grants for the pilot projects:

151.11 (1) the ability of the proposed projects to accomplish the objectives described in
 151.12 subdivision 2;

151.13 (2) the size of the target population to be served; and

151.14 (3) geographical distribution.

151.15 (c) The commissioner shall review overall status of the projects initiatives at least
 151.16 every two years and recommend any legislative changes needed by January 15 of each
 151.17 odd-numbered year.

151.18 (d) The commissioner may waive administrative rule requirements which are
 151.19 incompatible with the implementation of the pilot project.

151.20 (e) The commissioner may exempt the participating counties from fiscal sanctions
 151.21 for noncompliance with requirements in laws and rules which are incompatible with the
 151.22 implementation of the pilot project.

151.23 (f) The commissioner may award grants to an entity designated by a county board or
 151.24 group of county boards to pay for start-up and implementation costs of the pilot project.

151.25 Sec. 4. Minnesota Statutes 2012, section 245.4682, subdivision 2, is amended to read:

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

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

151.30 (2) bring to the legislature, and the State Advisory Council on Mental Health, by
 151.31 January 15, 2008, recommendations for legislation to update the role of counties and to
 151.32 clarify the case management roles, functions, and decision-making authority of health
 151.33 plans and counties, and to clarify county retention of the responsibility for the delivery of
 151.34 social services as required under subdivision 3, paragraph (a);

152.1 (3) withhold implementation of any recommended changes in case management
 152.2 roles, functions, and decision-making authority until after the release of the report due
 152.3 January 15, 2008;

152.4 (4) ensure continuity of care for persons affected by these reforms including
 152.5 ensuring client choice of provider by requiring broad provider networks and developing
 152.6 mechanisms to facilitate a smooth transition of service responsibilities;

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

152.9 (6) ensure client access to applicable protections and appeals; and

152.10 (7) make budget transfers necessary to implement the reallocation of services and
 152.11 client responsibilities between counties and health care programs that do not increase the
 152.12 state and county costs and efficiently allocate state funds.

152.13 (b) When making transfers under paragraph (a) necessary to implement movement
 152.14 of responsibility for clients and services between counties and health care programs,
 152.15 the commissioner, in consultation with counties, shall ensure that any transfer of state
 152.16 grants to health care programs, including the value of case management transfer grants
 152.17 under section 256B.0625, subdivision 20, does not exceed the value of the services being
 152.18 transferred for the latest 12-month period for which data is available. The commissioner
 152.19 may make quarterly adjustments based on the availability of additional data during the
 152.20 first four quarters after the transfers first occur. If case management transfer grants under
 152.21 section 256B.0625, subdivision 20, are repealed and the value, based on the last year prior
 152.22 to repeal, exceeds the value of the services being transferred, the difference becomes an
 152.23 ongoing part of each county's adult ~~and children's~~ mental health grants under sections
 152.24 245.4661, ~~245.4889~~, and 256E.12.

152.25 (c) This appropriation is not authorized to be expended after December 31, 2010,
 152.26 unless approved by the legislature.

152.27 Sec. 5. Minnesota Statutes 2012, section 245.4875, subdivision 8, is amended to read:

152.28 Subd. 8. **Transition services.** The county board may continue to provide mental
 152.29 health services as defined in sections 245.487 to 245.4889 to persons over 18 years of
 152.30 age, but under 21 years of age, if the person was receiving case management or family
 152.31 community support services prior to age 18, and if one of the following conditions is met:

152.32 (1) the person is receiving special education services through the local school
 152.33 district; ~~or~~

152.34 (2) it is in the best interest of the person to continue services defined in sections
 152.35 245.487 to 245.4889; or

153.1 (3) the person is requesting services and the services are medically necessary.

153.2 Sec. 6. Minnesota Statutes 2012, section 245.4881, subdivision 1, is amended to read:

153.3 Subdivision 1. **Availability of case management services.** (a) The county board
153.4 shall provide case management services for each child with severe emotional disturbance
153.5 who is a resident of the county and the child's family who request or consent to the services.
153.6 Case management services ~~may be continued~~ must be offered to be provided for a child with
153.7 a serious emotional disturbance who is over the age of 18 consistent with section 245.4875,
153.8 subdivision 8, or the child's legal representative, provided the child's service needs can be
153.9 met within the children's service system. Before discontinuing case management services
153.10 under this subdivision for children between the ages of 17 and 21, a transition plan
153.11 must be developed. The transition plan must be developed with the child and, with the
153.12 consent of a child age 18 or over, the child's parent, guardian, or legal representative. The
153.13 transition plan should include plans for health insurance, housing, education, employment,
153.14 and treatment. Staffing ratios must be sufficient to serve the needs of the clients. The case
153.15 manager must meet the requirements in section 245.4871, subdivision 4.

153.16 (b) Except as permitted by law and the commissioner under demonstration projects,
153.17 case management services provided to children with severe emotional disturbance eligible
153.18 for medical assistance must be billed to the medical assistance program under sections
153.19 256B.02, subdivision 8, and 256B.0625.

153.20 (c) Case management services are eligible for reimbursement under the medical
153.21 assistance program. Costs of mentoring, supervision, and continuing education may be
153.22 included in the reimbursement rate methodology used for case management services under
153.23 the medical assistance program.

153.24 Sec. 7. Minnesota Statutes 2012, section 246.18, subdivision 8, is amended to read:

153.25 Subd. 8. **State-operated services account.** (a) The state-operated services account is
153.26 established in the special revenue fund. Revenue generated by new state-operated services
153.27 listed under this section established after July 1, 2010, that are not enterprise activities must
153.28 be deposited into the state-operated services account, unless otherwise specified in law:

- 153.29 (1) intensive residential treatment services;
153.30 (2) foster care services; and
153.31 (3) psychiatric extensive recovery treatment services.

153.32 (b) Funds deposited in the state-operated services account are available to the
153.33 commissioner of human services for the purposes of:

154.1 (1) providing services needed to transition individuals from institutional settings
 154.2 within state-operated services to the community when those services have no other
 154.3 adequate funding source;

154.4 (2) grants to providers participating in mental health specialty treatment services
 154.5 under section 245.4661; and

154.6 (3) to fund the operation of the Intensive Residential Treatment Service program in
 154.7 Willmar.

154.8 Sec. 8. Minnesota Statutes 2012, section 246.18, is amended by adding a subdivision
 154.9 to read:

154.10 Subd. 9. **Transfers.** The commissioner may transfer state mental health grant funds
 154.11 to the account in subdivision 8 for noncovered allowable costs of a provider certified and
 154.12 licensed under section 256B.0622 and operating under section 246.014.

154.13 Sec. 9. Minnesota Statutes 2012, section 253B.10, subdivision 1, is amended to read:

154.14 Subdivision 1. **Administrative requirements.** (a) When a person is committed,
 154.15 the court shall issue a warrant or an order committing the patient to the custody of the
 154.16 head of the treatment facility. The warrant or order shall state that the patient meets the
 154.17 statutory criteria for civil commitment.

154.18 (b) The commissioner shall prioritize patients being admitted from jail or a
 154.19 correctional institution who are:

154.20 (1) ordered confined in a state hospital for an examination under Minnesota Rules of
 154.21 Criminal Procedure, rules 20.01, subdivision 4, paragraph (a), and 20.02, subdivision 2;

154.22 (2) under civil commitment for competency treatment and continuing supervision
 154.23 under Minnesota Rules of Criminal Procedure, rule 20.01, subdivision 7;

154.24 (3) found not guilty by reason of mental illness under Minnesota Rules of Criminal
 154.25 Procedure, rule 20.02, subdivision 8, and under civil commitment or are ordered to be
 154.26 detained in a state hospital or other facility pending completion of the civil commitment
 154.27 proceedings; or

154.28 (4) committed under this chapter to the commissioner after dismissal of the patient's
 154.29 criminal charges.

154.30 Patients described in this paragraph must be admitted to a service operated by the
 154.31 commissioner within 48 hours. The commitment must be ordered by the court as provided
 154.32 in section 253B.09, subdivision 1, paragraph (c).

154.33 (c) Upon the arrival of a patient at the designated treatment facility, the head of the
 154.34 facility shall retain the duplicate of the warrant and endorse receipt upon the original

155.1 warrant or acknowledge receipt of the order. The endorsed receipt or acknowledgment
 155.2 must be filed in the court of commitment. After arrival, the patient shall be under the
 155.3 control and custody of the head of the treatment facility.

155.4 (d) Copies of the petition for commitment, the court's findings of fact and
 155.5 conclusions of law, the court order committing the patient, the report of the examiners,
 155.6 and the prepetition report shall be provided promptly to the treatment facility.

155.7 Sec. 10. Minnesota Statutes 2012, section 254B.13, is amended to read:

155.8 **254B.13 PILOT PROJECTS; CHEMICAL HEALTH CARE.**

155.9 Subdivision 1. **Authorization for navigator pilot projects.** The commissioner may
 155.10 approve and implement navigator pilot projects developed under the planning process
 155.11 required under Laws 2009, chapter 79, article 7, section 26, to provide alternatives to and
 155.12 enhance coordination of the delivery of chemical health services required under section
 155.13 254B.03.

155.14 Subd. 2. **Program design and implementation.** (a) The commissioner and
 155.15 counties participating in the navigator pilot projects shall continue to work in partnership
 155.16 to refine and implement the navigator pilot projects initiated under Laws 2009, chapter
 155.17 79, article 7, section 26.

155.18 (b) The commissioner and counties participating in the navigator pilot projects shall
 155.19 complete the planning phase ~~by June 30, 2010~~, and, if approved by the commissioner for
 155.20 implementation, enter into agreements governing the operation of the navigator pilot
 155.21 projects with implementation scheduled no earlier than July 1, 2010.

155.22 Subd. 2a. **Eligibility for navigator pilot program.** (a) To be considered for
 155.23 participation in a navigator pilot program, an individual must:

155.24 (1) be a resident of a county with an approved navigator program;

155.25 (2) be eligible for consolidated chemical dependency treatment fund services;

155.26 (3) be a voluntary participant in the navigator program;

155.27 (4) satisfy one of the following items:

155.28 (i) have at least one severity rating of three or above in dimension four, five, or six in
 155.29 a comprehensive assessment under Minnesota Rules, part 9530.6422; or

155.30 (ii) have at least one severity rating of two or above in dimension four, five, or six in
 155.31 a comprehensive assessment under Minnesota Rules, part 9530.6422, and be currently
 155.32 participating in a Rule 31 treatment program under Minnesota Rules, parts 9530.6405 to
 155.33 9530.6505, or be within 60 days following discharge after participation in a Rule 31
 155.34 treatment program; and

156.1 (5) have had at least two treatment episodes in the past two years, not limited
156.2 to episodes reimbursed by the consolidated chemical dependency treatment funds. An
156.3 admission to an emergency room, a detoxification program, or a hospital may be substituted
156.4 for one treatment episode if it resulted from the individual's substance use disorder.

156.5 (b) New eligibility criteria may be added as mutually agreed upon by the
156.6 commissioner and participating navigator programs.

156.7 Subd. 3. **Program evaluation.** The commissioner shall evaluate navigator pilot
156.8 projects under this section and report the results of the evaluation to the chairs and
156.9 ranking minority members of the legislative committees with jurisdiction over chemical
156.10 health issues by January 15, 2014. Evaluation of the navigator pilot projects must be
156.11 based on outcome evaluation criteria negotiated with the navigator pilot projects prior
156.12 to implementation.

156.13 Subd. 4. **Notice of navigator pilot project discontinuation.** Each county's
156.14 participation in the navigator pilot project may be discontinued for any reason by the county
156.15 or the commissioner of human services after 30 days' written notice to the other party.
156.16 ~~Any unspent funds held for the exiting county's pro rata share in the special revenue fund~~
156.17 ~~under the authority in subdivision 5, paragraph (d), shall be transferred to the consolidated~~
156.18 ~~chemical dependency treatment fund following discontinuation of the pilot project.~~

156.19 Subd. 5. **Duties of commissioner.** (a) Notwithstanding any other provisions in
156.20 this chapter, the commissioner may authorize navigator pilot projects to use chemical
156.21 dependency treatment funds to pay for nontreatment navigator pilot services:

156.22 (1) in addition to those authorized under section 254B.03, subdivision 2, paragraph
156.23 (a); and

156.24 (2) by vendors in addition to those authorized under section 254B.05 when not
156.25 providing chemical dependency treatment services.

156.26 (b) For purposes of this section, "nontreatment navigator pilot services" include
156.27 navigator services, peer support, family engagement and support, housing support, rent
156.28 subsidies, supported employment, and independent living skills.

156.29 (c) State expenditures for chemical dependency services and nontreatment navigator
156.30 pilot services provided by or through the navigator pilot projects must not be greater than
156.31 the chemical dependency treatment fund expected share of forecasted expenditures in the
156.32 absence of the navigator pilot projects. The commissioner may restructure the schedule of
156.33 payments between the state and participating counties under the local agency share and
156.34 division of cost provisions under section 254B.03, subdivisions 3 and 4, as necessary to
156.35 facilitate the operation of the navigator pilot projects.

157.1 ~~(d) To the extent that state fiscal year expenditures within a pilot project are less~~
 157.2 ~~than the expected share of forecasted expenditures in the absence of the pilot projects,~~
 157.3 ~~the commissioner shall deposit the unexpended funds in a separate account within the~~
 157.4 ~~consolidated chemical dependency treatment fund, and make these funds available for~~
 157.5 ~~expenditure by the pilot projects the following year. To the extent that treatment and~~
 157.6 ~~nontreatment pilot services expenditures within the pilot project exceed the amount~~
 157.7 ~~expected in the absence of the pilot projects, the pilot project county or counties are~~
 157.8 ~~responsible for the portion of nontreatment pilot services expenditures in excess of the~~
 157.9 ~~otherwise expected share of forecasted expenditures.~~

157.10 ~~(e)~~ (d) The commissioner may waive administrative rule requirements that are
 157.11 incompatible with the implementation of the navigator pilot project, except that any
 157.12 chemical dependency treatment funded under this section must continue to be provided
 157.13 by a licensed treatment provider.

157.14 ~~(f)~~ (e) The commissioner shall not approve or enter into any agreement related to
 157.15 navigator pilot projects authorized under this section that puts current or future federal
 157.16 funding at risk.

157.17 (f) The commissioner shall provide participating navigator pilot projects with
 157.18 transactional data, reports, provider data, and other data generated by county activity to
 157.19 assess and measure outcomes. This information must be transmitted or made available in
 157.20 an acceptable form to participating navigator pilot projects at least once every six months
 157.21 or within a reasonable time following the commissioner's receipt of information from the
 157.22 counties needed to comply with this paragraph.

157.23 Subd. 6. **Duties of county board.** The county board, or other county entity that
 157.24 is approved to administer a navigator pilot project, shall:

157.25 (1) administer the navigator pilot project in a manner consistent with the objectives
 157.26 described in subdivision 2 and the planning process in subdivision 5;

157.27 (2) ensure that no one is denied chemical dependency treatment services for which
 157.28 they would otherwise be eligible under section 254A.03, subdivision 3; and

157.29 (3) provide the commissioner with timely and pertinent information as negotiated in
 157.30 agreements governing operation of the navigator pilot projects.

157.31 Subd. 7. **Managed care.** An individual who is eligible for the navigator pilot
 157.32 program under subdivision 2a is excluded from mandatory enrollment in managed care
 157.33 until these services are included in the health plan's benefit set.

157.34 Subd. 8. **Authorization for continuation of navigator pilots.** The navigator pilot
 157.35 projects implemented pursuant to subdivision 1 are authorized to continue operation after
 157.36 July 1, 2013, under existing agreements governing operation of the pilot projects.

158.1 **EFFECTIVE DATE.** The amendments to subdivisions 1 to 6 and 8 are effective
158.2 August 1, 2013. Subdivision 7 is effective July 1, 2013.

158.3 Sec. 11. **[254B.14] CONTINUUM OF CARE PILOT PROJECTS; CHEMICAL**
158.4 **HEALTH CARE.**

158.5 Subdivision 1. **Authorization for continuum of care pilot projects.** The
158.6 commissioner shall establish chemical dependency continuum of care pilot projects to
158.7 begin implementing the measures developed with stakeholder input and identified in the
158.8 report completed pursuant to Laws 2012, chapter 247, article 5, section 8. The pilot
158.9 projects are intended to improve the effectiveness and efficiency of the service continuum
158.10 for chemically dependent individuals in Minnesota while reducing duplication of efforts
158.11 and promoting scientifically supported practices.

158.12 Subd. 2. **Program implementation.** (a) The commissioner, in coordination with
158.13 representatives of the Minnesota Association of County Social Service Administrators
158.14 and the Minnesota Inter-County Association, shall develop a process for identifying and
158.15 selecting interested counties and providers for participation in the continuum of care pilot
158.16 projects. There will be three pilot projects; one representing the northern region, one for
158.17 the metro region, and one for the southern region. The selection process of counties and
158.18 providers must include consideration of population size, geographic distribution, cultural
158.19 and racial demographics, and provider accessibility. The commissioner shall identify
158.20 counties and providers that are selected for participation in the continuum of care pilot
158.21 projects no later than September 30, 2013.

158.22 (b) The commissioner and entities participating in the continuum of care pilot
158.23 projects shall enter into agreements governing the operation of the continuum of care pilot
158.24 projects. The agreements shall identify pilot project outcomes and include timelines for
158.25 implementation and beginning operation of the pilot projects.

158.26 (c) Entities that are currently participating in the navigator pilot project are
158.27 eligible to participate in the continuum of care pilot project subsequent to or instead of
158.28 participating in the navigator pilot project.

158.29 (d) The commissioner may waive administrative rule requirements that are
158.30 incompatible with implementation of the continuum of care pilot projects.

158.31 (e) Notwithstanding section 254A.19, the commissioner may designate noncounty
158.32 entities to complete chemical use assessments and placement authorizations required
158.33 under section 254A.19 and Minnesota Rules, parts 9530.6600 to 9530.6655. Section
158.34 254A.19, subdivision 3, is applicable to the continuum of care pilot projects at the
158.35 discretion of the commissioner.

159.1 Subd. 3. **Program design.** (a) The operation of the pilot projects shall include:
 159.2 (1) new services that are responsive to the chronic nature of substance use disorder;
 159.3 (2) telehealth services, when appropriate to address barriers to services;
 159.4 (3) services that assure integration with the mental health delivery system when
 159.5 appropriate;
 159.6 (4) services that address the needs of diverse populations; and
 159.7 (5) an assessment and access process that permits clients to present directly to a
 159.8 service provider for a substance use disorder assessment and authorization of services.

159.9 (b) Prior to implementation of the continuum of care pilot projects, a utilization
 159.10 review process must be developed and agreed to by the commissioner, participating
 159.11 counties, and providers. The utilization review process shall be described in the
 159.12 agreements governing operation of the continuum of care pilot projects.

159.13 Subd. 4. **Notice of project discontinuation.** Each entity's participation in the
 159.14 continuum of care pilot project may be discontinued for any reason by the county or the
 159.15 commissioner after 30 days' written notice to the entity.

159.16 Subd. 5. **Duties of commissioner.** (a) Notwithstanding any other provisions in this
 159.17 chapter, the commissioner may authorize chemical dependency treatment funds to pay for
 159.18 nontreatment services arranged by continuum of care pilot projects. Individuals who are
 159.19 currently accessing Rule 31 treatment services are eligible for concurrent participation in
 159.20 the continuum of care pilot projects.

159.21 (b) County expenditures for continuum of care pilot project services shall not
 159.22 be greater than their expected share of forecasted expenditures in the absence of the
 159.23 continuum of care pilot projects.

159.24 **EFFECTIVE DATE.** This section is effective August 1, 2013.

159.25 Sec. 12. [256B.0616] **MENTAL HEALTH CERTIFIED FAMILY PEER**
 159.26 **SPECIALIST.**

159.27 Subdivision 1. **Scope.** Medical assistance covers mental health certified family peer
 159.28 specialists services, as established in subdivision 2, subject to federal approval, if provided
 159.29 to recipients who have an emotional disturbance or severe emotional disturbance under
 159.30 chapter 245, and are provided by a certified family peer specialist who has completed the
 159.31 training under subdivision 5. A family peer specialist cannot provide services to the
 159.32 peer specialist's family.

159.33 Subd. 2. **Establishment.** The commissioner of human services shall establish a
 159.34 certified family peer specialists program model which:

- 160.1 (1) provides nonclinical family peer support counseling, building on the strengths
 160.2 of families and helping them achieve desired outcomes;
 160.3 (2) collaborates with others providing care or support to the family;
 160.4 (3) provides nonadversarial advocacy;
 160.5 (4) promotes the individual family culture in the treatment milieu;
 160.6 (5) links parents to other parents in the community;
 160.7 (6) offers support and encouragement;
 160.8 (7) assists parents in developing coping mechanisms and problem-solving skills;
 160.9 (8) promotes resiliency, self-advocacy, development of natural supports, and
 160.10 maintenance of skills learned in other support services;
 160.11 (9) establishes and provides peer led parent support groups; and
 160.12 (10) increases the child's ability to function better within the child's home, school,
 160.13 and community by educating parents on community resources, assisting with problem
 160.14 solving, and educating parents on mental illnesses.

160.15 Subd. 3. **Eligibility.** Family peer support services may be located in inpatient
 160.16 hospitalization, partial hospitalization, residential treatment, treatment foster care, day
 160.17 treatment, children's therapeutic services and supports, or crisis services.

160.18 Subd. 4. **Peer support specialist program providers.** The commissioner shall
 160.19 develop a process to certify family peer support specialist programs, in accordance with
 160.20 the federal guidelines, in order for the program to bill for reimbursable services. Family
 160.21 peer support programs must operate within an existing mental health community provider
 160.22 or center.

160.23 Subd. 5. **Certified family peer specialist training and certification.** The
 160.24 commissioner shall develop a training and certification process for certified family peer
 160.25 specialists who must be at least 21 years of age and have a high school diploma or its
 160.26 equivalent. The candidates must have raised or are currently raising a child with a mental
 160.27 illness, have had experience navigating the children's mental health system, and must
 160.28 demonstrate leadership and advocacy skills and a strong dedication to family-driven and
 160.29 family-focused services. The training curriculum must teach participating family peer
 160.30 specialists specific skills relevant to providing peer support to other parents. In addition
 160.31 to initial training and certification, the commissioner shall develop ongoing continuing
 160.32 educational workshops on pertinent issues related to family peer support counseling.

160.33 Sec. 13. Minnesota Statutes 2012, section 256B.0623, subdivision 2, is amended to read:

160.34 Subd. 2. **Definitions.** For purposes of this section, the following terms have the
 160.35 meanings given them.

161.1 (a) "Adult rehabilitative mental health services" means mental health services
161.2 which are rehabilitative and enable the recipient to develop and enhance psychiatric
161.3 stability, social competencies, personal and emotional adjustment, ~~and~~ independent living,
161.4 parenting skills, and community skills, when these abilities are impaired by the symptoms
161.5 of mental illness. Adult rehabilitative mental health services are also appropriate when
161.6 provided to enable a recipient to retain stability and functioning, if the recipient would
161.7 be at risk of significant functional decompensation or more restrictive service settings
161.8 without these services.

161.9 (1) Adult rehabilitative mental health services instruct, assist, and support the
161.10 recipient in areas such as: interpersonal communication skills, community resource
161.11 utilization and integration skills, crisis assistance, relapse prevention skills, health care
161.12 directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking
161.13 and nutrition skills, transportation skills, medication education and monitoring, mental
161.14 illness symptom management skills, household management skills, employment-related
161.15 skills, parenting skills, and transition to community living services.

161.16 (2) These services shall be provided to the recipient on a one-to-one basis in the
161.17 recipient's home or another community setting or in groups.

161.18 (b) "Medication education services" means services provided individually or in
161.19 groups which focus on educating the recipient about mental illness and symptoms; the role
161.20 and effects of medications in treating symptoms of mental illness; and the side effects of
161.21 medications. Medication education is coordinated with medication management services
161.22 and does not duplicate it. Medication education services are provided by physicians,
161.23 pharmacists, physician's assistants, or registered nurses.

161.24 (c) "Transition to community living services" means services which maintain
161.25 continuity of contact between the rehabilitation services provider and the recipient and
161.26 which facilitate discharge from a hospital, residential treatment program under Minnesota
161.27 Rules, chapter 9505, board and lodging facility, or nursing home. Transition to community
161.28 living services are not intended to provide other areas of adult rehabilitative mental health
161.29 services.

161.30 Sec. 14. Minnesota Statutes 2012, section 256B.0625, subdivision 48, is amended to
161.31 read:

161.32 Subd. 48. **Psychiatric consultation to primary care practitioners.** Effective
161.33 ~~January 1, 2006~~, Medical assistance covers consultation provided by a psychiatrist,
161.34 psychologist, or an advanced practice registered nurse certified in psychiatric mental
161.35 health via telephone, e-mail, facsimile, or other means of communication to primary care

162.1 practitioners, including pediatricians. The need for consultation and the receipt of the
162.2 consultation must be documented in the patient record maintained by the primary care
162.3 practitioner. If the patient consents, and subject to federal limitations and data privacy
162.4 provisions, the consultation may be provided without the patient present.

162.5 Sec. 15. Minnesota Statutes 2012, section 256B.0625, subdivision 56, is amended to
162.6 read:

162.7 Subd. 56. **Medical service coordination.** (a)(1) Medical assistance covers in-reach
162.8 community-based service coordination that is performed through a hospital emergency
162.9 department as an eligible procedure under a state healthcare program for a frequent user.
162.10 A frequent user is defined as an individual who has frequented the hospital emergency
162.11 department for services three or more times in the previous four consecutive months.
162.12 In-reach community-based service coordination includes navigating services to address a
162.13 client's mental health, chemical health, social, economic, and housing needs, or any other
162.14 activity targeted at reducing the incidence of emergency room and other nonmedically
162.15 necessary health care utilization.

162.16 (2) Medical assistance covers in-reach community-based service coordination that
162.17 is performed through a hospital emergency department or inpatient psychiatric unit
162.18 for a child or young adult up to age 21 with a serious emotional disturbance who has
162.19 frequented the hospital emergency room two or more times in the previous consecutive
162.20 three months or been admitted to an inpatient psychiatric unit two or more times in the
162.21 previous consecutive four months, or is being discharged to a shelter.

162.22 (b) Reimbursement must be made in 15-minute increments and allowed for up to 60
162.23 days posthospital discharge based upon the specific identified emergency department visit
162.24 or inpatient admitting event. In-reach community-based service coordination shall seek to
162.25 connect frequent users with existing covered services available to them, including, but not
162.26 limited to, targeted case management, waiver case management, or care coordination in a
162.27 health care home. For children and young adults with a serious emotional disturbance,
162.28 in-reach community-based service coordination includes navigating and arranging for
162.29 community-based services prior to discharge to address a client's mental health, chemical
162.30 health, social, educational, family support and housing needs, or any other activity targeted
162.31 at reducing multiple incidents of emergency room use, inpatient readmissions, and other
162.32 nonmedically necessary health care utilization. In-reach services shall seek to connect
162.33 them with existing covered services, including targeted case management, waiver case
162.34 management, care coordination in a health care home, children's therapeutic services and
162.35 supports, crisis services, and respite care. Eligible in-reach service coordinators must hold

163.1 a minimum of a bachelor's degree in social work, public health, corrections, or a related
163.2 field. The commissioner shall submit any necessary application for waivers to the Centers
163.3 for Medicare and Medicaid Services to implement this subdivision.

163.4 (c)(1) For the purposes of this subdivision, "in-reach community-based service
163.5 coordination" means the practice of a community-based worker with training, knowledge,
163.6 skills, and ability to access a continuum of services, including housing, transportation,
163.7 chemical and mental health treatment, employment, education, and peer support services,
163.8 by working with an organization's staff to transition an individual back into the individual's
163.9 living environment. In-reach community-based service coordination includes working
163.10 with the individual during their discharge and for up to a defined amount of time in the
163.11 individual's living environment, reducing the individual's need for readmittance.

163.12 (2) Hospitals utilizing in-reach service coordinators shall report annually to the
163.13 commissioner on the number of adults, children, and adolescents served; the postdischarge
163.14 services which they accessed; and emergency department/psychiatric hospitalization
163.15 readmissions. The commissioner shall ensure that services and payments provided under
163.16 in-reach care coordination do not duplicate services or payments provided under section
163.17 256B.0753, 256B.0755, or 256B.0625, subdivision 20.

163.18 Sec. 16. Minnesota Statutes 2012, section 256B.0625, is amended by adding a
163.19 subdivision to read:

163.20 Subd. 61. **Family psychoeducation services.** Effective July 1, 2013, or upon
163.21 federal approval, whichever is later, medical assistance covers family psychoeducation
163.22 services provided to a child up to age 21 with a diagnosed mental health condition when
163.23 identified in the child's individual treatment plan and provided by a licensed mental health
163.24 professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a
163.25 clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C, who
163.26 has determined it medically necessary to involve family members in the child's care. For
163.27 the purposes of this subdivision, "family psychoeducation services" means information
163.28 or demonstration provided to an individual or family as part of an individual, family,
163.29 multifamily group, or peer group session to explain, educate, and support the child and
163.30 family in understanding a child's symptoms of mental illness, the impact on the child's
163.31 development, and needed components of treatment and skill development so that the
163.32 individual, family, or group can help the child to prevent relapse, prevent the acquisition
163.33 of comorbid disorders, and to achieve optimal mental health and long-term resilience.

164.1 Sec. 17. Minnesota Statutes 2012, section 256B.0625, is amended by adding a
164.2 subdivision to read:

164.3 Subd. 62. **Mental health clinical care consultation.** Effective July 1, 2013, or upon
164.4 federal approval, whichever is later, medical assistance covers clinical care consultation
164.5 for a person up to age 21 who is diagnosed with a complex mental health condition or a
164.6 mental health condition that co-occurs with other complex and chronic conditions, when
164.7 described in the person's individual treatment plan and provided by a licensed mental
164.8 health professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a
164.9 clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C. For the
164.10 purposes of this subdivision, "clinical care consultation" means communication from a
164.11 treating mental health professional to other providers or educators not under the clinical
164.12 supervision of the treating mental health professional who are working with the same client
164.13 to inform, inquire, and instruct regarding the client's symptoms; strategies for effective
164.14 engagement, care, and intervention needs; treatment expectations across service settings;
164.15 and to direct and coordinate clinical service components provided to the client and family.

164.16 Sec. 18. Minnesota Statutes 2012, section 256B.0943, subdivision 1, is amended to read:

164.17 Subdivision 1. **Definitions.** For purposes of this section, the following terms have
164.18 the meanings given them.

164.19 (a) "Children's therapeutic services and supports" means the flexible package of
164.20 mental health services for children who require varying therapeutic and rehabilitative
164.21 levels of intervention. The services are time-limited interventions that are delivered using
164.22 various treatment modalities and combinations of services designed to reach treatment
164.23 outcomes identified in the individual treatment plan.

164.24 (b) "Clinical supervision" means the overall responsibility of the mental health
164.25 professional for the control and direction of individualized treatment planning, service
164.26 delivery, and treatment review for each client. A mental health professional who is an
164.27 enrolled Minnesota health care program provider accepts full professional responsibility
164.28 for a supervisee's actions and decisions, instructs the supervisee in the supervisee's work,
164.29 and oversees or directs the supervisee's work.

164.30 (c) "County board" means the county board of commissioners or board established
164.31 under sections 402.01 to 402.10 or 471.59.

164.32 (d) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a.

164.33 (e) "Culturally competent provider" means a provider who understands and can
164.34 utilize to a client's benefit the client's culture when providing services to the client. A
164.35 provider may be culturally competent because the provider is of the same cultural or

165.1 ethnic group as the client or the provider has developed the knowledge and skills through
165.2 training and experience to provide services to culturally diverse clients.

165.3 (f) "Day treatment program" for children means a site-based structured program
165.4 consisting of group psychotherapy for more than three individuals and other intensive
165.5 therapeutic services provided by a multidisciplinary team, under the clinical supervision
165.6 of a mental health professional.

165.7 (g) "Diagnostic assessment" has the meaning given in section 245.4871, subdivision
165.8 11.

165.9 (h) "Direct service time" means the time that a mental health professional, mental
165.10 health practitioner, or mental health behavioral aide spends face-to-face with a client
165.11 and the client's family. Direct service time includes time in which the provider obtains
165.12 a client's history or provides service components of children's therapeutic services and
165.13 supports. Direct service time does not include time doing work before and after providing
165.14 direct services, including scheduling, maintaining clinical records, consulting with others
165.15 about the client's mental health status, preparing reports, receiving clinical supervision,
165.16 and revising the client's individual treatment plan.

165.17 (i) "Direction of mental health behavioral aide" means the activities of a mental
165.18 health professional or mental health practitioner in guiding the mental health behavioral
165.19 aide in providing services to a client. The direction of a mental health behavioral aide
165.20 must be based on the client's individualized treatment plan and meet the requirements in
165.21 subdivision 6, paragraph (b), clause (5).

165.22 (j) "Emotional disturbance" has the meaning given in section 245.4871, subdivision
165.23 15. For persons at least age 18 but under age 21, mental illness has the meaning given in
165.24 section 245.462, subdivision 20, paragraph (a).

165.25 (k) "Individual behavioral plan" means a plan of intervention, treatment, and
165.26 services for a child written by a mental health professional or mental health practitioner,
165.27 under the clinical supervision of a mental health professional, to guide the work of the
165.28 mental health behavioral aide.

165.29 (l) "Individual treatment plan" has the meaning given in section 245.4871,
165.30 subdivision 21.

165.31 (m) "Mental health behavioral aide services" means medically necessary one-on-one
165.32 activities performed by a trained paraprofessional to assist a child retain or generalize
165.33 psychosocial skills as taught by a mental health professional or mental health practitioner
165.34 and as described in the child's individual treatment plan and individual behavior plan.
165.35 Activities involve working directly with the child or child's family as provided in
165.36 subdivision 9, paragraph (b), clause (4).

166.1 (n) "Mental health professional" means an individual as defined in section 245.4871,
166.2 subdivision 27, clauses (1) to (6), or tribal vendor as defined in section 256B.02,
166.3 subdivision 7, paragraph (b).

166.4 (o) "Mental health service plan development" includes:

166.5 (1) the development, review, and revision of a child's individual treatment plan,
166.6 as provided in Minnesota Rules, part 9505.0371, subpart 7, including involvement of
166.7 the client or client's parents, primary caregiver, or other person authorized to consent to
166.8 mental health services for the client, and including arrangement of treatment and support
166.9 activities specified in the individual treatment plan; and

166.10 (2) administering standardized outcome measurement instruments, determined
166.11 and updated by the commissioner, as periodically needed to evaluate the effectiveness
166.12 of treatment for children receiving clinical services and reporting outcome measures,
166.13 as required by the commissioner.

166.14 ~~(p)~~ (p) "Preschool program" means a day program licensed under Minnesota Rules,
166.15 parts 9503.0005 to 9503.0175, and enrolled as a children's therapeutic services and
166.16 supports provider to provide a structured treatment program to a child who is at least 33
166.17 months old but who has not yet attended the first day of kindergarten.

166.18 ~~(q)~~ (q) "Skills training" means individual, family, or group training, delivered
166.19 by or under the direction of a mental health professional, designed to facilitate the
166.20 acquisition of psychosocial skills that are medically necessary to rehabilitate the child
166.21 to an age-appropriate developmental trajectory heretofore disrupted by a psychiatric
166.22 illness or to self-monitor, compensate for, cope with, counteract, or replace skills deficits
166.23 or maladaptive skills acquired over the course of a psychiatric illness. Skills training
166.24 is subject to the following requirements:

166.25 (1) a mental health professional or a mental health practitioner must provide skills
166.26 training;

166.27 (2) the child must always be present during skills training; however, a brief absence
166.28 of the child for no more than ten percent of the session unit may be allowed to redirect or
166.29 instruct family members;

166.30 (3) skills training delivered to children or their families must be targeted to the
166.31 specific deficits or maladaptations of the child's mental health disorder and must be
166.32 prescribed in the child's individual treatment plan;

166.33 (4) skills training delivered to the child's family must teach skills needed by parents
166.34 to enhance the child's skill development and to help the child use in daily life the skills
166.35 previously taught by a mental health professional or mental health practitioner and to
166.36 develop or maintain a home environment that supports the child's progressive use skills;

167.1 (5) group skills training may be provided to multiple recipients who, because of the
 167.2 nature of their emotional, behavioral, or social dysfunction, can derive mutual benefit from
 167.3 interaction in a group setting, which must be staffed as follows:

167.4 (i) one mental health professional or one mental health practitioner under supervision
 167.5 of a licensed mental health professional must work with a group of four to eight clients; or

167.6 (ii) two mental health professionals or two mental health practitioners under
 167.7 supervision of a licensed mental health professional, or one professional plus one
 167.8 practitioner must work with a group of nine to 12 clients.

167.9 Sec. 19. Minnesota Statutes 2012, section 256B.0943, subdivision 2, is amended to read:

167.10 Subd. 2. **Covered service components of children's therapeutic services and**
 167.11 **supports.** (a) Subject to federal approval, medical assistance covers medically necessary
 167.12 children's therapeutic services and supports as defined in this section that an eligible
 167.13 provider entity certified under subdivision 4 provides to a client eligible under subdivision
 167.14 3.

167.15 (b) The service components of children's therapeutic services and supports are:

167.16 (1) individual, family, and group psychotherapy;

167.17 (2) individual, family, or group skills training provided by a mental health
 167.18 professional or mental health practitioner;

167.19 (3) crisis assistance;

167.20 (4) mental health behavioral aide services; ~~and~~

167.21 (5) direction of a mental health behavioral aide; ~~;~~

167.22 (6) mental health service plan development;

167.23 (7) clinical care consultation provided by a mental health professional under section
 167.24 256B.0625, subdivision 62;

167.25 (8) family psychoeducation under section 256B.0625, subdivision 61; and

167.26 (9) services provided by a family peer specialist under section 256B.0616.

167.27 (c) Service components in paragraph (b) may be combined to constitute therapeutic
 167.28 programs, including day treatment programs and therapeutic preschool programs.

167.29 Sec. 20. Minnesota Statutes 2012, section 256B.0943, subdivision 7, is amended to read:

167.30 Subd. 7. **Qualifications of individual and team providers.** (a) An individual
 167.31 or team provider working within the scope of the provider's practice or qualifications
 167.32 may provide service components of children's therapeutic services and supports that are
 167.33 identified as medically necessary in a client's individual treatment plan.

167.34 (b) An individual provider must be qualified as:

- 168.1 (1) a mental health professional as defined in subdivision 1, paragraph (n); or
 168.2 (2) a mental health practitioner as defined in section 245.4871, subdivision 26. The
 168.3 mental health practitioner must work under the clinical supervision of a mental health
 168.4 professional; or
 168.5 (3) a mental health behavioral aide working under the clinical supervision of a
 168.6 mental health professional to implement the rehabilitative mental health services identified
 168.7 in the client's individual treatment plan and individual behavior plan.
- 168.8 (A) A level I mental health behavioral aide must:
 168.9 (i) be at least 18 years old;
 168.10 (ii) have a high school diploma or general equivalency diploma (GED) or two years
 168.11 of experience as a primary caregiver to a child with severe emotional disturbance within
 168.12 the previous ten years; and
 168.13 (iii) meet preservice and continuing education requirements under subdivision 8.
- 168.14 (B) A level II mental health behavioral aide must:
 168.15 (i) be at least 18 years old;
 168.16 (ii) have an associate or bachelor's degree or 4,000 hours of experience in delivering
 168.17 clinical services in the treatment of mental illness concerning children or adolescents or
 168.18 complete a certificate program established under subdivision 8a; and
 168.19 (iii) meet preservice and continuing education requirements in subdivision 8.
- 168.20 (c) A preschool program multidisciplinary team must include at least one mental
 168.21 health professional and one or more of the following individuals under the clinical
 168.22 supervision of a mental health professional:
 168.23 (i) a mental health practitioner; or
 168.24 (ii) a program person, including a teacher, assistant teacher, or aide, who meets the
 168.25 qualifications and training standards of a level I mental health behavioral aide.
- 168.26 (d) A day treatment multidisciplinary team must include at least one mental health
 168.27 professional and one mental health practitioner.

168.28 Sec. 21. Minnesota Statutes 2012, section 256B.0943, is amended by adding a
 168.29 subdivision to read:

168.30 Subd. 8a. **Level II mental health behavioral aide.** The commissioner of human
 168.31 services, in collaboration with the Board of Trustees of the Minnesota State Colleges and
 168.32 Universities, shall develop a certificate program of not fewer than 11 credits for level II
 168.33 mental health behavioral aides. The program shall include classroom and field-based
 168.34 learning. The program components must include, but not be limited to, mental illnesses

169.1 in children, parent and family perspectives, skill training, documentation and reporting,
 169.2 communication skills, and cultural competence.

169.3 Sec. 22. Minnesota Statutes 2012, section 256B.0946, is amended to read:

169.4 **256B.0946 INTENSIVE TREATMENT IN FOSTER CARE.**

169.5 Subdivision 1. **Required covered service components.** (a) ~~Effective July 1, 2006,~~
 169.6 upon enactment and subject to federal approval, medical assistance covers medically
 169.7 necessary intensive treatment services described under paragraph (b) that are provided
 169.8 by a provider entity eligible under subdivision 3 to a client eligible under subdivision 2
 169.9 who is placed in a ~~treatment~~ foster home licensed under Minnesota Rules, parts 2960.3000
 169.10 to 2960.3340.

169.11 (b) Intensive treatment services to children with ~~severe emotional disturbance~~ mental
 169.12 illness residing in ~~treatment foster care~~ family settings ~~must meet the relevant standards~~
 169.13 ~~for mental health services under sections 245.487 to 245.4889. In addition, that comprise~~
 169.14 specific required service components provided in clauses (1) to (5), are reimbursed by
 169.15 medical assistance ~~must~~ when they meet the following standards:

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

169.18 (1) psychotherapy provided by a mental health professional as defined in Minnesota
 169.19 Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota
 169.20 Rules, part 9505.0371, subpart 5, item C;

169.21 ~~(2) psychotherapy, crisis assistance, and skills training components must meet the~~
 169.22 provided according to standards for children's therapeutic services and supports in section
 169.23 256B.0943; ~~and~~

169.24 (3) individual family, and group psychoeducation services under supervision of,
 169.25 defined in subdivision 1a, paragraph (q), provided by a mental health professional; or a
 169.26 clinical trainee;

169.27 (4) clinical care consultation, as defined in subdivision 1a, and provided by a mental
 169.28 health professional or a clinical trainee; and

169.29 (5) service delivery payment requirements as provided under subdivision 4.

169.30 Subd. 1a. **Definitions.** For the purposes of this section, the following terms have
 169.31 the meanings given them.

169.32 (a) "Clinical care consultation" means communication from a treating clinician to
 169.33 other providers working with the same client to inform, inquire, and instruct regarding
 169.34 the client's symptoms, strategies for effective engagement, care and intervention needs,
 169.35 and treatment expectations across service settings, including but not limited to the client's

170.1 school, social services, day care, probation, home, primary care, medication prescribers,
170.2 disabilities services, and other mental health providers and to direct and coordinate clinical
170.3 service components provided to the client and family.

170.4 (b) "Clinical supervision" means the documented time a clinical supervisor and
170.5 supervisee spend together to discuss the supervisee's work, to review individual client
170.6 cases, and for the supervisee's professional development. It includes the documented
170.7 oversight and supervision responsibility for planning, implementation, and evaluation of
170.8 services for a client's mental health treatment.

170.9 (c) "Clinical supervisor" means the mental health professional who is responsible
170.10 for clinical supervision.

170.11 (d) "Clinical trainee" has the meaning given in Minnesota Rules, part 9505.0371,
170.12 subpart 5, item C;

170.13 (e) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a,
170.14 including the development of a plan that addresses prevention and intervention strategies
170.15 to be used in a potential crisis, but does not include actual crisis intervention.

170.16 (f) "Culturally appropriate" means providing mental health services in a manner that
170.17 incorporates the child's cultural influences, as defined in Minnesota Rules, part 9505.0370,
170.18 subpart 9, into interventions as a way to maximize resiliency factors and utilize cultural
170.19 strengths and resources to promote overall wellness.

170.20 (g) "Culture" means the distinct ways of living and understanding the world that
170.21 are used by a group of people and are transmitted from one generation to another or
170.22 adopted by an individual.

170.23 (h) "Diagnostic assessment" has the meaning given in Minnesota Rules, part
170.24 9505.0370, subpart 11.

170.25 (i) "Family" means a person who is identified by the client or the client's parent or
170.26 guardian as being important to the client's mental health treatment. Family may include,
170.27 but is not limited to, parents, foster parents, children, spouse, committed partners, former
170.28 spouses, persons related by blood or adoption, persons who are a part of the client's
170.29 permanency plan, or persons who are presently residing together as a family unit.

170.30 (j) "Foster care" has the meaning given in section 260C.007, subdivision 18.

170.31 (k) "Foster family setting" means the foster home in which the license holder resides.

170.32 (l) "Individual treatment plan" has the meaning given in Minnesota Rules, part
170.33 9505.0370, subpart 15.

170.34 (m) "Mental health practitioner" has the meaning given in Minnesota Rules, part
170.35 9505.0370, subpart 17.

171.1 (n) "Mental health professional" has the meaning given in Minnesota Rules, part
 171.2 9505.0370, subpart 18.

171.3 (o) "Mental illness" has the meaning given in Minnesota Rules, part 9505.0370,
 171.4 subpart 20.

171.5 (p) "Parent" has the meaning given in section 260C.007, subdivision 25.

171.6 (q) "Psychoeducation services" means information or demonstration provided to
 171.7 an individual, family, or group to explain, educate, and support the individual, family, or
 171.8 group in understanding a child's symptoms of mental illness, the impact on the child's
 171.9 development, and needed components of treatment and skill development so that the
 171.10 individual, family, or group can help the child to prevent relapse, prevent the acquisition
 171.11 of comorbid disorders, and to achieve optimal mental health and long-term resilience.

171.12 (r) "Psychotherapy" has the meaning given in Minnesota Rules, part 9505.0370,
 171.13 subpart 27.

171.14 (s) "Team consultation and treatment planning" means the coordination of treatment
 171.15 plans and consultation among providers in a group concerning the treatment needs of the
 171.16 child, including disseminating the child's treatment service schedule to all members of the
 171.17 service team. Team members must include all mental health professionals working with
 171.18 the child, a parent, the child unless the team lead or parent deem it clinically inappropriate,
 171.19 and at least two of the following: an individualized education program case manager;
 171.20 probation agent; children's mental health case manager; child welfare worker, including
 171.21 adoption or guardianship worker; primary care provider; foster parent; and any other
 171.22 member of the child's service team.

171.23 **Subd. 2. Determination of client eligibility.** ~~A client's eligibility to receive~~
 171.24 ~~treatment foster care under this section shall be determined by~~ An eligible recipient is an
 171.25 individual, from birth through age 20, who is currently placed in a foster home licensed
 171.26 under Minnesota Rules, parts 2960.3000 to 2960.3340, and has received a diagnostic
 171.27 assessment; and an evaluation of level of care needed, and development of an individual
 171.28 treatment plan, as defined in paragraphs (a) to (e) and (b).

171.29 (a) The diagnostic assessment must:

171.30 (1) meet criteria described in Minnesota Rules, part 9505.0372, subpart 1, and be
 171.31 conducted by a psychiatrist, licensed psychologist, or licensed independent clinical social
 171.32 worker that is mental health professional or a clinical trainee;

171.33 (2) determine whether or not a child meets the criteria for mental illness, as defined
 171.34 in Minnesota Rules, part 9505.0370, subpart 20;

171.35 (3) document that intensive treatment services are medically necessary within a
 171.36 foster family setting to ameliorate identified symptoms and functional impairments;

- 172.1 ~~(4) be performed within 180 days prior to~~ before the start of service; and
- 172.2 ~~(2) include current diagnoses on all five axes of the client's current mental health~~
- 172.3 ~~status;~~
- 172.4 ~~(3) determine whether or not a child meets the criteria for severe emotional~~
- 172.5 ~~disturbance in section 245.4871, subdivision 6, or for serious and persistent mental illness~~
- 172.6 ~~in section 245.462, subdivision 20; and~~
- 172.7 ~~(4) be completed annually until age 18. For individuals between age 18 and 21,~~
- 172.8 ~~unless a client's mental health condition has changed markedly since the client's most~~
- 172.9 ~~recent diagnostic assessment, annual updating is necessary. For the purpose of this section,~~
- 172.10 ~~"updating" means a written summary, including current diagnoses on all five axes, by a~~
- 172.11 ~~mental health professional of the client's current mental status and service needs.~~
- 172.12 (5) be completed as either a standard or extended diagnostic assessment annually to
- 172.13 determine continued eligibility for the service.
- 172.14 (b) The evaluation of level of care must be conducted by the placing county with
- 172.15 an instrument, tribe, or case manager in conjunction with the diagnostic assessment as
- 172.16 described by Minnesota Rules, part 9505.0372, subpart 1, item B, using a validated tool
- 172.17 approved by the commissioner of human services and not subject to the rulemaking
- 172.18 process, consistent with section 245.4885, subdivision 1, paragraph (d), the result of which
- 172.19 evaluation demonstrates that the child requires intensive intervention without 24-hour
- 172.20 medical monitoring. The commissioner shall update the list of approved level of care
- 172.21 instruments tools annually and publish on the department's Web site.
- 172.22 (c) The individual treatment plan must be:
- 172.23 (1) ~~based on the information in the client's diagnostic assessment;~~
- 172.24 (2) ~~developed through a child-centered, family driven planning process that identifies~~
- 172.25 ~~service needs and individualized, planned, and culturally appropriate interventions that~~
- 172.26 ~~contain specific measurable treatment goals and objectives for the client and treatment~~
- 172.27 ~~strategies for the client's family and foster family;~~
- 172.28 (3) ~~reviewed at least once every 90 days and revised; and~~
- 172.29 (4) ~~signed by the client or, if appropriate, by the client's parent or other person~~
- 172.30 ~~authorized by statute to consent to mental health services for the client.~~
- 172.31 Subd. 3. **Eligible mental health services providers.** (a) Eligible providers for
- 172.32 intensive children's mental health services in a foster family setting must be certified
- 172.33 by the state and have a service provision contract with a county board or a reservation
- 172.34 tribal council and must be able to demonstrate the ability to provide all of the services
- 172.35 required in this section.

173.1 (b) For purposes of this section, a provider agency must have an individual
 173.2 placement agreement for each recipient and must be a licensed child placing agency, under
 173.3 Minnesota Rules, parts 9543.0010 to 9543.0150, and either be:

173.4 (1) a county county-operated entity certified by the state;

173.5 (2) an Indian Health Services facility operated by a tribe or tribal organization under
 173.6 funding authorized by United States Code, title 25, sections 450f to 450n, or title 3 of the
 173.7 Indian Self-Determination Act, Public Law 93-638, section 638 (facilities or providers); or

173.8 (3) a noncounty entity under contract with a county board.

173.9 (c) Certified providers that do not meet the service delivery standards required in
 173.10 this section shall be subject to a decertification process.

173.11 (d) For the purposes of this section, all services delivered to a client must be
 173.12 provided by a mental health professional or a clinical trainee.

173.13 Subd. 4. **Eligible provider responsibilities Service delivery payment**

173.14 **requirements.** (a) To be an eligible provider for payment under this section, a provider
 173.15 must develop and practice written policies and procedures for treatment foster care services
 173.16 intensive treatment in foster care, consistent with subdivision 1, paragraph (b), clauses (1),
 173.17 (2), and (3) and comply with the following requirements in paragraphs (b) to (n).

173.18 (b) In delivering services under this section, a treatment foster care provider must
 173.19 ensure that staff caseload size reasonably enables the provider to play an active role in
 173.20 service planning, monitoring, delivering, and reviewing for discharge planning to meet
 173.21 the needs of the client, the client's foster family, and the birth family, as specified in each
 173.22 client's individual treatment plan.

173.23 (b) A qualified clinical supervisor, as defined in and performing in compliance with
 173.24 Minnesota Rules, part 9505.0371, subpart 5, item D, must supervise the treatment and
 173.25 provision of services described in this section.

173.26 (c) Each client receiving treatment services must receive an extended diagnostic
 173.27 assessment, as described in Minnesota Rules, part 9505.0372, subpart 1, item C, within
 173.28 30 days of enrollment in this service unless the client has a previous extended diagnostic
 173.29 assessment that the client, parent, and mental health professional agree still accurately
 173.30 describes the client's current mental health functioning.

173.31 (d) Each previous and current mental health, school, and physical health treatment
 173.32 provider must be contacted to request documentation of treatment and assessments that the
 173.33 eligible client has received and this information must be reviewed and incorporated into
 173.34 the diagnostic assessment and team consultation and treatment planning review process.

174.1 (e) Each client receiving treatment must be assessed for a trauma history and
174.2 the client's treatment plan must document how the results of the assessment will be
174.3 incorporated into treatment.

174.4 (f) Each client receiving treatment services must have an individual treatment plan
174.5 that is reviewed, evaluated, and signed every 90 days using the team consultation and
174.6 treatment planning process, as defined in subdivision 1a, paragraph (s).

174.7 (g) Care consultation, as defined in subdivision 1a, paragraph (a), must be provided
174.8 in accordance with the client's individual treatment plan.

174.9 (h) Each client must have a crisis assistance plan within ten days of initiating
174.10 services and must have access to clinical phone support 24 hours per day, seven days per
174.11 week, during the course of treatment, and the crisis plan must demonstrate coordination
174.12 with the local or regional mobile crisis intervention team.

174.13 (i) Services must be delivered and documented at least three days per week, equaling
174.14 at least six hours of treatment per week, unless reduced units of service are specified on
174.15 the treatment plan as part of transition or on a discharge plan to another service or level of
174.16 care. Documentation must comply with Minnesota Rules, parts 9505.2175 and 9505.2197.

174.17 (j) Location of service delivery must be in the client's home, day care setting,
174.18 school, or other community-based setting that is specified on the client's individualized
174.19 treatment plan.

174.20 (k) Treatment must be developmentally and culturally appropriate for the client.

174.21 (l) Services must be delivered in continual collaboration and consultation with the
174.22 client's medical providers and, in particular, with prescribers of psychotropic medications,
174.23 including those prescribed on an off-label basis, and members of the service team must be
174.24 aware of the medication regimen and potential side effects.

174.25 (m) Parents, siblings, foster parents, and members of the child's permanency plan
174.26 must be involved in treatment and service delivery unless otherwise noted in the treatment
174.27 plan.

174.28 (n) Transition planning for the child must be conducted starting with the first
174.29 treatment plan and must be addressed throughout treatment to support the child's
174.30 permanency plan and postdischarge mental health service needs.

174.31 Subd. 5. **Service authorization.** The commissioner will administer authorizations
174.32 for services under this section in compliance with section 256B.0625, subdivision 25.

174.33 Subd. 6. **Excluded services.** (a) Services in clauses (1) to ~~(4)~~ (7) are not covered
174.34 under this section and are not eligible for medical assistance payment as components of
174.35 intensive treatment in foster care services, but may be billed separately:

175.1 ~~(1) treatment foster care services provided in violation of medical assistance policy~~
 175.2 ~~in Minnesota Rules, part 9505.0220;~~

175.3 ~~(2) service components of children's therapeutic services and supports~~
 175.4 ~~simultaneously provided by more than one treatment foster care provider;~~

175.5 ~~(3) home and community-based waiver services; and~~

175.6 ~~(4) treatment foster care services provided to a child without a level of care~~
 175.7 ~~determination according to section 245.4885, subdivision 1.~~

175.8 (1) inpatient psychiatric hospital treatment;

175.9 (2) mental health targeted case management;

175.10 (3) partial hospitalization;

175.11 (4) medication management;

175.12 (5) children's mental health day treatment services;

175.13 (6) crisis response services under section 256B.0944; and

175.14 (7) transportation.

175.15 (b) Children receiving intensive treatment in foster care services are not eligible for
 175.16 medical assistance reimbursement for the following services while receiving intensive
 175.17 treatment in foster care:

175.18 ~~(1) mental health case management services under section 256B.0625, subdivision~~
 175.19 ~~20; and~~

175.20 ~~(2) (1) psychotherapy and skill skills training components of children's therapeutic~~
 175.21 ~~services and supports under section 256B.0625, subdivision 35b;~~

175.22 (2) mental health behavioral aide services as defined in section 256B.0943,
 175.23 subdivision 1, paragraph (m);

175.24 (3) home and community-based waiver services;

175.25 (4) mental health residential treatment; and

175.26 (5) room and board costs as defined in section 256I.03, subdivision 6.

175.27 Subd. 7. **Medical assistance payment and rate setting.** The commissioner shall
 175.28 establish a single daily per-client encounter rate for intensive treatment in foster care
 175.29 services. The rate must be constructed to cover only eligible services delivered to an
 175.30 eligible recipient by an eligible provider, as prescribed in subdivision 1, paragraph (b).

175.31 Sec. 23. Minnesota Statutes 2012, section 256B.761, is amended to read:

175.32 **256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.**

175.33 (a) Effective for services rendered on or after July 1, 2001, payment for medication
 175.34 management provided to psychiatric patients, outpatient mental health services, day
 175.35 treatment services, home-based mental health services, and family community support

176.1 services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the
176.2 50th percentile of 1999 charges.

176.3 (b) Effective July 1, 2001, the medical assistance rates for outpatient mental health
176.4 services provided by an entity that operates: (1) a Medicare-certified comprehensive
176.5 outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1,
176.6 1993, with at least 33 percent of the clients receiving rehabilitation services in the most
176.7 recent calendar year who are medical assistance recipients, will be increased by 38 percent,
176.8 when those services are provided within the comprehensive outpatient rehabilitation
176.9 facility and provided to residents of nursing facilities owned by the entity.

176.10 (c) The commissioner shall establish three levels of payment for mental health
176.11 diagnostic assessment, based on three levels of complexity. The aggregate payment under
176.12 the tiered rates must not exceed the projected aggregate payments for mental health
176.13 diagnostic assessment under the previous single rate. The new rate structure is effective
176.14 January 1, 2011, or upon federal approval, whichever is later.

176.15 (d) In addition to rate increases otherwise provided, the commissioner may
176.16 restructure coverage policy and rates to improve access to adult rehabilitative mental
176.17 health services under section 256B.0623 and related mental health support services under
176.18 section 256B.021, subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and
176.19 2016, the projected state share of increased costs due to this paragraph is transferred
176.20 from adult mental health grants under sections 245.4661 and 256E.12. The transfer for
176.21 fiscal year 2016 is a permanent base adjustment for subsequent fiscal years. Payments
176.22 made to managed care plans and county-based purchasing plans under sections 256B.69,
176.23 256B.692, and 256L.12 shall reflect the rate changes described in this paragraph.

176.24 Sec. 24. Minnesota Statutes 2012, section 256I.05, subdivision 1e, is amended to read:

176.25 Subd. 1e. **Supplementary rate for certain facilities.** (a) Notwithstanding the
176.26 provisions of subdivisions 1a and 1c, beginning July 1, 2005, a county agency shall
176.27 negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to
176.28 exceed \$700 per month, including any legislatively authorized inflationary adjustments,
176.29 for a group residential housing provider that:

176.30 (1) is located in Hennepin County and has had a group residential housing contract
176.31 with the county since June 1996;

176.32 (2) operates in three separate locations a 75-bed facility, a 50-bed facility, and a
176.33 26-bed facility; and

177.1 (3) serves a chemically dependent clientele, providing 24 hours per day supervision
 177.2 and limiting a resident's maximum length of stay to 13 months out of a consecutive
 177.3 24-month period.

177.4 (b) Notwithstanding subdivisions 1a and 1c, a county agency shall negotiate a
 177.5 supplementary rate in addition to the rate specified in subdivision 1, not to exceed \$700
 177.6 per month, including any legislatively authorized inflationary adjustments, of a group
 177.7 residential provider that:

177.8 (1) is located in St. Louis County and has had a group residential housing contract
 177.9 with the county since 2006;

177.10 (2) operates a 62-bed facility; and

177.11 (3) serves a chemically dependent adult male clientele, providing 24 hours per
 177.12 day supervision and limiting a resident's maximum length of stay to 13 months out of
 177.13 a consecutive 24-month period.

177.14 ~~(e) Notwithstanding subdivisions 1a and 1c, beginning July 1, 2013, a county agency~~
 177.15 ~~shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not~~
 177.16 ~~to exceed \$700 per month, including any legislatively authorized inflationary adjustments,~~
 177.17 ~~for the group residential provider described under paragraphs (a) and (b), not to exceed~~
 177.18 ~~an additional 115 beds.~~

177.19 Sec. 25. **CHILD AND ADOLESCENT BEHAVIORAL HEALTH SERVICES.**

177.20 The commissioner of human services shall, in consultation with children's mental
 177.21 health community providers, hospitals providing care to children, children's mental health
 177.22 advocates, and other interested parties, develop recommendations and legislation, if
 177.23 necessary, for the state-operated child and adolescent behavioral health services facility
 177.24 to ensure that:

177.25 (1) the facility and the services provided meet the needs of children with serious
 177.26 emotional disturbances, autism spectrum disorders, reactive attachment disorder, PTSD,
 177.27 serious emotional disturbance co-occurring with a developmental disability, borderline
 177.28 personality disorder, schizophrenia, fetal alcohol spectrum disorders, brain injuries,
 177.29 violent tendencies, and complex medical issues;

177.30 (2) qualified personnel and staff can be recruited who have specific expertise and
 177.31 training to treat the children in the facility; and

177.32 (3) the treatment provided at the facility is high-quality, effective treatment.

177.33 Sec. 26. **PILOT PROVIDER INPUT SURVEY OF PEDIATRIC SERVICES AND**
 177.34 **CHILDREN'S MENTAL HEALTH SERVICES.**

178.1 (a) To assess the efficiency and other operational issues in the management of the
178.2 health care delivery system, the commissioner of human services shall initiate a provider
178.3 survey. The pilot survey shall consist of an electronic survey of providers of pediatric
178.4 home health care services and children's mental health services to identify and measure
178.5 issues that arise in dealing with the management of medical assistance. To the maximum
178.6 degree possible, existing technology shall be used and interns sought to analyze the results.

178.7 (b) The survey questions must focus on seven key business functions provided
178.8 by medical assistance contractors: provider inquiries; provider outreach and education;
178.9 claims processing; appeals; provider enrollment; medical review; and provider audit and
178.10 reimbursement. The commissioner must consider the results of the survey in evaluating
178.11 and renewing managed care and fee-for-service management contracts.

178.12 (c) The commissioner shall report by January 15, 2014, the results of the survey to
178.13 the chairs of the health and human services policy and finance committees and shall
178.14 make recommendations on the value of implementing an annual survey with a rotating
178.15 list of provider groups as a component of the continuous quality improvement system for
178.16 medical assistance.

178.17 **Sec. 27. MENTALLY ILL AND DANGEROUS COMMITMENTS**
178.18 **STAKEHOLDERS GROUP.**

178.19 (a) The commissioner of human services, in consultation with the state court
178.20 administrator, shall convene a stakeholder group to develop recommendations for the
178.21 legislature that address issues raised in the February 2013 Office of the Legislative
178.22 Auditor report on State-Operated Services for persons committed to the commissioner as
178.23 mentally ill and dangerous under Minnesota Statutes, section 253B.18. Stakeholders must
178.24 include representatives from the Department of Human Services, county human services,
178.25 county attorneys, commitment defense attorneys, the ombudsman for mental health and
178.26 developmental disabilities, the federal protection and advocacy system, and consumers
178.27 and advocates for persons with mental illnesses.

178.28 (b) The stakeholder group shall provide recommendations in the following areas:

178.29 (1) the role of the special review board, including the scope of authority of the
178.30 special review board and the authority of the commissioner to accept or reject special
178.31 review board recommendations;

178.32 (2) review of special review board decisions by the district court;

178.33 (3) annual district court review of commitment, scope of court authority, and
178.34 appropriate review criteria;

179.1 (4) options, including annual court hearing and review, as alternatives to
 179.2 indeterminate commitment under Minnesota Statutes, section 253B.18; and
 179.3 (5) extension of the right to petition the court under Minnesota Statutes,
 179.4 section 253B.17, to those committed under Minnesota Statutes, section 253B.18.
 179.5 The commissioner of human services and the state court administrator shall provide
 179.6 relevant data for the group's consideration in developing these recommendations,
 179.7 including numbers of proceedings in each category and costs associated with court and
 179.8 administrative proceedings under Minnesota Statutes, section 253B.18.
 179.9 (c) By January 15, 2014, the commissioner of human services shall submit the
 179.10 recommendations of the stakeholder group to the chairs and ranking minority members
 179.11 of the committees of the legislature with jurisdiction over civil commitment and human
 179.12 services issues.

179.13 ARTICLE 5

179.14 DEPARTMENT OF HUMAN SERVICES PROGRAM INTEGRITY AND 179.15 OFFICE OF INSPECTOR GENERAL

179.16 Section 1. Minnesota Statutes 2012, section 13.461, is amended by adding a
 179.17 subdivision to read:

179.18 Subd. 7b. **Child care provider and recipient fraud investigations.** Data related
 179.19 to child care fraud and recipient fraud investigations are governed by section 245E.01,
 179.20 subdivision 15.

179.21 Sec. 2. Minnesota Statutes 2012, section 243.166, subdivision 7, is amended to read:

179.22 Subd. 7. **Use of data.** (a) Except as otherwise provided in subdivision 7a or sections
 179.23 244.052 and 299C.093, the data provided under this section is private data on individuals
 179.24 under section 13.02, subdivision 12.

179.25 (b) The data may be used only for by law enforcement and corrections agencies for
 179.26 law enforcement and corrections purposes.

179.27 (c) The commissioner of human services is authorized to have access to the data for:

179.28 (1) state-operated services, as defined in section 246.014, ~~are also authorized to~~
 179.29 ~~have access to the data~~ for the purposes described in section 246.13, subdivision 2,
 179.30 paragraph (b); and

179.31 (2) purposes of completing background studies under chapter 245C.

179.32 Sec. 3. Minnesota Statutes 2012, section 245C.04, is amended by adding a subdivision
 179.33 to read:

180.1 Subd. 4a. **Agency background studies.** (a) The commissioner shall develop and
180.2 implement an electronic process for the regular transfer of new criminal case information
180.3 that is added to the Minnesota court information system. The commissioner's system
180.4 must include for review only information that relates to individuals who have been the
180.5 subject of a background study under this chapter that remain affiliated with the agency
180.6 that initiated the background study. For purposes of this paragraph, an individual remains
180.7 affiliated with an agency that initiated the background study until the agency informs the
180.8 commissioner that the individual is no longer affiliated. When any individual no longer
180.9 affiliated according to this paragraph returns to a position requiring a background study
180.10 under this chapter, the agency with whom the individual is again affiliated shall initiate
180.11 a new background study regardless of the length of time the individual was no longer
180.12 affiliated with the agency.

180.13 (b) The commissioner shall develop and implement an online system for agencies that
180.14 initiate background studies under this chapter to access and maintain records of background
180.15 studies initiated by that agency. The system must show all active background study subjects
180.16 affiliated with that agency and the status of each individual's background study. Each
180.17 agency that initiates background studies must use this system to notify the commissioner
180.18 of discontinued affiliation for purposes of the processes required under paragraph (a).

180.19 Sec. 4. Minnesota Statutes 2012, section 245C.08, subdivision 1, is amended to read:

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

180.23 (1) information related to names of substantiated perpetrators of maltreatment of
180.24 vulnerable adults that has been received by the commissioner as required under section
180.25 626.557, subdivision 9c, paragraph (j);

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

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

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

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

181.4 (6) for a background study related to a child foster care application for licensure or
181.5 adoptions, the commissioner shall also review:

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

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

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

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

181.18 Sec. 5. Minnesota Statutes 2012, section 245C.32, subdivision 2, is amended to read:

181.19 Subd. 2. **Use.** (a) The commissioner may also use these systems and records to
181.20 obtain and provide criminal history data from the Bureau of Criminal Apprehension,
181.21 criminal history data held by the commissioner, and data about substantiated maltreatment
181.22 under section 626.556 or 626.557, for other purposes, provided that:

181.23 (1) the background study is specifically authorized in statute; or

181.24 (2) the request is made with the informed consent of the subject of the study as
181.25 provided in section 13.05, subdivision 4.

181.26 (b) An individual making a request under paragraph (a), clause (2), must agree in
181.27 writing not to disclose the data to any other individual without the consent of the subject
181.28 of the data.

181.29 (c) The commissioner may recover the cost of obtaining and providing background
181.30 study data by charging the individual or entity requesting the study a fee of no more
181.31 than \$20 per study. The fees collected under this paragraph are appropriated to the
181.32 commissioner for the purpose of conducting background studies.

181.33 (d) The commissioner shall recover the cost of obtaining background study data
181.34 required under section 524.5-118 through a fee of \$100 per study for an individual who
181.35 has not lived outside Minnesota for the past ten years, and a fee of \$115 for an individual

182.1 who has resided outside of Minnesota for any period during the ten years preceding the
 182.2 background study. The commissioner shall recover, from the individual, any additional
 182.3 fees charged by other states' licensing agencies that are associated with these data requests.
 182.4 Fees under subdivision 3 also apply when criminal history data from the National Criminal
 182.5 Records Repository is required.

182.6 **Sec. 6. [245E.01] CHILD CARE PROVIDER AND RECIPIENT FRAUD**
 182.7 **INVESTIGATIONS WITHIN THE CHILD CARE ASSISTANCE PROGRAM.**

182.8 Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in this
 182.9 subdivision have the meanings given them.

182.10 (b) "Applicant" has the meaning given in section 119B.011, subdivision 2.

182.11 (c) "Child care assistance program" means any of the assistance programs under
 182.12 chapter 119B.

182.13 (d) "Commissioner" means the commissioner of human services.

182.14 (e) "Controlling individual" has the meaning given in section 245A.02, subdivision
 182.15 5a.

182.16 (f) "County" means a local county child care assistance program staff or
 182.17 subcontracted staff, or a county investigator acting on behalf of the commissioner.

182.18 (g) "Department" means the Department of Human Services.

182.19 (h) "Financial misconduct" or "misconduct" means an entity's or individual's acts or
 182.20 omissions that result in fraud and abuse or error against the Department of Human Services.

182.21 (i) "Identify" means to furnish the full name, current or last known address, phone
 182.22 number, and e-mail address of the individual or business entity.

182.23 (j) "License holder" has the meaning given in section 245A.02, subdivision 9.

182.24 (k) "Mail" means the use of any mail service with proof of delivery and receipt.

182.25 (l) "Provider" means either a provider as defined in section 119B.011, subdivision
 182.26 19, or a legal unlicensed provider as defined in section 119B.011, subdivision 16.

182.27 (m) "Recipient" means a family receiving assistance as defined under section
 182.28 119B.011, subdivision 13.

182.29 (n) "Terminate" means revocation of participation in the child care assistance
 182.30 program.

182.31 Subd. 2. **Investigating provider or recipient financial misconduct.** The
 182.32 department shall investigate alleged or suspected financial misconduct by providers and
 182.33 errors related to payments issued by the child care assistance program under this chapter.
 182.34 Recipients, employees, and staff may be investigated when the evidence shows that their

183.1 conduct is related to the financial misconduct of a provider, license holder, or controlling
 183.2 individual.

183.3 Subd. 3. **Scope of investigations.** (a) The department may contact any person,
 183.4 agency, organization, or other entity that is necessary to an investigation.

183.5 (b) The department may examine or interview any individual, document, or piece of
 183.6 evidence that may lead to information that is relevant to child care assistance program
 183.7 benefits, payments, and child care provider authorizations. This includes, but is not
 183.8 limited to:

183.9 (1) child care assistance program payments;

183.10 (2) services provided by the program or related to child care assistance program
 183.11 recipients;

183.12 (3) services provided to a provider;

183.13 (4) provider financial records of any type;

183.14 (5) daily attendance records of the children receiving services from the provider;

183.15 (6) billings; and

183.16 (7) verification of the credentials of a license holder, controlling individual,
 183.17 employee, staff person, contractor, subcontractor, and entities under contract with the
 183.18 provider to provide services or maintain service and the provider's financial records
 183.19 related to those services.

183.20 Subd. 4. **Determination of investigation.** After completing its investigation, the
 183.21 department shall issue one of the following determinations:

183.22 (1) no violation of child care assistance requirements occurred;

183.23 (2) there is insufficient evidence to show that a violation of child care assistance
 183.24 requirements occurred;

183.25 (3) a preponderance of evidence shows a violation of child care assistance program
 183.26 law, rule, or policy; or

183.27 (4) there exists a credible allegation of fraud.

183.28 Subd. 5. **Actions or administrative sanctions.** (a) In addition to section 256.98,
 183.29 after completing the determination under subdivision 4, the department may take one or
 183.30 more of the actions or sanctions specified in this subdivision.

183.31 (b) The department may take the following actions:

183.32 (1) refer the investigation to law enforcement or a county attorney for possible
 183.33 criminal prosecution;

183.34 (2) refer relevant information to the department's licensing division, the child care
 183.35 assistance program, the Department of Education, the federal child and adult care food
 183.36 program, or appropriate child or adult protection agency;

184.1 (3) enter into a settlement agreement with a provider, license holder, controlling
184.2 individual, or recipient; or

184.3 (4) refer the matter for review by a prosecutorial agency with appropriate jurisdiction
184.4 for possible civil action under the Minnesota False Claims Act, chapter 15C.

184.5 (c) The department may impose sanctions by:

184.6 (1) pursuing administrative disqualification through hearings or waivers;

184.7 (2) establishing and seeking monetary recovery or recoupment; or

184.8 (3) issuing an order of corrective action that states the practices that are violations of
184.9 child care assistance program policies, laws, or regulations, and that they must be corrected.

184.10 Subd. 6. **Duty to provide access.** (a) A provider, license holder, controlling
184.11 individual, employee, staff person, or recipient has an affirmative duty to provide access
184.12 upon request to information specified under subdivision 8 or the program facility.

184.13 (b) Failure to provide access may result in denial or termination of authorizations for
184.14 or payments to a recipient, provider, license holder, or controlling individual in the child
184.15 care assistance program.

184.16 (c) When a provider fails to provide access, a 15-day notice of denial or termination
184.17 must be issued to the provider, which prohibits the provider from participating in the child
184.18 care assistance program. Notice must be sent to recipients whose children are under the
184.19 provider's care pursuant to Minnesota Rules, part 3400.0185.

184.20 (d) If the provider continues to fail to provide access at the expiration of the 15-day
184.21 notice period, child care assistance program payments to the provider must be denied
184.22 beginning the 16th day following notice of the initial failure or refusal to provide access.
184.23 The department may rescind the denial based upon good cause if the provider submits in
184.24 writing a good cause basis for having failed or refused to provide access. The writing must
184.25 be postmarked no later than the 15th day following the provider's notice of initial failure
184.26 to provide access. Additionally, the provider, license holder, or controlling individual
184.27 must immediately provide complete, ongoing access to the department. Repeated failures
184.28 to provide access must, after the initial failure or for any subsequent failure, result in
184.29 termination from participation in the child care assistance program.

184.30 (e) The department, at its own expense, may photocopy or otherwise duplicate
184.31 records referenced in subdivision 8. Photocopying must be done on the provider's
184.32 premises on the day of the request or other mutually agreeable time, unless removal of
184.33 records is specifically permitted by the provider. If requested, a provider, license holder,
184.34 or controlling individual, or a designee, must assist the investigator in duplicating any
184.35 record, including a hard copy or electronically stored data, on the day of the request.

185.1 (f) A provider, license holder, controlling individual, employee, or staff person must
 185.2 grant the department access during the department's normal business hours, and any hours
 185.3 that the program is operated, to examine the provider's program or the records listed in
 185.4 subdivision 8. A provider shall make records available at the provider's place of business
 185.5 on the day for which access is requested, unless the provider and the department both agree
 185.6 otherwise. The department's normal business hours are 8:00 a.m. to 5:00 p.m., Monday
 185.7 through Friday, excluding state holidays as defined in section 645.44, subdivision 5.

185.8 Subd. 7. **Honest and truthful statements.** It shall be unlawful for a provider,
 185.9 license holder, controlling individual, or recipient to:

185.10 (1) falsify, conceal, or cover up by any trick, scheme, or device a material fact;

185.11 (2) make any materially false, fictitious, or fraudulent statement or representation; or

185.12 (3) make or use any false writing or document knowing the same to contain any

185.13 materially false, fictitious, or fraudulent statement or entry related to any child care

185.14 assistance program services that the provider, license holder, or controlling individual

185.15 supplies or in relation to any child care assistance payments received by a provider, license

185.16 holder, or controlling individual or to any fraud investigator or law enforcement officer

185.17 conducting a financial misconduct investigation.

185.18 Subd. 8. **Record retention.** (a) The following records must be maintained,
 185.19 controlled, and made immediately accessible to license holders, providers, and controlling
 185.20 individuals. The records must be organized and labeled to correspond to categories that
 185.21 make them easy to identify so that they can be made available immediately upon request
 185.22 to an investigator acting on behalf of the commissioner at the provider's place of business:

185.23 (1) payroll ledgers, canceled checks, bank deposit slips, and any other accounting
 185.24 records;

185.25 (2) daily attendance records required by and that comply with section 119B.125,
 185.26 subdivision 6;

185.27 (3) billing transmittal forms requesting payments from the child care assistance
 185.28 program and billing adjustments related to child care assistance program payments;

185.29 (4) records identifying all persons, corporations, partnerships, and entities with an
 185.30 ownership or controlling interest in the provider's child care business;

185.31 (5) employee records identifying those persons currently employed by the provider's
 185.32 child care business or who have been employed by the business at any time within the
 185.33 previous five years. The records must include each employee's name, hourly and annual
 185.34 salary, qualifications, position description, job title, and dates of employment. In addition,
 185.35 employee records that must be made available include the employee's time sheets, current

186.1 home address of the employee or last known address of any former employee, and
186.2 documentation of background studies required under chapter 119B or 245C;
186.3 (6) records related to transportation of children in care, including but not limited to:
186.4 (i) the dates and times that transportation is provided to children for transportation to
186.5 and from the provider's business location for any purpose. For transportation related to
186.6 field trips or locations away from the provider's business location, the names and addresses
186.7 of those field trips and locations must also be provided;
186.8 (ii) the name, business address, phone number, and Web site address, if any, of the
186.9 transportation service utilized; and
186.10 (iii) all billing or transportation records related to the transportation.
186.11 (b) A provider, license holder, or controlling individual must retain all records
186.12 in paragraph (a) for at least six years after the date the record is created. Microfilm or
186.13 electronically stored records satisfy the record keeping requirements of this subdivision.
186.14 (c) A provider, license holder, or controlling individual who withdraws or is
186.15 terminated from the child care assistance program must retain the records required under
186.16 this subdivision and make them available to the department on demand.
186.17 (d) If the ownership of a provider changes, the transferor, unless otherwise provided
186.18 by law or by written agreement with the transferee, is responsible for maintaining,
186.19 preserving, and upon request from the department, making available the records related to
186.20 the provider that were generated before the date of the transfer. Any written agreement
186.21 affecting this provision must be held in the possession of the transferor and transferee.
186.22 The written agreement must be provided to the department or county immediately upon
186.23 request, and the written agreement must be retained by the transferor and transferee for six
186.24 years after the agreement is fully executed.
186.25 (e) In the event of an appealed case, the provider must retain all records required in
186.26 this subdivision for the duration of the appeal or six years, whichever is longer.
186.27 (f) A provider's use of electronic record keeping or electronic signatures is governed
186.28 by chapter 325L.
186.29 **Subd. 9. Factors regarding imposition of administrative sanctions. (a) The**
186.30 **department shall consider the following factors in determining the administrative sanctions**
186.31 **to be imposed:**
186.32 **(1) nature and extent of financial misconduct;**
186.33 **(2) history of financial misconduct;**
186.34 **(3) actions taken or recommended by other state agencies, other divisions of the**
186.35 **department, and court and administrative decisions;**
186.36 **(4) prior imposition of sanctions;**

187.1 (5) size and type of provider;
 187.2 (6) information obtained through an investigation from any source;
 187.3 (7) convictions or pending criminal charges; and
 187.4 (8) any other information relevant to the acts or omissions related to the financial
 187.5 misconduct.

187.6 (b) Any single factor under paragraph (a) may be determinative of the department's
 187.7 decision of whether and what sanctions are imposed.

187.8 Subd. 10. **Written notice of department sanction.** (a) The department shall give
 187.9 notice in writing to a person of an administrative sanction that is to be imposed. The notice
 187.10 shall be sent by mail as defined in subdivision 1, paragraph (k).

187.11 (b) The notice shall state:

187.12 (1) the factual basis for the department's determination;

187.13 (2) the sanction the department intends to take;

187.14 (3) the dollar amount of the monetary recovery or recoupment, if any;

187.15 (4) how the dollar amount was computed;

187.16 (5) the right to dispute the department's determination and to provide evidence;

187.17 (6) the right to appeal the department's proposed sanction; and

187.18 (7) the option to meet informally with department staff, and to bring additional
 187.19 documentation or information, to resolve the issues.

187.20 (c) In cases of determinations resulting in denial or termination of payments, in
 187.21 addition to the requirements of paragraph (b), the notice must state:

187.22 (1) the length of the denial or termination;

187.23 (2) the requirements and procedures for reinstatement; and

187.24 (3) the provider's right to submit documents and written arguments against the
 187.25 denial or termination of payments for review by the department before the effective date
 187.26 of denial or termination.

187.27 (d) The submission of documents and written argument for review by the department
 187.28 under paragraph (b), clause (5) or (7), or paragraph (c), clause (3), does not stay the
 187.29 deadline for filing an appeal.

187.30 (e) Unless timely appealed, the effective date of the proposed sanction shall be 30
 187.31 days after the license holder's, provider's, controlling individual's, or recipient's receipt of
 187.32 the notice. If a timely appeal is made, the proposed sanction shall be delayed pending
 187.33 the final outcome of the appeal. Implementation of a proposed sanction following the
 187.34 resolution of a timely appeal may be postponed if, in the opinion of the department, the
 187.35 delay of sanction is necessary to protect the health or safety of children in care. The
 187.36 department may consider the economic hardship of a person in implementing the proposed

188.1 sanction, but economic hardship shall not be a determinative factor in implementing the
188.2 proposed sanction.

188.3 (f) Requests for an informal meeting to attempt to resolve issues and requests
188.4 for appeals must be sent or delivered to the department's Office of Inspector General,
188.5 Financial Fraud and Abuse Division.

188.6 Subd. 11. **Appeal of department sanction under this section.** (a) If the department
188.7 does not pursue a criminal action against a provider, license holder, controlling individual,
188.8 or recipient for financial misconduct, but the department imposes an administrative
188.9 sanction, any individual or entity against whom the sanction was imposed may appeal the
188.10 department's administrative sanction under this section pursuant to section 119B.16 or
188.11 256.045 with the additional requirements in clauses (1) to (4). An appeal must specify:

188.12 (1) each disputed item, the reason for the dispute, and an estimate of the dollar
188.13 amount involved for each disputed item, if appropriate;

188.14 (2) the computation that is believed to be correct, if appropriate;

188.15 (3) the authority in the statute or rule relied upon for each disputed item; and

188.16 (4) the name, address, and phone number of the person at the provider's place of
188.17 business with whom contact may be made regarding the appeal.

188.18 (b) An appeal is considered timely only if postmarked or received by the
188.19 department's Office of Inspector General, Financial Fraud and Abuse Division within 30
188.20 days after receiving a notice of department sanction.

188.21 (c) Before the appeal hearing, the department may deny or terminate authorizations
188.22 or payment to the entity or individual if the department determines that the action is
188.23 necessary to protect the public welfare or the interests of the child care assistance program.

188.24 Subd. 12. **Consolidated hearings with licensing sanction.** If a financial
188.25 misconduct sanction has an appeal hearing right and it is timely appealed, and a licensing
188.26 sanction exists for which there is an appeal hearing right and the sanction is timely
188.27 appealed, and the overpayment recovery action and licensing sanction involve the same
188.28 set of facts, the overpayment recovery action and licensing sanction must be consolidated
188.29 in the contested case hearing related to the licensing sanction.

188.30 Subd. 13. **Grounds for and methods of monetary recovery.** (a) The department
188.31 may obtain monetary recovery from a provider who has been improperly paid by the
188.32 child care assistance program, regardless of whether the error was intentional or county
188.33 error. The department does not need to establish a pattern as a precondition of monetary
188.34 recovery of erroneous or false billing claims, duplicate billing claims, or billing claims
188.35 based on false statements or financial misconduct.

189.1 (b) The department shall obtain monetary recovery from providers by the following
189.2 means:

189.3 (1) permitting voluntary repayment of money, either in lump-sum payment or
189.4 installment payments;

189.5 (2) using any legal collection process;

189.6 (3) deducting or withholding program payments; or

189.7 (4) utilizing the means set forth in chapter 16D.

189.8 Subd. 14. **Reporting of suspected fraudulent activity.** (a) A person who, in
189.9 good faith, makes a report of or testifies in any action or proceeding in which financial
189.10 misconduct is alleged, and who is not involved in, has not participated in, or has not aided
189.11 and abetted, conspired, or colluded in the financial misconduct, shall have immunity from
189.12 any liability, civil or criminal, that results by reason of the person's report or testimony.
189.13 For the purpose of any proceeding, the good faith of any person reporting or testifying
189.14 under this provision shall be presumed.

189.15 (b) If a person that is or has been involved in, participated in, aided and abetted,
189.16 conspired, or colluded in the financial misconduct reports the financial misconduct,
189.17 the department may consider that person's report and assistance in investigating the
189.18 misconduct as a mitigating factor in the department's pursuit of civil, criminal, or
189.19 administrative remedies.

189.20 Subd. 15. **Data privacy.** Data of any kind obtained or created in relation to a provider
189.21 or recipient investigation under this section is defined, classified, and protected the same as
189.22 all other data under section 13.46, and this data has the same classification as licensing data.

189.23 Subd. 16. **Monetary recovery; random sample extrapolation.** The department is
189.24 authorized to calculate the amount of monetary recovery from a provider, license holder, or
189.25 controlling individual based upon extrapolation from a statistical random sample of claims
189.26 submitted by the provider, license holder, or controlling individual and paid by the child
189.27 care assistance program. The department's random sample extrapolation shall constitute a
189.28 rebuttable presumption of the accuracy of the calculation of monetary recovery. If the
189.29 presumption is not rebutted by the provider, license holder, or controlling individual in the
189.30 appeal process, the department shall use the extrapolation as the monetary recovery figure.
189.31 The department may use sampling and extrapolation to calculate the amount of monetary
189.32 recovery if the claims to be reviewed represent services to 50 or more children in care.

189.33 Subd. 17. **Effect of department's monetary penalty determination.** Unless
189.34 a timely and proper appeal is received by the department's Office of Inspector General,
189.35 Financial Fraud and Abuse Division, the department's administrative determination or
189.36 sanction shall be considered a final department determination.

190.1 Subd. 18. Office of Inspector General recoveries. Overpayment recoveries
 190.2 resulting from child care provider fraud investigations initiated by the department's Office
 190.3 of Inspector General's fraud investigations staff are excluded from the county recovery
 190.4 provision in section 119B.11, subdivision 3.

190.5 Sec. 7. Minnesota Statutes 2012, section 256B.04, subdivision 21, is amended to read:

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

190.11 (b) An enrolled provider that is also licensed by the commissioner under chapter
 190.12 245A must designate an individual as the entity's compliance officer. The compliance
 190.13 officer must:

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

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

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

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

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

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

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

190.30 (c) The commissioner may revoke the enrollment of an ordering or rendering
 190.31 provider for a period of not more than one year, if the provider fails to maintain and, upon
 190.32 request from the commissioner, provide access to documentation relating to written orders
 190.33 or requests for payment for durable medical equipment, certifications for home health
 190.34 services, or referrals for other items or services written or ordered by such provider, when
 190.35 the commissioner has identified a pattern of a lack of documentation. A pattern means a

191.1 failure to maintain documentation or provide access to documentation on more than one
191.2 occasion. Nothing in this paragraph limits the authority of the commissioner to sanction a
191.3 provider under the provisions of section 256B.064.

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

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

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

191.24 (g) As a condition of enrollment, all durable medical equipment, prosthetics,
191.25 orthotics, and supplies (DMEPOS) suppliers operating in Minnesota are required to name
191.26 the Department of Human Services, in addition to the Centers for Medicare and Medicaid
191.27 Services, as an obligee on all surety performance bonds required pursuant to section
191.28 4312(a) of the Balanced Budget Act of 1997, Public Law 105-33, amending Social
191.29 Security Act, section 1834(a). The performance bond must also allow for recovery of
191.30 costs and fees in pursuing a claim on the bond.

191.31 (h) The Department of Human Services may require a provider to purchase a
191.32 performance surety bond as a condition of initial enrollment, reenrollment, reinstatement,
191.33 or continued enrollment if: (1) the provider fails to demonstrate financial viability; (2) the
191.34 department determines there is significant evidence of or potential for fraud and abuse
191.35 by the provider; or (3) the provider or category of providers is designated high-risk
191.36 pursuant to paragraph (a) and Code of Federal Regulations, title 42, section 455.450, or

192.1 the department otherwise finds it is in the best interest of the Medicaid program to do so.
192.2 The performance bond must be in an amount of \$100,000 or ten percent of the provider's
192.3 payments from Medicaid during the immediately preceding 12 months, whichever is
192.4 greater. The performance bond must name the Department of Human Services as an
192.5 obligee and must allow for recovery of costs and fees in pursuing a claim on the bond.

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

192.7 Sec. 8. Minnesota Statutes 2012, section 256B.04, is amended by adding a subdivision
192.8 to read:

192.9 Subd. 22. **Application fee.** (a) The commissioner must collect and retain federally
192.10 required nonrefundable application fees to pay for provider screening activities in
192.11 accordance with Code of Federal Regulations, title 42, section 455, subpart E. The
192.12 enrollment application must be made under the procedures specified by the commissioner,
192.13 in the form specified by the commissioner, and accompanied by an application fee
192.14 described in paragraph (b), or a request for a hardship exception as described in the
192.15 specified procedures. Application fees must be deposited in the provider screening account
192.16 in the special revenue fund. Amounts in the provider screening account are appropriated
192.17 to the commissioner for costs associated with the provider screening activities required
192.18 in Code of Federal Regulations, title 42, section 455, subpart E. The commissioner
192.19 shall conduct screening activities as required by Code of Federal Regulations, title 42,
192.20 section 455, subpart E, and as otherwise provided by law, to include database checks,
192.21 unannounced pre- and postenrollment site visits, fingerprinting, and criminal background
192.22 studies. The commissioner must revalidate all providers under this subdivision at least
192.23 once every five years.

192.24 (b) The application fee under this subdivision is \$532 for the calendar year 2013.
192.25 For calendar year 2014 and subsequent years, the fee:

192.26 (1) is adjusted by the percentage change to the consumer price index for all urban
192.27 consumers, United States city average, for the 12-month period ending with June of the
192.28 previous year. The resulting fee must be announced in the Federal Register;

192.29 (2) is effective from January 1 to December 31 of a calendar year;

192.30 (3) is required on the submission of an initial application, an application to establish
192.31 a new practice location, an application for reenrollment when the provider is not enrolled
192.32 at the time of application of reenrollment, or at revalidation when required by federal
192.33 regulation; and

192.34 (4) must be in the amount in effect for the calendar year during which the application
192.35 for enrollment, new practice location, or reenrollment is being submitted.

- 193.1 (c) The application fee under this subdivision cannot be charged to:
 193.2 (1) providers who are enrolled in Medicare or who provide documentation of
 193.3 payment of the fee to, and enrollment with, another state;
 193.4 (2) providers who are enrolled but are required to submit new applications for
 193.5 purposes of reenrollment; or
 193.6 (3) a provider who enrolls as an individual.

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

193.8 Sec. 9. Minnesota Statutes 2012, section 256B.064, subdivision 1a, is amended to read:

193.9 Subd. 1a. **Grounds for sanctions against vendors.** The commissioner may
 193.10 impose sanctions against a vendor of medical care for any of the following: (1) fraud,
 193.11 theft, or abuse in connection with the provision of medical care to recipients of public
 193.12 assistance; (2) a pattern of presentment of false or duplicate claims or claims for services
 193.13 not medically necessary; (3) a pattern of making false statements of material facts for
 193.14 the purpose of obtaining greater compensation than that to which the vendor is legally
 193.15 entitled; (4) suspension or termination as a Medicare vendor; (5) refusal to grant the state
 193.16 agency access during regular business hours to examine all records necessary to disclose
 193.17 the extent of services provided to program recipients and appropriateness of claims for
 193.18 payment; (6) failure to repay an overpayment or a fine finally established under this
 193.19 section; and (7) failure to correct errors in the maintenance of health service or financial
 193.20 records for which a fine was imposed or after issuance of a warning by the commissioner;
 193.21 and (8) any reason for which a vendor could be excluded from participation in the
 193.22 Medicare program under section 1128, 1128A, or 1866(b)(2) of the Social Security Act.
 193.23 The determination of services not medically necessary may be made by the commissioner
 193.24 in consultation with a peer advisory task force appointed by the commissioner on the
 193.25 recommendation of appropriate professional organizations. The task force expires as
 193.26 provided in section 15.059, subdivision 5.

193.27 Sec. 10. Minnesota Statutes 2012, section 256B.064, subdivision 1b, is amended to read:

193.28 Subd. 1b. **Sanctions available.** The commissioner may impose the following
 193.29 sanctions for the conduct described in subdivision 1a: suspension or withholding of
 193.30 payments to a vendor and suspending or terminating participation in the program, or
 193.31 imposition of a fine under subdivision 2, paragraph (f). When imposing sanctions under
 193.32 this section, the commissioner shall consider the nature, chronicity, or severity of the
 193.33 conduct and the effect of the conduct on the health and safety of persons served by the

194.1 vendor. Regardless of imposition of sanctions, the commissioner may make a referral
194.2 to the appropriate state licensing board.

194.3 Sec. 11. Minnesota Statutes 2012, section 256B.064, subdivision 2, is amended to read:

194.4 Subd. 2. **Imposition of monetary recovery and sanctions.** (a) The commissioner
194.5 shall determine any monetary amounts to be recovered and sanctions to be imposed upon
194.6 a vendor of medical care under this section. Except as provided in paragraphs (b) and
194.7 (d), neither a monetary recovery nor a sanction will be imposed by the commissioner
194.8 without prior notice and an opportunity for a hearing, according to chapter 14, on the
194.9 commissioner's proposed action, provided that the commissioner may suspend or reduce
194.10 payment to a vendor of medical care, except a nursing home or convalescent care facility,
194.11 after notice and prior to the hearing if in the commissioner's opinion that action is
194.12 necessary to protect the public welfare and the interests of the program.

194.13 (b) Except when the commissioner finds good cause not to suspend payments under
194.14 Code of Federal Regulations, title 42, section 455.23 (e) or (f), the commissioner shall
194.15 withhold or reduce payments to a vendor of medical care without providing advance
194.16 notice of such withholding or reduction if either of the following occurs:

194.17 (1) the vendor is convicted of a crime involving the conduct described in subdivision
194.18 1a; or

194.19 (2) the commissioner determines there is a credible allegation of fraud for which an
194.20 investigation is pending under the program. A credible allegation of fraud is an allegation
194.21 which has been verified by the state, from any source, including but not limited to:

194.22 (i) fraud hotline complaints;

194.23 (ii) claims data mining; and

194.24 (iii) patterns identified through provider audits, civil false claims cases, and law
194.25 enforcement investigations.

194.26 Allegations are considered to be credible when they have an indicia of reliability
194.27 and the state agency has reviewed all allegations, facts, and evidence carefully and acts
194.28 judiciously on a case-by-case basis.

194.29 (c) The commissioner must send notice of the withholding or reduction of payments
194.30 under paragraph (b) within five days of taking such action unless requested in writing by a
194.31 law enforcement agency to temporarily withhold the notice. The notice must:

194.32 (1) state that payments are being withheld according to paragraph (b);

194.33 (2) set forth the general allegations as to the nature of the withholding action, but
194.34 need not disclose any specific information concerning an ongoing investigation;

195.1 (3) except in the case of a conviction for conduct described in subdivision 1a, state
195.2 that the withholding is for a temporary period and cite the circumstances under which
195.3 withholding will be terminated;

195.4 (4) identify the types of claims to which the withholding applies; and

195.5 (5) inform the vendor of the right to submit written evidence for consideration by
195.6 the commissioner.

195.7 The withholding or reduction of payments will not continue after the commissioner
195.8 determines there is insufficient evidence of fraud by the vendor, or after legal proceedings
195.9 relating to the alleged fraud are completed, unless the commissioner has sent notice of
195.10 intention to impose monetary recovery or sanctions under paragraph (a).

195.11 (d) The commissioner shall suspend or terminate a vendor's participation in the
195.12 program without providing advance notice and an opportunity for a hearing when the
195.13 suspension or termination is required because of the vendor's exclusion from participation
195.14 in Medicare. Within five days of taking such action, the commissioner must send notice of
195.15 the suspension or termination. The notice must:

195.16 (1) state that suspension or termination is the result of the vendor's exclusion from
195.17 Medicare;

195.18 (2) identify the effective date of the suspension or termination; and

195.19 (3) inform the vendor of the need to be reinstated to Medicare before reapplying
195.20 for participation in the program.

195.21 (e) Upon receipt of a notice under paragraph (a) that a monetary recovery or
195.22 sanction is to be imposed, a vendor may request a contested case, as defined in section
195.23 14.02, subdivision 3, by filing with the commissioner a written request of appeal. The
195.24 appeal request must be received by the commissioner no later than 30 days after the date
195.25 the notification of monetary recovery or sanction was mailed to the vendor. The appeal
195.26 request must specify:

195.27 (1) each disputed item, the reason for the dispute, and an estimate of the dollar
195.28 amount involved for each disputed item;

195.29 (2) the computation that the vendor believes is correct;

195.30 (3) the authority in statute or rule upon which the vendor relies for each disputed item;

195.31 (4) the name and address of the person or entity with whom contacts may be made
195.32 regarding the appeal; and

195.33 (5) other information required by the commissioner.

195.34 (f) The commissioner may order a vendor to forfeit a fine for failure to fully document
195.35 services according to standards in this chapter and Minnesota Rules, chapter 9505. The
195.36 commissioner may assess fines if specific required components of documentation are

196.1 missing. The fine for incomplete documentation shall equal 20 percent of the amount paid
 196.2 on the claims for reimbursement submitted by the vendor, or up to \$5,000, whichever is less.

196.3 (g) The vendor shall pay the fine assessed on or before the payment date specified. If
 196.4 the vendor fails to pay the fine, the commissioner may withhold or reduce payments and
 196.5 recover the amount of the fine. A timely appeal shall stay payment of the fine until the
 196.6 commissioner issues a final order.

196.7 Sec. 12. Minnesota Statutes 2012, section 256B.0659, subdivision 21, is amended to
 196.8 read:

196.9 Subd. 21. **Requirements for initial enrollment of personal care assistance**
 196.10 **provider agencies.** (a) All personal care assistance provider agencies must provide, at the
 196.11 time of enrollment as a personal care assistance provider agency in a format determined
 196.12 by the commissioner, information and documentation that includes, but is not limited to,
 196.13 the following:

196.14 (1) the personal care assistance provider agency's current contact information
 196.15 including address, telephone number, and e-mail address;

196.16 (2) proof of surety bond coverage in the amount of ~~\$50,000~~ \$100,000 or ten percent
 196.17 of the provider's payments from Medicaid in the previous year, whichever is ~~less~~ more.

196.18 The performance bond must be in a form approved by the commissioner, must be renewed
 196.19 annually, and must allow for recovery of costs and fees in pursuing a claim on the bond;

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

196.21 (4) proof of workers' compensation insurance coverage;

196.22 (5) proof of liability insurance;

196.23 (6) a description of the personal care assistance provider agency's organization
 196.24 identifying the names of all owners, managing employees, staff, board of directors, and
 196.25 the affiliations of the directors, owners, or staff to other service providers;

196.26 (7) a copy of the personal care assistance provider agency's written policies and
 196.27 procedures including: hiring of employees; training requirements; service delivery;
 196.28 and employee and consumer safety including process for notification and resolution
 196.29 of consumer grievances, identification and prevention of communicable diseases, and
 196.30 employee misconduct;

196.31 (8) copies of all other forms the personal care assistance provider agency uses in
 196.32 the course of daily business including, but not limited to:

196.33 (i) a copy of the personal care assistance provider agency's time sheet if the time
 196.34 sheet varies from the standard time sheet for personal care assistance services approved

197.1 by the commissioner, and a letter requesting approval of the personal care assistance
197.2 provider agency's nonstandard time sheet;

197.3 (ii) the personal care assistance provider agency's template for the personal care
197.4 assistance care plan; and

197.5 (iii) the personal care assistance provider agency's template for the written
197.6 agreement in subdivision 20 for recipients using the personal care assistance choice
197.7 option, if applicable;

197.8 (9) a list of all training and classes that the personal care assistance provider agency
197.9 requires of its staff providing personal care assistance services;

197.10 (10) documentation that the personal care assistance provider agency and staff have
197.11 successfully completed all the training required by this section;

197.12 (11) documentation of the agency's marketing practices;

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

197.15 (13) documentation that the agency will use the following percentages of revenue
197.16 generated from the medical assistance rate paid for personal care assistance services
197.17 for employee personal care assistant wages and benefits: 72.5 percent of revenue in the
197.18 personal care assistance choice option and 72.5 percent of revenue from other personal
197.19 care assistance providers. The revenue generated by the qualified professional and the
197.20 reasonable costs associated with the qualified professional shall not be used in making
197.21 this calculation; and

197.22 (14) effective May 15, 2010, documentation that the agency does not burden
197.23 recipients' free exercise of their right to choose service providers by requiring personal
197.24 care assistants to sign an agreement not to work with any particular personal care
197.25 assistance recipient or for another personal care assistance provider agency after leaving
197.26 the agency and that the agency is not taking action on any such agreements or requirements
197.27 regardless of the date signed.

197.28 (b) Personal care assistance provider agencies shall provide the information specified
197.29 in paragraph (a) to the commissioner at the time the personal care assistance provider
197.30 agency enrolls as a vendor or upon request from the commissioner. The commissioner
197.31 shall collect the information specified in paragraph (a) from all personal care assistance
197.32 providers beginning July 1, 2009.

197.33 (c) All personal care assistance provider agencies shall require all employees in
197.34 management and supervisory positions and owners of the agency who are active in the
197.35 day-to-day management and operations of the agency to complete mandatory training
197.36 as determined by the commissioner before enrollment of the agency as a provider.

198.1 Employees in management and supervisory positions and owners who are active in
 198.2 the day-to-day operations of an agency who have completed the required training as
 198.3 an employee with a personal care assistance provider agency do not need to repeat
 198.4 the required training if they are hired by another agency, if they have completed the
 198.5 training within the past three years. By September 1, 2010, the required training must
 198.6 be available with meaningful access according to title VI of the Civil Rights Act and
 198.7 federal regulations adopted under that law or any guidance from the United States Health
 198.8 and Human Services Department. The required training must be available online or by
 198.9 electronic remote connection. The required training must provide for competency testing.
 198.10 Personal care assistance provider agency billing staff shall complete training about
 198.11 personal care assistance program financial management. This training is effective July 1,
 198.12 2009. Any personal care assistance provider agency enrolled before that date shall, if it
 198.13 has not already, complete the provider training within 18 months of July 1, 2009. Any new
 198.14 owners or employees in management and supervisory positions involved in the day-to-day
 198.15 operations are required to complete mandatory training as a requisite of working for the
 198.16 agency. Personal care assistance provider agencies certified for participation in Medicare
 198.17 as home health agencies are exempt from the training required in this subdivision. When
 198.18 available, Medicare-certified home health agency owners, supervisors, or managers must
 198.19 successfully complete the competency test.

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

198.21 Sec. 13. Minnesota Statutes 2012, section 299C.093, is amended to read:

198.22 **299C.093 DATABASE OF REGISTERED PREDATORY OFFENDERS.**

198.23 The superintendent of the Bureau of Criminal Apprehension shall maintain a
 198.24 computerized data system relating to individuals required to register as predatory offenders
 198.25 under section 243.166. To the degree feasible, the system must include the data required
 198.26 to be provided under section 243.166, subdivisions 4 and 4a, and indicate the time period
 198.27 that the person is required to register. The superintendent shall maintain this data in a
 198.28 manner that ensures that it is readily available to law enforcement agencies. This data is
 198.29 private data on individuals under section 13.02, subdivision 12, but may be used for law
 198.30 enforcement and corrections purposes. The commissioner of human services has access
 198.31 to the data for state-operated services, as defined in section 246.014, are also authorized
 198.32 to have access to the data for the purposes described in section 246.13, subdivision 2,
 198.33 paragraph (b), and for purposes of conducting background studies under chapter 245C.

199.1 Sec. 14. Minnesota Statutes 2012, section 524.5-118, subdivision 1, is amended to read:

199.2 Subdivision 1. **When required; exception.** (a) The court shall require a background
199.3 study under this section:

199.4 (1) before the appointment of a guardian or conservator, unless a background study
199.5 has been done on the person under this section within the previous ~~five~~ two years; and

199.6 (2) once every ~~five~~ two years after the appointment, if the person continues to serve
199.7 as a guardian or conservator.

199.8 (b) The background study must include:

199.9 (1) criminal history data from the Bureau of Criminal Apprehension, other criminal
199.10 history data held by the commissioner of human services, and data regarding whether the
199.11 person has been a perpetrator of substantiated maltreatment of a vulnerable adult and a
199.12 or minor;

199.13 ~~(e) The court shall request a search of the (2) criminal history data from the National~~
199.14 ~~Criminal Records Repository if the proposed guardian or conservator has not resided in~~
199.15 ~~Minnesota for the previous five ten years or if the Bureau of Criminal Apprehension~~
199.16 ~~information received from the commissioner of human services under subdivision 2,~~
199.17 ~~paragraph (b), indicates that the subject is a multistate offender or that the individual's~~
199.18 ~~multistate offender status is undetermined; and~~

199.19 (3) state licensing agency data if the proposed guardian or conservator has ever been
199.20 denied a professional license in the state of Minnesota or elsewhere that is directly related
199.21 to the responsibilities of a professional fiduciary, or has ever held a professional license
199.22 directly related to the responsibilities of a professional fiduciary that was conditioned,
199.23 suspended, revoked, or canceled.

199.24 ~~(d)~~ (c) If the guardian or conservator is not an individual, the background study must
199.25 be done on all individuals currently employed by the proposed guardian or conservator
199.26 who will be responsible for exercising powers and duties under the guardianship or
199.27 conservatorship.

199.28 ~~(e)~~ (d) If the court determines that it would be in the best interests of the ward or
199.29 protected person to appoint a guardian or conservator before the background study can
199.30 be completed, the court may make the appointment pending the results of the study,
199.31 however, the background study must then be completed as soon as reasonably possible
199.32 after appointment, no later than 30 days after appointment.

199.33 ~~(f)~~ (e) The fee for conducting a background study for appointment of a professional
199.34 guardian or conservator must be paid by the guardian or conservator. In other cases,
199.35 the fee must be paid as follows:

200.1 (1) if the matter is proceeding in forma pauperis, the fee is an expense for purposes
 200.2 of section 524.5-502, paragraph (a);

200.3 (2) if there is an estate of the ward or protected person, the fee must be paid from
 200.4 the estate; or

200.5 (3) in the case of a guardianship or conservatorship of the person that is not
 200.6 proceeding in forma pauperis, the court may order that the fee be paid by the guardian or
 200.7 conservator or by the court.

200.8 ~~(g)~~ (f) The requirements of this subdivision do not apply if the guardian or
 200.9 conservator is:

200.10 (1) a state agency or county;

200.11 (2) a parent or guardian of a proposed ward or protected person who has a
 200.12 developmental disability, if the parent or guardian has raised the proposed ward or
 200.13 protected person in the family home until the time the petition is filed, unless counsel
 200.14 appointed for the proposed ward or protected person under section 524.5-205, paragraph
 200.15 (d); 524.5-304, paragraph (b); 524.5-405, paragraph (a); or 524.5-406, paragraph (b),
 200.16 recommends a background study; or

200.17 (3) a bank with trust powers, bank and trust company, or trust company, organized
 200.18 under the laws of any state or of the United States and which is regulated by the
 200.19 commissioner of commerce or a federal regulator.

200.20 Sec. 15. Minnesota Statutes 2012, section 524.5-118, is amended by adding a
 200.21 subdivision to read:

200.22 Subd. 2a. Procedure; state licensing agency data. The court shall request
 200.23 the commissioner of human services to provide the court within 25 working days of
 200.24 receipt of the request with licensing agency data from Minnesota licensing agencies
 200.25 that the commissioner determines issue professional licenses directly related to the
 200.26 responsibilities of a professional fiduciary. The commissioner shall enter into agreements
 200.27 with these agencies to provide for electronic access to the relevant licensing data by the
 200.28 commissioner. The data provided by the commissioner to the court shall include, as
 200.29 applicable, license number and status; original date of issue; last renewal date; expiration
 200.30 date; date of the denial, condition, suspension, revocation, or cancellation; the name of the
 200.31 licensing agency that denied, conditioned, suspended, revoked, or canceled the license;
 200.32 and the basis for denial, condition, suspension, revocation, or cancellation of the license.
 200.33 If the proposed guardian or conservator has resided in a state other than Minnesota in the
 200.34 previous ten years, licensing agency data shall also include the licensing agency data
 200.35 from any other state where the proposed guardian or conservator resided. If the proposed

201.1 guardian or conservator has or has had a professional license in another state that is
201.2 directly related to the responsibilities of a professional fiduciary, state licensing agency
201.3 data shall also include data from the relevant licensing agency of that state.

201.4 Sec. 16. Minnesota Statutes 2012, section 524.5-303, is amended to read:

201.5 **524.5-303 JUDICIAL APPOINTMENT OF GUARDIAN: PETITION.**

201.6 (a) An individual or a person interested in the individual's welfare may petition for
201.7 a determination of incapacity, in whole or in part, and for the appointment of a limited
201.8 or unlimited guardian for the individual.

201.9 (b) The petition must set forth the petitioner's name, residence, current address if
201.10 different, relationship to the respondent, and interest in the appointment and, to the extent
201.11 known, state or contain the following with respect to the respondent and the relief requested:

201.12 (1) the respondent's name, age, principal residence, current street address, and, if
201.13 different, the address of the dwelling in which it is proposed that the respondent will
201.14 reside if the appointment is made;

201.15 (2) the name and address of the respondent's:

201.16 (i) spouse, or if the respondent has none, an adult with whom the respondent has
201.17 resided for more than six months before the filing of the petition; and

201.18 (ii) adult children or, if the respondent has none, the respondent's parents and adult
201.19 brothers and sisters, or if the respondent has none, at least one of the adults nearest in
201.20 kinship to the respondent who can be found;

201.21 (3) the name of the administrative head and address of the institution where the
201.22 respondent is a patient, resident, or client of any hospital, nursing home, home care
201.23 agency, or other institution;

201.24 (4) the name and address of any legal representative for the respondent;

201.25 (5) the name, address, and telephone number of any person nominated as guardian
201.26 by the respondent in any manner permitted by law, including a health care agent nominated
201.27 in a health care directive;

201.28 (6) the name, address, and telephone number of any proposed guardian and the
201.29 reason why the proposed guardian should be selected;

201.30 (7) the name and address of any health care agent or proxy appointed pursuant to
201.31 a health care directive as defined in section 145C.01, a living will under chapter 145B,
201.32 or other similar document executed in another state and enforceable under the laws of
201.33 this state;

201.34 (8) the reason why guardianship is necessary, including a brief description of the
201.35 nature and extent of the respondent's alleged incapacity;

202.1 (9) if an unlimited guardianship is requested, the reason why limited guardianship
 202.2 is inappropriate and, if a limited guardianship is requested, the powers to be granted to
 202.3 the limited guardian; and

202.4 (10) a general statement of the respondent's property with an estimate of its value,
 202.5 including any insurance or pension, and the source and amount of any other anticipated
 202.6 income or receipts.

202.7 (c) The petition must also set forth the following information regarding the proposed
 202.8 guardian or any employee of the guardian responsible for exercising powers and duties
 202.9 under the guardianship:

202.10 (1) whether the proposed guardian has ever been removed for cause from serving as
 202.11 a guardian or conservator and, if so, the case number and court location; ~~and~~

202.12 (2) if the proposed guardian is a professional guardian or conservator, a summary of
 202.13 the proposed guardian's educational background and relevant work and other experience;₂

202.14 (3) whether the proposed guardian has ever applied for or held, at any time, any
 202.15 professional license, and if so, the name of the licensing agency, and as applicable, the
 202.16 license number and status; whether the license is active or has been denied, conditioned,
 202.17 suspended, revoked, or canceled; and the basis for the denial, condition, suspension,
 202.18 revocation, or cancellation of the license;

202.19 (4) whether the proposed guardian has ever been found civilly liable in an action
 202.20 that involved fraud, misrepresentation, material omission, misappropriation, theft, or
 202.21 conversion, and if so, the case number and court location;

202.22 (5) whether the proposed guardian has ever filed for or received protection under the
 202.23 bankruptcy laws, and if so, the case number and court location;

202.24 (6) whether the proposed guardian has any outstanding civil monetary judgments
 202.25 against the proposed guardian, and if so, the case number, court location, and outstanding
 202.26 amount owed;

202.27 (7) whether an order for protection or harassment restraining order has ever been
 202.28 issued against the proposed guardian, and if so, the case number and court location; and

202.29 (8) whether the proposed guardian has ever been convicted of a crime other than a
 202.30 petty misdemeanor or traffic offense, and if so, the case number and the crime of which
 202.31 the guardian was convicted.

202.32 Sec. 17. Minnesota Statutes 2012, section 524.5-316, is amended to read:

202.33 **524.5-316 REPORTS; MONITORING OF GUARDIANSHIP; COURT**
 202.34 **ORDERS.**

203.1 (a) A guardian shall report to the court in writing on the condition of the ward at least
 203.2 annually and whenever ordered by the court. A copy of the report must be provided to the
 203.3 ward and to interested persons of record with the court. A report must state or contain:

203.4 (1) the current mental, physical, and social condition of the ward;

203.5 (2) the living arrangements for all addresses of the ward during the reporting period;

203.6 (3) any restrictions placed on the ward's right to communication and visitation with
 203.7 persons of the ward's choice and the factual bases for those restrictions;

203.8 (4) the medical, educational, vocational, and other services provided to the ward and
 203.9 the guardian's opinion as to the adequacy of the ward's care;

203.10 (5) a recommendation as to the need for continued guardianship and any
 203.11 recommended changes in the scope of the guardianship;

203.12 (6) an address and telephone number where the guardian can be contacted; and

203.13 ~~(7) whether the guardian has ever been removed for cause from serving as a guardian~~
 203.14 ~~or conservator and, if so, the case number and court location;~~

203.15 ~~(8) any changes occurring that would affect the accuracy of information contained~~
 203.16 ~~in the most recent criminal background study of the guardian conducted under section~~
 203.17 ~~524.5-118; and~~

203.18 ~~(9)~~ (7) if applicable, the amount of reimbursement for services rendered to the ward
 203.19 that the guardian received during the previous year that were not reimbursed by county
 203.20 contract.

203.21 (b) A guardian shall report to the court in writing within 30 days of the occurrence of
 203.22 any of the events listed in this paragraph. The guardian must report any of the occurrences
 203.23 in this paragraph and follow the same reporting requirements in this paragraph for
 203.24 any employee of the guardian responsible for exercising powers and duties under the
 203.25 guardianship. A copy of the report must be provided to the ward and to interested persons
 203.26 of record with the court. A guardian shall report when:

203.27 (1) the guardian is removed for cause from serving as a guardian or conservator, and
 203.28 if so, the case number and court location;

203.29 (2) the guardian has a professional license denied, conditioned, suspended, revoked,
 203.30 or canceled, and if so, the licensing agency and license number, and the basis for denial,
 203.31 condition, suspension, revocation, or cancellation of the license;

203.32 (3) the guardian is found civilly liable in an action that involves fraud,
 203.33 misrepresentation, material omission, misappropriation, theft, or conversion, and if so, the
 203.34 case number and court location;

203.35 (4) the guardian files for or receives protection under the bankruptcy laws, and
 203.36 if so, the case number and court location;

204.1 (5) a civil monetary judgment is entered against the guardian, and if so, the case
 204.2 number, court location, and outstanding amount owed;

204.3 (6) the guardian is convicted of a crime other than a petty misdemeanor or traffic
 204.4 offense, and if so, the case number and court location; or

204.5 (7) an order for protection or harassment restraining order is issued against the
 204.6 guardian, and if so, the case number and court location.

204.7 ~~(b)~~ (c) A ward or interested person of record with the court may submit to the court a
 204.8 written statement disputing statements or conclusions regarding the condition of the ward
 204.9 or addressing any disciplinary or legal action that are is contained in the report guardian's
 204.10 reports and may petition the court for an order that is in the best interests of the ward or
 204.11 for other appropriate relief.

204.12 ~~(e)~~ (d) An interested person may notify the court in writing that the interested person
 204.13 does not wish to receive copies of reports required under this section.

204.14 ~~(d)~~ (e) The court may appoint a visitor to review a report, interview the ward or
 204.15 guardian, and make any other investigation the court directs.

204.16 ~~(e)~~ (f) The court shall establish a system for monitoring guardianships, including the
 204.17 filing and review of annual reports. If an annual report is not filed within 60 days of the
 204.18 required date, the court shall issue an order to show cause.

204.19 (g) If a guardian fails to comply with this section, the court may decline to appoint that
 204.20 person as a guardian or conservator, or may remove a person as guardian or conservator.

204.21 Sec. 18. Minnesota Statutes 2012, section 524.5-403, is amended to read:

204.22 **524.5-403 ORIGINAL PETITION FOR APPOINTMENT OR PROTECTIVE**
 204.23 **ORDER.**

204.24 (a) The following may petition for the appointment of a conservator or for any
 204.25 other appropriate protective order:

204.26 (1) the person to be protected;

204.27 (2) an individual interested in the estate, affairs, or welfare of the person to be
 204.28 protected; or

204.29 (3) a person who would be adversely affected by lack of effective management of
 204.30 the property and business affairs of the person to be protected.

204.31 (b) The petition must set forth the petitioner's name, residence, current address
 204.32 if different, relationship to the respondent, and interest in the appointment or other
 204.33 protective order, and, to the extent known, state or contain the following with respect to
 204.34 the respondent and the relief requested:

205.1 (1) the respondent's name, age, principal residence, current street address, and, if
205.2 different, the address of the dwelling where it is proposed that the respondent will reside if
205.3 the appointment is made;

205.4 (2) if the petition alleges impairment in the respondent's ability to receive and
205.5 evaluate information, a brief description of the nature and extent of the respondent's
205.6 alleged impairment;

205.7 (3) if the petition alleges that the respondent is missing, detained, or unable to
205.8 return to the United States, a statement of the relevant circumstances, including the time
205.9 and nature of the disappearance or detention and a description of any search or inquiry
205.10 concerning the respondent's whereabouts;

205.11 (4) the name and address of the respondent's:

205.12 (i) spouse, or if the respondent has none, an adult with whom the respondent has
205.13 resided for more than six months before the filing of the petition; and

205.14 (ii) adult children or, if the respondent has none, the respondent's parents and adult
205.15 brothers and sisters or, if the respondent has none, at least one of the adults nearest in
205.16 kinship to the respondent who can be found;

205.17 (5) the name of the administrative head and address of the institution where the
205.18 respondent is a patient, resident, or client of any hospital, nursing home, home care
205.19 agency, or other institution;

205.20 (6) the name and address of any legal representative for the respondent;

205.21 (7) the name and address of any health care agent or proxy appointed pursuant to
205.22 a health care directive as defined in section 145C.01, a living will under chapter 145B,
205.23 or other similar document executed in another state and enforceable under the laws of
205.24 this state;

205.25 (8) a general statement of the respondent's property with an estimate of its value,
205.26 including any insurance or pension, and the source and amount of other anticipated
205.27 income or receipts; and

205.28 (9) the reason why a conservatorship or other protective order is in the best interest
205.29 of the respondent.

205.30 (c) If a conservatorship is requested, the petition must also set forth to the extent
205.31 known:

205.32 (1) the name, address, and telephone number of any proposed conservator and the
205.33 reason why the proposed conservator should be selected;

205.34 (2) the name, address, and telephone number of any person nominated as conservator
205.35 by the respondent if the respondent has attained 14 years of age; and

206.1 (3) the type of conservatorship requested and, if an unlimited conservatorship,
 206.2 the reason why limited conservatorship is inappropriate or, if a limited conservatorship,
 206.3 the property to be placed under the conservator's control and any limitation on the
 206.4 conservator's powers and duties.

206.5 (d) The petition must also set forth the following information regarding the proposed
 206.6 conservator or any employee of the conservator responsible for exercising powers and
 206.7 duties under the conservatorship:

206.8 (1) whether the proposed conservator has ever been removed for cause from serving
 206.9 as a guardian or conservator and, if so, the case number and court location; ~~and~~

206.10 (2) if the proposed conservator is a professional guardian or conservator, a summary
 206.11 of the proposed conservator's educational background and relevant work and other
 206.12 experience;

206.13 (3) whether the proposed conservator has ever applied for or held, at any time, any
 206.14 professional license, and if so, the name of the licensing agency, and as applicable, the
 206.15 license number and status; whether the license is active or has been denied, conditioned,
 206.16 suspended, revoked, or canceled; and the basis for the denial, condition, suspension,
 206.17 revocation, or cancellation of the license;

206.18 (4) whether the proposed conservator has ever been found civilly liable in an action
 206.19 that involved fraud, misrepresentation, material omission, misappropriation, theft, or
 206.20 conversion, and if so, the case number and court location;

206.21 (5) whether the proposed conservator has ever filed for or received protection under
 206.22 the bankruptcy laws, and if so, the case number and court location;

206.23 (6) whether the proposed conservator has any outstanding civil monetary judgments
 206.24 against the proposed conservator, and if so, the case number, court location, and
 206.25 outstanding amount owed;

206.26 (7) whether an order for protection or harassment restraining order has ever been
 206.27 issued against the proposed conservator, and if so, the case number and court location; and

206.28 (8) whether the proposed conservator has ever been convicted of a crime other than
 206.29 a petty misdemeanor or traffic offense, and if so, the case number and the crime of which
 206.30 the conservator was convicted.

206.31 Sec. 19. Minnesota Statutes 2012, section 524.5-420, is amended to read:

206.32 **524.5-420 REPORTS; APPOINTMENT OF VISITOR; MONITORING;**
 206.33 **COURT ORDERS.**

206.34 (a) A conservator shall report to the court for administration of the estate annually
 206.35 unless the court otherwise directs, upon resignation or removal, upon termination of the

207.1 conservatorship, and at other times as the court directs. An order, after notice and hearing,
 207.2 allowing an intermediate report of a conservator adjudicates liabilities concerning the
 207.3 matters adequately disclosed in the accounting. An order, after notice and hearing, allowing
 207.4 a final report adjudicates all previously unsettled liabilities relating to the conservatorship.

207.5 (b) A report must state or contain a listing of the assets of the estate under the
 207.6 conservator's control and a listing of the receipts, disbursements, and distributions during
 207.7 the reporting period.

207.8 (c) The report must also state:

207.9 (1) an address and telephone number where the conservator can be contacted;

207.10 (2) whether the conservator has ever been removed for cause from serving as a
 207.11 guardian or conservator and, if so, the case number and court locations; and

207.12 (3) any changes occurring that would affect the accuracy of information contained in
 207.13 the most recent criminal background study of the conservator conducted under section
 207.14 524.5-118.

207.15 (d) A conservator shall report to the court in writing within 30 days of the occurrence
 207.16 of any of the events listed in this paragraph. The conservator must report any of the
 207.17 occurrences in this paragraph and follow the same reporting requirements in this paragraph
 207.18 for any employee of the conservator responsible for exercising powers and duties under
 207.19 the conservatorship. A copy of the report must be provided to the protected person and to
 207.20 interested persons of record with the court. A conservator shall report when:

207.21 (1) the conservator is removed for cause from serving as a guardian or conservator,
 207.22 and if so, the case number and court location;

207.23 (2) the conservator has a professional license denied, conditioned, suspended,
 207.24 revoked, or canceled, and if so, the licensing agency and license number, and the basis for
 207.25 denial, condition, suspension, revocation, or cancellation of the license;

207.26 (3) the conservator is found civilly liable in an action that involves fraud,
 207.27 misrepresentation, material omission, misappropriation, theft, or conversion, and if so, the
 207.28 case number and court location;

207.29 (4) the conservator files for or receives protection under the bankruptcy laws, and
 207.30 if so, the case number and court location;

207.31 (5) a civil monetary judgment is entered against the conservator, and if so, the case
 207.32 number, court location, and outstanding amount owed;

207.33 (6) the conservator is convicted of a crime other than a petty misdemeanor or traffic
 207.34 offense, and if so, the case number and court location; or

207.35 (7) an order for protection or harassment restraining order is issued against the
 207.36 conservator, and if so, the case number and court location.

208.1 ~~(d)~~ (e) A protected person or an interested person of record with the court may
 208.2 submit to the court a written statement disputing account statements regarding the
 208.3 administration of the estate or addressing any disciplinary or legal action that are is
 208.4 contained in the ~~report~~ reports and may petition the court for any order that is in the best
 208.5 interests of the protected person and the estate or for other appropriate relief.

208.6 ~~(e)~~ (f) An interested person may notify the court in writing that the interested person
 208.7 does not wish to receive copies of reports required under this section.

208.8 ~~(f)~~ (g) The court may appoint a visitor to review a report or plan, interview the
 208.9 protected person or conservator, and make any other investigation the court directs. In
 208.10 connection with a report, the court may order a conservator to submit the assets of the
 208.11 estate to an appropriate examination to be made in a manner the court directs.

208.12 ~~(g)~~ (h) The court shall establish a system for monitoring of conservatorships,
 208.13 including the filing and review of conservators' reports and plans. If an annual report is
 208.14 not filed within 60 days of the required date, the court shall issue an order to show cause.

208.15 (i) If a conservator fails to comply with this section, the court may decline to appoint
 208.16 that person as a guardian or conservator, or may remove a person as guardian or conservator.

208.17 Sec. 20. **INSTRUCTIONS TO THE COMMISSIONER.**

208.18 In collaboration with labor organizations, the commissioner of human services shall
 208.19 develop clear and consistent standards for state-operated services programs to:

208.20 (1) address direct service staffing shortages;

208.21 (2) identify and help resolve workplace safety issues; and

208.22 (3) elevate the use and visibility of performance measures and objectives related to
 208.23 overtime use.

208.24 **ARTICLE 6**

208.25 **HEALTH CARE**

208.26 Section 1. Minnesota Statutes 2012, section 245.03, subdivision 1, is amended to read:

208.27 Subdivision 1. **Establishment.** There is created a Department of Human Services.

208.28 A commissioner of human services shall be appointed by the governor under the
 208.29 provisions of section 15.06. The commissioner shall be selected on the basis of ability and
 208.30 experience in welfare and without regard to political affiliations. The commissioner ~~shall~~
 208.31 may appoint a up to two deputy commissioner commissioners.

208.32 Sec. 2. Minnesota Statutes 2012, section 256.9657, subdivision 3, is amended to read:

209.1 Subd. 3. **Surcharge on HMOs and community integrated service networks.** (a)
209.2 Effective October 1, 1992, each health maintenance organization with a certificate of
209.3 authority issued by the commissioner of health under chapter 62D and each community
209.4 integrated service network licensed by the commissioner under chapter 62N shall pay to
209.5 the commissioner of human services a surcharge equal to six-tenths of one percent of the
209.6 total premium revenues of the health maintenance organization or community integrated
209.7 service network as reported to the commissioner of health according to the schedule in
209.8 subdivision 4.

209.9 (b) Effective July 1, 2013, to June 30, 2015, the surcharge under paragraph (a) is
209.10 increased to 1.48 percent.

209.11 (c) For purposes of this subdivision, total premium revenue means:

209.12 (1) premium revenue recognized on a prepaid basis from individuals and groups
209.13 for provision of a specified range of health services over a defined period of time which
209.14 is normally one month, excluding premiums paid to a health maintenance organization
209.15 or community integrated service network from the Federal Employees Health Benefit
209.16 Program;

209.17 (2) premiums from Medicare wraparound subscribers for health benefits which
209.18 supplement Medicare coverage;

209.19 (3) Medicare revenue, as a result of an arrangement between a health maintenance
209.20 organization or a community integrated service network and the Centers for Medicare
209.21 and Medicaid Services of the federal Department of Health and Human Services, for
209.22 services to a Medicare beneficiary, excluding Medicare revenue that states are prohibited
209.23 from taxing under sections 1854, 1860D-12, and 1876 of title XVIII of the federal Social
209.24 Security Act, codified as United States Code, title 42, sections 1395mm, 1395w-112, and
209.25 1395w-24, respectively, as they may be amended from time to time; and

209.26 (4) medical assistance revenue, as a result of an arrangement between a health
209.27 maintenance organization or community integrated service network and a Medicaid state
209.28 agency, for services to a medical assistance beneficiary.

209.29 If advance payments are made under clause (1) or (2) to the health maintenance
209.30 organization or community integrated service network for more than one reporting period,
209.31 the portion of the payment that has not yet been earned must be treated as a liability.

209.32 ~~(e)~~ (d) When a health maintenance organization or community integrated service
209.33 network merges or consolidates with or is acquired by another health maintenance
209.34 organization or community integrated service network, the surviving corporation or the
209.35 new corporation shall be responsible for the annual surcharge originally imposed on
209.36 each of the entities or corporations subject to the merger, consolidation, or acquisition,

210.1 regardless of whether one of the entities or corporations does not retain a certificate of
 210.2 authority under chapter 62D or a license under chapter 62N.

210.3 ~~(d)~~ (e) Effective July 1 of each year, the surviving corporation's or the new
 210.4 corporation's surcharge shall be based on the revenues earned in the second previous
 210.5 calendar year by all of the entities or corporations subject to the merger, consolidation,
 210.6 or acquisition regardless of whether one of the entities or corporations does not retain a
 210.7 certificate of authority under chapter 62D or a license under chapter 62N until the total
 210.8 premium revenues of the surviving corporation include the total premium revenues of all
 210.9 the merged entities as reported to the commissioner of health.

210.10 ~~(e)~~ (f) When a health maintenance organization or community integrated service
 210.11 network, which is subject to liability for the surcharge under this chapter, transfers,
 210.12 assigns, sells, leases, or disposes of all or substantially all of its property or assets, liability
 210.13 for the surcharge imposed by this chapter is imposed on the transferee, assignee, or buyer
 210.14 of the health maintenance organization or community integrated service network.

210.15 ~~(f)~~ (g) In the event a health maintenance organization or community integrated
 210.16 service network converts its licensure to a different type of entity subject to liability
 210.17 for the surcharge under this chapter, but survives in the same or substantially similar
 210.18 form, the surviving entity remains liable for the surcharge regardless of whether one of
 210.19 the entities or corporations does not retain a certificate of authority under chapter 62D
 210.20 or a license under chapter 62N.

210.21 ~~(g)~~ (h) The surcharge assessed to a health maintenance organization or community
 210.22 integrated service network ends when the entity ceases providing services for premiums
 210.23 and the cessation is not connected with a merger, consolidation, acquisition, or conversion.

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

210.25 Subd. 3a. **Payments.** (a) Acute care hospital billings under the medical
 210.26 assistance program must not be submitted until the recipient is discharged. However,
 210.27 the commissioner shall establish monthly interim payments for inpatient hospitals that
 210.28 have individual patient lengths of stay over 30 days regardless of diagnostic category.
 210.29 Except as provided in section 256.9693, medical assistance reimbursement for treatment
 210.30 of mental illness shall be reimbursed based on diagnostic classifications. Individual
 210.31 hospital payments established under this section and sections 256.9685, 256.9686, and
 210.32 256.9695, in addition to third-party and recipient liability, for discharges occurring during
 210.33 the rate year shall not exceed, in aggregate, the charges for the medical assistance covered
 210.34 inpatient services paid for the same period of time to the hospital. This payment limitation
 210.35 shall be calculated separately for medical assistance and general assistance medical

211.1 care services. The limitation on general assistance medical care shall be effective for
211.2 admissions occurring on or after July 1, 1991. Services that have rates established under
211.3 subdivision 11 or 12, must be limited separately from other services. After consulting with
211.4 the affected hospitals, the commissioner may consider related hospitals one entity and
211.5 may merge the payment rates while maintaining separate provider numbers. The operating
211.6 and property base rates per admission or per day shall be derived from the best Medicare
211.7 and claims data available when rates are established. The commissioner shall determine
211.8 the best Medicare and claims data, taking into consideration variables of recency of the
211.9 data, audit disposition, settlement status, and the ability to set rates in a timely manner.
211.10 The commissioner shall notify hospitals of payment rates by December 1 of the year
211.11 preceding the rate year. The rate setting data must reflect the admissions data used to
211.12 establish relative values. Base year changes from 1981 to the base year established for the
211.13 rate year beginning January 1, 1991, and for subsequent rate years, shall not be limited
211.14 to the limits ending June 30, 1987, on the maximum rate of increase under subdivision
211.15 1. The commissioner may adjust base year cost, relative value, and case mix index data
211.16 to exclude the costs of services that have been discontinued by the October 1 of the year
211.17 preceding the rate year or that are paid separately from inpatient services. Inpatient stays
211.18 that encompass portions of two or more rate years shall have payments established based
211.19 on payment rates in effect at the time of admission unless the date of admission preceded
211.20 the rate year in effect by six months or more. In this case, operating payment rates for
211.21 services rendered during the rate year in effect and established based on the date of
211.22 admission shall be adjusted to the rate year in effect by the hospital cost index.

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

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

211.31 (d) In addition to the reduction in paragraphs (b) and (c), the total payment for
211.32 fee-for-service admissions occurring on or after August 1, 2005, made to hospitals for
211.33 inpatient services before third-party liability and spenddown, is reduced 6.0 percent
211.34 from the current statutory rates. Mental health services within diagnosis related groups
211.35 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.
211.36 Notwithstanding section 256.9686, subdivision 7, for purposes of this paragraph, medical

212.1 assistance does not include general assistance medical care. Payments made to managed
212.2 care plans shall be reduced for services provided on or after January 1, 2006, to reflect
212.3 this reduction.

212.4 (e) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
212.5 fee-for-service admissions occurring on or after July 1, 2008, through June 30, 2009, made
212.6 to hospitals for inpatient services before third-party liability and spenddown, is reduced
212.7 3.46 percent from the current statutory rates. Mental health services with diagnosis related
212.8 groups 424 to 432 and facilities defined under subdivision 16 are excluded from this
212.9 paragraph. Payments made to managed care plans shall be reduced for services provided
212.10 on or after January 1, 2009, through June 30, 2009, to reflect this reduction.

212.11 (f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for
212.12 fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2011, made
212.13 to hospitals for inpatient services before third-party liability and spenddown, is reduced
212.14 1.9 percent from the current statutory rates. Mental health services with diagnosis related
212.15 groups 424 to 432 and facilities defined under subdivision 16 are excluded from this
212.16 paragraph. Payments made to managed care plans shall be reduced for services provided
212.17 on or after July 1, 2009, through June 30, 2011, to reflect this reduction.

212.18 (g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment
212.19 for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for
212.20 inpatient services before third-party liability and spenddown, is reduced 1.79 percent
212.21 from the current statutory rates. Mental health services with diagnosis related groups
212.22 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph.
212.23 Payments made to managed care plans shall be reduced for services provided on or after
212.24 July 1, 2011, to reflect this reduction.

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

212.31 (i) In addition to the reductions in paragraphs (b), (c), (d), (g), and (h), the total
212.32 payment for fee-for-service admissions occurring on or after July 1, 2011, made to
212.33 hospitals for inpatient services before third-party liability and spenddown, is reduced
212.34 1.96 percent from the current statutory rates. Facilities defined under subdivision 16 are
212.35 excluded from this paragraph. Payments made to managed care plans shall be reduced for
212.36 services provided on or after January 1, 2011, to reflect this reduction.

213.1 (j) For admissions occurring on or after January 1, 2015, the rate for inpatient
213.2 hospital services must be increased 1.4 percent from the rate in effect on December 31,
213.3 2014. Payments made to managed care plans and county-based purchasing plans shall
213.4 not be adjusted to reflect payments under this paragraph.

213.5 Sec. 4. Minnesota Statutes 2012, section 256.969, subdivision 29, is amended to read:

213.6 Subd. 29. **Reimbursement for the fee increase for the early hearing detection**
213.7 **and intervention program.** (a) For admissions occurring on or after July 1, 2010,
213.8 payment rates shall be adjusted to include the increase to the fee that is effective on July 1,
213.9 2010, for the early hearing detection and intervention program recipients under section
213.10 144.125, subdivision 1, that is paid by the hospital for public program recipients. This
213.11 payment increase shall be in effect until the increase is fully recognized in the base year
213.12 cost under subdivision 2b. This payment shall be included in payments to contracted
213.13 managed care organizations.

213.14 (b) For admissions occurring on or after July 1, 2013, payment rates shall be adjusted
213.15 to include the increase to the fee that is effective July 1, 2013, for the early hearing detection
213.16 and intervention program recipients under section 144.125, subdivision 1, that is paid by
213.17 the hospital for public program recipients. This payment increase shall be in effect until
213.18 the increase is fully recognized in the base-year cost under subdivision 2b. This payment
213.19 shall be included in payments to managed care plans and county-based purchasing plans.

213.20 Sec. 5. Minnesota Statutes 2012, section 256B.055, subdivision 14, is amended to read:

213.21 Subd. 14. **Persons detained by law.** (a) Medical assistance may be paid for an
213.22 inmate of a correctional facility who is conditionally released as authorized under section
213.23 241.26, 244.065, or 631.425, if the individual does not require the security of a public
213.24 detention facility and is housed in a halfway house or community correction center, or
213.25 under house arrest and monitored by electronic surveillance in a residence approved
213.26 by the commissioner of corrections, and if the individual meets the other eligibility
213.27 requirements of this chapter.

213.28 (b) An individual who is enrolled in medical assistance, and who is charged with a
213.29 crime and incarcerated for less than 12 months shall be suspended from eligibility at the
213.30 time of incarceration until the individual is released. Upon release, medical assistance
213.31 eligibility is reinstated without reapplication using a reinstatement process and form, if the
213.32 individual is otherwise eligible.

213.33 (c) An individual, regardless of age, who is considered an inmate of a public
213.34 institution as defined in Code of Federal Regulations, title 42, section 435.1010, and

214.1 who meets the eligibility requirements in section 256B.056, is not eligible for medical
 214.2 assistance, except for covered services received while an inpatient in a medical institution
 214.3 as defined in Code of Federal Regulations, title 42, section 435.1010. Security issues,
 214.4 including costs, related to the inpatient treatment of an inmate are the responsibility of the
 214.5 entity with jurisdiction over the inmate.

214.6 **EFFECTIVE DATE.** This section is effective January 1, 2014.

214.7 Sec. 6. Minnesota Statutes 2012, section 256B.06, subdivision 4, is amended to read:

214.8 Subd. 4. **Citizenship requirements.** (a) Eligibility for medical assistance is limited
 214.9 to citizens of the United States, qualified noncitizens as defined in this subdivision, and
 214.10 other persons residing lawfully in the United States. Citizens or nationals of the United
 214.11 States must cooperate in obtaining satisfactory documentary evidence of citizenship or
 214.12 nationality according to the requirements of the federal Deficit Reduction Act of 2005,
 214.13 Public Law 109-171.

214.14 (b) "Qualified noncitizen" means a person who meets one of the following
 214.15 immigration criteria:

214.16 (1) admitted for lawful permanent residence according to United States Code, title 8;

214.17 (2) admitted to the United States as a refugee according to United States Code,
 214.18 title 8, section 1157;

214.19 (3) granted asylum according to United States Code, title 8, section 1158;

214.20 (4) granted withholding of deportation according to United States Code, title 8,
 214.21 section 1253(h);

214.22 (5) paroled for a period of at least one year according to United States Code, title 8,
 214.23 section 1182(d)(5);

214.24 (6) granted conditional entrant status according to United States Code, title 8,
 214.25 section 1153(a)(7);

214.26 (7) determined to be a battered noncitizen by the United States Attorney General
 214.27 according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996,
 214.28 title V of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;

214.29 (8) is a child of a noncitizen determined to be a battered noncitizen by the United
 214.30 States Attorney General according to the Illegal Immigration Reform and Immigrant
 214.31 Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill,
 214.32 Public Law 104-200; or

214.33 (9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public
 214.34 Law 96-422, the Refugee Education Assistance Act of 1980.

215.1 (c) All qualified noncitizens who were residing in the United States before August
215.2 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for
215.3 medical assistance with federal financial participation.

215.4 (d) Beginning December 1, 1996, qualified noncitizens who entered the United
215.5 States on or after August 22, 1996, and who otherwise meet the eligibility requirements
215.6 of this chapter are eligible for medical assistance with federal participation for five years
215.7 if they meet one of the following criteria:

215.8 (1) refugees admitted to the United States according to United States Code, title 8,
215.9 section 1157;

215.10 (2) persons granted asylum according to United States Code, title 8, section 1158;

215.11 (3) persons granted withholding of deportation according to United States Code,
215.12 title 8, section 1253(h);

215.13 (4) veterans of the United States armed forces with an honorable discharge for
215.14 a reason other than noncitizen status, their spouses and unmarried minor dependent
215.15 children; or

215.16 (5) persons on active duty in the United States armed forces, other than for training,
215.17 their spouses and unmarried minor dependent children.

215.18 Beginning July 1, 2010, children and pregnant women who are noncitizens
215.19 described in paragraph (b) or who are lawfully present in the United States as defined
215.20 in Code of Federal Regulations, title 8, section 103.12, and who otherwise meet
215.21 eligibility requirements of this chapter, are eligible for medical assistance with federal
215.22 financial participation as provided by the federal Children's Health Insurance Program
215.23 Reauthorization Act of 2009, Public Law 111-3.

215.24 (e) Nonimmigrants who otherwise meet the eligibility requirements of this chapter
215.25 are eligible for the benefits as provided in paragraphs (f) to (h). For purposes of this
215.26 subdivision, a "nonimmigrant" is a person in one of the classes listed in United States
215.27 Code, title 8, section 1101(a)(15).

215.28 (f) Payment shall also be made for care and services that are furnished to noncitizens,
215.29 regardless of immigration status, who otherwise meet the eligibility requirements of
215.30 this chapter, if such care and services are necessary for the treatment of an emergency
215.31 medical condition.

215.32 (g) For purposes of this subdivision, the term "emergency medical condition" means
215.33 a medical condition that meets the requirements of United States Code, title 42, section
215.34 1396b(v).

215.35 (h)(1) Notwithstanding paragraph (g), services that are necessary for the treatment
215.36 of an emergency medical condition are limited to the following:

216.1 (i) services delivered in an emergency room or by an ambulance service licensed
 216.2 under chapter 144E that are directly related to the treatment of an emergency medical
 216.3 condition;

216.4 (ii) services delivered in an inpatient hospital setting following admission from an
 216.5 emergency room or clinic for an acute emergency condition; and

216.6 (iii) follow-up services that are directly related to the original service provided
 216.7 to treat the emergency medical condition and are covered by the global payment made
 216.8 to the provider.

216.9 (2) Services for the treatment of emergency medical conditions do not include:

216.10 (i) services delivered in an emergency room or inpatient setting to treat a
 216.11 nonemergency condition;

216.12 (ii) organ transplants, stem cell transplants, and related care;

216.13 (iii) services for routine prenatal care;

216.14 (iv) continuing care, including long-term care, nursing facility services, home health
 216.15 care, adult day care, day training, or supportive living services;

216.16 (v) elective surgery;

216.17 (vi) outpatient prescription drugs, unless the drugs are administered or dispensed as
 216.18 part of an emergency room visit;

216.19 (vii) preventative health care and family planning services;

216.20 ~~(viii) dialysis;~~

216.21 ~~(ix) chemotherapy or therapeutic radiation services;~~

216.22 ~~(x) (viii) rehabilitation services;~~

216.23 ~~(xi) (ix) physical, occupational, or speech therapy;~~

216.24 ~~(xii) (x) transportation services;~~

216.25 ~~(xiii) (xi) case management;~~

216.26 ~~(xiv) (xii) prosthetics, orthotics, durable medical equipment, or medical supplies;~~

216.27 ~~(xv) (xiii) dental services;~~

216.28 ~~(xvi) (xiv) hospice care;~~

216.29 ~~(xvii) (xv) audiology services and hearing aids;~~

216.30 ~~(xviii) (xvi) podiatry services;~~

216.31 ~~(xix) (xvii) chiropractic services;~~

216.32 ~~(xx) (xviii) immunizations;~~

216.33 ~~(xxi) (xix) vision services and eyeglasses;~~

216.34 ~~(xxii) (xx) waiver services;~~

216.35 ~~(xxiii) (xxi) individualized education programs; or~~

216.36 ~~(xxiv) (xxii) chemical dependency treatment.~~

217.1 (i) Beginning July 1, 2009, pregnant noncitizens who are undocumented,
 217.2 nonimmigrants, or lawfully present in the United States as defined in Code of Federal
 217.3 Regulations, title 8, section 103.12, are not covered by a group health plan or health
 217.4 insurance coverage according to Code of Federal Regulations, title 42, section 457.310,
 217.5 and who otherwise meet the eligibility requirements of this chapter, are eligible for
 217.6 medical assistance through the period of pregnancy, including labor and delivery, and 60
 217.7 days postpartum, to the extent federal funds are available under title XXI of the Social
 217.8 Security Act, and the state children's health insurance program.

217.9 (j) Beginning October 1, 2003, persons who are receiving care and rehabilitation
 217.10 services from a nonprofit center established to serve victims of torture and are otherwise
 217.11 ineligible for medical assistance under this chapter are eligible for medical assistance
 217.12 without federal financial participation. These individuals are eligible only for the period
 217.13 during which they are receiving services from the center. Individuals eligible under this
 217.14 paragraph shall not be required to participate in prepaid medical assistance.

217.15 (k) Notwithstanding paragraph (h), clause (2), the following services are covered as
 217.16 emergency medical conditions under paragraph (f) except where coverage is prohibited
 217.17 under federal law:

217.18 (1) dialysis services provided in a hospital or freestanding dialysis facility; and
 217.19 (2) surgery and the administration of chemotherapy, radiation, and related services
 217.20 necessary to treat cancer if the recipient has a cancer diagnosis that is not in remission
 217.21 and requires surgery, chemotherapy, or radiation treatment.

217.22 (l) The commissioner or its third party medical review agent may authorize payment
 217.23 for follow-up care and alternative services, including, but not limited to, long-term care
 217.24 services that would not otherwise be paid for under this subdivision if the commissioner
 217.25 determines that the services, if provided, will directly prevent a medicalemergency from
 217.26 immediately occurring.

217.27 Sec. 7. Minnesota Statutes 2012, section 256B.0625, is amended by adding a
 217.28 subdivision to read:

217.29 Subd. 28b. **Doula services.** Medical assistance covers doula services provided by a
 217.30 certified doula as defined in section 148.995, subdivision 2, of the mother's choice. For
 217.31 purposes of this section, "doula services" means childbirth education and support services,
 217.32 including emotional and physical support provided during pregnancy, labor, birth, and
 217.33 postpartum.

217.34 **EFFECTIVE DATE.** This section is effective July 1, 2014, or upon federal
 217.35 approval, whichever is later, and applies to services provided on or after the effective date.

218.1 Sec. 8. Minnesota Statutes 2012, section 256B.0625, subdivision 31, is amended to read:

218.2 Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical
218.3 supplies and equipment. Separate payment outside of the facility's payment rate shall
218.4 be made for wheelchairs and wheelchair accessories for recipients who are residents
218.5 of intermediate care facilities for the developmentally disabled. Reimbursement for
218.6 wheelchairs and wheelchair accessories for ICF/MR recipients shall be subject to the same
218.7 conditions and limitations as coverage for recipients who do not reside in institutions. A
218.8 wheelchair purchased outside of the facility's payment rate is the property of the recipient.
218.9 The commissioner may set reimbursement rates for specified categories of medical
218.10 supplies at levels below the Medicare payment rate.

218.11 (b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies
218.12 must enroll as a Medicare provider.

218.13 (c) When necessary to ensure access to durable medical equipment, prosthetics,
218.14 orthotics, or medical supplies, the commissioner may exempt a vendor from the Medicare
218.15 enrollment requirement if:

218.16 (1) the vendor supplies only one type of durable medical equipment, prosthetic,
218.17 orthotic, or medical supply;

218.18 (2) the vendor serves ten or fewer medical assistance recipients per year;

218.19 (3) the commissioner finds that other vendors are not available to provide same or
218.20 similar durable medical equipment, prosthetics, orthotics, or medical supplies; and

218.21 (4) the vendor complies with all screening requirements in this chapter and Code of
218.22 Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from
218.23 the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare
218.24 and Medicaid Services approved national accreditation organization as complying with
218.25 the Medicare program's supplier and quality standards and the vendor serves primarily
218.26 pediatric patients.

218.27 (d) Durable medical equipment means a device or equipment that:

218.28 (1) can withstand repeated use;

218.29 (2) is generally not useful in the absence of an illness, injury, or disability; and

218.30 (3) is provided to correct or accommodate a physiological disorder or physical
218.31 condition or is generally used primarily for a medical purpose.

218.32 (e) Electronic tablets may be considered durable medical equipment if the electronic
218.33 tablet will be used as an augmentative and alternative communication system as defined
218.34 under subdivision 31a, paragraph (a). To be covered by medical assistance, the device
218.35 must be locked in order to prevent use not related to communication.

219.1 Sec. 9. Minnesota Statutes 2012, section 256B.0625, is amended by adding a
219.2 subdivision to read:

219.3 Subd. 31b. Preferred diabetic testing supply program. (a) The commissioner
219.4 shall implement a point-of-sale preferred diabetic testing supply program by January 1,
219.5 2014. Medical assistance coverage for diabetic testing supplies shall conform to the
219.6 limitations established under the program. The commissioner may enter into a contract
219.7 with a vendor for the purpose of participating in a preferred diabetic testing supply list and
219.8 supplemental rebate program. The commissioner shall ensure that any contract meets all
219.9 federal requirements and maximizes federal financial participation. The commissioner
219.10 shall maintain an accurate and up-to-date list on the department's Web site.

219.11 (b) The commissioner may add to, delete from, and otherwise modify the preferred
219.12 diabetic testing supply program drug list after consulting with the Drug Formulary
219.13 Committee and appropriate medial specialists and providing public notice and the
219.14 opportunity for public comment.

219.15 (c) The commissioner shall adopt and administer the preferred diabetic testing
219.16 supply program as part of the administration of the diabetic testing supply rebate program.
219.17 Reimbursement for diabetic testing supplies not on the preferred diabetic testing supply
219.18 list may be subject to prior authorization.

219.19 (d) All claims for diabetic testing supplies in categories on the preferred diabetic
219.20 testing supply list must be submitted by enrolled pharmacy providers using the most
219.21 current National Council of Prescription Drug Providers electronic claims standard.

219.22 (e) For purposes of this subdivision, "preferred diabetic testing supply list" means a
219.23 list of diabetic testing supplies selected by the commissioner, for which prior authorization
219.24 is not required.

219.25 (f) The commissioner shall seek any federal waivers or approvals necessary to
219.26 implement this subdivision.

219.27 Sec. 10. Minnesota Statutes 2012, section 256B.0625, subdivision 39, is amended to
219.28 read:

219.29 Subd. 39. **Childhood immunizations.** Providers who administer pediatric vaccines
219.30 within the scope of their licensure, and who are enrolled as a medical assistance provider,
219.31 must enroll in the pediatric vaccine administration program established by section 13631
219.32 of the Omnibus Budget Reconciliation Act of 1993. Medical assistance shall pay ~~an~~
219.33 ~~\$8.50 fee per dose~~ for administration of the vaccine to children eligible for medical
219.34 assistance. Medical assistance does not pay for vaccines that are available at no cost from
219.35 the pediatric vaccine administration program.

220.1 Sec. 11. Minnesota Statutes 2012, section 256B.0625, subdivision 58, is amended to
220.2 read:

220.3 Subd. 58. **Early and periodic screening, diagnosis, and treatment services.**

220.4 Medical assistance covers early and periodic screening, diagnosis, and treatment services
220.5 (EPSDT). The payment amount for a complete EPSDT screening shall not include charges
220.6 for vaccines that are available at no cost to the provider and shall not exceed the rate
220.7 established per Minnesota Rules, part 9505.0445, item M, effective October 1, 2010.

220.8 Sec. 12. Minnesota Statutes 2012, section 256B.0625, is amended by adding a
220.9 subdivision to read:

220.10 Subd. 61. **Payment for multiple services provided on the same day.** The
220.11 commissioner shall not prohibit payment, including supplemental payments, for mental
220.12 health services or dental services provided to a patient by a clinic or health care
220.13 professional solely because the mental health or dental services were provided on the same
220.14 day as other covered health services furnished by the same provider.

220.15 Sec. 13. Minnesota Statutes 2012, section 256B.0631, subdivision 1, is amended to read:

220.16 Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical
220.17 assistance benefit plan shall include the following cost-sharing for all recipients, effective
220.18 for services provided on or after September 1, 2011:

220.19 (1) \$3 per nonpreventive visit, except as provided in paragraph (b). For purposes
220.20 of this subdivision, a visit means an episode of service which is required because of
220.21 a recipient's symptoms, diagnosis, or established illness, and which is delivered in an
220.22 ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse
220.23 midwife, advanced practice nurse, audiologist, optician, or optometrist;

220.24 (2) \$3.50 for nonemergency visits to a hospital-based emergency room, except that
220.25 this co-payment shall be increased to \$20 upon federal approval;

220.26 (3) \$3 per brand-name drug prescription and \$1 per generic drug prescription,
220.27 subject to a \$12 per month maximum for prescription drug co-payments. No co-payments
220.28 shall apply to antipsychotic drugs when used for the treatment of mental illness;

220.29 (4) effective January 1, 2012, a family deductible equal to the maximum amount
220.30 allowed under Code of Federal Regulations, title 42, part 447.54; and

220.31 (5) for individuals identified by the commissioner with income at or below 100
220.32 percent of the federal poverty guidelines, total monthly cost-sharing must not exceed five
220.33 percent of family income. For purposes of this paragraph, family income is the total

221.1 earned and unearned income of the individual and the individual's spouse, if the spouse is
 221.2 enrolled in medical assistance and also subject to the five percent limit on cost-sharing.

221.3 (b) Recipients of medical assistance are responsible for all co-payments and
 221.4 deductibles in this subdivision.

221.5 (c) Notwithstanding paragraph (b), the commissioner, through the contracting
 221.6 process under sections 256B.69 and 256B.692, may allow managed care plans and
 221.7 county-based purchasing plans to waive the family deductible under paragraph (a),
 221.8 clause (4). The value of the family deductible shall not be included in the capitation
 221.9 payment to managed care plans and county-based purchasing plans. Managed care plans
 221.10 and county-based purchasing plans shall certify annually to the commissioner the dollar
 221.11 value of the family deductible.

221.12 (d) Notwithstanding paragraph (b), the commissioner ~~may~~ shall waive the collection
 221.13 of the family deductible described under paragraph (a), clause (4), from individuals and
 221.14 allow long-term care and waived service providers to assume responsibility for payment.

221.15 (e) Notwithstanding paragraph (b), the commissioner, through the contracting
 221.16 process under section 256B.0756 shall allow the pilot program in Hennepin County to
 221.17 waive co-payments. The value of the co-payments shall not be included as part of the
 221.18 payment system for the integrated health care delivery networks under the pilot program.

221.19 Sec. 14. Minnesota Statutes 2012, section 256B.0756, is amended to read:

221.20 **256B.0756 HENNEPIN AND RAMSEY COUNTIES PILOT PROGRAM.**

221.21 (a) The commissioner, upon federal approval of a new waiver request or amendment
 221.22 of an existing demonstration, may establish a pilot program in Hennepin County or Ramsey
 221.23 County, or both, to test alternative and innovative integrated health care delivery networks.

221.24 (b) Individuals eligible for the pilot program shall be individuals who are eligible for
 221.25 medical assistance under section 256B.055, ~~subdivision 15~~, and who reside in Hennepin
 221.26 County or Ramsey County. The commissioner may identify individuals to be enrolled
 221.27 in the Hennepin County pilot program by zip code or by whether the individuals would
 221.28 benefit from an integrated health care delivery network.

221.29 (c) Individuals enrolled in the pilot program shall be enrolled in an integrated
 221.30 health care delivery network in their county of residence. The integrated health care
 221.31 delivery network in Hennepin County shall be a network, such as an accountable care
 221.32 organization or a community-based collaborative care network, created by or including
 221.33 Hennepin County Medical Center. The integrated health care delivery network in Ramsey
 221.34 County shall be a network, such as an accountable care organization or community-based
 221.35 collaborative care network, created by or including Regions Hospital.

222.1 ~~(d) The commissioner shall cap pilot program enrollment at 7,000 enrollees for~~
 222.2 ~~Hennepin County and 3,500 enrollees for Ramsey County.~~

222.3 ~~(e)~~ (d) In developing a payment system for the pilot programs, the commissioner
 222.4 shall establish a total cost of care for the recipients enrolled in the pilot programs that
 222.5 equals the cost of care that would otherwise be spent for these enrollees in the prepaid
 222.6 medical assistance program.

222.7 ~~(f) Counties may transfer funds necessary to support the nonfederal share of~~
 222.8 ~~payments for integrated health care delivery networks in their county. Such transfers per~~
 222.9 ~~county shall not exceed 15 percent of the expected expenses for county enrollees.~~

222.10 ~~(g)~~ (e) The commissioner shall apply to the federal government for, or as appropriate,
 222.11 cooperate with counties, providers, or other entities that are applying for any applicable
 222.12 grant or demonstration under the Patient Protection and Affordable Health Care Act, Public
 222.13 Law 111-148, or the Health Care and Education Reconciliation Act of 2010, Public Law
 222.14 111-152, that would further the purposes of or assist in the creation of an integrated health
 222.15 care delivery network for the purposes of this subdivision, including, but not limited to, a
 222.16 global payment demonstration or the community-based collaborative care network grants.

222.17 Sec. 15. Minnesota Statutes 2012, section 256B.196, subdivision 2, is amended to read:

222.18 Subd. 2. **Commissioner's duties.** (a) For the purposes of this subdivision and
 222.19 subdivision 3, the commissioner shall determine the fee-for-service outpatient hospital
 222.20 services upper payment limit for nonstate government hospitals. The commissioner shall
 222.21 then determine the amount of a supplemental payment to Hennepin County Medical
 222.22 Center and Regions Hospital for these services that would increase medical assistance
 222.23 spending in this category to the aggregate upper payment limit for all nonstate government
 222.24 hospitals in Minnesota. In making this determination, the commissioner shall allot the
 222.25 available increases between Hennepin County Medical Center and Regions Hospital
 222.26 based on the ratio of medical assistance fee-for-service outpatient hospital payments to
 222.27 the two facilities. The commissioner shall adjust this allotment as necessary based on
 222.28 federal approvals, the amount of intergovernmental transfers received from Hennepin and
 222.29 Ramsey Counties, and other factors, in order to maximize the additional total payments.
 222.30 The commissioner shall inform Hennepin County and Ramsey County of the periodic
 222.31 intergovernmental transfers necessary to match federal Medicaid payments available
 222.32 under this subdivision in order to make supplementary medical assistance payments to
 222.33 Hennepin County Medical Center and Regions Hospital equal to an amount that when
 222.34 combined with existing medical assistance payments to nonstate governmental hospitals
 222.35 would increase total payments to hospitals in this category for outpatient services to

223.1 the aggregate upper payment limit for all hospitals in this category in Minnesota. Upon
223.2 receipt of these periodic transfers, the commissioner shall make supplementary payments
223.3 to Hennepin County Medical Center and Regions Hospital.

223.4 (b) For the purposes of this subdivision and subdivision 3, the commissioner shall
223.5 determine an upper payment limit for physicians and other billing professionals affiliated
223.6 with Hennepin County Medical Center and with Regions Hospital. The upper payment
223.7 limit shall be based on the average commercial rate or be determined using another method
223.8 acceptable to the Centers for Medicare and Medicaid Services. The commissioner shall
223.9 inform Hennepin County and Ramsey County of the periodic intergovernmental transfers
223.10 necessary to match the federal Medicaid payments available under this subdivision in order
223.11 to make supplementary payments to physicians and other billing professionals affiliated
223.12 with Hennepin County Medical Center and to make supplementary payments to physicians
223.13 and other billing professionals affiliated with Regions Hospital through HealthPartners
223.14 Medical Group equal to the difference between the established medical assistance
223.15 payment for physician and other billing professional services and the upper payment limit.
223.16 Upon receipt of these periodic transfers, the commissioner shall make supplementary
223.17 payments to physicians and other billing professionals affiliated with Hennepin County
223.18 Medical Center and shall make supplementary payments to physicians and other billing
223.19 professionals affiliated with Regions Hospital through HealthPartners Medical Group.

223.20 (c) Beginning January 1, 2010, Hennepin County and Ramsey County may make
223.21 monthly voluntary intergovernmental transfers to the commissioner in amounts not to
223.22 exceed \$12,000,000 per year from Hennepin County and \$6,000,000 per year from
223.23 Ramsey County. The commissioner shall increase the medical assistance capitation
223.24 payments to any licensed health plan under contract with the medical assistance program
223.25 that agrees to make enhanced payments to Hennepin County Medical Center or Regions
223.26 Hospital. The increase shall be in an amount equal to the annual value of the monthly
223.27 transfers plus federal financial participation, with each health plan receiving its pro rata
223.28 share of the increase based on the pro rata share of medical assistance admissions to
223.29 Hennepin County Medical Center and Regions Hospital by those plans. Upon the request
223.30 of the commissioner, health plans shall submit individual-level cost data for verification
223.31 purposes. The commissioner may ratably reduce these payments on a pro rata basis in
223.32 order to satisfy federal requirements for actuarial soundness. If payments are reduced,
223.33 transfers shall be reduced accordingly. Any licensed health plan that receives increased
223.34 medical assistance capitation payments under the intergovernmental transfer described in
223.35 this paragraph shall increase its medical assistance payments to Hennepin County Medical

224.1 Center and Regions Hospital by the same amount as the increased payments received in
 224.2 the capitation payment described in this paragraph.

224.3 (d) For the purposes of this subdivision and subdivision 3, the commissioner shall
 224.4 determine an upper payment limit for ambulance services affiliated with Hennepin County
 224.5 Medical Center. The upper payment limit shall be based on the average commercial
 224.6 rate or be determined using another method acceptable to the Centers for Medicare and
 224.7 Medicaid Services. The commissioner shall inform Hennepin County of the periodic
 224.8 intergovernmental transfers necessary to match the federal Medicaid payments available
 224.9 under this subdivision in order to make supplementary payments to Hennepin County
 224.10 Medical Center equal to the difference between the established medical assistance
 224.11 payment for ambulance services and the upper payment limit. Upon receipt of these
 224.12 periodic transfers, the commissioner shall make supplementary payments to Hennepin
 224.13 County Medical Center.

224.14 (e) The commissioner shall inform the transferring governmental entities on an
 224.15 ongoing basis of the need for any changes needed in the intergovernmental transfers in
 224.16 order to continue the payments under paragraphs (a) to ~~(e)~~ (d), at their maximum level,
 224.17 including increases in upper payment limits, changes in the federal Medicaid match, and
 224.18 other factors.

224.19 ~~(e)~~ (f) The payments in paragraphs (a) to ~~(e)~~ (d) shall be implemented independently
 224.20 of each other, subject to federal approval and to the receipt of transfers under subdivision 3.

224.21 Sec. 16. Minnesota Statutes 2012, section 256B.69, subdivision 5c, is amended to read:

224.22 Subd. 5c. **Medical education and research fund.** (a) The commissioner of human
 224.23 services shall transfer each year to the medical education and research fund established
 224.24 under section 62J.692, an amount specified in this subdivision. The commissioner shall
 224.25 calculate the following:

224.26 (1) an amount equal to the reduction in the prepaid medical assistance payments as
 224.27 specified in this clause. Until January 1, 2002, the county medical assistance capitation
 224.28 base rate prior to plan specific adjustments and after the regional rate adjustments under
 224.29 subdivision 5b is reduced 6.3 percent for Hennepin County, two percent for the remaining
 224.30 metropolitan counties, and no reduction for nonmetropolitan Minnesota counties; and after
 224.31 January 1, 2002, the county medical assistance capitation base rate prior to plan specific
 224.32 adjustments is reduced 6.3 percent for Hennepin County, two percent for the remaining
 224.33 metropolitan counties, and 1.6 percent for nonmetropolitan Minnesota counties. Nursing
 224.34 facility and elderly waiver payments and demonstration project payments operating
 224.35 under subdivision 23 are excluded from this reduction. The amount calculated under

225.1 this clause shall not be adjusted for periods already paid due to subsequent changes to
225.2 the capitation payments;

225.3 (2) beginning July 1, 2003, \$4,314,000 from the capitation rates paid under this
225.4 section;

225.5 (3) beginning July 1, 2002, an additional \$12,700,000 from the capitation rates
225.6 paid under this section; and

225.7 (4) beginning July 1, 2003, an additional \$4,700,000 from the capitation rates paid
225.8 under this section.

225.9 (b) This subdivision shall be effective upon approval of a federal waiver which
225.10 allows federal financial participation in the medical education and research fund. The
225.11 amount specified under paragraph (a), clauses (1) to (4), shall not exceed the total amount
225.12 transferred for fiscal year 2009. Any excess shall first reduce the amounts specified under
225.13 paragraph (a), clauses (2) to (4). Any excess following this reduction shall proportionally
225.14 reduce the amount specified under paragraph (a), clause (1).

225.15 (c) Beginning September 1, 2011, of the amount in paragraph (a), the commissioner
225.16 shall transfer \$21,714,000 each fiscal year to the medical education and research fund.

225.17 (d) Beginning September 1, 2011, of the amount in paragraph (a), following the
225.18 transfer under paragraph (c), the commissioner shall transfer to the medical education
225.19 research fund \$23,936,000 in fiscal years 2012 and 2013 and ~~\$36,744,000~~ \$43,148,000 in
225.20 fiscal year 2014 and thereafter.

225.21 Sec. 17. Minnesota Statutes 2012, section 256B.69, subdivision 31, is amended to read:

225.22 Subd. 31. **Payment reduction.** (a) Beginning September 1, 2011, the commissioner
225.23 shall reduce payments and limit future rate increases paid to managed care plans and
225.24 county-based purchasing plans. The limits in paragraphs (a) to (f) shall be achieved
225.25 on a statewide aggregate basis by program. The commissioner may use competitive
225.26 bidding, payment reductions, or other reductions to achieve the reductions and limits
225.27 in this subdivision.

225.28 (b) Beginning September 1, 2011, the commissioner shall reduce payments to
225.29 managed care plans and county-based purchasing plans as follows:

225.30 (1) 2.0 percent for medical assistance elderly basic care. This shall not apply
225.31 to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver
225.32 services;

225.33 (2) 2.82 percent for medical assistance families and children;

225.34 (3) 10.1 percent for medical assistance adults without children; and

225.35 (4) 6.0 percent for MinnesotaCare families and children.

226.1 (c) Beginning January 1, 2012, the commissioner shall limit rates paid to managed
 226.2 care plans and county-based purchasing plans for calendar year 2012 to a percentage of
 226.3 the rates in effect on August 31, 2011, as follows:

226.4 (1) 98 percent for medical assistance elderly basic care. This shall not apply to
 226.5 Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver
 226.6 services;

226.7 (2) 97.18 percent for medical assistance families and children;

226.8 (3) 89.9 percent for medical assistance adults without children; and

226.9 (4) 94 percent for MinnesotaCare families and children.

226.10 (d) Beginning January 1, 2013, to December 31, 2013, the commissioner shall limit
 226.11 the maximum annual trend increases to rates paid to managed care plans and county-based
 226.12 purchasing plans as follows:

226.13 (1) 7.5 percent for medical assistance elderly basic care. This shall not apply
 226.14 to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver
 226.15 services;

226.16 (2) 5.0 percent for medical assistance special needs basic care;

226.17 (3) 2.0 percent for medical assistance families and children;

226.18 (4) 3.0 percent for medical assistance adults without children;

226.19 (5) 3.0 percent for MinnesotaCare families and children; and

226.20 (6) 3.0 percent for MinnesotaCare adults without children.

226.21 (e) The commissioner may limit trend increases to less than the maximum.

226.22 Beginning ~~July~~ January 1, 2014, the commissioner shall limit the maximum annual trend
 226.23 increases to rates paid to managed care plans and county-based purchasing plans as
 226.24 follows for calendar years 2014 ~~and~~, 2015, 2016, and 2017:

226.25 (1) ~~7.5~~ 6.0 percent for medical assistance elderly basic care. This shall not apply
 226.26 to ~~Medicare cost-sharing, nursing facility, personal care assistance, and~~ elderly waiver
 226.27 services;

226.28 (2) ~~5.0~~ 0.5 percent for medical assistance special needs basic care;

226.29 (3) ~~2.0~~ 0.5 percent for medical assistance families and children;

226.30 (4) ~~3.0~~ 0 percent for medical assistance adults without children;

226.31 (5) 3.0 percent for MinnesotaCare families and children; and

226.32 (6) 4.0 percent for MinnesotaCare adults without children.

226.33 The commissioner may limit trend increases to less than the maximum.

226.34 Sec. 18. Minnesota Statutes 2012, section 256B.69, is amended by adding a
 226.35 subdivision to read:

227.1 Subd. 34. **Risk corridors.** (a) Effective for services rendered on or after January 1,
 227.2 2014, the commissioner shall establish risk corridors that are actuarially sound for each
 227.3 managed care plan and each county-based purchasing plan providing services under this
 227.4 section and section 256B.692. The risk corridors shall be calculated annually based on the
 227.5 calendar year's net underwriting gain or loss. If the managed care plan or county-based
 227.6 purchasing plan achieved a net underwriting gain of greater than three percent of
 227.7 revenue, any excess must be repaid to the commissioner by July 31 of the year following
 227.8 calculation of the risk corridor year. If the managed care plan or county-based purchasing
 227.9 plan has incurred a net underwriting loss greater than three percent of total revenue, any
 227.10 excess must be repaid to the managed care plan or county-based purchasing plan by
 227.11 the commissioner by July 31 of the year following calculation of the risk corridor year.
 227.12 Determination of total revenues and net underwriting gain or loss must be based on the
 227.13 Minnesota supplement report #1 that is filed on April 1 of the year following calculation
 227.14 of the risk corridor and adjusted for the actual withhold calculation under subdivision 5a
 227.15 and section 256L.12, subdivision 9. The report must be filed with the commissioner of
 227.16 health and must be made available on the Department of Health's Web site.

227.17 (b) This subdivision shall not apply to the special demonstration projects under
 227.18 subdivisions 23 and 28.

227.19 Sec. 19. Minnesota Statutes 2012, section 256B.76, subdivision 1, is amended to read:

227.20 Subdivision 1. **Physician reimbursement.** (a) Effective for services rendered on
 227.21 or after October 1, 1992, the commissioner shall make payments for physician services
 227.22 as follows:

227.23 (1) payment for level one Centers for Medicare and Medicaid Services' common
 227.24 procedural coding system codes titled "office and other outpatient services," "preventive
 227.25 medicine new and established patient," "delivery, antepartum, and postpartum care,"
 227.26 "critical care," cesarean delivery and pharmacologic management provided to psychiatric
 227.27 patients, and level three codes for enhanced services for prenatal high risk, shall be paid
 227.28 at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June
 227.29 30, 1992. If the rate on any procedure code within these categories is different than the
 227.30 rate that would have been paid under the methodology in section 256B.74, subdivision 2,
 227.31 then the larger rate shall be paid;

227.32 (2) payments for all other services shall be paid at the lower of (i) submitted charges,
 227.33 or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

227.34 (3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th
 227.35 percentile of 1989, less the percent in aggregate necessary to equal the above increases

228.1 except that payment rates for home health agency services shall be the rates in effect
228.2 on September 30, 1992.

228.3 (b) Effective for services rendered on or after January 1, 2000, payment rates for
228.4 physician and professional services shall be increased by three percent over the rates
228.5 in effect on December 31, 1999, except for home health agency and family planning
228.6 agency services. The increases in this paragraph shall be implemented January 1, 2000,
228.7 for managed care.

228.8 (c) Effective for services rendered on or after July 1, 2009, payment rates for
228.9 physician and professional services shall be reduced by five percent, except that for the
228.10 period July 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent
228.11 for the medical assistance and general assistance medical care programs, over the rates in
228.12 effect on June 30, 2009. This reduction and the reductions in paragraph (d) do not apply
228.13 to office or other outpatient visits, preventive medicine visits and family planning visits
228.14 billed by physicians, advanced practice nurses, or physician assistants in a family planning
228.15 agency or in one of the following primary care practices: general practice, general internal
228.16 medicine, general pediatrics, general geriatrics, and family medicine. This reduction
228.17 and the reductions in paragraph (d) do not apply to federally qualified health centers,
228.18 rural health centers, and Indian health services. Effective October 1, 2009, payments
228.19 made to managed care plans and county-based purchasing plans under sections 256B.69,
228.20 256B.692, and 256L.12 shall reflect the payment reduction described in this paragraph.

228.21 (d) Effective for services rendered on or after July 1, 2010, payment rates for
228.22 physician and professional services shall be reduced an additional seven percent over
228.23 the five percent reduction in rates described in paragraph (c). This additional reduction
228.24 does not apply to physical therapy services, occupational therapy services, and speech
228.25 pathology and related services provided on or after July 1, 2010. This additional reduction
228.26 does not apply to physician services billed by a psychiatrist or an advanced practice nurse
228.27 with a specialty in mental health. Effective October 1, 2010, payments made to managed
228.28 care plans and county-based purchasing plans under sections 256B.69, 256B.692, and
228.29 256L.12 shall reflect the payment reduction described in this paragraph.

228.30 (e) Effective for services rendered on or after September 1, 2011, through June 30,
228.31 2013, payment rates for physician and professional services shall be reduced three percent
228.32 from the rates in effect on August 31, 2011. This reduction does not apply to physical
228.33 therapy services, occupational therapy services, and speech pathology and related services.

228.34 (f) Effective for services rendered on or after January 1, 2015, payment rates for
228.35 physician and professional services, including physical therapy, occupational therapy,
228.36 speech pathology, and mental health services shall be increased by five percent from

229.1 the rates in effect on December 31, 2014. This increase does not apply to federally
 229.2 qualified health centers, rural health centers, and Indian health services. Payments made to
 229.3 managed care plans and county-based purchasing plans shall not be adjusted to reflect
 229.4 payments under this paragraph.

229.5 Sec. 20. Minnesota Statutes 2012, section 256B.76, subdivision 4, is amended to read:

229.6 Subd. 4. **Critical access dental providers.** (a) Effective for dental services rendered
 229.7 on or after January 1, 2002, the commissioner shall increase reimbursements to dentists
 229.8 and dental clinics deemed by the commissioner to be critical access dental providers.
 229.9 For dental services rendered on or after July 1, 2007, the commissioner shall increase
 229.10 reimbursement by ~~30~~ 35 percent above the reimbursement rate that would otherwise be
 229.11 paid to the critical access dental provider. The commissioner shall pay the managed
 229.12 care plans and county-based purchasing plans in amounts sufficient to reflect increased
 229.13 reimbursements to critical access dental providers as approved by the commissioner.

229.14 (b) The commissioner shall designate the following dentists and dental clinics as
 229.15 critical access dental providers:

229.16 (1) nonprofit community clinics that:

229.17 (i) have nonprofit status in accordance with chapter 317A;

229.18 (ii) have tax exempt status in accordance with the Internal Revenue Code, section
 229.19 501(c)(3);

229.20 (iii) are established to provide oral health services to patients who are low income,
 229.21 uninsured, have special needs, and are underserved;

229.22 (iv) have professional staff familiar with the cultural background of the clinic's
 229.23 patients;

229.24 (v) charge for services on a sliding fee scale designed to provide assistance to
 229.25 low-income patients based on current poverty income guidelines and family size;

229.26 (vi) do not restrict access or services because of a patient's financial limitations
 229.27 or public assistance status; and

229.28 (vii) have free care available as needed;

229.29 (2) federally qualified health centers, rural health clinics, and public health clinics;

229.30 (3) city or county owned and operated hospital-based dental clinics;

229.31 (4) a dental clinic or dental group owned and operated by a nonprofit corporation in
 229.32 accordance with chapter 317A with more than 10,000 patient encounters per year with
 229.33 patients who are uninsured or covered by medical assistance, ~~general assistance medical~~
 229.34 ~~care~~, or MinnesotaCare; and

- 230.1 (5) a dental clinic owned and operated by the University of Minnesota or the
230.2 Minnesota State Colleges and Universities system-; and
- 230.3 (6) private practicing dentists if:
- 230.4 (i) the dentist's office is located within a health professional shortage area as defined
230.5 under Code of Federal Regulations, title 42, part 5, and United States Code, title 42,
230.6 section 254E;
- 230.7 (ii) more than 50 percent of the dentist's patient encounters per year are with patients
230.8 who are uninsured or covered by medical assistance or MinnesotaCare;
- 230.9 (iii) the dentist does not restrict access or services because of a patient's financial
230.10 limitations or public assistance status; and
- 230.11 (iv) the level of service provided by the dentist is critical to maintaining adequate
230.12 levels of patient access within the service area in which the dentist operates.
- 230.13 ~~(e) The commissioner may designate a dentist or dental clinic as a critical access~~
230.14 ~~dental provider if the dentist or dental clinic is willing to provide care to patients covered~~
230.15 ~~by medical assistance, general assistance medical care, or MinnesotaCare at a level which~~
230.16 ~~significantly increases access to dental care in the service area.~~
- 230.17 ~~(d)~~ (c) A designated critical access clinic shall receive the reimbursement rate
230.18 specified in paragraph (a) for dental services provided off site at a private dental office if
230.19 the following requirements are met:
- 230.20 (1) the designated critical access dental clinic is located within a health professional
230.21 shortage area as defined under Code of Federal Regulations, title 42, part 5, and United
230.22 States Code, title 42, section 254E, and is located outside the seven-county metropolitan
230.23 area;
- 230.24 (2) the designated critical access dental clinic is not able to provide the service
230.25 and refers the patient to the off-site dentist;
- 230.26 (3) the service, if provided at the critical access dental clinic, would be reimbursed
230.27 at the critical access reimbursement rate;
- 230.28 (4) the dentist and allied dental professionals providing the services off site are
230.29 licensed and in good standing under chapter 150A;
- 230.30 (5) the dentist providing the services is enrolled as a medical assistance provider;
- 230.31 (6) the critical access dental clinic submits the claim for services provided off site
230.32 and receives the payment for the services; and
- 230.33 (7) the critical access dental clinic maintains dental records for each claim submitted
230.34 under this paragraph, including the name of the dentist, the off-site location, and the
230.35 license number of the dentist and allied dental professionals providing the services.

231.1 Sec. 21. Minnesota Statutes 2012, section 256B.76, is amended by adding a
231.2 subdivision to read:

231.3 Subd. 7. **Payment for certain primary care services and immunization**
231.4 **administration.** Payment for certain primary care services and immunization
231.5 administration services rendered on or after January 1, 2013, through December 31, 2014,
231.6 shall be made in accordance with section 1902(a)(13) of the Social Security Act.

231.7 Sec. 22. Minnesota Statutes 2012, section 256B.764, is amended to read:

231.8 **256B.764 REIMBURSEMENT FOR FAMILY PLANNING SERVICES.**

231.9 (a) Effective for services rendered on or after July 1, 2007, payment rates for family
231.10 planning services shall be increased by 25 percent over the rates in effect June 30, 2007,
231.11 when these services are provided by a community clinic as defined in section 145.9268,
231.12 subdivision 1.

231.13 (b) Effective for services rendered on or after July 1, 2014, payment rates for
231.14 family planning services shall be increased by 20 percent over the rates in effect June
231.15 30, 2014, when these services are provided by a community clinic as defined in section
231.16 145.9268, subdivision 1. The commissioner shall adjust capitation rates to managed care
231.17 and county-based purchasing plans to reflect this increase, and shall require plans to pass
231.18 on the full amount of the rate increase to eligible community clinics, in the form of higher
231.19 payment rates for family planning services.

231.20 Sec. 23. Minnesota Statutes 2012, section 256B.766, is amended to read:

231.21 **256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.**

231.22 (a) Effective for services provided on or after July 1, 2009, total payments for basic
231.23 care services, shall be reduced by three percent, except that for the period July 1, 2009,
231.24 through June 30, 2011, total payments shall be reduced by 4.5 percent for the medical
231.25 assistance and general assistance medical care programs, prior to third-party liability and
231.26 spenddown calculation. Effective July 1, 2010, the commissioner shall classify physical
231.27 therapy services, occupational therapy services, and speech-language pathology and
231.28 related services as basic care services. The reduction in this paragraph shall apply to
231.29 physical therapy services, occupational therapy services, and speech-language pathology
231.30 and related services provided on or after July 1, 2010.

231.31 (b) Payments made to managed care plans and county-based purchasing plans shall
231.32 be reduced for services provided on or after October 1, 2009, to reflect the reduction
231.33 effective July 1, 2009, and payments made to the plans shall be reduced effective October
231.34 1, 2010, to reflect the reduction effective July 1, 2010.

232.1 (c) Effective for services provided on or after September 1, 2011, through June 30,
 232.2 2013, total payments for outpatient hospital facility fees shall be reduced by five percent
 232.3 from the rates in effect on August 31, 2011.

232.4 (d) Effective for services provided on or after September 1, 2011, through June
 232.5 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies
 232.6 and durable medical equipment not subject to a volume purchase contract, prosthetics
 232.7 and orthotics, renal dialysis services, laboratory services, public health nursing services,
 232.8 physical therapy services, occupational therapy services, speech therapy services,
 232.9 eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume
 232.10 purchase contract, and anesthesia services, and hospice services shall be reduced by three
 232.11 percent from the rates in effect on August 31, 2011.

232.12 (e) Effective for services provided on or after January 1, 2015, payments for
 232.13 ambulatory surgery centers facility fees, medical supplies and durable medical equipment
 232.14 not subject to a volume purchase contract, prosthetics and orthotics, hospice services,
 232.15 renal dialysis services, laboratory services, public health nursing services, eyeglasses
 232.16 not subject to a volume purchase contract, and hearing aids not subject to a volume
 232.17 purchase contract shall be increased by three percent. Payments made to managed care
 232.18 plans and county-based purchasing plans shall not be adjusted to reflect payments under
 232.19 this paragraph.

232.20 ~~(e)~~ (f) This section does not apply to physician and professional services, inpatient
 232.21 hospital services, family planning services, mental health services, dental services,
 232.22 prescription drugs, medical transportation, federally qualified health centers, rural health
 232.23 centers, Indian health services, and Medicare cost-sharing.

232.24 Sec. 24. Minnesota Statutes 2012, section 295.52, subdivision 8, is amended to read:

232.25 Subd. 8. **Contingent reduction in tax rate.** (a) By December 1 of each year,
 232.26 beginning in 2011, the commissioner of management and budget shall determine the
 232.27 projected balance in the health care access fund for the biennium.

232.28 (b) If the commissioner of management and budget determines that the projected
 232.29 balance in the health care access fund for the biennium reflects a ratio of revenues to
 232.30 expenditures and transfers greater than 125 percent, and if the actual cash balance in the
 232.31 fund is adequate, as determined by the commissioner of management and budget, the
 232.32 commissioner, in consultation with the commissioner of revenue, shall reduce the tax rates
 232.33 levied under subdivisions 1, 1a, 2, 3, and 4, for the subsequent calendar year sufficient
 232.34 to reduce the structural balance in the fund. The rate may be reduced to the extent that
 232.35 the projected revenues for the biennium do not exceed 125 percent of expenditures and

233.1 transfers. The new rate shall be rounded to the nearest one-tenth of one percent. The rate
 233.2 reduction under this paragraph expires at the end of each calendar year and is subject to an
 233.3 annual redetermination by the commissioner of management and budget.

233.4 ~~(e) For purposes of the analysis defined in paragraph (b), the commissioner of~~
 233.5 ~~management and budget shall include projected revenues, notwithstanding the repeal of~~
 233.6 ~~the tax imposed under this section effective January 1, 2020.~~

233.7 Sec. 25. Laws 2012, chapter 247, article 1, section 28, is amended to read:

233.8 Sec. 28. **EMERGENCY MEDICAL ASSISTANCE STUDY.**

233.9 (a) The commissioner of human services shall convene a work group to develop a
 233.10 plan to provide coordinated and cost-effective health care and coverage for individuals
 233.11 who meet eligibility standards for emergency medical assistance and who are ineligible
 233.12 for other state public programs. The commissioner shall consult with work group shall
 233.13 consist of representatives of relevant stakeholders in the development of the plan,
 233.14 including but not limited to safety net hospitals, nonprofit health care coverage programs,
 233.15 nonprofit community clinics, and counties. The ~~commissioner~~ work group shall consider
 233.16 the following elements:

233.17 (1) strategies to provide individuals with the most appropriate care in the appropriate
 233.18 setting, utilizing higher quality and lower cost providers;

233.19 (2) payment mechanisms to encourage providers to manage the care of these
 233.20 populations, and to produce lower cost of care and better patient outcomes;

233.21 (3) ensure coverage and payment options that address the unique needs of those
 233.22 needing episodic care, chronic care, and long-term care services;

233.23 (4) strategies for coordinating health care and nonhealth care services, and
 233.24 integrating with existing coverage; and

233.25 (5) other issues and strategies to ensure cost-effective and coordinated delivery
 233.26 of coverage and services.

233.27 (b) The commissioner shall submit the plan of the work group to the chairs and
 233.28 ranking minority members of the legislative committees with jurisdiction over health and
 233.29 human services policy and financing by ~~January 15~~ July 15, 2013.

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

233.31 Sec. 26. Laws 2013, chapter 1, section 6, is amended to read:

233.32 Sec. 6. **TRANSFER.**

233.33 (a) The commissioner of management and budget shall transfer from the health care
 233.34 access fund to the general fund up to \$21,319,000 in fiscal year 2014; up to \$42,314,000

234.1 in fiscal year 2015; up to \$56,147,000 in fiscal year 2016; and up to \$64,683,000 in fiscal
234.2 year 2017.

234.3 (b) The commissioner of human services shall determine the difference between the
234.4 actual cost to the medical assistance program of adding 19 and 20 year olds and caretaker
234.5 populations with income between 100 and 138 percent of the federal poverty guidelines
234.6 and the cost of adding those populations that was estimated during the 2013 legislative
234.7 session based on the data from the February 2013 forecast.

234.8 (c) For each fiscal year from 2014 to 2017, the commissioner of human services shall
234.9 certify and report to the commissioner of management and budget the actual cost difference
234.10 of adding 19 and 20 year olds and caretaker populations with income between 100 and
234.11 138 percent of the federal poverty guidelines, as determined under paragraph (b), by June
234.12 30 of each fiscal year. In each fiscal year, the commissioner of management and budget
234.13 shall reduce the transfer under paragraph (a) by the amount of the costs certified under
234.14 paragraph (b). If, for any fiscal year, the amount of the cost difference determined under
234.15 paragraph (b) exceeds the amount of the transfer, the transfer for that year must be zero.

234.16 Sec. 27. **340B PROVIDER PRESCRIPTION DRUGS REIMBURSEMENT**
234.17 **STUDY.**

234.18 (a) The commissioner of human services shall study and make recommendations on
234.19 changes to standardize the medical assistance reimbursement rates for prescription drugs
234.20 obtained through the federal 340B Program and dispensed to medical assistance enrollees.
234.21 The study must examine the current medical assistance rate 340B providers are receiving
234.22 through claims submissions and make recommendations on an overall reimbursement
234.23 discount that will pay the same for drugs dispensed through the 340B Program as is paid
234.24 for drugs dispensed by non340B providers, taking into consideration any federal rebate.

234.25 (b) The commissioner shall consult with 340B providers that would be most
234.26 affected by a change in the reimbursement formula, including but not limited to safety net
234.27 hospitals, children's hospitals, community health centers, and family planning clinics.

234.28 (c) The commissioner shall submit recommendations to the chairs and ranking
234.29 minority members of the legislative committees and divisions with jurisdiction over health
234.30 and human services policy and finance by January 15, 2014.

234.31 Sec. 28. **DENTAL ACCESS AND REIMBURSEMENT REPORT.**

234.32 Subdivision 1. Study. (a) The commissioner of human services shall study the
234.33 current oral health and dental services delivery system for Minnesota public health
234.34 care programs to improve access and ensure cost-effective delivery of services. The

235.1 commissioner shall make recommendations on modifying the delivery of services and
 235.2 reimbursement methods, including modifications to the critical access dental provider
 235.3 payments under Minnesota Statutes, section 256B.76, subdivision 4.

235.4 (b) The commissioner shall consult with dental providers enrolled in Minnesota
 235.5 health care programs, including providers who serve substantial numbers of low-income
 235.6 and uninsured patients and are currently receiving enhanced critical access dental provider
 235.7 payments.

235.8 Subd. 2. **Service delivery and reimbursement methods.** The recommendations
 235.9 must address:

235.10 (1) targeting state funding and critical access dental payments to improve access
 235.11 to oral health services for individuals enrolled in Minnesota health care programs who
 235.12 are not receiving timely and appropriate dental services;

235.13 (2) encouraging the use of cost-effective service delivery methods, workforce
 235.14 innovations, and the delivery of preventive services, including, but not limited to, dental
 235.15 sealants that will reduce dental disease and future costs of treatment;

235.16 (3) improving access in all geographic areas of the state;

235.17 (4) encouraging the use of tele-dentistry and mobile dental equipment to serve
 235.18 underserved patients and communities;

235.19 (5) evaluating the use of a single administrator delivery model;

235.20 (6) compensating providers for the added costs to providers of serving low-income
 235.21 and underserved patients and populations who experience the greatest oral health
 235.22 disparities in terms of incidence of oral health disease and access to and utilization of
 235.23 needed oral health services;

235.24 (7) encouraging coordination of oral health care with other health care services;

235.25 (8) preventing overtreatment, fraud, and abuse; and

235.26 (9) reducing administrative costs for the state and for dental providers.

235.27 Subd. 3. **Report.** The commissioner shall submit a report on the recommendations to
 235.28 the chairs and ranking minority members of the of the legislative committees and divisions
 235.29 with jurisdiction over health and human services policy and finance by December 15, 2013.

235.30 Sec. 29. **REPEALER.**

235.31 Laws 2011, First Special Session chapter 9, article 6, section 97, subdivision 6, is
 235.32 repealed.

236.1 **ARTICLE 7**

236.2 **CONTINUING CARE**

236.3 Section 1. Minnesota Statutes 2012, section 144.0724, subdivision 6, is amended to read:

236.4 Subd. 6. **Penalties for late or nonsubmission.** (a) A facility that fails to complete
 236.5 or submit an assessment for a RUG-III or RUG-IV classification within seven days of the
 236.6 time requirements in subdivisions 4 and 5 is subject to a reduced rate for that resident.
 236.7 The reduced rate shall be the lowest rate for that facility. The reduced rate is effective on
 236.8 the day of admission for new admission assessments or on the day that the assessment
 236.9 was due for all other assessments and continues in effect until the first day of the month
 236.10 following the date of submission of the resident's assessment.

236.11 (b) If loss of revenue due to penalties incurred by a facility for any period of 92 days
 236.12 are equal to or greater than 1.0 percent of the total operating costs on the facility's most
 236.13 recent annual statistical and cost report, a facility may apply to the commissioner of
 236.14 human services for a reduction in the total penalty amount. The commissioner of human
 236.15 services, in consultation with the commissioner of health, may, at the sole discretion of
 236.16 the commissioner of human services, limit the penalty for residents covered by medical
 236.17 assistance to 15 days.

236.18 Sec. 2. Minnesota Statutes 2012, section 245A.03, subdivision 7, is amended to read:

236.19 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an
 236.20 initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to
 236.21 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to
 236.22 9555.6265, under this chapter for a physical location that will not be the primary residence
 236.23 of the license holder for the entire period of licensure. If a license is issued during this
 236.24 moratorium, and the license holder changes the license holder's primary residence away
 236.25 from the physical location of the foster care license, the commissioner shall revoke the
 236.26 license according to section 245A.07. Exceptions to the moratorium include:

236.27 (1) foster care settings that are required to be registered under chapter 144D;

236.28 (2) foster care licenses replacing foster care licenses in existence on May 15, 2009,
 236.29 and determined to be needed by the commissioner under paragraph (b);

236.30 (3) new foster care licenses determined to be needed by the commissioner under
 236.31 paragraph (b) for the closure of a nursing facility, ICF/MR, or regional treatment center;
 236.32 or; restructuring of state-operated services that limits the capacity of state-operated
 236.33 facilities;or allowing movement to the community for people who no longer require the

237.1 level of care provided in state-operated facilities as provided under section 256B.092,
 237.2 subdivision 13, or 256B.49, subdivision 24;

237.3 (4) new foster care licenses determined to be needed by the commissioner under
 237.4 paragraph (b) for persons requiring hospital level care; or

237.5 (5) new foster care licenses determined to be needed by the commissioner for the
 237.6 transition of people from personal care assistance to the home and community-based
 237.7 services.

237.8 (b) The commissioner shall determine the need for newly licensed foster care homes
 237.9 as defined under this subdivision. As part of the determination, the commissioner shall
 237.10 consider the availability of foster care capacity in the area in which the licensee seeks to
 237.11 operate, and the recommendation of the local county board. The determination by the
 237.12 commissioner must be final. A determination of need is not required for a change in
 237.13 ownership at the same address.

237.14 ~~(e) The commissioner shall study the effects of the license moratorium under this~~
 237.15 ~~subdivision and shall report back to the legislature by January 15, 2011. This study shall~~
 237.16 ~~include, but is not limited to the following:~~

237.17 ~~(1) the overall capacity and utilization of foster care beds where the physical location~~
 237.18 ~~is not the primary residence of the license holder prior to and after implementation~~
 237.19 ~~of the moratorium;~~

237.20 ~~(2) the overall capacity and utilization of foster care beds where the physical~~
 237.21 ~~location is the primary residence of the license holder prior to and after implementation~~
 237.22 ~~of the moratorium; and~~

237.23 ~~(3) the number of licensed and occupied ICF/MR beds prior to and after~~
 237.24 ~~implementation of the moratorium.~~

237.25 ~~(d)~~ (c) When a foster care recipient moves out of a foster home that is not the primary
 237.26 residence of the license holder according to section 256B.49, subdivision 15, paragraph
 237.27 (f), the county shall immediately inform the Department of Human Services Licensing
 237.28 Division. The department shall decrease the statewide licensed capacity for foster care
 237.29 settings where the physical location is not the primary residence of the license holder, if
 237.30 the voluntary changes described in paragraph ~~(f)~~ (e) are not sufficient to meet the savings
 237.31 required by reductions in licensed bed capacity under Laws 2011, First Special Session
 237.32 chapter 9, article 7, sections 1 and 40, paragraph (f), and maintain statewide long-term
 237.33 care residential services capacity within budgetary limits. Implementation of the statewide
 237.34 licensed capacity reduction shall begin on July 1, 2013. The commissioner shall delicense
 237.35 up to 128 beds by June 30, 2014, using the needs determination process. Under this
 237.36 paragraph, the commissioner has the authority to reduce unused licensed capacity of a

238.1 current foster care program to accomplish the consolidation or closure of settings. Under
 238.2 this paragraph, the commissioner has the authority to manage statewide capacity, including
 238.3 adjusting the capacity available to each county and adjusting statewide available capacity,
 238.4 to meet the statewide needs identified through the process in paragraph (e). A decreased
 238.5 licensed capacity according to this paragraph is not subject to appeal under this chapter.

238.6 ~~(e)~~ (d) Residential settings that would otherwise be subject to the decreased license
 238.7 capacity established in paragraph ~~(d)~~ (c) shall be exempt under the following circumstances:

238.8 (1) until August 1, 2013, the license holder's beds occupied by residents whose
 238.9 primary diagnosis is mental illness and the license holder is:

238.10 (i) a provider of assertive community treatment (ACT) or adult rehabilitative mental
 238.11 health services (ARMHS) as defined in section 256B.0623;

238.12 (ii) a mental health center certified under Minnesota Rules, parts 9520.0750 to
 238.13 9520.0870;

238.14 (iii) a mental health clinic certified under Minnesota Rules, parts 9520.0750 to
 238.15 9520.0870; or

238.16 (iv) a provider of intensive residential treatment services (IRTS) licensed under
 238.17 Minnesota Rules, parts 9520.0500 to 9520.0670; or

238.18 (2) the license holder's beds occupied by residents whose primary diagnosis is
 238.19 mental illness and the license holder is certified under the requirements in subdivision 6a.

238.20 ~~(f)~~ (e) A resource need determination process, managed at the state level, using the
 238.21 available reports required by section 144A.351, and other data and information shall
 238.22 be used to determine where the reduced capacity required under paragraph ~~(d)~~ (c) will
 238.23 be implemented. The commissioner shall consult with the stakeholders described in
 238.24 section 144A.351, and employ a variety of methods to improve the state's capacity to
 238.25 meet long-term care service needs within budgetary limits, including seeking proposals
 238.26 from service providers or lead agencies to change service type, capacity, or location to
 238.27 improve services, increase the independence of residents, and better meet needs identified
 238.28 by the long-term care services reports and statewide data and information. By February
 238.29 ~~1 of each, 2013, and August 1, 2014, and each following~~ year, the commissioner shall
 238.30 provide information and data on the overall capacity of licensed long-term care services,
 238.31 actions taken under this subdivision to manage statewide long-term care services and
 238.32 supports resources, and any recommendations for change to the legislative committees
 238.33 with jurisdiction over health and human services budget.

238.34 ~~(g)~~ (f) At the time of application and reapplication for licensure, the applicant and the
 238.35 license holder that are subject to the moratorium or an exclusion established in paragraph
 238.36 (a) are required to inform the commissioner whether the physical location where the foster

239.1 care will be provided is or will be the primary residence of the license holder for the entire
 239.2 period of licensure. If the primary residence of the applicant or license holder changes, the
 239.3 applicant or license holder must notify the commissioner immediately. The commissioner
 239.4 shall print on the foster care license certificate whether or not the physical location is the
 239.5 primary residence of the license holder.

239.6 ~~(h)~~ (g) License holders of foster care homes identified under paragraph ~~(g)~~ (f) that
 239.7 are not the primary residence of the license holder and that also provide services in the
 239.8 foster care home that are covered by a federally approved home and community-based
 239.9 services waiver, as authorized under section 256B.0915, 256B.092, or 256B.49, must
 239.10 inform the human services licensing division that the license holder provides or intends to
 239.11 provide these waiver-funded services. These license holders must be considered registered
 239.12 under section 256B.092, subdivision 11, paragraph (c), and this registration status must
 239.13 be identified on their license certificates.

239.14 Sec. 3. Minnesota Statutes 2012, section 252.291, is amended by adding a subdivision
 239.15 to read:

239.16 Subd. 2b. Nicollet County facility project. The commissioner of health shall
 239.17 certify one additional bed in an intermediate care facility for persons with developmental
 239.18 disabilities in Nicollet County.

239.19 Sec. 4. Minnesota Statutes 2012, section 256.9657, subdivision 1, is amended to read:

239.20 Subdivision 1. **Nursing home license surcharge.** (a) Effective July 1, 1993,
 239.21 each non-state-operated nursing home licensed under chapter 144A shall pay to the
 239.22 commissioner an annual surcharge according to the schedule in subdivision 4. The
 239.23 surcharge shall be calculated as \$620 per licensed bed. If the number of licensed beds is
 239.24 ~~reduced~~ changed, the surcharge shall be based on the number of remaining licensed beds
 239.25 the second month following the receipt of timely notice by the commissioner of human
 239.26 services that the number of beds have been delicensed has been changed. The nursing home
 239.27 must notify the commissioner of health in writing when the number of beds are delicensed
 239.28 is changed. The commissioner of health must notify the commissioner of human services
 239.29 within ten working days after receiving written notification. If the notification is received
 239.30 by the commissioner of human services by the ~~15th~~ third of the month, the invoice for the
 239.31 second following month must be ~~reduced~~ changed to recognize the delicensing change
 239.32 in the number of beds. ~~Beds on layaway status continue to be subject to the surcharge.~~
 239.33 The commissioner of human services must acknowledge a medical care surcharge appeal
 239.34 within 30 days of receipt of the written appeal from the provider.

240.1 (b) Effective July 1, 1994, the surcharge in paragraph (a) shall be increased to \$625.

240.2 (c) Effective August 15, 2002, the surcharge under paragraph (b) shall be increased
240.3 to \$990.

240.4 (d) Effective July 15, 2003, the surcharge under paragraph (c) shall be increased
240.5 to \$2,815.

240.6 (e) Effective July 15, 2013, the surcharge under paragraph (d) shall be increased
240.7 to \$3,255.

240.8 (f) The commissioner may reduce, and may subsequently restore, the surcharge under
240.9 paragraph ~~(d)~~ (e) based on the commissioner's determination of a permissible surcharge.

240.10 ~~(f) (g) Between April 1, 2002, and August 15, 2004~~ July 1, 2013, and June 30,
240.11 2014, a facility governed by this subdivision may elect to assume full participation in
240.12 the medical assistance program by agreeing to comply with all of the requirements of
240.13 the medical assistance program, including the rate equalization law in section 256B.48,
240.14 subdivision 1, paragraph (a), and all other requirements established in law or rule, and
240.15 to begin intake of new medical assistance recipients. Rates will be determined under
240.16 Minnesota Rules, parts 9549.0010 to 9549.0080. Notwithstanding section 256B.431,
240.17 subdivision 27, paragraph (i), rate calculations will be subject to limits as prescribed
240.18 in rule and law. Other than the adjustments in sections 256B.431, subdivisions 30 and
240.19 32; 256B.437, subdivision 3, paragraph (b), Minnesota Rules, part 9549.0057, and any
240.20 other applicable legislation enacted prior to the finalization of rates, facilities assuming
240.21 full participation in medical assistance under this paragraph are not eligible for any rate
240.22 adjustments until the July 1 following their settle-up period.

240.23 Sec. 5. Minnesota Statutes 2012, section 256.9657, subdivision 3a, is amended to read:

240.24 Subd. 3a. ~~ICF/MR~~ ICF/DD **license surcharge.** (a) Effective July 1, 2003, each
240.25 non-state-operated facility as defined under section 256B.501, subdivision 1, shall pay
240.26 to the commissioner an annual surcharge according to the schedule in subdivision 4,
240.27 paragraph (d). The annual surcharge shall be \$1,040 per licensed bed. If the number of
240.28 licensed beds is reduced, the surcharge shall be based on the number of remaining licensed
240.29 beds the second month following the receipt of timely notice by the commissioner of
240.30 human services that beds have been delicensed. The facility must notify the commissioner
240.31 of health in writing when beds are delicensed. The commissioner of health must notify
240.32 the commissioner of human services within ten working days after receiving written
240.33 notification. If the notification is received by the commissioner of human services by
240.34 the 15th of the month, the invoice for the second following month must be reduced to
240.35 recognize the delicensing of beds. The commissioner may reduce, and may subsequently

241.1 restore, the surcharge under this subdivision based on the commissioner's determination of
241.2 a permissible surcharge.

241.3 (b) Effective July 1, 2013, the surcharge under paragraph (a) is increased to \$3,679
241.4 per licensed bed.

241.5 Sec. 6. Minnesota Statutes 2012, section 256B.0625, subdivision 13e, is amended to
241.6 read:

241.7 Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment
241.8 shall be the lower of the actual acquisition costs of the drugs or the maximum allowable
241.9 cost by the commissioner plus the fixed dispensing fee; or the usual and customary price
241.10 charged to the public. The amount of payment basis must be reduced to reflect all discount
241.11 amounts applied to the charge by any provider/insurer agreement or contract for submitted
241.12 charges to medical assistance programs. The net submitted charge may not be greater
241.13 than the patient liability for the service. The pharmacy dispensing fee shall be \$3.65,
241.14 except that the dispensing fee for intravenous solutions which must be compounded by the
241.15 pharmacist shall be \$8 per bag, \$14 per bag for cancer chemotherapy products, and \$30
241.16 per bag for total parenteral nutritional products dispensed in one liter quantities, or \$44 per
241.17 bag for total parenteral nutritional products dispensed in quantities greater than one liter.
241.18 Actual acquisition cost includes quantity and other special discounts except time and cash
241.19 discounts. The actual acquisition cost of a drug shall be estimated by the commissioner at
241.20 wholesale acquisition cost plus four percent for independently owned pharmacies located
241.21 in a designated rural area within Minnesota, and at wholesale acquisition cost plus two
241.22 percent for all other pharmacies. A pharmacy is "independently owned" if it is one of four
241.23 or fewer pharmacies under the same ownership nationally. A "designated rural area" means
241.24 an area defined as a small rural area or isolated rural area according to the four-category
241.25 classification of the Rural Urban Commuting Area system developed for the United States
241.26 Health Resources and Services Administration. Wholesale acquisition cost is defined as the
241.27 manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the
241.28 United States, not including prompt pay or other discounts, rebates, or reductions in price,
241.29 for the most recent month for which information is available, as reported in wholesale price
241.30 guides or other publications of drug or biological pricing data. The maximum allowable
241.31 cost of a multisource drug may be set by the commissioner and it shall be comparable to,
241.32 but no higher than, the maximum amount paid by other third-party payors in this state who
241.33 have maximum allowable cost programs. Establishment of the amount of payment for
241.34 drugs shall not be subject to the requirements of the Administrative Procedure Act.

242.1 (b) An additional dispensing fee of \$.30 may be added to the dispensing fee paid
242.2 to pharmacists for legend drug prescriptions dispensed to residents of long-term care
242.3 facilities when a unit dose blister card system, approved by the department, is used. Under
242.4 this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The
242.5 National Drug Code (NDC) from the drug container used to fill the blister card must be
242.6 identified on the claim to the department. The unit dose blister card containing the drug
242.7 must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that
242.8 govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will
242.9 be required to credit the department for the actual acquisition cost of all unused drugs that
242.10 are eligible for reuse. The commissioner may permit the drug clozapine to be dispensed in
242.11 a quantity that is less than a 30-day supply.

242.12 (c) Whenever a maximum allowable cost has been set for a multisource drug,
242.13 payment shall be the lower of the usual and customary price charged to the public or the
242.14 maximum allowable cost established by the commissioner unless prior authorization
242.15 for the brand name product has been granted according to the criteria established by
242.16 the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the
242.17 prescriber has indicated "dispense as written" on the prescription in a manner consistent
242.18 with section 151.21, subdivision 2.

242.19 (d) The basis for determining the amount of payment for drugs administered in an
242.20 outpatient setting shall be the lower of the usual and customary cost submitted by the
242.21 provider or 106 percent of the average sales price as determined by the United States
242.22 Department of Health and Human Services pursuant to title XVIII, section 1847a of the
242.23 federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost
242.24 set by the commissioner. If average sales price is unavailable, the amount of payment
242.25 must be lower of the usual and customary cost submitted by the provider or the wholesale
242.26 acquisition cost, the specialty pharmacy rate, or the maximum allowable cost set by the
242.27 commissioner. The payment for drugs administered in an outpatient setting shall be made
242.28 to the administering facility or practitioner. A retail or specialty pharmacy dispensing a
242.29 drug for administration in an outpatient setting is not eligible for direct reimbursement.

242.30 (e) The commissioner may negotiate lower reimbursement rates for specialty
242.31 pharmacy products than the rates specified in paragraph (a). The commissioner may
242.32 require individuals enrolled in the health care programs administered by the department
242.33 to obtain specialty pharmacy products from providers with whom the commissioner has
242.34 negotiated lower reimbursement rates. Specialty pharmacy products are defined as those
242.35 used by a small number of recipients or recipients with complex and chronic diseases
242.36 that require expensive and challenging drug regimens. Examples of these conditions

243.1 include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis
 243.2 C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms
 243.3 of cancer. Specialty pharmaceutical products include injectable and infusion therapies,
 243.4 biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies
 243.5 that require complex care. The commissioner shall consult with the formulary committee
 243.6 to develop a list of specialty pharmacy products subject to this paragraph. In consulting
 243.7 with the formulary committee in developing this list, the commissioner shall take into
 243.8 consideration the population served by specialty pharmacy products, the current delivery
 243.9 system and standard of care in the state, and access to care issues. The commissioner shall
 243.10 have the discretion to adjust the reimbursement rate to prevent access to care issues.

243.11 (f) Home infusion therapy services provided by home infusion therapy pharmacies
 243.12 must be paid at rates according to subdivision 8d.

243.13 **EFFECTIVE DATE.** This section is effective January 1, 2014.

243.14 Sec. 7. Minnesota Statutes 2012, section 256B.0915, subdivision 3a, is amended to read:

243.15 Subd. 3a. **Elderly waiver cost limits.** (a) The monthly limit for the cost of
 243.16 waived services to an individual elderly waiver client except for individuals described in
 243.17 ~~paragraph~~ paragraphs (b) and (d) shall be the weighted average monthly nursing facility
 243.18 rate of the case mix resident class to which the elderly waiver client would be assigned
 243.19 under Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance
 243.20 needs allowance as described in subdivision 1d, paragraph (a), until the first day of the
 243.21 state fiscal year in which the resident assessment system as described in section 256B.438
 243.22 for nursing home rate determination is implemented. Effective on the first day of the state
 243.23 fiscal year in which the resident assessment system as described in section 256B.438 for
 243.24 nursing home rate determination is implemented and the first day of each subsequent state
 243.25 fiscal year, the monthly limit for the cost of waived services to an individual elderly
 243.26 waiver client shall be the rate of the case mix resident class to which the waiver client
 243.27 would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, in effect on
 243.28 the last day of the previous state fiscal year, adjusted by any legislatively adopted home
 243.29 and community-based services percentage rate adjustment.

243.30 (b) The monthly limit for the cost of waived services to an individual elderly
 243.31 waiver client assigned to a case mix classification A under paragraph (a) with:

243.32 (1) no dependencies in activities of daily living; or

243.33 (2) up to two dependencies in bathing, dressing, grooming, walking, and eating

243.34 when the dependency score in eating is three or greater as determined by an assessment
 243.35 performed under section 256B.0911

244.1 shall be \$1,750 per month effective on July 1, 2011, for all new participants enrolled in
244.2 the program on or after July 1, 2011. This monthly limit shall be applied to all other
244.3 participants who meet this criteria at reassessment. This monthly limit shall be increased
244.4 annually as described in paragraph (a).

244.5 (c) If extended medical supplies and equipment or environmental modifications are
244.6 or will be purchased for an elderly waiver client, the costs may be prorated for up to
244.7 12 consecutive months beginning with the month of purchase. If the monthly cost of a
244.8 recipient's waived services exceeds the monthly limit established in paragraph (a) or
244.9 (b), the annual cost of all waived services shall be determined. In this event, the annual
244.10 cost of all waived services shall not exceed 12 times the monthly limit of waived
244.11 services as described in paragraph (a) or (b).

244.12 (d) Effective July 1, 2013, the monthly cost limit of waiver services, including
244.13 any necessary home care services described in section 256B.0651, subdivision 2, for
244.14 individuals who meet the criteria as ventilator-dependent given in section 256B.0651,
244.15 subdivision 1, paragraph (g), shall be the average of the monthly medical assistance
244.16 amount established for home care services as described in section 256B.0652, subdivision
244.17 7, and the annual average contracted amount established by the commissioner for nursing
244.18 facility services for ventilator-dependent individuals. This monthly limit shall be increased
244.19 annually as described in paragraph (a).

244.20 Sec. 8. Minnesota Statutes 2012, section 256B.0915, is amended by adding a
244.21 subdivision to read:

244.22 Subd. 3j. **Individual community living support.** Upon federal approval, there
244.23 is established a new service called individual community living support (ICLS) that is
244.24 available on the elderly waiver. ICLS providers may not be the landlord of recipients, nor
244.25 have any interest in the recipient's housing. ICLS must be delivered in a single-family
244.26 home or apartment where the service recipient or their family owns or rents, as
244.27 demonstrated by a lease agreement, and maintains control over the individual unit. Case
244.28 managers or care coordinators must develop individual ICLS plans in consultation with
244.29 the client using a tool developed by the commissioner. The commissioner shall establish
244.30 payment rates and mechanisms to align payments with the type and amount of service
244.31 provided, assure statewide uniformity for payment rates, and assure cost-effectiveness.
244.32 Licensing standards for ICLS shall be reviewed jointly by the Departments of Health and
244.33 Human Services to avoid conflict with provider regulatory standards pursuant to section
244.34 144A.43 and chapter 245D.

245.1 Sec. 9. Minnesota Statutes 2012, section 256B.0916, is amended by adding a
245.2 subdivision to read:

245.3 Subd. 11. **Excess spending.** County and tribal agencies are responsible for spending
245.4 in excess of the allocation made by the commissioner. In the event a county or tribal
245.5 agency spends in excess of the allocation made by the commissioner for a given allocation
245.6 period, they must submit a corrective action plan to the commissioner. The plan must state
245.7 the actions the agency will take to correct their overspending for the year following the
245.8 period when the overspending occurred. Failure to correct overspending shall result in
245.9 recoupment of spending in excess of the allocation. Nothing in this subdivision shall be
245.10 construed as reducing the county's responsibility to offer and make available feasible
245.11 home and community-based options to eligible waiver recipients within the resources
245.12 allocated to them for that purpose.

245.13 Sec. 10. Minnesota Statutes 2012, section 256B.092, subdivision 11, is amended to read:

245.14 Subd. 11. **Residential support services.** (a) Upon federal approval, there is
245.15 established a new service called residential support that is available on the community
245.16 alternative care, community alternatives for disabled individuals, developmental
245.17 disabilities, and brain injury waivers. Existing waiver service descriptions must be
245.18 modified to the extent necessary to ensure there is no duplication between other services.
245.19 Residential support services must be provided by vendors licensed as a community
245.20 residential setting as defined in section 245A.11, subdivision 8.

245.21 (b) Residential support services must meet the following criteria:

245.22 (1) providers of residential support services must own or control the residential site;

245.23 (2) the residential site must not be the primary residence of the license holder;

245.24 (3) the residential site must have a designated program supervisor responsible for
245.25 program oversight, development, and implementation of policies and procedures;

245.26 (4) the provider of residential support services must provide supervision, training,
245.27 and assistance as described in the person's coordinated service and support plan; and

245.28 (5) the provider of residential support services must meet the requirements of
245.29 licensure and additional requirements of the person's coordinated service and support plan.

245.30 (c) Providers of residential support services that meet the definition in paragraph

245.31 (a) must be registered using a process determined by the commissioner beginning July

245.32 1, 2009. Providers licensed to provide child foster care under Minnesota Rules, parts

245.33 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts

245.34 9555.5105 to 9555.6265, and that meet the requirements in section 245A.03, subdivision

245.35 7, paragraph ~~(g)~~ (f), are considered registered under this section.

246.1 Sec. 11. Minnesota Statutes 2012, section 256B.092, subdivision 12, is amended to read:

246.2 Subd. 12. **Waivered services statewide priorities.** (a) The commissioner shall
 246.3 establish statewide priorities for individuals on the waiting list for developmental
 246.4 disabilities (DD) waiver services, as of January 1, 2010. The statewide priorities must
 246.5 include, but are not limited to, individuals who continue to have a need for waiver services
 246.6 after they have maximized the use of state plan services and other funding resources,
 246.7 including natural supports, prior to accessing waiver services, and who meet at least one
 246.8 of the following criteria:

246.9 (1) no longer require the intensity of services provided where they are currently
 246.10 living; or

246.11 (2) make a request to move from an institutional setting.

246.12 (b) After the priorities in paragraph (a) are met, priority must also be given to
 246.13 individuals who meet at least one of the following criteria:

246.14 (1) have unstable living situations due to the age, incapacity, or sudden loss of
 246.15 the primary caregivers;

246.16 (2) are moving from an institution due to bed closures;

246.17 (3) experience a sudden closure of their current living arrangement;

246.18 (4) require protection from confirmed abuse, neglect, or exploitation;

246.19 (5) experience a sudden change in need that can no longer be met through state plan
 246.20 services or other funding resources alone; or

246.21 (6) meet other priorities established by the department.

246.22 ~~(b)~~ (c) When allocating resources to lead agencies, the commissioner must take into
 246.23 consideration the number of individuals waiting who meet statewide priorities and the
 246.24 lead agencies' current use of waiver funds and existing service options. The commissioner
 246.25 has the authority to transfer funds between counties, groups of counties, and tribes to
 246.26 accommodate statewide priorities and resource needs while accounting for a necessary
 246.27 base level reserve amount for each county, group of counties, and tribe.

246.28 ~~(e) The commissioner shall evaluate the impact of the use of statewide priorities and~~
 246.29 ~~provide recommendations to the legislature on whether to continue the use of statewide~~
 246.30 ~~priorities in the November 1, 2011, annual report required by the commissioner in sections~~
 246.31 ~~256B.0916, subdivision 7, and 256B.49, subdivision 21.~~

246.32 Sec. 12. Minnesota Statutes 2012, section 256B.092, is amended by adding a
 246.33 subdivision to read:

246.34 Subd. 14. **Reduce avoidable behavioral crisis emergency room admissions,**
 246.35 **psychiatric inpatient hospitalizations, and commitments to institutions.** (a) Persons

247.1 receiving home and community-based services authorized under this section who have
 247.2 had two or more admissions within a calendar year to an emergency room, psychiatric
 247.3 unit, or institution must receive consultation from a mental health professional as defined
 247.4 in section 245.462, subdivision 18, or a behavioral professional as defined in the home
 247.5 and community-based services state plan within 30 days of discharge. The mental health
 247.6 professional or behavioral professional must:

247.7 (1) conduct a functional assessment of the crisis incident as defined in section
 247.8 245D.02, subdivision 11, which led to the hospitalization with the goal of developing
 247.9 proactive strategies as well as necessary reactive strategies to reduce the likelihood of
 247.10 future avoidable hospitalizations due to a behavioral crisis;

247.11 (2) use the results of the functional assessment to amend the coordinated service and
 247.12 support plan set forth in section 245D.02, subdivision 4b, to address the potential need
 247.13 for additional staff training, increased staffing, access to crisis mobility services, mental
 247.14 health services, use of technology, and crisis stabilization services in section 256B.0624,
 247.15 subdivision 7; and

247.16 (3) identify the need for additional consultation, testing, and mental health crisis
 247.17 intervention team services as defined in section 245D.02, subdivision 20, psychotropic
 247.18 medication use and monitoring under section 245D.051, and the frequency and duration
 247.19 of ongoing consultation.

247.20 (b) For the purposes of this subdivision, "institution" includes, but is not limited to,
 247.21 the Anoka-Metro Regional Treatment Center and the Minnesota Security Hospital.

247.22 Sec. 13. Minnesota Statutes 2012, section 256B.095, is amended to read:

247.23 **256B.095 QUALITY ASSURANCE SYSTEM ESTABLISHED.**

247.24 (a) Effective July 1, 1998, a quality assurance system for persons with developmental
 247.25 disabilities, which includes an alternative quality assurance licensing system for programs,
 247.26 is established in Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice,
 247.27 Steele, Wabasha, and Winona Counties for the purpose of improving the quality of
 247.28 services provided to persons with developmental disabilities. A county, at its option, may
 247.29 choose to have all programs for persons with developmental disabilities located within
 247.30 the county licensed under chapter 245A using standards determined under the alternative
 247.31 quality assurance licensing system or may continue regulation of these programs under the
 247.32 licensing system operated by the commissioner. ~~The project expires on June 30, 2014.~~

247.33 (b) Effective July 1, 2003, a county not listed in paragraph (a) may apply to
 247.34 participate in the quality assurance system established under paragraph (a). The

248.1 commission established under section 256B.0951 may, at its option, allow additional
248.2 counties to participate in the system.

248.3 (c) Effective July 1, 2003, any county or group of counties not listed in paragraph (a)
248.4 may establish a quality assurance system under this section. A new system established
248.5 under this section shall have the same rights and duties as the system established
248.6 under paragraph (a). A new system shall be governed by a commission under section
248.7 256B.0951. The commissioner shall appoint the initial commission members based
248.8 on recommendations from advocates, families, service providers, and counties in the
248.9 geographic area included in the new system. Counties that choose to participate in a
248.10 new system shall have the duties assigned under section 256B.0952. The new system
248.11 shall establish a quality assurance process under section 256B.0953. The provisions of
248.12 section 256B.0954 shall apply to a new system established under this paragraph. The
248.13 commissioner shall delegate authority to a new system established under this paragraph
248.14 according to section 256B.0955.

248.15 (d) Effective July 1, 2007, the quality assurance system may be expanded to include
248.16 programs for persons with disabilities and older adults.

248.17 (e) Effective July 1, 2013, a provider of service located in a county listed in
248.18 paragraph (a) that is a non-opted-in county may opt in to the quality assurance system
248.19 provided the county where services are provided indicates its agreement with a county
248.20 with a delegation agreement with the Department of Human Services.

248.21 **EFFECTIVE DATE.** This section is effective July 1, 2013.

248.22 Sec. 14. Minnesota Statutes 2012, section 256B.0951, subdivision 1, is amended to read:

248.23 Subdivision 1. **Membership.** The Quality Assurance Commission is established.
248.24 The commission consists of at least 14 but not more than 21 members as follows: at
248.25 least three but not more than five members representing advocacy organizations; at
248.26 least three but not more than five members representing consumers, families, and their
248.27 legal representatives; at least three but not more than five members representing service
248.28 providers; at least three but not more than five members representing counties; and the
248.29 commissioner of human services or the commissioner's designee. The first commission
248.30 shall establish membership guidelines for the transition and recruitment of membership for
248.31 the commission's ongoing existence. Members of the commission who do not receive a
248.32 salary or wages from an employer for time spent on commission duties may receive a per
248.33 diem payment when performing commission duties and functions. All members may be
248.34 reimbursed for expenses related to commission activities. ~~Notwithstanding the provisions~~
248.35 ~~of section 15.059, subdivision 5, the commission expires on June 30, 2014.~~

249.1 Sec. 15. Minnesota Statutes 2012, section 256B.0951, subdivision 4, is amended to read:

249.2 Subd. 4. **Commission's authority to recommend variances of licensing**
249.3 **standards.** The commission may recommend to the commissioners of human services
249.4 and health variances from the standards governing licensure of programs for persons with
249.5 ~~developmental~~ disabilities in order to improve the quality of services by implementing
249.6 an alternative ~~developmental~~ disabilities licensing system if the commission determines
249.7 that the alternative licensing system does not adversely affect the health or safety of
249.8 persons being served by the licensed program nor compromise the qualifications of staff
249.9 to provide services.

249.10 Sec. 16. Minnesota Statutes 2012, section 256B.0952, subdivision 1, is amended to read:

249.11 Subdivision 1. **Notification.** Counties or providers shall give notice to the
249.12 commission and commissioners of human services and health of intent to join the
249.13 alternative quality assurance licensing system. A county or provider choosing to participate
249.14 in the alternative quality assurance licensing system commits to participate for three years.

249.15 Sec. 17. Minnesota Statutes 2012, section 256B.0952, subdivision 5, is amended to read:

249.16 Subd. 5. **Quality assurance teams.** Quality assurance teams shall be comprised
249.17 of county staff; providers; consumers, families, and their legal representatives; members
249.18 of advocacy organizations; and other involved community members. Team members
249.19 must satisfactorily complete the training program approved by the commission and must
249.20 demonstrate performance-based competency. Team members are not considered to be
249.21 county employees for purposes of workers' compensation, unemployment insurance, or
249.22 state retirement laws solely on the basis of participation on a quality assurance team. ~~The~~
249.23 ~~county may pay~~ A per diem may be paid to team members for time spent on alternative
249.24 quality assurance process matters. All team members may be reimbursed for expenses
249.25 related to their participation in the alternative process.

249.26 Sec. 18. Minnesota Statutes 2012, section 256B.0955, is amended to read:

249.27 **256B.0955 DUTIES OF THE COMMISSIONER OF HUMAN SERVICES.**

249.28 (a) Effective July 1, 1998, the commissioner of human services shall delegate
249.29 authority to perform licensing functions and activities, in accordance with section
249.30 245A.16, to counties participating in the alternative quality assurance licensing system.
249.31 The commissioner shall not license or reimburse a facility, program, or service for persons
249.32 with ~~developmental~~ disabilities in a county that participates in the alternative quality
249.33 assurance licensing system if the commissioner has received from the appropriate county

250.1 notification that the facility, program, or service has been reviewed by a quality assurance
250.2 team and has failed to qualify for licensure.

250.3 (b) The commissioner may conduct random licensing inspections based on outcomes
250.4 adopted under section 256B.0951 at facilities, programs, and services governed by the
250.5 alternative quality assurance licensing system. The role of such random inspections shall
250.6 be to verify that the alternative quality assurance licensing system protects the safety
250.7 and well-being of consumers and maintains the availability of high-quality services for
250.8 persons with developmental disabilities.

250.9 **EFFECTIVE DATE.** This section is effective July 1, 2013.

250.10 Sec. 19. Minnesota Statutes 2012, section 256B.097, subdivision 1, is amended to read:

250.11 Subdivision 1. **Scope.** (a) In order to improve the quality of services provided to
250.12 Minnesotans with disabilities and to meet the requirements of the federally approved home
250.13 and community-based waivers under section 1915c of the Social Security Act, a State
250.14 Quality Assurance, Quality Improvement, and Licensing System for Minnesotans receiving
250.15 disability services is enacted. This system is a partnership between the Department of
250.16 Human Services and the State Quality Council established under subdivision 3.

250.17 (b) This system is a result of the recommendations from the Department of Human
250.18 Services' licensing and alternative quality assurance study mandated under Laws 2005,
250.19 First Special Session chapter 4, article 7, section 57, and presented to the legislature
250.20 in February 2007.

250.21 (c) The disability services eligible under this section include:

250.22 (1) the home and community-based services waiver programs for persons with
250.23 developmental disabilities under section 256B.092, subdivision 4, or section 256B.49,
250.24 including brain injuries and services for those who qualify for nursing facility level of care
250.25 or hospital facility level of care and any other services licensed under chapter 245D;

250.26 (2) home care services under section 256B.0651;

250.27 (3) family support grants under section 252.32;

250.28 (4) consumer support grants under section 256.476;

250.29 (5) semi-independent living services under section 252.275; and

250.30 (6) services provided through an intermediate care facility for the developmentally
250.31 disabled.

250.32 (d) For purposes of this section, the following definitions apply:

250.33 (1) "commissioner" means the commissioner of human services;

250.34 (2) "council" means the State Quality Council under subdivision 3;

251.1 (3) "Quality Assurance Commission" means the commission under section
 251.2 256B.0951; and

251.3 (4) "system" means the State Quality Assurance, Quality Improvement and
 251.4 Licensing System under this section.

251.5 Sec. 20. Minnesota Statutes 2012, section 256B.097, subdivision 3, is amended to read:

251.6 Subd. 3. **State Quality Council.** (a) There is hereby created a State Quality
 251.7 Council which must define regional quality councils, and carry out a community-based,
 251.8 person-directed quality review component, and a comprehensive system for effective
 251.9 incident reporting, investigation, analysis, and follow-up.

251.10 (b) By August 1, 2011, the commissioner of human services shall appoint the
 251.11 members of the initial State Quality Council. Members shall include representatives
 251.12 from the following groups:

251.13 (1) disability service recipients and their family members;

251.14 (2) during the first ~~two~~ four years of the State Quality Council, there must be at least
 251.15 three members from the Region 10 stakeholders. As regional quality councils are formed
 251.16 under subdivision 4, each regional quality council shall appoint one member;

251.17 (3) disability service providers;

251.18 (4) disability advocacy groups; and

251.19 (5) county human services agencies and staff from the Department of Human
 251.20 Services and Ombudsman for Mental Health and Developmental Disabilities.

251.21 (c) Members of the council who do not receive a salary or wages from an employer
 251.22 for time spent on council duties may receive a per diem payment when performing council
 251.23 duties and functions.

251.24 (d) The State Quality Council shall:

251.25 (1) assist the Department of Human Services in fulfilling federally mandated
 251.26 obligations by monitoring disability service quality and quality assurance and
 251.27 improvement practices in Minnesota;

251.28 (2) establish state quality improvement priorities with methods for achieving results
 251.29 and provide an annual report to the legislative committees with jurisdiction over policy
 251.30 and funding of disability services on the outcomes, improvement priorities, and activities
 251.31 undertaken by the commission during the previous state fiscal year;

251.32 (3) identify issues pertaining to financial and personal risk that impede Minnesotans
 251.33 with disabilities from optimizing choice of community-based services; and

251.34 (4) recommend to the chairs and ranking minority members of the legislative
 251.35 committees with jurisdiction over human services and civil law by January 15, 2013

252.1 2014, statutory and rule changes related to the findings under clause (3) that promote
252.2 individualized service and housing choices balanced with appropriate individualized
252.3 protection.

252.4 (e) The State Quality Council, in partnership with the commissioner, shall:

252.5 (1) approve and direct implementation of the community-based, person-directed
252.6 system established in this section;

252.7 (2) recommend an appropriate method of funding this system, and determine the
252.8 feasibility of the use of Medicaid, licensing fees, as well as other possible funding options;

252.9 (3) approve measurable outcomes in the areas of health and safety, consumer
252.10 evaluation, education and training, providers, and systems;

252.11 (4) establish variable licensure periods not to exceed three years based on outcomes
252.12 achieved; and

252.13 (5) in cooperation with the Quality Assurance Commission, design a transition plan
252.14 for licensed providers from Region 10 into the alternative licensing system ~~by July 1, 2013~~.

252.15 (f) The State Quality Council shall notify the commissioner of human services that a
252.16 facility, program, or service has been reviewed by quality assurance team members under
252.17 subdivision 4, paragraph (b), clause (13), and qualifies for a license.

252.18 (g) The State Quality Council, in partnership with the commissioner, shall establish
252.19 an ongoing review process for the system. The review shall take into account the
252.20 comprehensive nature of the system which is designed to evaluate the broad spectrum of
252.21 licensed and unlicensed entities that provide services to persons with disabilities. The
252.22 review shall address efficiencies and effectiveness of the system.

252.23 (h) The State Quality Council may recommend to the commissioner certain
252.24 variances from the standards governing licensure of programs for persons with disabilities
252.25 in order to improve the quality of services so long as the recommended variances do
252.26 not adversely affect the health or safety of persons being served or compromise the
252.27 qualifications of staff to provide services.

252.28 (i) The safety standards, rights, or procedural protections referenced under
252.29 subdivision 2, paragraph (c), shall not be varied. The State Quality Council may make
252.30 recommendations to the commissioner or to the legislature in the report required under
252.31 paragraph (c) regarding alternatives or modifications to the safety standards, rights, or
252.32 procedural protections referenced under subdivision 2, paragraph (c).

252.33 (j) The State Quality Council may hire staff to perform the duties assigned in this
252.34 subdivision.

252.35 Sec. 21. Minnesota Statutes 2012, section 256B.431, subdivision 44, is amended to read:

253.1 Subd. 44. **Property rate increase increases for a facility in Bloomington effective**
 253.2 **November 1, 2010 certain nursing facilities.** (a) Notwithstanding any other law to the
 253.3 contrary, money available for moratorium projects under section 144A.073, subdivision
 253.4 11, shall be used, effective November 1, 2010, to fund an approved moratorium exception
 253.5 project for a nursing facility in Bloomington licensed for 137 beds as of November 1,
 253.6 2010, up to a total property rate adjustment of \$19.33.

253.7 (b) Effective June 1, 2012, any nursing facility in McLeod County licensed for 110
 253.8 beds shall have its replacement-cost-new limit under subdivision 17e adjusted to allow
 253.9 \$1,129,463 of a completed construction project to increase the property payment rate.
 253.10 Notwithstanding any other law to the contrary, money available under section 144A.073,
 253.11 subdivision 11, after the completion of the moratorium exception approval process in 2013
 253.12 under section 144A.073, subdivision 3, shall be used to reduce the fiscal impact to the
 253.13 medical assistance budget for the increase in the replacement-cost-new limit.

253.14 (c) Effective July 1, 2012, any nursing facility in Dakota County licensed for
 253.15 61 beds shall have their replacement-cost-new limit under subdivision 17e adjusted to
 253.16 allow \$1,407,624 of a completed construction project to increase their property payment
 253.17 rate. Effective September 1, 2013, or later, their replacement-cost-new limit under
 253.18 subdivision 17e shall be adjusted to allow \$1,244,599 of a completed construction project
 253.19 to increase the property payment rate. Notwithstanding any other law to the contrary,
 253.20 money available under section 144A.073, subdivision 11, after the completion of the
 253.21 moratorium exception approval process in 2013 under section 144A.073, subdivision 3,
 253.22 shall be used to reduce the fiscal impact to the medical assistance budget for the increase
 253.23 in the replacement-cost-new limit.

253.24 **EFFECTIVE DATE.** Paragraph (b) is effective retroactively from June 1, 2012.
 253.25 Paragraph (c) is effective retroactively from July 1, 2012.

253.26 Sec. 22. Minnesota Statutes 2012, section 256B.434, subdivision 4, is amended to read:

253.27 Subd. 4. **Alternate rates for nursing facilities.** (a) For nursing facilities which
 253.28 have their payment rates determined under this section rather than section 256B.431, the
 253.29 commissioner shall establish a rate under this subdivision. The nursing facility must enter
 253.30 into a written contract with the commissioner.

253.31 (b) A nursing facility's case mix payment rate for the first rate year of a facility's
 253.32 contract under this section is the payment rate the facility would have received under
 253.33 section 256B.431.

253.34 (c) A nursing facility's case mix payment rates for the second and subsequent years
 253.35 of a facility's contract under this section are the previous rate year's contract payment

254.1 rates plus an inflation adjustment and, for facilities reimbursed under this section or
254.2 section 256B.431, an adjustment to include the cost of any increase in Health Department
254.3 licensing fees for the facility taking effect on or after July 1, 2001. The index for the
254.4 inflation adjustment must be based on the change in the Consumer Price Index-All Items
254.5 (United States City average) (CPI-U) forecasted by the commissioner of management and
254.6 budget's national economic consultant, as forecasted in the fourth quarter of the calendar
254.7 year preceding the rate year. The inflation adjustment must be based on the 12-month
254.8 period from the midpoint of the previous rate year to the midpoint of the rate year for
254.9 which the rate is being determined. For the rate years beginning on July 1, 1999, July 1,
254.10 2000, July 1, 2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006,
254.11 July 1, 2007, July 1, 2008, October 1, 2009, and October 1, 2010, this paragraph shall
254.12 apply only to the property-related payment rate. For the rate years beginning on October
254.13 1, 2011, ~~and~~ October 1, 2012, October 1, 2013, October 1, 2014, October 1, 2015, and
254.14 October 1, 2016, the rate adjustment under this paragraph shall be suspended. Beginning
254.15 in 2005, adjustment to the property payment rate under this section and section 256B.431
254.16 shall be effective on October 1. In determining the amount of the property-related payment
254.17 rate adjustment under this paragraph, the commissioner shall determine the proportion of
254.18 the facility's rates that are property-related based on the facility's most recent cost report.

254.19 (d) The commissioner shall develop additional incentive-based payments of up to
254.20 five percent above a facility's operating payment rate for achieving outcomes specified
254.21 in a contract. The commissioner may solicit contract amendments and implement those
254.22 which, on a competitive basis, best meet the state's policy objectives. The commissioner
254.23 shall limit the amount of any incentive payment and the number of contract amendments
254.24 under this paragraph to operate the incentive payments within funds appropriated for this
254.25 purpose. The contract amendments may specify various levels of payment for various
254.26 levels of performance. Incentive payments to facilities under this paragraph may be in the
254.27 form of time-limited rate adjustments or onetime supplemental payments. In establishing
254.28 the specified outcomes and related criteria, the commissioner shall consider the following
254.29 state policy objectives:

- 254.30 (1) successful diversion or discharge of residents to the residents' prior home or other
254.31 community-based alternatives;
- 254.32 (2) adoption of new technology to improve quality or efficiency;
- 254.33 (3) improved quality as measured in the Nursing Home Report Card;
- 254.34 (4) reduced acute care costs; and
- 254.35 (5) any additional outcomes proposed by a nursing facility that the commissioner
254.36 finds desirable.

255.1 (e) Notwithstanding the threshold in section 256B.431, subdivision 16, facilities that
255.2 take action to come into compliance with existing or pending requirements of the life
255.3 safety code provisions or federal regulations governing sprinkler systems must receive
255.4 reimbursement for the costs associated with compliance if all of the following conditions
255.5 are met:

255.6 (1) the expenses associated with compliance occurred on or after January 1, 2005,
255.7 and before December 31, 2008;

255.8 (2) the costs were not otherwise reimbursed under subdivision 4f or section
255.9 144A.071 or 144A.073; and

255.10 (3) the total allowable costs reported under this paragraph are less than the minimum
255.11 threshold established under section 256B.431, subdivision 15, paragraph (e), and
255.12 subdivision 16.

255.13 The commissioner shall use money appropriated for this purpose to provide to qualifying
255.14 nursing facilities a rate adjustment beginning October 1, 2007, and ending September 30,
255.15 2008. Nursing facilities that have spent money or anticipate the need to spend money
255.16 to satisfy the most recent life safety code requirements by (1) installing a sprinkler
255.17 system or (2) replacing all or portions of an existing sprinkler system may submit to the
255.18 commissioner by June 30, 2007, on a form provided by the commissioner the actual
255.19 costs of a completed project or the estimated costs, based on a project bid, of a planned
255.20 project. The commissioner shall calculate a rate adjustment equal to the allowable
255.21 costs of the project divided by the resident days reported for the report year ending
255.22 September 30, 2006. If the costs from all projects exceed the appropriation for this
255.23 purpose, the commissioner shall allocate the money appropriated on a pro rata basis to the
255.24 qualifying facilities by reducing the rate adjustment determined for each facility by an
255.25 equal percentage. Facilities that used estimated costs when requesting the rate adjustment
255.26 shall report to the commissioner by January 31, 2009, on the use of this money on a
255.27 form provided by the commissioner. If the nursing facility fails to provide the report, the
255.28 commissioner shall recoup the money paid to the facility for this purpose. If the facility
255.29 reports expenditures allowable under this subdivision that are less than the amount received
255.30 in the facility's annualized rate adjustment, the commissioner shall recoup the difference.

255.31 Sec. 23. Minnesota Statutes 2012, section 256B.437, subdivision 6, is amended to read:

255.32 Subd. 6. **Planned closure rate adjustment.** (a) The commissioner of human
255.33 services shall calculate the amount of the planned closure rate adjustment available under
255.34 subdivision 3, paragraph (b), for up to 5,140 beds according to clauses (1) to (4):

256.1 (1) the amount available is the net reduction of nursing facility beds multiplied
 256.2 by \$2,080;

256.3 (2) the total number of beds in the nursing facility or facilities receiving the planned
 256.4 closure rate adjustment must be identified;

256.5 (3) capacity days are determined by multiplying the number determined under
 256.6 clause (2) by 365; and

256.7 (4) the planned closure rate adjustment is the amount available in clause (1), divided
 256.8 by capacity days determined under clause (3).

256.9 (b) A planned closure rate adjustment under this section is effective on the first day
 256.10 of the month following completion of closure of the facility designated for closure in
 256.11 the application and becomes part of the nursing facility's ~~total operating~~ external fixed
 256.12 payment rate.

256.13 (c) Applicants may use the planned closure rate adjustment to allow for a property
 256.14 payment for a new nursing facility or an addition to an existing nursing facility or as
 256.15 an ~~operating payment~~ external fixed rate adjustment. Applications approved under this
 256.16 subdivision are exempt from other requirements for moratorium exceptions under section
 256.17 144A.073, subdivisions 2 and 3.

256.18 (d) Upon the request of a closing facility, the commissioner must allow the facility a
 256.19 closure rate adjustment as provided under section 144A.161, subdivision 10.

256.20 (e) A facility that has received a planned closure rate adjustment may reassign it
 256.21 to another facility that is under the same ownership at any time within three years of its
 256.22 effective date. The amount of the adjustment shall be computed according to paragraph (a).

256.23 (f) If the per bed dollar amount specified in paragraph (a), clause (1), is increased,
 256.24 the commissioner shall recalculate planned closure rate adjustments for facilities that
 256.25 delicense beds under this section on or after July 1, 2001, to reflect the increase in the per
 256.26 bed dollar amount. The recalculated planned closure rate adjustment shall be effective
 256.27 from the date the per bed dollar amount is increased.

256.28 (g) For planned closures approved after June 30, 2009, the commissioner of human
 256.29 services shall calculate the amount of the planned closure rate adjustment available under
 256.30 subdivision 3, paragraph (b), according to paragraph (a), clauses (1) to (4).

256.31 (h) ~~Beginning Between~~ Between July 16, 2011, and June 30, 2013, the commissioner shall ~~no~~
 256.32 ~~longer~~ not accept applications for planned closure rate adjustments under subdivision 3.

256.33 Sec. 24. Minnesota Statutes 2012, section 256B.441, subdivision 53, is amended to read:

256.34 Subd. 53. **Calculation of payment rate for external fixed costs.** The commissioner
 256.35 shall calculate a payment rate for external fixed costs.

257.1 (a) For a facility licensed as a nursing home, the portion related to section 256.9657
 257.2 shall be equal to ~~\$8.86~~ \$10.58. For a facility licensed as both a nursing home and a
 257.3 boarding care home, the portion related to section 256.9657 shall be equal to ~~\$8.86~~
 257.4 \$10.58 multiplied by the result of its number of nursing home beds divided by its total
 257.5 number of licensed beds.

257.6 (b) The portion related to the licensure fee under section 144.122, paragraph (d),
 257.7 shall be the amount of the fee divided by actual resident days.

257.8 (c) The portion related to scholarships shall be determined under section 256B.431,
 257.9 subdivision 36.

257.10 (d) The portion related to long-term care consultation shall be determined according
 257.11 to section 256B.0911, subdivision 6.

257.12 (e) The portion related to development and education of resident and family advisory
 257.13 councils under section 144A.33 shall be \$5 divided by 365.

257.14 (f) The portion related to planned closure rate adjustments shall be as determined
 257.15 under section 256B.437, subdivision 6, ~~and Minnesota Statutes 2010, section 256B.436.~~
 257.16 Planned closure rate adjustments that take effect before October 1, 2014, shall no longer
 257.17 be included in the payment rate for external fixed costs beginning October 1, 2016.
 257.18 Planned closure rate adjustments that take effect on or after October 1, 2014, shall no
 257.19 longer be included in the payment rate for external fixed costs beginning on October 1 of
 257.20 the first year not less than two years after their effective date.

257.21 (g) The portions related to property insurance, real estate taxes, special assessments,
 257.22 and payments made in lieu of real estate taxes directly identified or allocated to the nursing
 257.23 facility shall be the actual amounts divided by actual resident days.

257.24 (h) The portion related to the Public Employees Retirement Association shall be
 257.25 actual costs divided by resident days.

257.26 (i) The single bed room incentives shall be as determined under section 256B.431,
 257.27 subdivision 42. Single bed room incentives that take effect before October 1, 2014, shall
 257.28 no longer be included in the payment rate for external fixed costs beginning October 1,
 257.29 2016. Single bed room incentives that take effect on or after October 1, 2014, shall no
 257.30 longer be included in the payment rate for external fixed costs beginning on October 1 of
 257.31 the first year not less than two years after their effective date.

257.32 (j) The payment rate for external fixed costs shall be the sum of the amounts in
 257.33 paragraphs (a) to (i).

257.34 **EFFECTIVE DATE.** This section is effective June 1, 2013

257.35 Sec. 25. Minnesota Statutes 2012, section 256B.441, subdivision 55, is amended to read:

258.1 Subd. 55. **Phase-in of rebased operating payment rates.** (a) For the rate years
 258.2 beginning October 1, 2008, to October 1, 2015, the operating payment rate calculated
 258.3 under this section shall be phased in by blending the operating rate with the operating
 258.4 payment rate determined under section 256B.434. For purposes of this subdivision, the
 258.5 rate to be used that is determined under section 256B.434 shall not include the portion of
 258.6 the operating payment rate related to performance-based incentive payments under section
 258.7 256B.434, subdivision 4, paragraph (d):

258.8 (1) for the rate year beginning October 1, 2008, the operating payment rate for each
 258.9 facility shall be 13 percent of the operating payment rate from this section, and 87 percent
 258.10 of the operating payment rate from section 256B.434;

258.11 (2) for the rate period from October 1, 2009, to September 30, 2013, no rate
 258.12 adjustments shall be implemented under this section, but shall be determined under
 258.13 section 256B.434;

258.14 (3) for the rate year beginning October 1, 2013, the operating payment rate for each
 258.15 facility shall be ~~65~~ 15.4 percent of the operating payment rate from this section, and ~~35~~
 258.16 84.6 percent of the operating payment rate from section 256B.434; and

258.17 (4) for the rate year beginning October 1, ~~2014~~ 2015, the operating payment rate for
 258.18 each facility shall be ~~82~~ 24.3 percent of the operating payment rate from this section, and
 258.19 ~~1875.7~~ percent of the operating payment rate from section 256B.434.

258.20 ~~for the rate year beginning October 1, 2015, the operating payment rate for each~~
 258.21 ~~facility shall be the operating payment rate determined under this section. The blending~~
 258.22 ~~of operating payment rates under this section shall be performed separately for each~~
 258.23 ~~RUG's class.~~

258.24 (b) For the rate year beginning October 1, 2008, the commissioner shall apply limits
 258.25 to the operating payment rate increases under paragraph (a) by creating a minimum
 258.26 percentage increase and a maximum percentage increase:

258.27 (1) each nursing facility that receives a blended October 1, 2008, operating payment
 258.28 rate increase under paragraph (a) of less than one percent, when compared to its operating
 258.29 payment rate on September 30, 2008, computed using rates with RUG's weight of 1.00,
 258.30 shall receive a rate adjustment of one percent;

258.31 (2) the commissioner shall determine a maximum percentage increase that will
 258.32 result in savings equal to the cost of allowing the minimum increase in clause (1). Nursing
 258.33 facilities with a blended October 1, 2008, operating payment rate increase under paragraph
 258.34 (a) greater than the maximum percentage increase determined by the commissioner, when
 258.35 compared to its operating payment rate on September 30, 2008, computed using rates with
 258.36 a RUG's weight of 1.00, shall receive the maximum percentage increase;

259.1 (3) nursing facilities with a blended October 1, 2008, operating payment rate
 259.2 increase under paragraph (a) greater than one percent and less than the maximum
 259.3 percentage increase determined by the commissioner, when compared to its operating
 259.4 payment rate on September 30, 2008, computed using rates with a RUG's weight of 1.00,
 259.5 shall receive the blended October 1, 2008, operating payment rate increase determined
 259.6 under paragraph (a); and

259.7 (4) the October 1, 2009, through October 1, 2015, operating payment rate for
 259.8 facilities receiving the maximum percentage increase determined in clause (2) shall be
 259.9 the amount determined under paragraph (a) less the difference between the amount
 259.10 determined under paragraph (a) for October 1, 2008, and the amount allowed under clause
 259.11 (2). This rate restriction does not apply to rate increases provided in any other section.

259.12 (c) A portion of the funds received under this subdivision that are in excess of
 259.13 operating payment rates that a facility would have received under section 256B.434, as
 259.14 determined in accordance with clauses (1) to (3), shall be subject to the requirements in
 259.15 section 256B.434, subdivision 19, paragraphs (b) to (h);;

259.16 (1) determine the amount of additional funding available to a facility, which shall be
 259.17 equal to total medical assistance resident days from the most recent reporting year times
 259.18 the difference between the blended rate determined in paragraph (a) for the rate year being
 259.19 computed and the blended rate for the prior year;;

259.20 (2) determine the portion of all operating costs, for the most recent reporting year,
 259.21 that are compensation related. If this value exceeds 75 percent, use 75 percent;;

259.22 (3) subtract the amount determined in clause (2) from 75 percent;; and

259.23 (4) the portion of the fund received under this subdivision that shall be subject to the
 259.24 requirements in section 256B.434, subdivision 19, paragraphs (b) to (h), shall equal the
 259.25 amount determined in clause (1) times the amount determined in clause (3).

259.26 Sec. 26. Minnesota Statutes 2012, section 256B.441, subdivision 56, is amended to read:

259.27 Subd. 56. **Hold harmless.** For the rate years beginning October 1, 2008, to October
 259.28 1, 2016, no nursing facility shall receive an operating cost payment rate less than its
 259.29 operating cost payment rate under section 256B.434. ~~For rate years beginning between~~
 259.30 ~~October 1, 2009, and October 1, 2015, no nursing facility shall receive an operating~~
 259.31 ~~payment rate less than its operating payment rate in effect on September 30, 2009.~~ The
 259.32 comparison of operating payment rates under this section shall be made for a RUG's
 259.33 rate with a weight of 1.00.

259.34 Sec. 27. Minnesota Statutes 2012, section 256B.441, subdivision 62, is amended to read:

260.1 Subd. 62. **Repeal of rebased operating payment rates.** Notwithstanding
260.2 subdivision 54 or 55, no further steps toward phase-in of rebased operating payment rates
260.3 shall be taken, except for subdivision 55, paragraph (a), clauses (3) and (4).

260.4 Sec. 28. Minnesota Statutes 2012, section 256B.49, subdivision 11a, is amended to read:

260.5 Subd. 11a. **Waivered services statewide priorities.** (a) The commissioner shall
260.6 establish statewide priorities for individuals on the waiting list for community alternative
260.7 care, community alternatives for disabled individuals, and brain injury waiver services,
260.8 as of January 1, 2010. The statewide priorities must include, but are not limited to,
260.9 individuals who continue to have a need for waiver services after they have maximized the
260.10 use of state plan services and other funding resources, including natural supports, prior to
260.11 accessing waiver services, and who meet at least one of the following criteria:

260.12 (1) no longer require the intensity of services provided where they are currently
260.13 living; or

260.14 (2) make a request to move from an institutional setting.

260.15 (b) After the priorities in paragraph (a) are met, priority must also be given to
260.16 individuals who meet at least one of the following criteria:

260.17 (1) have unstable living situations due to the age, incapacity, or sudden loss of
260.18 the primary caregivers;

260.19 (2) are moving from an institution due to bed closures;

260.20 (3) experience a sudden closure of their current living arrangement;

260.21 (4) require protection from confirmed abuse, neglect, or exploitation;

260.22 (5) experience a sudden change in need that can no longer be met through state plan
260.23 services or other funding resources alone; or

260.24 (6) meet other priorities established by the department.

260.25 ~~(b)~~ (c) When allocating resources to lead agencies, the commissioner must take into
260.26 consideration the number of individuals waiting who meet statewide priorities and the
260.27 lead agencies' current use of waiver funds and existing service options. The commissioner
260.28 has the authority to transfer funds between counties, groups of counties, and tribes to
260.29 accommodate statewide priorities and resource needs while accounting for a necessary
260.30 base level reserve amount for each county, group of counties, and tribe.

260.31 ~~(e) The commissioner shall evaluate the impact of the use of statewide priorities and~~
260.32 ~~provide recommendations to the legislature on whether to continue the use of statewide~~
260.33 ~~priorities in the November 1, 2011, annual report required by the commissioner in sections~~
260.34 ~~256B.0916, subdivision 7, and 256B.49, subdivision 21.~~

261.1 Sec. 29. Minnesota Statutes 2012, section 256B.49, subdivision 15, is amended to read:

261.2 Subd. 15. **Coordinated service and support plan; comprehensive transitional**
261.3 **service plan; maintenance service plan.** (a) Each recipient of home and community-based
261.4 waived services shall be provided a copy of the written coordinated service and support
261.5 plan which meets the requirements in section 256B.092, subdivision 1b.

261.6 (b) In developing the comprehensive transitional service plan, the individual
261.7 receiving services, the case manager, and the guardian, if applicable, will identify the
261.8 transitional service plan fundamental service outcome and anticipated timeline to achieve
261.9 this outcome. Within the first 20 days following a recipient's request for an assessment or
261.10 reassessment, the transitional service planning team must be identified. A team leader must
261.11 be identified who will be responsible for assigning responsibility and communicating with
261.12 team members to ensure implementation of the transition plan and ongoing assessment and
261.13 communication process. The team leader should be an individual, such as the case manager
261.14 or guardian, who has the opportunity to follow the recipient to the next level of service.

261.15 Within ten days following an assessment, a comprehensive transitional service plan
261.16 must be developed incorporating elements of a comprehensive functional assessment and
261.17 including short-term measurable outcomes and timelines for achievement of and reporting
261.18 on these outcomes. Functional milestones must also be identified and reported according
261.19 to the timelines agreed upon by the transitional service planning team. In addition, the
261.20 comprehensive transitional service plan must identify additional supports that may assist
261.21 in the achievement of the fundamental service outcome such as the development of greater
261.22 natural community support, increased collaboration among agencies, and technological
261.23 supports.

261.24 The timelines for reporting on functional milestones will prompt a reassessment of
261.25 services provided, the units of services, rates, and appropriate service providers. It is
261.26 the responsibility of the transitional service planning team leader to review functional
261.27 milestone reporting to determine if the milestones are consistent with observable skills
261.28 and that milestone achievement prompts any needed changes to the comprehensive
261.29 transitional service plan.

261.30 For those whose fundamental transitional service outcome involves the need to
261.31 procure housing, a plan for the recipient to seek the resources necessary to secure the least
261.32 restrictive housing possible should be incorporated into the plan, including employment
261.33 and public supports such as housing access and shelter needy funding.

261.34 (c) Counties and other agencies responsible for funding community placement and
261.35 ongoing community supportive services are responsible for the implementation of the

262.1 comprehensive transitional service plans. Oversight responsibilities include both ensuring
262.2 effective transitional service delivery and efficient utilization of funding resources.

262.3 (d) Following one year of transitional services, the transitional services planning team
262.4 will make a determination as to whether or not the individual receiving services requires
262.5 the current level of continuous and consistent support in order to maintain the recipient's
262.6 current level of functioning. Recipients who are determined to have not had a significant
262.7 change in functioning for 12 months must move from a transitional to a maintenance
262.8 service plan. Recipients on a maintenance service plan must be reassessed to determine if
262.9 the recipient would benefit from a transitional service plan at least every 12 months and at
262.10 other times when there has been a significant change in the recipient's functioning. This
262.11 assessment should consider any changes to technological or natural community supports.

262.12 (e) When a county is evaluating denials, reductions, or terminations of home and
262.13 community-based services under section 256B.49 for an individual, the case manager
262.14 shall offer to meet with the individual or the individual's guardian in order to discuss
262.15 the prioritization of service needs within the coordinated service and support plan,
262.16 comprehensive transitional service plan, or maintenance service plan. The reduction in
262.17 the authorized services for an individual due to changes in funding for waived services
262.18 may not exceed the amount needed to ensure medically necessary services to meet the
262.19 individual's health, safety, and welfare.

262.20 (f) At the time of reassessment, local agency case managers shall assess each recipient
262.21 of community alternatives for disabled individuals or brain injury waived services
262.22 currently residing in a licensed adult foster home that is not the primary residence of the
262.23 license holder, or in which the license holder is not the primary caregiver, to determine if
262.24 that recipient could appropriately be served in a community-living setting. If appropriate
262.25 for the recipient, the case manager shall offer the recipient, through a person-centered
262.26 planning process, the option to receive alternative housing and service options. In the
262.27 event that the recipient chooses to transfer from the adult foster home, the vacated bed
262.28 shall not be filled with another recipient of waiver services and group residential housing
262.29 and the licensed capacity shall be reduced accordingly, unless the savings required by the
262.30 licensed bed closure reductions under Laws 2011, First Special Session chapter 9, article 7,
262.31 sections 1 and 40, paragraph (f), for foster care settings where the physical location is not
262.32 the primary residence of the license holder are met through voluntary changes described
262.33 in section 245A.03, subdivision 7, paragraph ~~(f)~~(e), or as provided under paragraph (a),
262.34 clauses (3) and (4). If the adult foster home becomes no longer viable due to these transfers,
262.35 the county agency, with the assistance of the department, shall facilitate a consolidation of
262.36 settings or closure. This reassessment process shall be completed by July 1, 2013.

263.1 Sec. 30. Minnesota Statutes 2012, section 256B.49, is amended by adding a
263.2 subdivision to read:

263.3 Subd. 25. **Reduce avoidable behavioral crisis emergency room admissions,**
263.4 **psychiatric inpatient hospitalizations, and commitments to institutions.** (a) Persons
263.5 receiving home and community-based services authorized under this section who have
263.6 two or more admissions within a calendar year to an emergency room, psychiatric unit,
263.7 or institution must receive consultation from a mental health professional as defined in
263.8 section 245.462, subdivision 18, or a behavioral professional as defined in the home and
263.9 community-based services state plan within 30 days of discharge. The mental health
263.10 professional or behavioral professional must:

263.11 (1) conduct a functional assessment of the crisis incident as defined in section
263.12 245D.02, subdivision 11, which led to the hospitalization with the goal of developing
263.13 proactive strategies as well as necessary reactive strategies to reduce the likelihood of
263.14 future avoidable hospitalizations due to a behavioral crisis;

263.15 (2) use the results of the functional assessment to amend the coordinated service and
263.16 support plan in section 245D.02, subdivision 4b, to address the potential need for additional
263.17 staff training, increased staffing, access to crisis mobility services, mental health services,
263.18 use of technology, and crisis stabilization services in section 256B.0624, subdivision 7; and

263.19 (3) identify the need for additional consultation, testing, mental health crisis
263.20 intervention team services as defined in section 245D.02, subdivision 20, psychotropic
263.21 medication use and monitoring under section 245D.051, and the frequency and duration
263.22 of ongoing consultation.

263.23 (b) For the purposes of this subdivision, "institution" includes, but is not limited to,
263.24 the Anoka-Metro Regional Treatment Center and the Minnesota Security Hospital.

263.25 Sec. 31. Minnesota Statutes 2012, section 256B.49, is amended by adding a
263.26 subdivision to read:

263.27 Subd. 26. **Excess allocations.** County and tribal agencies will be responsible for
263.28 authorizations in excess of the allocation made by the commissioner. In the event a county
263.29 or tribal agency authorizes in excess of the allocation made by the commissioner for a
263.30 given allocation period, the county or tribal agency must submit a corrective action plan to
263.31 the commissioner. The plan must state the actions the agency will take to correct their
263.32 overauthorization for the year following the period when the overspending occurred.
263.33 Failure to correct overauthorizations shall result in recoupment of authorizations in excess
263.34 of the allocation. Nothing in this subdivision shall be construed as reducing the county's

264.1 responsibility to offer and make available feasible home and community-based options to
264.2 eligible waiver recipients within the resources allocated to them for that purpose.

264.3 Sec. 32. Minnesota Statutes 2012, section 256B.492, is amended to read:

264.4 **256B.492 HOME AND COMMUNITY-BASED SETTINGS FOR PEOPLE**
264.5 **WITH DISABILITIES.**

264.6 (a) Individuals receiving services under a home and community-based waiver under
264.7 section 256B.092 or 256B.49 may receive services in the following settings:

264.8 (1) an individual's own home or family home;

264.9 (2) a licensed adult foster care setting of up to five people; and

264.10 (3) community living settings as defined in section 256B.49, subdivision 23, where
264.11 individuals with disabilities may reside in all of the units in a building of four or fewer
264.12 units, and no more than the greater of four or 25 percent of the units in a multifamily
264.13 building of more than four units, unless required by the Housing Opportunities for Persons
264.14 with AIDS Program.

264.15 (b) The settings in paragraph (a) must not:

264.16 (1) be located in a building that is a publicly or privately operated facility that
264.17 provides institutional treatment or custodial care;

264.18 (2) be located in a building on the grounds of or adjacent to a public or private
264.19 institution;

264.20 (3) be a housing complex designed expressly around an individual's diagnosis or
264.21 disability, unless required by the Housing Opportunities for Persons with AIDS Program;

264.22 (4) be segregated based on a disability, either physically or because of setting
264.23 characteristics, from the larger community; and

264.24 (5) have the qualities of an institution which include, but are not limited to:
264.25 regimented meal and sleep times, limitations on visitors, and lack of privacy. Restrictions
264.26 agreed to and documented in the person's individual service plan shall not result in a
264.27 residence having the qualities of an institution as long as the restrictions for the person are
264.28 not imposed upon others in the same residence and are the least restrictive alternative,
264.29 imposed for the shortest possible time to meet the person's needs.

264.30 (c) The provisions of paragraphs (a) and (b) do not apply to any setting in which
264.31 individuals receive services under a home and community-based waiver as of July 1,
264.32 2012, and the setting does not meet the criteria of this section.

264.33 (d) Notwithstanding paragraph (c), a program in Hennepin County established as
264.34 part of a Hennepin County demonstration project is qualified for the exception allowed
264.35 under paragraph (c).

265.1 (e) The commissioner shall submit an amendment to the waiver plan no later than
265.2 December 31, 2012.

265.3 Sec. 33. Minnesota Statutes 2012, section 256B.493, subdivision 2, is amended to read:

265.4 Subd. 2. **Planned closure process needs determination.** The commissioner shall
265.5 announce and implement a program for planned closure of adult foster care homes. Planned
265.6 closure shall be the preferred method for achieving necessary budgetary savings required by
265.7 the licensed bed closure budget reduction in section 245A.03, subdivision 7, paragraph ~~(d)~~
265.8 (c). If additional closures are required to achieve the necessary savings, the commissioner
265.9 shall use the process and priorities in section 245A.03, subdivision 7, paragraph ~~(d)~~ (c).

265.10 Sec. 34. Minnesota Statutes 2012, section 256B.501, is amended by adding a
265.11 subdivision to read:

265.12 Subd. 14. Rate adjustment for ICF/DD in Cottonwood County. The
265.13 commissioner of health shall decertify three beds in an intermediate care facility for
265.14 persons with developmental disabilities with 21 certified beds located in Cottonwood
265.15 County. The total payment rate shall be \$282.62 per bed, per day.

265.16 Sec. 35. Minnesota Statutes 2012, section 256B.5012, is amended by adding a
265.17 subdivision to read:

265.18 Subd. 14. Rate increase effective June 1, 2013. For rate periods beginning on or
265.19 after June 1, 2013, the commissioner shall increase the total operating payment rate for
265.20 each facility reimbursed under this section by \$7.81 per day. The increase shall not be
265.21 subject to any annual percentage increase.

265.22 EFFECTIVE DATE. This section is effective June 1, 2013.

265.23 Sec. 36. Minnesota Statutes 2012, section 256B.5012, is amended by adding a
265.24 subdivision to read:

265.25 Subd. 15. ICF/DD rate increases effective January 1, 2015, and July 1, 2015. (a)
265.26 Notwithstanding subdivision 12, for each facility reimbursed under this section, for the rate
265.27 period beginning January 1, 2015, the commissioner shall increase operating payments
265.28 equal to one percent of the operating payment rates in effect on December 31, 2014.
265.29 For the rate period beginning July 1, 2015, the commissioner shall increase operating
265.30 payments equal to one percent of the operating payment rates in effect on June 30, 2015.

265.31 (b) For each facility, the commissioner shall apply the rate increase based on
265.32 occupied beds, using the percentage specified in this subdivision multiplied by the total

266.1 payment rate, including the variable rate, but excluding the property-related payment
266.2 rate in effect on the preceding date. The total rate increase shall include the adjustment
266.3 provided in section 256B.501, subdivision 12.

266.4 Sec. 37. Minnesota Statutes 2012, section 256D.44, subdivision 5, is amended to read:

266.5 Subd. 5. **Special needs.** In addition to the state standards of assistance established in
266.6 subdivisions 1 to 4, payments are allowed for the following special needs of recipients of
266.7 Minnesota supplemental aid who are not residents of a nursing home, a regional treatment
266.8 center, or a group residential housing facility.

266.9 (a) The county agency shall pay a monthly allowance for medically prescribed
266.10 diets if the cost of those additional dietary needs cannot be met through some other
266.11 maintenance benefit. The need for special diets or dietary items must be prescribed by
266.12 a licensed physician. Costs for special diets shall be determined as percentages of the
266.13 allotment for a one-person household under the thrifty food plan as defined by the United
266.14 States Department of Agriculture. The types of diets and the percentages of the thrifty
266.15 food plan that are covered are as follows:

266.16 (1) high protein diet, at least 80 grams daily, 25 percent of thrifty food plan;

266.17 (2) controlled protein diet, 40 to 60 grams and requires special products, 100 percent
266.18 of thrifty food plan;

266.19 (3) controlled protein diet, less than 40 grams and requires special products, 125
266.20 percent of thrifty food plan;

266.21 (4) low cholesterol diet, 25 percent of thrifty food plan;

266.22 (5) high residue diet, 20 percent of thrifty food plan;

266.23 (6) pregnancy and lactation diet, 35 percent of thrifty food plan;

266.24 (7) gluten-free diet, 25 percent of thrifty food plan;

266.25 (8) lactose-free diet, 25 percent of thrifty food plan;

266.26 (9) antidumping diet, 15 percent of thrifty food plan;

266.27 (10) hypoglycemic diet, 15 percent of thrifty food plan; or

266.28 (11) ketogenic diet, 25 percent of thrifty food plan.

266.29 (b) Payment for nonrecurring special needs must be allowed for necessary home
266.30 repairs or necessary repairs or replacement of household furniture and appliances using
266.31 the payment standard of the AFDC program in effect on July 16, 1996, for these expenses,
266.32 as long as other funding sources are not available.

266.33 (c) A fee for guardian or conservator service is allowed at a reasonable rate
266.34 negotiated by the county or approved by the court. This rate shall not exceed five percent

267.1 of the assistance unit's gross monthly income up to a maximum of \$100 per month. If the
267.2 guardian or conservator is a member of the county agency staff, no fee is allowed.

267.3 (d) The county agency shall continue to pay a monthly allowance of \$68 for
267.4 restaurant meals for a person who was receiving a restaurant meal allowance on June 1,
267.5 1990, and who eats two or more meals in a restaurant daily. The allowance must continue
267.6 until the person has not received Minnesota supplemental aid for one full calendar month
267.7 or until the person's living arrangement changes and the person no longer meets the criteria
267.8 for the restaurant meal allowance, whichever occurs first.

267.9 (e) A fee of ten percent of the recipient's gross income or \$25, whichever is less,
267.10 is allowed for representative payee services provided by an agency that meets the
267.11 requirements under SSI regulations to charge a fee for representative payee services. This
267.12 special need is available to all recipients of Minnesota supplemental aid regardless of
267.13 their living arrangement.

267.14 (f)(1) Notwithstanding the language in this subdivision, an amount equal to the
267.15 maximum allotment authorized by the federal Food Stamp Program for a single individual
267.16 which is in effect on the first day of July of each year will be added to the standards of
267.17 assistance established in subdivisions 1 to 4 for adults under the age of 65 who qualify
267.18 as shelter needy and are: (i) relocating from an institution, or an adult mental health
267.19 residential treatment program under section 256B.0622; (ii) eligible for the self-directed
267.20 supports option as defined under section 256B.0657, subdivision 2; or (iii) home and
267.21 community-based waiver recipients living in their own home or rented or leased apartment
267.22 which is not owned, operated, or controlled by a provider of service not related by blood
267.23 or marriage, unless allowed under paragraph (g).

267.24 (2) Notwithstanding subdivision 3, paragraph (c), an individual eligible for the
267.25 shelter needy benefit under this paragraph is considered a household of one. An eligible
267.26 individual who receives this benefit prior to age 65 may continue to receive the benefit
267.27 after the age of 65.

267.28 (3) "Shelter needy" means that the assistance unit incurs monthly shelter costs that
267.29 exceed 40 percent of the assistance unit's gross income before the application of this
267.30 special needs standard. "Gross income" for the purposes of this section is the applicant's or
267.31 recipient's income as defined in section 256D.35, subdivision 10, or the standard specified
267.32 in subdivision 3, paragraph (a) or (b), whichever is greater. A recipient of a federal or
267.33 state housing subsidy, that limits shelter costs to a percentage of gross income, shall not be
267.34 considered shelter needy for purposes of this paragraph.

267.35 (g) Notwithstanding this subdivision, to access housing and services as provided
267.36 in paragraph (f), the recipient may choose housing that may be owned, operated, or

268.1 controlled by the recipient's service provider. In a multifamily building of more than four
268.2 units, the maximum number of units that may be used by recipients of this program shall
268.3 be the greater of four units or 25 percent of the units in the building, unless required by the
268.4 Housing Opportunities for Persons with AIDS Program. In multifamily buildings of four
268.5 or fewer units, all of the units may be used by recipients of this program. When housing is
268.6 controlled by the service provider, the individual may choose the individual's own service
268.7 provider as provided in section 256B.49, subdivision 23, clause (3). When the housing is
268.8 controlled by the service provider, the service provider shall implement a plan with the
268.9 recipient to transition the lease to the recipient's name. Within two years of signing the
268.10 initial lease, the service provider shall transfer the lease entered into under this subdivision
268.11 to the recipient. In the event the landlord denies this transfer, the commissioner may
268.12 approve an exception within sufficient time to ensure the continued occupancy by the
268.13 recipient. This paragraph expires June 30, 2016.

268.14 Sec. 38. Laws 2011, First Special Session chapter 9, article 7, section 39, subdivision
268.15 14, is amended to read:

268.16 Subd. 14. **Assessment and reassessment.** (a) Assessments of each recipient's
268.17 strengths, informal support systems, and need for services shall be completed within 20
268.18 working days of the recipient's request as provided in section 256B.0911. Reassessment
268.19 of each recipient's strengths, support systems, and need for services shall be conducted
268.20 at least every 12 months and at other times when there has been a significant change in
268.21 the recipient's functioning.

268.22 (b) There must be a determination that the client requires a hospital level of care or a
268.23 nursing facility level of care as defined in section 256B.0911, subdivision 4a, paragraph
268.24 (d), at initial and subsequent assessments to initiate and maintain participation in the
268.25 waiver program.

268.26 (c) Regardless of other assessments identified in section 144.0724, subdivision 4, as
268.27 appropriate to determine nursing facility level of care for purposes of medical assistance
268.28 payment for nursing facility services, only face-to-face assessments conducted according
268.29 to section 256B.0911, subdivisions 3a, 3b, and 4d, that result in a hospital level of care
268.30 determination or a nursing facility level of care determination must be accepted for
268.31 purposes of initial and ongoing access to waiver services payment.

268.32 (d) Persons with developmental disabilities who apply for services under the nursing
268.33 facility level waiver programs shall be screened for the appropriate level of care according
268.34 to section 256B.092.

269.1 (e) Recipients who are found eligible for home and community-based services under
 269.2 this section before their 65th birthday may remain eligible for these services after their
 269.3 65th birthday if they continue to meet all other eligibility factors.

269.4 ~~(f) The commissioner shall develop criteria to identify recipients whose level of~~
 269.5 ~~functioning is reasonably expected to improve and reassess these recipients to establish~~
 269.6 ~~a baseline assessment. Recipients who meet these criteria must have a comprehensive~~
 269.7 ~~transitional service plan developed under subdivision 15, paragraphs (b) and (c), and be~~
 269.8 ~~reassessed every six months until there has been no significant change in the recipient's~~
 269.9 ~~functioning for at least 12 months. After there has been no significant change in the~~
 269.10 ~~recipient's functioning for at least 12 months, reassessments of the recipient's strengths,~~
 269.11 ~~informal support systems, and need for services shall be conducted at least every 12~~
 269.12 ~~months and at other times when there has been a significant change in the recipient's~~
 269.13 ~~functioning. Counties, case managers, and service providers are responsible for~~
 269.14 ~~conducting these reassessments and shall complete the reassessments out of existing funds.~~

269.15 Sec. 39. Laws 2012, chapter 247, article 6, section 4, is amended to read:

269.16 Sec. 4. **BOARD OF NURSING HOME**
 269.17 **ADMINISTRATORS**

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10,000

269.18 **Administrative Services Unit.** This
 269.19 appropriation is to provide a grant to the
 269.20 Minnesota Ambulance Association to
 269.21 coordinate and prepare an assessment of
 269.22 the extent and costs of uncompensated care
 269.23 as a direct result of emergency responses
 269.24 on interstate highways in Minnesota.
 269.25 The study will collect appropriate
 269.26 information from medical response units
 269.27 and ambulance services regulated under
 269.28 Minnesota Statutes, chapter 144E, and to
 269.29 the extent possible, firefighting agencies.
 269.30 In preparing the assessment, the Minnesota
 269.31 Ambulance Association shall consult with
 269.32 its membership, the Minnesota Fire Chiefs
 269.33 Association, the Office of the State Fire
 269.34 Marshal, and the Emergency Medical
 269.35 Services Regulatory Board. The findings

270.1 of the assessment will be reported to the
270.2 chairs and ranking minority members of the
270.3 legislative committees with jurisdiction over
270.4 health and public safety by January 1, 2013.

270.5 This is a onetime appropriation.

270.6 Sec. 40. **DIRECTION TO COMMISSIONER.**

270.7 The commissioner of human services shall request authority, in whatever form is
270.8 necessary, from the federal Centers for Medicare and Medicaid Services to allow persons
270.9 under age 65 participating in the home and community-based services waivers to continue
270.10 to use the disregard of the nonassisted spouse's income and assets instead of the spousal
270.11 impoverishment provisions under the federal Patient Protection and Affordable Care Act,
270.12 Public Law 111-148, section 2404, as amended by the federal Health Care and Education
270.13 Reconciliation Act of 2010, Public Law 111-152, and any amendments to, or regulations
270.14 or guidance issued under, those acts.

270.15 Sec. 41. **RECOMMENDATIONS ON RAISING THE ASSET LIMITS FOR**
270.16 **SENIORS AND PERSONS WITH DISABILITIES.**

270.17 The commissioner of human services shall consult with interested stakeholders to
270.18 develop recommendations and a request for a federal 1115 demonstration waiver in order
270.19 to increase the asset limit for individuals eligible for medical assistance due to disability
270.20 or age who are not residing in a nursing facility, intermediate care facility for persons
270.21 with developmental disabilities, or other institution whose costs for room and board are
270.22 covered by medical assistance or state funds. The recommendations must be provided to
270.23 the legislative committees and divisions with jurisdiction over health and human services
270.24 policy and finance by February 1, 2014.

270.25 Sec. 42. **NURSING HOME LEVEL OF CARE REPORT.**

270.26 (a) The commissioner of human services shall report on the impact of the
270.27 modification to the nursing facility level of care to be implemented January 1, 2014,
270.28 including the following:

270.29 (1) the number of individuals who lose eligibility for home and community-based
270.30 services waivers under Minnesota Statutes, sections 256B.0915 and 256B.49, and
270.31 alternative care under Minnesota Statutes, section 256B.0913;

270.32 (2) the number of individuals who lose eligibility for medical assistance; and

270.33 (3) for individuals reported under clauses (1) and (2), and to the extent possible:

271.1 (i) their living situation before and after nursing facility level of care implementation;
 271.2 and

271.3 (ii) the programs or services they received before and after nursing facility level of
 271.4 care implementation, including, but not limited to, personal care assistant services and
 271.5 essential community supports.

271.6 (b) The commissioner of human services shall report to the chairs and ranking
 271.7 minority members of the legislative committees and divisions with jurisdiction over health
 271.8 and human services policy and finance with the information required under paragraph
 271.9 (a). A preliminary report shall be submitted on October 1, 2014, and a final report shall
 271.10 be submitted February 15, 2015.

271.11 Sec. 43. **ASSISTIVE TECHNOLOGY EQUIPMENT FOR HOME AND**
 271.12 **COMMUNITY-BASED SERVICES WAIVERS FUNDING DEVELOPMENT.**

271.13 (a) For the purposes of this section, "assistive technology equipment" includes
 271.14 computer tablets, passive sensors, and other forms of technology allowing increased
 271.15 safety and independence, and used by those receiving services through a home and
 271.16 community-based services waiver under Minnesota Statutes, sections 256B.0915,
 271.17 256B.092, and 256B.49.

271.18 (b) The commissioner of human services shall develop recommendations for
 271.19 assistive technology equipment funding to enable individuals receiving services identified
 271.20 in paragraph (a) to live in the least restrictive setting possible. In developing the funding,
 271.21 the commissioner shall examine funding for the following:

271.22 (1) an assessment process to match the appropriate assistive technology equipment
 271.23 with the waiver recipient, including when the recipient's condition changes or progresses;

271.24 (2) the use of monitoring services, if applicable, to the assistive technology
 271.25 equipment identified in clause (1);

271.26 (3) the leasing of assistive technology equipment as a possible alternative to
 271.27 purchasing the equipment; and

271.28 (4) ongoing support services, such as technological support.

271.29 (c) The commissioner shall provide the chairs and ranking minority members of the
 271.30 legislative committees and divisions with jurisdiction over health and human services
 271.31 policy and finance a recommendation for implementing an assistive technology equipment
 271.32 program as developed in paragraph (b) by February 1, 2014.

271.33 Sec. 44. **PROVIDER RATE AND GRANT INCREASES EFFECTIVE JANUARY**
 271.34 **1, 2015, AND JULY 1, 2015.**

272.1 (a) The commissioner of human services shall increase reimbursement rates, grants,
272.2 allocations, individual limits, and rate limits, as applicable, by one percent for the rate
272.3 period beginning January 1, 2015, and by one percent for the rate period beginning July 1,
272.4 2015, for services rendered on or after those dates. County or tribal contracts for services
272.5 specified in this section must be amended to pass through these rate increases within 60
272.6 days of the effective date.

272.7 (b) The rate changes described in this section must be provided to:

272.8 (1) home and community-based waived services for persons with developmental
272.9 disabilities or related conditions, including consumer-directed community supports, under
272.10 Minnesota Statutes, section 256B.501;

272.11 (2) waived services under community alternatives for disabled individuals,
272.12 including consumer-directed community supports, under Minnesota Statutes, section
272.13 256B.49;

272.14 (3) community alternative care waived services, including consumer-directed
272.15 community supports, under Minnesota Statutes, section 256B.49;

272.16 (4) brain injury waived services, including consumer-directed community
272.17 supports, under Minnesota Statutes, section 256B.49;

272.18 (5) home and community-based waived services for the elderly under Minnesota
272.19 Statutes, section 256B.0915;

272.20 (6) nursing services and home health services under Minnesota Statutes, section
272.21 256B.0625, subdivision 6a;

272.22 (7) personal care services and qualified professional supervision of personal care
272.23 services under Minnesota Statutes, section 256B.0625, subdivisions 6a and 19a;

272.24 (8) private duty nursing services under Minnesota Statutes, section 256B.0625,
272.25 subdivision 7;

272.26 (9) day training and habilitation services for adults with developmental disabilities
272.27 or related conditions under Minnesota Statutes, sections 252.40 to 252.46, including the
272.28 additional cost of rate adjustments on day training and habilitation services, provided as a
272.29 social service, under Minnesota Statutes, section 256M.60;

272.30 (10) alternative care services under Minnesota Statutes, section 256B.0913;

272.31 (11) living skills training programs for persons with intractable epilepsy who need
272.32 assistance in the transition to independent living under Laws 1988, chapter 689;

272.33 (12) semi-independent living services (SILS) under Minnesota Statutes, section
272.34 252.275, including SILS funding under county social services grants formerly funded
272.35 under Minnesota Statutes, chapter 256I;

272.36 (13) consumer support grants under Minnesota Statutes, section 256.476;

273.1 (14) family support grants under Minnesota Statutes, section 252.32;

273.2 (15) housing access grants under Minnesota Statutes, section 256B.0658;

273.3 (16) self-advocacy grants under Laws 2009, chapter 101; and

273.4 (17) technology grants under Laws 2009, chapter 79.

273.5 (c) A managed care plan receiving state payments for the services in this section

273.6 must include these increases in their payments to providers. To implement the rate increase

273.7 in this section, capitation rates paid by the commissioner to managed care organizations

273.8 under Minnesota Statutes, section 256B.69, shall reflect a one percent increase for the

273.9 specified services for the period beginning January 1, 2015.

273.10 (d) Counties shall increase the budget for each recipient of consumer-directed

273.11 community supports by the amounts in paragraph (a) on the effective dates in paragraph (a).

273.12 **Sec. 45. SAFETY NET FOR HOME AND COMMUNITY-BASED SERVICES**

273.13 **WAIVERS.**

273.14 The commissioner of human services shall submit a request by December 31, 2013,

273.15 to the federal government to amend the home and community-based services waivers for

273.16 individuals with disabilities authorized under Minnesota Statutes, section 256B.49, to

273.17 modify the financial management of the home and community-based services waivers

273.18 to provide a state-administered safety net when costs for an individual increase above

273.19 an identified threshold. The implementation of the safety net may result in a decreased

273.20 allocation for individual counties, tribes, or collaboratives of counties or tribes, but must

273.21 not result in a net decreased statewide allocation.

273.22 **Sec. 46. SHARED LIVING MODEL.**

273.23 The commissioner of human services shall develop and promote a shared living model

273.24 option for individuals receiving services through the home and community-based services

273.25 wavers for individuals with disabilities, authorized under Minnesota Statutes, section

273.26 256B.092 or 256B.49, as an option for individuals who require 24-hour assistance. The

273.27 option must be a companion model with a limit of one or two individuals receiving support

273.28 in the home, planned respite for the caregiver, and the availability of intensive training

273.29 and support on the needs of the individual or individuals. Any necessary amendments to

273.30 implement the model must be submitted to the federal government by December 31, 2013.

273.31 **Sec. 47. MONEY FOLLOWS THE PERSON GRANT.**

274.1 The commissioner of human services shall submit to the federal government all
 274.2 necessary waiver amendments to implement the Money Follows the Person federal grant
 274.3 by December 31, 2013.

274.4 Sec. 48. **REPEALER.**

274.5 Minnesota Statutes 2012, sections 256B.096, subdivisions 1, 2, 3, and 4; and
 274.6 256B.5012, subdivision 13; and Laws 2011, First Special Session chapter 9, article 7,
 274.7 section 54, as amended by Laws 2012, chapter 247, article 4, section 42, and Laws 2012,
 274.8 chapter 298, section 3, are repealed.

274.9 **ARTICLE 8**

274.10 **WAIVER PROVIDER STANDARDS**

274.11 Section 1. Minnesota Statutes 2012, section 13.461, is amended by adding a
 274.12 subdivision to read:

274.13 Subd. 7c. **Human services license holders.** Section 245D.095, subdivision 3,
 274.14 requires certain license holders to protect service recipient records in accordance with
 274.15 specified provisions of this chapter.

274.16 Sec. 2. Minnesota Statutes 2012, section 145C.01, subdivision 7, is amended to read:

274.17 Subd. 7. **Health care facility.** "Health care facility" means a hospital or other entity
 274.18 licensed under sections 144.50 to 144.58, a nursing home licensed to serve adults under
 274.19 section 144A.02, a home care provider licensed under sections 144A.43 to 144A.47,
 274.20 an adult foster care provider licensed under chapter 245A and Minnesota Rules, parts
 274.21 9555.5105 to 9555.6265, a community residential setting licensed under chapter 245D, or
 274.22 a hospice provider licensed under sections 144A.75 to 144A.755.

274.23 Sec. 3. Minnesota Statutes 2012, section 243.166, subdivision 4b, is amended to read:

274.24 Subd. 4b. **Health care facility; notice of status.** (a) For the purposes of this
 274.25 subdivision, "health care facility" means a facility:

274.26 (1) licensed by the commissioner of health as a hospital, boarding care home or
 274.27 supervised living facility under sections 144.50 to 144.58, or a nursing home under
 274.28 chapter 144A;

274.29 (2) registered by the commissioner of health as a housing with services establishment
 274.30 as defined in section 144D.01; or

274.31 (3) licensed by the commissioner of human services as a residential facility under
 274.32 chapter 245A to provide adult foster care, adult mental health treatment, chemical

275.1 dependency treatment to adults, or residential services to persons with ~~developmental~~
275.2 disabilities.

275.3 (b) Prior to admission to a health care facility, a person required to register under
275.4 this section shall disclose to:

275.5 (1) the health care facility employee processing the admission the person's status
275.6 as a registered predatory offender under this section; and

275.7 (2) the person's corrections agent, or if the person does not have an assigned
275.8 corrections agent, the law enforcement authority with whom the person is currently
275.9 required to register, that inpatient admission will occur.

275.10 (c) A law enforcement authority or corrections agent who receives notice under
275.11 paragraph (b) or who knows that a person required to register under this section is
275.12 planning to be admitted and receive, or has been admitted and is receiving health care
275.13 at a health care facility shall notify the administrator of the facility and deliver a fact
275.14 sheet to the administrator containing the following information: (1) name and physical
275.15 description of the offender; (2) the offender's conviction history, including the dates of
275.16 conviction; (3) the risk level classification assigned to the offender under section 244.052,
275.17 if any; and (4) the profile of likely victims.

275.18 (d) Except for a hospital licensed under sections 144.50 to 144.58, if a health care
275.19 facility receives a fact sheet under paragraph (c) that includes a risk level classification for
275.20 the offender, and if the facility admits the offender, the facility shall distribute the fact
275.21 sheet to all residents at the facility. If the facility determines that distribution to a resident
275.22 is not appropriate given the resident's medical, emotional, or mental status, the facility
275.23 shall distribute the fact sheet to the patient's next of kin or emergency contact.

275.24 Sec. 4. **[245.8251] POSITIVE SUPPORT STRATEGIES AND EMERGENCY**
275.25 **MANUAL RESTRAINT; LICENSED FACILITIES AND PROGRAMS.**

275.26 Subdivision 1. Rules. The commissioner of human services shall, within 24 months
275.27 of enactment of this section, adopt rules governing the use of positive support strategies,
275.28 safety interventions, and emergency use of manual restraint in facilities and services
275.29 licensed under chapter 245D.

275.30 Subd. 2. Data collection. (a) The commissioner shall, with stakeholder input,
275.31 develop data collection elements specific to incidents on the use of controlled procedures
275.32 with persons receiving services from providers regulated under Minnesota Rules, parts
275.33 9525.2700 to 9525.2810, and incidents involving persons receiving services from
275.34 providers identified to be licensed under chapter 245D effective January 1, 2014. Providers

276.1 shall report the data in a format and at a frequency provided by the commissioner of
 276.2 human services.

276.3 (b) Beginning July 1, 2013, providers regulated under Minnesota Rules, parts
 276.4 9525.2700 to 9525.2810, shall submit data regarding the use of all controlled procedures
 276.5 in a format and at a frequency provided by the commissioner.

276.6 Sec. 5. Minnesota Statutes 2012, section 245A.02, subdivision 10, is amended to read:

276.7 Subd. 10. **Nonresidential program.** "Nonresidential program" means care,
 276.8 supervision, rehabilitation, training or habilitation of a person provided outside the
 276.9 person's own home and provided for fewer than 24 hours a day, including adult day
 276.10 care programs; and chemical dependency or chemical abuse programs that are located
 276.11 in a nursing home or hospital and receive public funds for providing chemical abuse or
 276.12 chemical dependency treatment services under chapter 254B. Nonresidential programs
 276.13 include home and community-based services ~~and semi-independent living services~~ for
 276.14 persons with ~~developmental~~ disabilities or persons age 65 and older that are provided in
 276.15 or outside of a person's own home under chapter 245D.

276.16 Sec. 6. Minnesota Statutes 2012, section 245A.02, subdivision 14, is amended to read:

276.17 Subd. 14. **Residential program.** "Residential program" means a program
 276.18 that provides 24-hour-a-day care, supervision, food, lodging, rehabilitation, training,
 276.19 education, habilitation, or treatment outside a person's own home, including a program
 276.20 in an intermediate care facility for four or more persons with developmental disabilities;
 276.21 and chemical dependency or chemical abuse programs that are located in a hospital
 276.22 or nursing home and receive public funds for providing chemical abuse or chemical
 276.23 dependency treatment services under chapter 254B. Residential programs include home
 276.24 and community-based services for persons with ~~developmental~~ disabilities or persons age
 276.25 65 and older that are provided in or outside of a person's own home under chapter 245D.

276.26 Sec. 7. Minnesota Statutes 2012, section 245A.03, subdivision 7, is amended to read:

276.27 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial
 276.28 license for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340,
 276.29 or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under
 276.30 this chapter for a physical location that will not be the primary residence of the license
 276.31 holder for the entire period of licensure. If a license is issued during this moratorium, and
 276.32 the license holder changes the license holder's primary residence away from the physical
 276.33 location of the foster care license, the commissioner shall revoke the license according

277.1 to section 245A.07. The commissioner shall not issue an initial license for a community
277.2 residential setting licensed under chapter 245D. Exceptions to the moratorium include:

277.3 (1) foster care settings that are required to be registered under chapter 144D;

277.4 (2) foster care licenses replacing foster care licenses in existence on May 15, 2009, or
277.5 community residential setting licenses replacing adult foster care licenses in existence on
277.6 December 31, 2013, and determined to be needed by the commissioner under paragraph (b);

277.7 (3) new foster care licenses or community residential setting licenses determined to
277.8 be needed by the commissioner under paragraph (b) for the closure of a nursing facility,
277.9 ICF/MR, or regional treatment center, or restructuring of state-operated services that
277.10 limits the capacity of state-operated facilities;

277.11 (4) new foster care licenses or community residential setting licenses determined
277.12 to be needed by the commissioner under paragraph (b) for persons requiring hospital
277.13 level care; or

277.14 (5) new foster care licenses or community residential setting licenses determined to
277.15 be needed by the commissioner for the transition of people from personal care assistance
277.16 to the home and community-based services.

277.17 (b) The commissioner shall determine the need for newly licensed foster care
277.18 homes or community residential settings as defined under this subdivision. As part of the
277.19 determination, the commissioner shall consider the availability of foster care capacity in
277.20 the area in which the licensee seeks to operate, and the recommendation of the local
277.21 county board. The determination by the commissioner must be final. A determination of
277.22 need is not required for a change in ownership at the same address.

277.23 (c) The commissioner shall study the effects of the license moratorium under this
277.24 subdivision and shall report back to the legislature by January 15, 2011. This study shall
277.25 include, but is not limited to the following:

277.26 (1) the overall capacity and utilization of foster care beds where the physical location
277.27 is not the primary residence of the license holder prior to and after implementation
277.28 of the moratorium;

277.29 (2) the overall capacity and utilization of foster care beds where the physical
277.30 location is the primary residence of the license holder prior to and after implementation
277.31 of the moratorium; and

277.32 (3) the number of licensed and occupied ICF/MR beds prior to and after
277.33 implementation of the moratorium.

277.34 (d) When a ~~foster care recipient~~ resident served by the program moves out of a
277.35 foster home that is not the primary residence of the license holder according to section
277.36 256B.49, subdivision 15, paragraph (f), or the community residential setting, the county

278.1 shall immediately inform the Department of Human Services Licensing Division.
278.2 The department shall decrease the statewide licensed capacity for foster care settings
278.3 where the physical location is not the primary residence of the license holder, or for
278.4 community residential settings, if the voluntary changes described in paragraph (f) are
278.5 not sufficient to meet the savings required by reductions in licensed bed capacity under
278.6 Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40, paragraph (f),
278.7 and maintain statewide long-term care residential services capacity within budgetary
278.8 limits. Implementation of the statewide licensed capacity reduction shall begin on July
278.9 1, 2013. The commissioner shall delicense up to 128 beds by June 30, 2014, using the
278.10 needs determination process. Under this paragraph, the commissioner has the authority
278.11 to reduce unused licensed capacity of a current foster care program, or the community
278.12 residential settings, to accomplish the consolidation or closure of settings. A decreased
278.13 licensed capacity according to this paragraph is not subject to appeal under this chapter.

278.14 (e) Residential settings that would otherwise be subject to the decreased license
278.15 capacity established in paragraph (d) shall be exempt under the following circumstances:

278.16 (1) until August 1, 2013, the license holder's beds occupied by residents whose
278.17 primary diagnosis is mental illness and the license holder is:

278.18 (i) a provider of assertive community treatment (ACT) or adult rehabilitative mental
278.19 health services (ARMHS) as defined in section 256B.0623;

278.20 (ii) a mental health center certified under Minnesota Rules, parts 9520.0750 to
278.21 9520.0870;

278.22 (iii) a mental health clinic certified under Minnesota Rules, parts 9520.0750 to
278.23 9520.0870; or

278.24 (iv) a provider of intensive residential treatment services (IRTS) licensed under
278.25 Minnesota Rules, parts 9520.0500 to 9520.0670; or

278.26 (2) the license holder is certified under the requirements in subdivision 6a or section
278.27 245D.33.

278.28 (f) A resource need determination process, managed at the state level, using the
278.29 available reports required by section 144A.351, and other data and information shall
278.30 be used to determine where the reduced capacity required under paragraph (d) will be
278.31 implemented. The commissioner shall consult with the stakeholders described in section
278.32 144A.351, and employ a variety of methods to improve the state's capacity to meet
278.33 long-term care service needs within budgetary limits, including seeking proposals from
278.34 service providers or lead agencies to change service type, capacity, or location to improve
278.35 services, increase the independence of residents, and better meet needs identified by the
278.36 long-term care services reports and statewide data and information. By February 1 of each

279.1 year, the commissioner shall provide information and data on the overall capacity of
279.2 licensed long-term care services, actions taken under this subdivision to manage statewide
279.3 long-term care services and supports resources, and any recommendations for change to
279.4 the legislative committees with jurisdiction over health and human services budget.

279.5 (g) At the time of application and reapplication for licensure, the applicant and the
279.6 license holder that are subject to the moratorium or an exclusion established in paragraph
279.7 (a) are required to inform the commissioner whether the physical location where the foster
279.8 care will be provided is or will be the primary residence of the license holder for the entire
279.9 period of licensure. If the primary residence of the applicant or license holder changes, the
279.10 applicant or license holder must notify the commissioner immediately. The commissioner
279.11 shall print on the foster care license certificate whether or not the physical location is the
279.12 primary residence of the license holder.

279.13 (h) License holders of foster care homes identified under paragraph (g) that are not
279.14 the primary residence of the license holder and that also provide services in the foster care
279.15 home that are covered by a federally approved home and community-based services
279.16 waiver, as authorized under section 256B.0915, 256B.092, or 256B.49, must inform the
279.17 human services licensing division that the license holder provides or intends to provide
279.18 these waiver-funded services. ~~These license holders must be considered registered under~~
279.19 ~~section 256B.092, subdivision 11, paragraph (c), and this registration status must be~~
279.20 ~~identified on their license certificates.~~

279.21 Sec. 8. Minnesota Statutes 2012, section 245A.03, subdivision 8, is amended to read:

279.22 Subd. 8. **Excluded providers seeking licensure.** Nothing in this section shall
279.23 prohibit a program that is excluded from licensure under subdivision 2, paragraph
279.24 (a), clause ~~(28)~~ (26), from seeking licensure. The commissioner shall ensure that any
279.25 application received from such an excluded provider is processed in the same manner as
279.26 all other applications for child care center licensure.

279.27 Sec. 9. Minnesota Statutes 2012, section 245A.042, subdivision 3, is amended to read:

279.28 Subd. 3. **Implementation.** (a) The commissioner shall implement the
279.29 responsibilities of this chapter according to the timelines in paragraphs (b) and (c)
279.30 only within the limits of available appropriations or other administrative cost recovery
279.31 methodology.

279.32 (b) The licensure of home and community-based services according to this section
279.33 shall be implemented January 1, 2014. License applications shall be received and
279.34 processed on a phased-in schedule as determined by the commissioner beginning July

280.1 1, 2013. Licenses will be issued thereafter upon the commissioner's determination that
280.2 the application is complete according to section 245A.04.

280.3 (c) Within the limits of available appropriations or other administrative cost recovery
280.4 methodology, implementation of compliance monitoring must be phased in after January
280.5 1, 2014.

280.6 (1) Applicants who do not currently hold a license issued under ~~this chapter~~ 245B
280.7 must receive an initial compliance monitoring visit after 12 months of the effective date of
280.8 the initial license for the purpose of providing technical assistance on how to achieve and
280.9 maintain compliance with the applicable law or rules governing the provision of home and
280.10 community-based services under chapter 245D. If during the review the commissioner
280.11 finds that the license holder has failed to achieve compliance with an applicable law or
280.12 rule and this failure does not imminently endanger the health, safety, or rights of the
280.13 persons served by the program, the commissioner may issue a licensing review report with
280.14 recommendations for achieving and maintaining compliance.

280.15 (2) Applicants who do currently hold a license issued under this chapter must receive
280.16 a compliance monitoring visit after 24 months of the effective date of the initial license.

280.17 (d) Nothing in this subdivision shall be construed to limit the commissioner's
280.18 authority to suspend or revoke a license or issue a fine at any time under section 245A.07,
280.19 or ~~make issue~~ issue correction orders and make a license conditional for failure to comply with
280.20 applicable laws or rules under section 245A.06, based on the nature, chronicity, or severity
280.21 of the violation of law or rule and the effect of the violation on the health, safety, or
280.22 rights of persons served by the program.

280.23 Sec. 10. Minnesota Statutes 2012, section 245A.08, subdivision 2a, is amended to read:

280.24 Subd. 2a. **Consolidated contested case hearings.** (a) When a denial of a license
280.25 under section 245A.05 or a licensing sanction under section 245A.07, subdivision 3, is
280.26 based on a disqualification for which reconsideration was requested and which was not
280.27 set aside under section 245C.22, the scope of the contested case hearing shall include the
280.28 disqualification and the licensing sanction or denial of a license, unless otherwise specified
280.29 in this subdivision. When the licensing sanction or denial of a license is based on a
280.30 determination of maltreatment under section 626.556 or 626.557, or a disqualification for
280.31 serious or recurring maltreatment which was not set aside, the scope of the contested case
280.32 hearing shall include the maltreatment determination, disqualification, and the licensing
280.33 sanction or denial of a license, unless otherwise specified in this subdivision. In such
280.34 cases, a fair hearing under section 256.045 shall not be conducted as provided for in
280.35 sections 245C.27, 626.556, subdivision 10i, and 626.557, subdivision 9d.

281.1 (b) Except for family child care and child foster care, reconsideration of a
281.2 maltreatment determination under sections 626.556, subdivision 10i, and 626.557,
281.3 subdivision 9d, and reconsideration of a disqualification under section 245C.22, shall
281.4 not be conducted when:

281.5 (1) a denial of a license under section 245A.05, or a licensing sanction under section
281.6 245A.07, is based on a determination that the license holder is responsible for maltreatment
281.7 or the disqualification of a license holder is based on serious or recurring maltreatment;

281.8 (2) the denial of a license or licensing sanction is issued at the same time as the
281.9 maltreatment determination or disqualification; and

281.10 (3) the license holder appeals the maltreatment determination or disqualification,
281.11 and denial of a license or licensing sanction. In these cases, a fair hearing shall not be
281.12 conducted under sections 245C.27, 626.556, subdivision 10i, and 626.557, subdivision
281.13 9d. The scope of the contested case hearing must include the maltreatment determination,
281.14 disqualification, and denial of a license or licensing sanction.

281.15 Notwithstanding clauses (1) to (3), if the license holder appeals the maltreatment
281.16 determination or disqualification, but does not appeal the denial of a license or a licensing
281.17 sanction, reconsideration of the maltreatment determination shall be conducted under
281.18 sections 626.556, subdivision 10i, and 626.557, subdivision 9d, and reconsideration of the
281.19 disqualification shall be conducted under section 245C.22. In such cases, a fair hearing
281.20 shall also be conducted as provided under sections 245C.27, 626.556, subdivision 10i, and
281.21 626.557, subdivision 9d.

281.22 (c) In consolidated contested case hearings regarding sanctions issued in family child
281.23 care, child foster care, family adult day services, ~~and~~ adult foster care, and community
281.24 residential settings, the county attorney shall defend the commissioner's orders in
281.25 accordance with section 245A.16, subdivision 4.

281.26 (d) The commissioner's final order under subdivision 5 is the final agency action
281.27 on the issue of maltreatment and disqualification, including for purposes of subsequent
281.28 background studies under chapter 245C and is the only administrative appeal of the final
281.29 agency determination, specifically, including a challenge to the accuracy and completeness
281.30 of data under section 13.04.

281.31 (e) When consolidated hearings under this subdivision involve a licensing sanction
281.32 based on a previous maltreatment determination for which the commissioner has issued
281.33 a final order in an appeal of that determination under section 256.045, or the individual
281.34 failed to exercise the right to appeal the previous maltreatment determination under
281.35 section 626.556, subdivision 10i, or 626.557, subdivision 9d, the commissioner's order is
281.36 conclusive on the issue of maltreatment. In such cases, the scope of the administrative

282.1 law judge's review shall be limited to the disqualification and the licensing sanction or
 282.2 denial of a license. In the case of a denial of a license or a licensing sanction issued to
 282.3 a facility based on a maltreatment determination regarding an individual who is not the
 282.4 license holder or a household member, the scope of the administrative law judge's review
 282.5 includes the maltreatment determination.

282.6 (f) The hearings of all parties may be consolidated into a single contested case
 282.7 hearing upon consent of all parties and the administrative law judge, if:

282.8 (1) a maltreatment determination or disqualification, which was not set aside under
 282.9 section 245C.22, is the basis for a denial of a license under section 245A.05 or a licensing
 282.10 sanction under section 245A.07;

282.11 (2) the disqualified subject is an individual other than the license holder and upon
 282.12 whom a background study must be conducted under section 245C.03; and

282.13 (3) the individual has a hearing right under section 245C.27.

282.14 (g) When a denial of a license under section 245A.05 or a licensing sanction under
 282.15 section 245A.07 is based on a disqualification for which reconsideration was requested
 282.16 and was not set aside under section 245C.22, and the individual otherwise has no hearing
 282.17 right under section 245C.27, the scope of the administrative law judge's review shall
 282.18 include the denial or sanction and a determination whether the disqualification should
 282.19 be set aside, unless section 245C.24 prohibits the set-aside of the disqualification. In
 282.20 determining whether the disqualification should be set aside, the administrative law judge
 282.21 shall consider the factors under section 245C.22, subdivision 4, to determine whether the
 282.22 individual poses a risk of harm to any person receiving services from the license holder.

282.23 (h) Notwithstanding section 245C.30, subdivision 5, when a licensing sanction
 282.24 under section 245A.07 is based on the termination of a variance under section 245C.30,
 282.25 subdivision 4, the scope of the administrative law judge's review shall include the sanction
 282.26 and a determination whether the disqualification should be set aside, unless section
 282.27 245C.24 prohibits the set-aside of the disqualification. In determining whether the
 282.28 disqualification should be set aside, the administrative law judge shall consider the factors
 282.29 under section 245C.22, subdivision 4, to determine whether the individual poses a risk of
 282.30 harm to any person receiving services from the license holder.

282.31 Sec. 11. Minnesota Statutes 2012, section 245A.10, is amended to read:

282.32 **245A.10 FEES.**

282.33 Subdivision 1. **Application or license fee required, programs exempt from fee.**

282.34 (a) Unless exempt under paragraph (b), the commissioner shall charge a fee for evaluation
 282.35 of applications and inspection of programs which are licensed under this chapter.

283.1 (b) Except as provided under subdivision 2, no application or license fee shall be
283.2 charged for child foster care, adult foster care, ~~or~~ family and group family child care, or
283.3 a community residential setting.

283.4 Subd. 2. **County fees for background studies and licensing inspections.** (a) For
283.5 purposes of family and group family child care licensing under this chapter, a county
283.6 agency may charge a fee to an applicant or license holder to recover the actual cost of
283.7 background studies, but in any case not to exceed \$100 annually. A county agency may
283.8 also charge a license fee to an applicant or license holder not to exceed \$50 for a one-year
283.9 license or \$100 for a two-year license.

283.10 (b) A county agency may charge a fee to a legal nonlicensed child care provider or
283.11 applicant for authorization to recover the actual cost of background studies completed
283.12 under section 119B.125, but in any case not to exceed \$100 annually.

283.13 (c) Counties may elect to reduce or waive the fees in paragraph (a) or (b):

283.14 (1) in cases of financial hardship;

283.15 (2) if the county has a shortage of providers in the county's area;

283.16 (3) for new providers; or

283.17 (4) for providers who have attained at least 16 hours of training before seeking
283.18 initial licensure.

283.19 (d) Counties may allow providers to pay the applicant fees in paragraph (a) or (b) on
283.20 an installment basis for up to one year. If the provider is receiving child care assistance
283.21 payments from the state, the provider may have the fees under paragraph (a) or (b)
283.22 deducted from the child care assistance payments for up to one year and the state shall
283.23 reimburse the county for the county fees collected in this manner.

283.24 (e) For purposes of adult foster care and child foster care licensing, and licensing
283.25 the physical plant of a community residential setting, under this chapter, a county agency
283.26 may charge a fee to a corporate applicant or corporate license holder to recover the actual
283.27 cost of licensing inspections, not to exceed \$500 annually.

283.28 (f) Counties may elect to reduce or waive the fees in paragraph (e) under the
283.29 following circumstances:

283.30 (1) in cases of financial hardship;

283.31 (2) if the county has a shortage of providers in the county's area; or

283.32 (3) for new providers.

283.33 Subd. 3. **Application fee for initial license or certification.** (a) For fees required
283.34 under subdivision 1, an applicant for an initial license or certification issued by the
283.35 commissioner shall submit a \$500 application fee with each new application required
283.36 under this subdivision. An applicant for an initial day services facility license under

284.1 chapter 245D shall submit a \$250 application fee with each new application. The
284.2 application fee shall not be prorated, is nonrefundable, and is in lieu of the annual license
284.3 or certification fee that expires on December 31. The commissioner shall not process an
284.4 application until the application fee is paid.

284.5 (b) Except as provided in clauses (1) to ~~(4)~~ (3), an applicant shall apply for a license
284.6 to provide services at a specific location.

284.7 ~~(1) For a license to provide residential-based habilitation services to persons with~~
284.8 ~~developmental disabilities under chapter 245B, an applicant shall submit an application~~
284.9 ~~for each county in which the services will be provided. Upon licensure, the license~~
284.10 ~~holder may provide services to persons in that county plus no more than three persons~~
284.11 ~~at any one time in each of up to ten additional counties. A license holder in one county~~
284.12 ~~may not provide services under the home and community-based waiver for persons with~~
284.13 ~~developmental disabilities to more than three people in a second county without holding~~
284.14 ~~a separate license for that second county. Applicants or licensees providing services~~
284.15 ~~under this clause to not more than three persons remain subject to the inspection fees~~
284.16 ~~established in section 245A.10, subdivision 2, for each location. The license issued by~~
284.17 ~~the commissioner must state the name of each additional county where services are being~~
284.18 ~~provided to persons with developmental disabilities. A license holder must notify the~~
284.19 ~~commissioner before making any changes that would alter the license information listed~~
284.20 ~~under section 245A.04, subdivision 7, paragraph (a), including any additional counties~~
284.21 ~~where persons with developmental disabilities are being served.~~ For a license to provide
284.22 home and community-based services to persons with disabilities or age 65 and older under
284.23 chapter 245D, an applicant shall submit an application to provide services statewide.

284.24 (2) ~~For a license to provide supported employment, crisis respite, or~~
284.25 ~~semi-independent living services to persons with developmental disabilities under chapter~~
284.26 ~~245B, an applicant shall submit a single application to provide services statewide.~~

284.27 ~~(3) For a license to provide independent living assistance for youth under section~~
284.28 ~~245A.22, an applicant shall submit a single application to provide services statewide.~~

284.29 ~~(4)~~ (3) For a license for a private agency to provide foster care or adoption services
284.30 under Minnesota Rules, parts 9545.0755 to 9545.0845, an applicant shall submit a single
284.31 application to provide services statewide.

284.32 (c) The initial application fee charged under this subdivision does not include the
284.33 temporary license surcharge under section 16E.22.

284.34 Subd. 4. **License or certification fee for certain programs.** (a) Child care centers
284.35 shall pay an annual nonrefundable license fee based on the following schedule:

		Child Care Center
285.1		License Fee
285.2	Licensed Capacity	
285.3	1 to 24 persons	\$200
285.4	25 to 49 persons	\$300
285.5	50 to 74 persons	\$400
285.6	75 to 99 persons	\$500
285.7	100 to 124 persons	\$600
285.8	125 to 149 persons	\$700
285.9	150 to 174 persons	\$800
285.10	175 to 199 persons	\$900
285.11	200 to 224 persons	\$1,000
285.12	225 or more persons	\$1,100

285.13 ~~(b) A day training and habilitation program serving persons with developmental~~
 285.14 ~~disabilities or related conditions shall pay an annual nonrefundable license fee based on~~
 285.15 ~~the following schedule:~~

	Licensed Capacity	License Fee
285.16	1 to 24 persons	\$800
285.17	25 to 49 persons	\$1,000
285.18	50 to 74 persons	\$1,200
285.19	75 to 99 persons	\$1,400
285.20	100 to 124 persons	\$1,600
285.21	125 to 149 persons	\$1,800
285.22	150 or more persons	\$2,000

285.24 ~~Except as provided in paragraph (c), when a day training and habilitation program~~
 285.25 ~~serves more than 50 percent of the same persons in two or more locations in a community,~~
 285.26 ~~the day training and habilitation program shall pay a license fee based on the licensed~~
 285.27 ~~capacity of the largest facility and the other facility or facilities shall be charged a license~~
 285.28 ~~fee based on a licensed capacity of a residential program serving one to 24 persons.~~

285.29 ~~(c) When a day training and habilitation program serving persons with developmental~~
 285.30 ~~disabilities or related conditions seeks a single license allowed under section 245B.07,~~
 285.31 ~~subdivision 12, clause (2) or (3), the licensing fee must be based on the combined licensed~~
 285.32 ~~capacity for each location.~~

285.33 ~~(d) A program licensed to provide supported employment services to persons~~
 285.34 ~~with developmental disabilities under chapter 245B shall pay an annual nonrefundable~~
 285.35 ~~license fee of \$650.~~

285.36 ~~(e) A program licensed to provide crisis respite services to persons with~~
 285.37 ~~developmental disabilities under chapter 245B shall pay an annual nonrefundable license~~
 285.38 ~~fee of \$700.~~

286.1 ~~(f) A program licensed to provide semi-independent living services to persons~~
 286.2 ~~with developmental disabilities under chapter 245B shall pay an annual nonrefundable~~
 286.3 ~~license fee of \$700.~~

286.4 ~~(g) A program licensed to provide residential-based habilitation services under the~~
 286.5 ~~home and community-based waiver for persons with developmental disabilities shall pay~~
 286.6 ~~an annual license fee that includes a base rate of \$690 plus \$60 times the number of clients~~
 286.7 ~~served on the first day of July of the current license year.~~

286.8 ~~(h) A residential program certified by the Department of Health as an intermediate~~
 286.9 ~~care facility for persons with developmental disabilities (ICF/MR) and a noncertified~~
 286.10 ~~residential program licensed to provide health or rehabilitative services for persons~~
 286.11 ~~with developmental disabilities shall pay an annual nonrefundable license fee based on~~
 286.12 ~~the following schedule:~~

286.13	Licensed Capacity	License Fee
286.14	1 to 24 persons	\$535
286.15	25 to 49 persons	\$735
286.16	50 or more persons	\$935

286.17 (b) A program licensed to provide one or more of the home and community-based
 286.18 services and supports identified under chapter 245D to persons with disabilities or age
 286.19 65 and older, shall pay an annual nonrefundable license fee that includes a base rate of
 286.20 \$563, plus \$46 times the number of persons served on the last day of June of the current
 286.21 license year for programs serving ten or more persons. The fee is limited to a maximum of
 286.22 200 persons, regardless of the actual number of persons served. Programs serving nine
 286.23 or fewer persons pay only the base rate.

286.24 (c) A facility licensed under chapter 245D to provide day services shall pay an
 286.25 annual nonrefundable license fee of \$100.

286.26 ~~(i) (d) A chemical dependency treatment program licensed under Minnesota Rules,~~
 286.27 ~~parts 9530.6405 to 9530.6505, to provide chemical dependency treatment shall pay an~~
 286.28 ~~annual nonrefundable license fee based on the following schedule:~~

286.29	Licensed Capacity	License Fee
286.30	1 to 24 persons	\$600
286.31	25 to 49 persons	\$800
286.32	50 to 74 persons	\$1,000
286.33	75 to 99 persons	\$1,200
286.34	100 or more persons	\$1,400

286.35 ~~(j) (e) A chemical dependency program licensed under Minnesota Rules, parts~~
 286.36 ~~9530.6510 to 9530.6590, to provide detoxification services shall pay an annual~~
 286.37 ~~nonrefundable license fee based on the following schedule:~~

287.1	Licensed Capacity	License Fee
287.2	1 to 24 persons	\$760
287.3	25 to 49 persons	\$960
287.4	50 or more persons	\$1,160

287.5 ~~(k)~~ (f) Except for child foster care, a residential facility licensed under Minnesota
 287.6 Rules, chapter 2960, to serve children shall pay an annual nonrefundable license fee
 287.7 based on the following schedule:

287.8	Licensed Capacity	License Fee
287.9	1 to 24 persons	\$1,000
287.10	25 to 49 persons	\$1,100
287.11	50 to 74 persons	\$1,200
287.12	75 to 99 persons	\$1,300
287.13	100 or more persons	\$1,400

287.14 ~~(l)~~ (g) A residential facility licensed under Minnesota Rules, parts 9520.0500 to
 287.15 9520.0670, to serve persons with mental illness shall pay an annual nonrefundable license
 287.16 fee based on the following schedule:

287.17	Licensed Capacity	License Fee
287.18	1 to 24 persons	\$2,525
287.19	25 or more persons	\$2,725

287.20 ~~(m)~~ (h) A residential facility licensed under Minnesota Rules, parts 9570.2000 to
 287.21 9570.3400, to serve persons with physical disabilities shall pay an annual nonrefundable
 287.22 license fee based on the following schedule:

287.23	Licensed Capacity	License Fee
287.24	1 to 24 persons	\$450
287.25	25 to 49 persons	\$650
287.26	50 to 74 persons	\$850
287.27	75 to 99 persons	\$1,050
287.28	100 or more persons	\$1,250

287.29 ~~(n)~~ (i) A program licensed to provide independent living assistance for youth under
 287.30 section 245A.22 shall pay an annual nonrefundable license fee of \$1,500.

287.31 ~~(o)~~ (j) A private agency licensed to provide foster care and adoption services under
 287.32 Minnesota Rules, parts 9545.0755 to 9545.0845, shall pay an annual nonrefundable
 287.33 license fee of \$875.

287.34 ~~(p)~~ (k) A program licensed as an adult day care center licensed under Minnesota
 287.35 Rules, parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based
 287.36 on the following schedule:

288.1	Licensed Capacity	License Fee
288.2	1 to 24 persons	\$500
288.3	25 to 49 persons	\$700
288.4	50 to 74 persons	\$900
288.5	75 to 99 persons	\$1,100
288.6	100 or more persons	\$1,300

288.7 ~~(q)~~ (l) A program licensed to provide treatment services to persons with sexual
 288.8 psychopathic personalities or sexually dangerous persons under Minnesota Rules, parts
 288.9 9515.3000 to 9515.3110, shall pay an annual nonrefundable license fee of \$20,000.

288.10 ~~(r)~~ (m) A mental health center or mental health clinic requesting certification for
 288.11 purposes of insurance and subscriber contract reimbursement under Minnesota Rules,
 288.12 parts 9520.0750 to 9520.0870, shall pay a certification fee of \$1,550 per year. If the
 288.13 mental health center or mental health clinic provides services at a primary location with
 288.14 satellite facilities, the satellite facilities shall be certified with the primary location without
 288.15 an additional charge.

288.16 Subd. 6. **License not issued until license or certification fee is paid.** The
 288.17 commissioner shall not issue a license or certification until the license or certification fee
 288.18 is paid. The commissioner shall send a bill for the license or certification fee to the billing
 288.19 address identified by the license holder. If the license holder does not submit the license or
 288.20 certification fee payment by the due date, the commissioner shall send the license holder
 288.21 a past due notice. If the license holder fails to pay the license or certification fee by the
 288.22 due date on the past due notice, the commissioner shall send a final notice to the license
 288.23 holder informing the license holder that the program license will expire on December 31
 288.24 unless the license fee is paid before December 31. If a license expires, the program is no
 288.25 longer licensed and, unless exempt from licensure under section 245A.03, subdivision 2,
 288.26 must not operate after the expiration date. After a license expires, if the former license
 288.27 holder wishes to provide licensed services, the former license holder must submit a new
 288.28 license application and application fee under subdivision 3.

288.29 Subd. 7. **Human services licensing fees to recover expenditures.** Notwithstanding
 288.30 section 16A.1285, subdivision 2, related to activities for which the commissioner charges
 288.31 a fee, the commissioner must plan to fully recover direct expenditures for licensing
 288.32 activities under this chapter over a five-year period. The commissioner may have
 288.33 anticipated expenditures in excess of anticipated revenues in a biennium by using surplus
 288.34 revenues accumulated in previous bienniums.

288.35 Subd. 8. **Deposit of license fees.** A human services licensing account is created in
 288.36 the state government special revenue fund. Fees collected under subdivisions 3 and 4 must

289.1 be deposited in the human services licensing account and are annually appropriated to the
 289.2 commissioner for licensing activities authorized under this chapter.

289.3 **EFFECTIVE DATE.** This section is effective July 1, 2013.

289.4 Sec. 12. Minnesota Statutes 2012, section 245A.11, subdivision 2a, is amended to read:

289.5 Subd. 2a. **Adult foster care and community residential setting license capacity.**

289.6 (a) The commissioner shall issue adult foster care and community residential setting
 289.7 licenses with a maximum licensed capacity of four beds, including nonstaff roomers and
 289.8 boarders, except that the commissioner may issue a license with a capacity of five beds,
 289.9 including roomers and boarders, according to paragraphs (b) to (f).

289.10 (b) ~~An adult foster care~~ The license holder may have a maximum license capacity
 289.11 of five if all persons in care are age 55 or over and do not have a serious and persistent
 289.12 mental illness or a developmental disability.

289.13 (c) The commissioner may grant variances to paragraph (b) to allow a ~~foster care~~
 289.14 ~~provider~~ facility with a licensed capacity of five persons to admit an individual under the
 289.15 age of 55 if the variance complies with section 245A.04, subdivision 9, and approval of
 289.16 the variance is recommended by the county in which the licensed ~~foster care provider~~
 289.17 facility is located.

289.18 (d) The commissioner may grant variances to paragraph (b) to allow the use of a fifth
 289.19 bed for emergency crisis services for a person with serious and persistent mental illness
 289.20 or a developmental disability, regardless of age, if the variance complies with section
 289.21 245A.04, subdivision 9, and approval of the variance is recommended by the county in
 289.22 which the licensed ~~foster care provider~~ facility is located.

289.23 (e) The commissioner may grant a variance to paragraph (b) to allow for the use of a
 289.24 fifth bed for respite services, as defined in section 245A.02, for persons with disabilities,
 289.25 regardless of age, if the variance complies with sections 245A.03, subdivision 7, and
 289.26 245A.04, subdivision 9, and approval of the variance is recommended by the county in
 289.27 which the licensed ~~foster care provider~~ facility is ~~licensed~~ located. Respite care may be
 289.28 provided under the following conditions:

289.29 (1) staffing ratios cannot be reduced below the approved level for the individuals
 289.30 being served in the home on a permanent basis;

289.31 (2) no more than two different individuals can be accepted for respite services in
 289.32 any calendar month and the total respite days may not exceed 120 days per program in
 289.33 any calendar year;

290.1 (3) the person receiving respite services must have his or her own bedroom, which
 290.2 could be used for alternative purposes when not used as a respite bedroom, and cannot be
 290.3 the room of another person who lives in the ~~foster care home~~ facility; and

290.4 (4) individuals living in the ~~foster care home~~ facility must be notified when the
 290.5 variance is approved. The provider must give 60 days' notice in writing to the residents
 290.6 and their legal representatives prior to accepting the first respite placement. Notice must
 290.7 be given to residents at least two days prior to service initiation, or as soon as the license
 290.8 holder is able if they receive notice of the need for respite less than two days prior to
 290.9 initiation, each time a respite client will be served, unless the requirement for this notice is
 290.10 waived by the resident or legal guardian.

290.11 (f) The commissioner may issue an adult foster care or community residential setting
 290.12 license with a capacity of five adults if the fifth bed does not increase the overall statewide
 290.13 capacity of licensed adult foster care or community residential setting beds in homes that
 290.14 are not the primary residence of the license holder, as identified in a plan submitted to the
 290.15 commissioner by the county, when the capacity is recommended by the county licensing
 290.16 agency of the county in which the facility is located and if the recommendation verifies that:

290.17 (1) the facility meets the physical environment requirements in the adult foster
 290.18 care licensing rule;

290.19 (2) the five-bed living arrangement is specified for each resident in the resident's:

290.20 (i) individualized plan of care;

290.21 (ii) individual service plan under section 256B.092, subdivision 1b, if required; or

290.22 (iii) individual resident placement agreement under Minnesota Rules, part

290.23 9555.5105, subpart 19, if required;

290.24 (3) the license holder obtains written and signed informed consent from each
 290.25 resident or resident's legal representative documenting the resident's informed choice
 290.26 to remain living in the home and that the resident's refusal to consent would not have
 290.27 resulted in service termination; and

290.28 (4) the facility was licensed for adult foster care before March 1, 2011.

290.29 (g) The commissioner shall not issue a new adult foster care license under paragraph
 290.30 (f) after June 30, 2016. The commissioner shall allow a facility with an adult foster care
 290.31 license issued under paragraph (f) before June 30, 2016, to continue with a capacity of five
 290.32 adults if the license holder continues to comply with the requirements in paragraph (f).

290.33 Sec. 13. Minnesota Statutes 2012, section 245A.11, subdivision 7, is amended to read:

290.34 Subd. 7. **Adult foster care; variance for alternate overnight supervision.** (a) The
 290.35 commissioner may grant a variance under section 245A.04, subdivision 9, to rule parts

291.1 requiring a caregiver to be present in an adult foster care home during normal sleeping
 291.2 hours to allow for alternative methods of overnight supervision. The commissioner may
 291.3 grant the variance if the local county licensing agency recommends the variance and the
 291.4 county recommendation includes documentation verifying that:

291.5 (1) the county has approved the license holder's plan for alternative methods of
 291.6 providing overnight supervision and determined the plan protects the residents' health,
 291.7 safety, and rights;

291.8 (2) the license holder has obtained written and signed informed consent from
 291.9 each resident or each resident's legal representative documenting the resident's or legal
 291.10 representative's agreement with the alternative method of overnight supervision; and

291.11 (3) the alternative method of providing overnight supervision, which may include
 291.12 the use of technology, is specified for each resident in the resident's: (i) individualized
 291.13 plan of care; (ii) individual service plan under section 256B.092, subdivision 1b, if
 291.14 required; or (iii) individual resident placement agreement under Minnesota Rules, part
 291.15 9555.5105, subpart 19, if required.

291.16 (b) To be eligible for a variance under paragraph (a), the adult foster care license
 291.17 holder must not have had a conditional license issued under section 245A.06, or any
 291.18 other licensing sanction issued under section 245A.07 during the prior 24 months based
 291.19 on failure to provide adequate supervision, health care services, or resident safety in
 291.20 the adult foster care home.

291.21 (c) A license holder requesting a variance under this subdivision to utilize
 291.22 technology as a component of a plan for alternative overnight supervision may request
 291.23 the commissioner's review in the absence of a county recommendation. Upon receipt of
 291.24 such a request from a license holder, the commissioner shall review the variance request
 291.25 with the county.

291.26 (d) A variance granted by the commissioner according to this subdivision before
 291.27 January 1, 2014, to a license holder for an adult foster care home must transfer with the
 291.28 license when the license converts to a community residential setting license under chapter
 291.29 245D. The terms and conditions of the variance remain in effect as approved at the time
 291.30 the variance was granted.

291.31 Sec. 14. Minnesota Statutes 2012, section 245A.11, subdivision 7a, is amended to read:

291.32 Subd. 7a. **Alternate overnight supervision technology; adult foster care license**
 291.33 **and community residential setting licenses.** (a) The commissioner may grant an
 291.34 applicant or license holder an adult foster care or community residential setting license
 291.35 for a residence that does not have a caregiver in the residence during normal sleeping

292.1 hours as required under Minnesota Rules, part 9555.5105, subpart 37, item B, or section
 292.2 245D.02, subdivision 33b, but uses monitoring technology to alert the license holder
 292.3 when an incident occurs that may jeopardize the health, safety, or rights of a foster
 292.4 care recipient. The applicant or license holder must comply with all other requirements
 292.5 under Minnesota Rules, parts 9555.5105 to 9555.6265, or applicable requirements under
 292.6 chapter 245D, and the requirements under this subdivision. The license printed by the
 292.7 commissioner must state in bold and large font:

292.8 (1) that the facility is under electronic monitoring; and

292.9 (2) the telephone number of the county's common entry point for making reports of
 292.10 suspected maltreatment of vulnerable adults under section 626.557, subdivision 9.

292.11 (b) Applications for a license under this section must be submitted directly to
 292.12 the Department of Human Services licensing division. The licensing division must
 292.13 immediately notify the ~~host county and lead county contract agency and the host county~~
 292.14 licensing agency. The licensing division must collaborate with the county licensing
 292.15 agency in the review of the application and the licensing of the program.

292.16 (c) Before a license is issued by the commissioner, and for the duration of the
 292.17 license, the applicant or license holder must establish, maintain, and document the
 292.18 implementation of written policies and procedures addressing the requirements in
 292.19 paragraphs (d) through (f).

292.20 (d) The applicant or license holder must have policies and procedures that:

292.21 (1) establish characteristics of target populations that will be admitted into the home,
 292.22 and characteristics of populations that will not be accepted into the home;

292.23 (2) explain the discharge process when a ~~foster care recipient~~ resident served by the
 292.24 program requires overnight supervision or other services that cannot be provided by the
 292.25 license holder due to the limited hours that the license holder is on site;

292.26 (3) describe the types of events to which the program will respond with a physical
 292.27 presence when those events occur in the home during time when staff are not on site, and
 292.28 how the license holder's response plan meets the requirements in paragraph (e), clause
 292.29 (1) or (2);

292.30 (4) establish a process for documenting a review of the implementation and
 292.31 effectiveness of the response protocol for the response required under paragraph (e),
 292.32 clause (1) or (2). The documentation must include:

292.33 (i) a description of the triggering incident;

292.34 (ii) the date and time of the triggering incident;

292.35 (iii) the time of the response or responses under paragraph (e), clause (1) or (2);

292.36 (iv) whether the response met the resident's needs;

293.1 (v) whether the existing policies and response protocols were followed; and

293.2 (vi) whether the existing policies and protocols are adequate or need modification.

293.3 When no physical presence response is completed for a three-month period, the
293.4 license holder's written policies and procedures must require a physical presence response
293.5 drill to be conducted for which the effectiveness of the response protocol under paragraph
293.6 (e), clause (1) or (2), will be reviewed and documented as required under this clause; and

293.7 (5) establish that emergency and nonemergency phone numbers are posted in a
293.8 prominent location in a common area of the home where they can be easily observed by a
293.9 person responding to an incident who is not otherwise affiliated with the home.

293.10 (e) The license holder must document and include in the license application which
293.11 response alternative under clause (1) or (2) is in place for responding to situations that
293.12 present a serious risk to the health, safety, or rights of ~~people receiving foster care services~~
293.13 ~~in the home~~ residents served by the program:

293.14 (1) response alternative (1) requires only the technology to provide an electronic
293.15 notification or alert to the license holder that an event is underway that requires a response.
293.16 Under this alternative, no more than ten minutes will pass before the license holder will be
293.17 physically present on site to respond to the situation; or

293.18 (2) response alternative (2) requires the electronic notification and alert system under
293.19 alternative (1), but more than ten minutes may pass before the license holder is present on
293.20 site to respond to the situation. Under alternative (2), all of the following conditions are met:

293.21 (i) the license holder has a written description of the interactive technological
293.22 applications that will assist the license holder in communicating with and assessing the
293.23 needs related to the care, health, and safety of the foster care recipients. This interactive
293.24 technology must permit the license holder to remotely assess the well being of the ~~foster~~
293.25 ~~care recipient~~ resident served by the program without requiring the initiation of the
293.26 foster care recipient. Requiring the foster care recipient to initiate a telephone call does
293.27 not meet this requirement;

293.28 (ii) the license holder documents how the remote license holder is qualified and
293.29 capable of meeting the needs of the foster care recipients and assessing foster care
293.30 recipients' needs under item (i) during the absence of the license holder on site;

293.31 (iii) the license holder maintains written procedures to dispatch emergency response
293.32 personnel to the site in the event of an identified emergency; and

293.33 (iv) each ~~foster care recipient's~~ resident's individualized plan of care, ~~individual~~
293.34 ~~service plan~~ coordinated service and support plan under ~~section~~ sections 256B.0913,
293.35 subdivision 8; 256B.0915, subdivision 6; 256B.092, subdivision 1b; and 256B.49,
293.36 subdivision 15, if required, or individual resident placement agreement under Minnesota

294.1 Rules, part 9555.5105, subpart 19, if required, identifies the maximum response time,
294.2 which may be greater than ten minutes, for the license holder to be on site for that foster
294.3 ~~care recipient~~ resident.

294.4 (f) Each ~~foster care recipient's~~ resident's placement agreement, individual service
294.5 agreement, and plan must clearly state that the adult foster care or community residential
294.6 setting license category is a program without the presence of a caregiver in the residence
294.7 during normal sleeping hours; the protocols in place for responding to situations that
294.8 present a serious risk to the health, safety, or rights of ~~foster care recipients~~ residents
294.9 served by the program under paragraph (e), clause (1) or (2); and a signed informed
294.10 consent from each ~~foster care recipient~~ resident served by the program or the person's
294.11 legal representative documenting the person's or legal representative's agreement with
294.12 placement in the program. If electronic monitoring technology is used in the home, the
294.13 informed consent form must also explain the following:

294.14 (1) how any electronic monitoring is incorporated into the alternative supervision
294.15 system;

294.16 (2) the backup system for any electronic monitoring in times of electrical outages or
294.17 other equipment malfunctions;

294.18 (3) how the caregivers or direct support staff are trained on the use of the technology;

294.19 (4) the event types and license holder response times established under paragraph (e);

294.20 (5) how the license holder protects ~~the foster care recipient's~~ each resident's privacy
294.21 related to electronic monitoring and related to any electronically recorded data generated
294.22 by the monitoring system. A ~~foster care recipient~~ resident served by the program may
294.23 not be removed from a program under this subdivision for failure to consent to electronic
294.24 monitoring. The consent form must explain where and how the electronically recorded
294.25 data is stored, with whom it will be shared, and how long it is retained; and

294.26 (6) the risks and benefits of the alternative overnight supervision system.

294.27 The written explanations under clauses (1) to (6) may be accomplished through
294.28 cross-references to other policies and procedures as long as they are explained to the
294.29 person giving consent, and the person giving consent is offered a copy.

294.30 (g) Nothing in this section requires the applicant or license holder to develop or
294.31 maintain separate or duplicative policies, procedures, documentation, consent forms, or
294.32 individual plans that may be required for other licensing standards, if the requirements of
294.33 this section are incorporated into those documents.

294.34 (h) The commissioner may grant variances to the requirements of this section
294.35 according to section 245A.04, subdivision 9.

295.1 (i) For the purposes of paragraphs (d) through (h), "license holder" has the meaning
295.2 under section 245A.2, subdivision 9, and additionally includes all staff, volunteers, and
295.3 contractors affiliated with the license holder.

295.4 (j) For the purposes of paragraph (e), the terms "assess" and "assessing" mean to
295.5 remotely determine what action the license holder needs to take to protect the well-being
295.6 of the foster care recipient.

295.7 (k) The commissioner shall evaluate license applications using the requirements
295.8 in paragraphs (d) to (f). The commissioner shall provide detailed application forms,
295.9 including a checklist of criteria needed for approval.

295.10 (l) To be eligible for a license under paragraph (a), the adult foster care or community
295.11 residential setting license holder must not have had a conditional license issued under
295.12 section 245A.06 or any licensing sanction under section 245A.07 during the prior 24
295.13 months based on failure to provide adequate supervision, health care services, or resident
295.14 safety in the adult foster care home or community residential setting.

295.15 (m) The commissioner shall review an application for an alternative overnight
295.16 supervision license within 60 days of receipt of the application. When the commissioner
295.17 receives an application that is incomplete because the applicant failed to submit required
295.18 documents or that is substantially deficient because the documents submitted do not meet
295.19 licensing requirements, the commissioner shall provide the applicant written notice
295.20 that the application is incomplete or substantially deficient. In the written notice to the
295.21 applicant, the commissioner shall identify documents that are missing or deficient and
295.22 give the applicant 45 days to resubmit a second application that is substantially complete.
295.23 An applicant's failure to submit a substantially complete application after receiving
295.24 notice from the commissioner is a basis for license denial under section 245A.05. The
295.25 commissioner shall complete subsequent review within 30 days.

295.26 (n) Once the application is considered complete under paragraph (m), the
295.27 commissioner will approve or deny an application for an alternative overnight supervision
295.28 license within 60 days.

295.29 (o) For the purposes of this subdivision, "supervision" means:

295.30 (1) oversight by a caregiver or direct support staff as specified in the individual
295.31 resident's place agreement or coordinated service and support plan and awareness of the
295.32 resident's needs and activities; and

295.33 (2) the presence of a caregiver or direct support staff in a residence during normal
295.34 sleeping hours, unless a determination has been made and documented in the individual's
295.35 coordinated service and support plan that the individual does not require the presence of a
295.36 caregiver or direct support staff during normal sleeping hours.

296.1 Sec. 15. Minnesota Statutes 2012, section 245A.11, subdivision 7b, is amended to read:

296.2 Subd. 7b. **Adult foster care data privacy and security.** (a) An adult foster care
296.3 or community residential setting license holder who creates, collects, records, maintains,
296.4 stores, or discloses any individually identifiable recipient data, whether in an electronic
296.5 or any other format, must comply with the privacy and security provisions of applicable
296.6 privacy laws and regulations, including:

296.7 (1) the federal Health Insurance Portability and Accountability Act of 1996
296.8 (HIPAA), Public Law 104-1; and the HIPAA Privacy Rule, Code of Federal Regulations,
296.9 title 45, part 160, and subparts A and E of part 164; and

296.10 (2) the Minnesota Government Data Practices Act as codified in chapter 13.

296.11 (b) For purposes of licensure, the license holder shall be monitored for compliance
296.12 with the following data privacy and security provisions:

296.13 (1) the license holder must control access to data on ~~foster care recipients~~ residents
296.14 served by the program according to the definitions of public and private data on individuals
296.15 under section 13.02; classification of the data on individuals as private under section
296.16 13.46, subdivision 2; and control over the collection, storage, use, access, protection,
296.17 and contracting related to data according to section 13.05, in which the license holder is
296.18 assigned the duties of a government entity;

296.19 (2) the license holder must provide each ~~foster care recipient~~ resident served by
296.20 the program with a notice that meets the requirements under section 13.04, in which
296.21 the license holder is assigned the duties of the government entity, and that meets the
296.22 requirements of Code of Federal Regulations, title 45, part 164.52. The notice shall
296.23 describe the purpose for collection of the data, and to whom and why it may be disclosed
296.24 pursuant to law. The notice must inform the ~~recipient~~ individual that the license holder
296.25 uses electronic monitoring and, if applicable, that recording technology is used;

296.26 (3) the license holder must not install monitoring cameras in bathrooms;

296.27 (4) electronic monitoring cameras must not be concealed from the ~~foster care~~
296.28 ~~recipients~~ residents served by the program; and

296.29 (5) electronic video and audio recordings of ~~foster care recipients~~ residents served
296.30 by the program shall be stored by the license holder for five days unless: (i) a ~~foster care~~
296.31 ~~recipient~~ resident served by the program or legal representative requests that the recording
296.32 be held longer based on a specific report of alleged maltreatment; or (ii) the recording
296.33 captures an incident or event of alleged maltreatment under section 626.556 or 626.557 or
296.34 a crime under chapter 609. When requested by a ~~recipient~~ resident served by the program
296.35 or when a recording captures an incident or event of alleged maltreatment or a crime, the
296.36 license holder must maintain the recording in a secured area for no longer than 30 days

297.1 to give the investigating agency an opportunity to make a copy of the recording. The
297.2 investigating agency will maintain the electronic video or audio recordings as required in
297.3 section 626.557, subdivision 12b.

297.4 (c) The commissioner shall develop, and make available to license holders and
297.5 county licensing workers, a checklist of the data privacy provisions to be monitored
297.6 for purposes of licensure.

297.7 Sec. 16. Minnesota Statutes 2012, section 245A.11, subdivision 8, is amended to read:

297.8 Subd. 8. **Community residential setting license.** (a) The commissioner shall
297.9 establish provider standards for residential support services that integrate service standards
297.10 and the residential setting under one license. The commissioner shall propose statutory
297.11 language and an implementation plan for licensing requirements for residential support
297.12 services to the legislature by January 15, 2012, as a component of the quality outcome
297.13 standards recommendations required by Laws 2010, chapter 352, article 1, section 24.

297.14 (b) Providers licensed under chapter 245B, and providing, contracting, or arranging
297.15 for services in settings licensed as adult foster care under Minnesota Rules, parts 9555.5105
297.16 to 9555.6265, ~~or child foster care under Minnesota Rules, parts 2960.3000 to 2960.3340;~~
297.17 and meeting the provisions of ~~section 256B.092, subdivision 11, paragraph (b) section~~
297.18 245D.02, subdivision 4a, must be required to obtain a community residential setting license.

297.19 Sec. 17. Minnesota Statutes 2012, section 245A.16, subdivision 1, is amended to read:

297.20 Subdivision 1. **Delegation of authority to agencies.** (a) County agencies and
297.21 private agencies that have been designated or licensed by the commissioner to perform
297.22 licensing functions and activities under section 245A.04 and background studies for family
297.23 child care under chapter 245C; to recommend denial of applicants under section 245A.05;
297.24 to issue correction orders, to issue variances, and recommend a conditional license under
297.25 section 245A.06, or to recommend suspending or revoking a license or issuing a fine under
297.26 section 245A.07, shall comply with rules and directives of the commissioner governing
297.27 those functions and with this section. The following variances are excluded from the
297.28 delegation of variance authority and may be issued only by the commissioner:

297.29 (1) dual licensure of family child care and child foster care, dual licensure of child
297.30 and adult foster care, and adult foster care and family child care;

297.31 (2) adult foster care maximum capacity;

297.32 (3) adult foster care minimum age requirement;

297.33 (4) child foster care maximum age requirement;

298.1 (5) variances regarding disqualified individuals except that county agencies may
 298.2 issue variances under section 245C.30 regarding disqualified individuals when the county
 298.3 is responsible for conducting a consolidated reconsideration according to sections 245C.25
 298.4 and 245C.27, subdivision 2, clauses (a) and (b), of a county maltreatment determination
 298.5 and a disqualification based on serious or recurring maltreatment; ~~and~~

298.6 (6) the required presence of a caregiver in the adult foster care residence during
 298.7 normal sleeping hours; and

298.8 (7) variances for community residential setting licenses under chapter 245D.

298.9 Except as provided in section 245A.14, subdivision 4, paragraph (e), a county agency
 298.10 must not grant a license holder a variance to exceed the maximum allowable family child
 298.11 care license capacity of 14 children.

298.12 (b) County agencies must report information about disqualification reconsiderations
 298.13 under sections 245C.25 and 245C.27, subdivision 2, paragraphs (a) and (b), and variances
 298.14 granted under paragraph (a), clause (5), to the commissioner at least monthly in a format
 298.15 prescribed by the commissioner.

298.16 (c) For family day care programs, the commissioner may authorize licensing reviews
 298.17 every two years after a licensee has had at least one annual review.

298.18 (d) For family adult day services programs, the commissioner may authorize
 298.19 licensing reviews every two years after a licensee has had at least one annual review.

298.20 (e) A license issued under this section may be issued for up to two years.

298.21 Sec. 18. Minnesota Statutes 2012, section 245D.02, is amended to read:

298.22 **245D.02 DEFINITIONS.**

298.23 Subdivision 1. **Scope.** The terms used in this chapter have the meanings given
 298.24 them in this section.

298.25 Subd. 2. **Annual and annually.** "Annual" and "annually" have the meaning given
 298.26 in section 245A.02, subdivision 2b.

298.27 Subd. 2a. **Authorized representative.** "Authorized representative" means a parent,
 298.28 family member, advocate, or other adult authorized by the person or the person's legal
 298.29 representative, to serve as a representative in connection with the provision of services
 298.30 licensed under this chapter. This authorization must be in writing or by another method
 298.31 that clearly indicates the person's free choice. The authorized representative must have no
 298.32 financial interest in the provision of any services included in the person's service delivery
 298.33 plan and must be capable of providing the support necessary to assist the person in the use
 298.34 of home and community-based services licensed under this chapter.

299.1 Subd. 3. **Case manager.** "Case manager" means the individual designated
299.2 to provide waiver case management services, care coordination, or long-term care
299.3 consultation, as specified in sections 256B.0913, 256B.0915, 256B.092, and 256B.49,
299.4 or successor provisions.

299.5 Subd. 3a. **Certification.** "Certification" means the commissioner's written
299.6 authorization for a license holder to provide specialized services based on certification
299.7 standards in section 245D.33. The term certification and its derivatives have the same
299.8 meaning and may be substituted for the term licensure and its derivatives in this chapter
299.9 and chapter 245A.

299.10 Subd. 4. **Commissioner.** "Commissioner" means the commissioner of the
299.11 Department of Human Services or the commissioner's designated representative.

299.12 Subd. 4a. **Community residential setting.** "Community residential setting" means
299.13 a residential program as identified in section 245A.11, subdivision 8, where residential
299.14 supports and services identified in section 245D.03, subdivision 1, paragraph (c), clause
299.15 (3), items (i) and (ii), are provided and the license holder is the owner, lessor, or tenant
299.16 of the facility licensed according to this chapter, and the license holder does not reside
299.17 in the facility.

299.18 Subd. 4b. **Coordinated service and support plan.** "Coordinated service and support
299.19 plan" has the meaning given in sections 256B.0913, subdivision 8; 256B.0915, subdivision
299.20 6; 256B.092, subdivision 1b; and 256B.49, subdivision 15, or successor provisions.

299.21 Subd. 4c. **Coordinated service and support plan addendum.** "Coordinated
299.22 service and support plan addendum" means the documentation that this chapter requires
299.23 of the license holder for each person receiving services.

299.24 Subd. 4d. **Corporate foster care.** "Corporate foster care" means a child foster
299.25 residence setting licensed according to Minnesota Rules, parts 2960.0010 to 2960.3340,
299.26 or an adult foster care home licensed according to Minnesota Rules, parts 9555.5105 to
299.27 9555.6265, where the license holder does not live in the home.

299.28 Subd. 4e. **Cultural competence or culturally competent.** "Cultural competence"
299.29 or "culturally competent" means the ability and the will to respond to the unique needs of
299.30 a person that arise from the person's culture and the ability to use the person's culture as a
299.31 resource or tool to assist with the intervention and help meet the person's needs.

299.32 Subd. 4f. **Day services facility.** "Day services facility" means a facility licensed
299.33 according to this chapter at which persons receive day services licensed under this chapter
299.34 from the license holder's direct support staff for a cumulative total of more than 30 days
299.35 within any 12-month period and the license holder is the owner, lessor, or tenant of the
299.36 facility.

300.1 Subd. 5. **Department.** "Department" means the Department of Human Services.

300.2 Subd. 6. **Direct contact.** "Direct contact" has the meaning given in section 245C.02,
300.3 subdivision 11, and is used interchangeably with the term "direct support service."

300.4 Subd. 6a. **Direct support staff or staff.** "Direct support staff" or "staff" means
300.5 employees of the license holder who have direct contact with persons served by the
300.6 program and includes temporary staff or subcontractors, regardless of employer, providing
300.7 program services for hire under the control of the license holder who have direct contact
300.8 with persons served by the program.

300.9 Subd. 7. **Drug.** "Drug" has the meaning given in section 151.01, subdivision 5.

300.10 Subd. 8. **Emergency.** "Emergency" means any event that affects the ordinary
300.11 daily operation of the program including, but not limited to, fires, severe weather, natural
300.12 disasters, power failures, or other events that threaten the immediate health and safety of
300.13 a person receiving services and that require calling 911, emergency evacuation, moving
300.14 to an emergency shelter, or temporary closure or relocation of the program to another
300.15 facility or service site for more than 24 hours.

300.16 Subd. 8a. **Emergency use of manual restraint.** "Emergency use of manual
300.17 restraint" means using a manual restraint when a person poses an imminent risk of
300.18 physical harm to self or others and is the least restrictive intervention that would achieve
300.19 safety. Property damage, verbal aggression, or a person's refusal to receive or participate
300.20 in treatment or programming on their own, do not constitute an emergency.

300.21 Subd. 8b. **Expanded support team.** "Expanded support team" means the members
300.22 of the support team defined in subdivision 46, and a licensed health or mental health
300.23 professional or other licensed, certified, or qualified professionals or consultants working
300.24 with the person and included in the team at the request of the person or the person's legal
300.25 representative.

300.26 Subd. 8c. **Family foster care.** "Family foster care" means a child foster family
300.27 setting licensed according to Minnesota Rules, parts 2960.0010 to 2960.3340, or an adult
300.28 foster care home licensed according to Minnesota Rules, parts 9555.5105 to 9555.6265,
300.29 where the license holder lives in the home.

300.30 Subd. 9. **Health services.** "Health services" means any service or treatment
300.31 consistent with the physical and mental health needs of the person, such as medication
300.32 administration and monitoring, medical, dental, nutritional, health monitoring, wellness
300.33 education, and exercise.

300.34 Subd. 10. **Home and community-based services.** "Home and community-based
300.35 services" means the services ~~subject to the provisions of this chapter~~ identified in section
300.36 245D.03, subdivision 1, and as defined in:

301.1 ~~(1) the federal~~ federally approved waiver plans governed by United States Code,
 301.2 title 42, sections 1396 et seq., ~~or the state's alternative care program according to section~~
 301.3 ~~256B.0913,~~ including the waivers for persons with disabilities under section 256B.49,
 301.4 subdivision 11, including the brain injury (BI) waiver, ~~plan;~~ the community alternative
 301.5 care (CAC) waiver, ~~plan;~~ the community alternatives for disabled individuals (CADI)
 301.6 waiver, ~~plan;~~ the developmental disability (DD) waiver, ~~plan~~ under section 256B.092,
 301.7 subdivision 5; the elderly waiver (EW), and plan under section 256B.0915, subdivision 1;
 301.8 or successor plans respective to each waiver; or

301.9 (2) the alternative care (AC) program under section 256B.0913.

301.10 Subd. 11. **Incident.** "Incident" means an occurrence ~~that affects the~~ which involves
 301.11 a person and requires the program to make a response that is not a part of the program's
 301.12 ordinary provision of services to a that person, and includes ~~any of the following:~~

301.13 (1) serious injury of a person as determined by section 245.91, subdivision 6;

301.14 (2) a person's death;

301.15 (3) any medical emergency, unexpected serious illness, or significant unexpected
 301.16 change in an illness or medical condition, ~~or the mental health status of a person that~~
 301.17 requires calling the program to call 911 or a mental health crisis intervention team,
 301.18 physician treatment, or hospitalization;

301.19 (4) any mental health crisis that requires the program to call 911 or a mental health
 301.20 crisis intervention team;

301.21 (5) an act or situation involving a person that requires the program to call 911,
 301.22 law enforcement, or the fire department;

301.23 ~~(4)~~ (6) a person's unauthorized or unexplained absence from a program;

301.24 ~~(5)~~ (7) physical aggression conduct by a person receiving services against another
 301.25 person receiving services that causes physical pain, injury, or persistent emotional distress,
 301.26 including, but not limited to, hitting, slapping, kicking, scratching, pinching, biting,
 301.27 pushing, and spitting;

301.28 (i) is so severe, pervasive, or objectively offensive that it substantially interferes with
 301.29 a person's opportunities to participate in or receive service or support;

301.30 (ii) places the person in actual and reasonable fear of harm;

301.31 (iii) places the person in actual and reasonable fear of damage to property of the
 301.32 person; or

301.33 (iv) substantially disrupts the orderly operation of the program;

301.34 ~~(6)~~ (8) any sexual activity between persons receiving services involving force or
 301.35 coercion as defined under section 609.341, subdivisions 3 and 14; or

301.36 (9) any emergency use of manual restraint as identified in section 245D.061; or

302.1 ~~(7)~~ (10) a report of alleged or suspected child or vulnerable adult maltreatment
302.2 under section 626.556 or 626.557.

302.3 **Subd. 11a. Intermediate care facility for persons with developmental disabilities**
302.4 **or ICF/DD.** "Intermediate care facility for persons with developmental disabilities" or
302.5 "ICF/DD" means a residential program licensed to serve four or more persons with
302.6 developmental disabilities under section 252.28 and chapter 245A and licensed as a
302.7 supervised living facility under chapter 144, which together are certified by the Department
302.8 of Health as an intermediate care facility for persons with developmental disabilities.

302.9 **Subd. 11b. Least restrictive alternative.** "Least restrictive alternative" means
302.10 the alternative method for providing supports and services that is the least intrusive and
302.11 most normalized given the level of supervision and protection required for the person.
302.12 This level of supervision and protection allows risk taking to the extent that there is no
302.13 reasonable likelihood that serious harm will happen to the person or others.

302.14 **Subd. 12. Legal representative.** "Legal representative" means the parent of a
302.15 person who is under 18 years of age, a court-appointed guardian, or other representative
302.16 with legal authority to make decisions about services for a person. Other representatives
302.17 with legal authority to make decisions include but are not limited to a health care agent or
302.18 an attorney-in-fact authorized through a health care directive or power of attorney.

302.19 **Subd. 13. License.** "License" has the meaning given in section 245A.02,
302.20 subdivision 8.

302.21 **Subd. 14. Licensed health professional.** "Licensed health professional" means a
302.22 person licensed in Minnesota to practice those professions described in section 214.01,
302.23 subdivision 2.

302.24 **Subd. 15. License holder.** "License holder" has the meaning given in section
302.25 245A.02, subdivision 9.

302.26 **Subd. 16. Medication.** "Medication" means a prescription drug or over-the-counter
302.27 drug. For purposes of this chapter, "medication" includes dietary supplements.

302.28 ~~**Subd. 17. Medication administration.** "Medication administration" means~~
302.29 ~~performing the following set of tasks to ensure a person takes both prescription and~~
302.30 ~~over-the-counter medications and treatments according to orders issued by appropriately~~
302.31 ~~licensed professionals, and includes the following:~~

302.32 ~~(1) checking the person's medication record;~~

302.33 ~~(2) preparing the medication for administration;~~

302.34 ~~(3) administering the medication to the person;~~

302.35 ~~(4) documenting the administration of the medication or the reason for not~~
302.36 ~~administering the medication; and~~

303.1 ~~(5) reporting to the prescriber or a nurse any concerns about the medication,~~
 303.2 ~~including side effects, adverse reactions, effectiveness, or the person's refusal to take the~~
 303.3 ~~medication or the person's self-administration of the medication.~~

303.4 ~~Subd. 18. **Medication assistance.** "Medication assistance" means providing verbal~~
 303.5 ~~or visual reminders to take regularly scheduled medication, which includes either of~~
 303.6 ~~the following:~~

303.7 ~~(1) bringing to the person and opening a container of previously set up medications~~
 303.8 ~~and emptying the container into the person's hand or opening and giving the medications~~
 303.9 ~~in the original container to the person, or bringing to the person liquids or food to~~
 303.10 ~~accompany the medication; or~~

303.11 ~~(2) providing verbal or visual reminders to perform regularly scheduled treatments~~
 303.12 ~~and exercises.~~

303.13 ~~Subd. 19. **Medication management.** "Medication management" means the~~
 303.14 ~~provision of any of the following:~~

303.15 ~~(1) medication-related services to a person;~~

303.16 ~~(2) medication setup;~~

303.17 ~~(3) medication administration;~~

303.18 ~~(4) medication storage and security;~~

303.19 ~~(5) medication documentation and charting;~~

303.20 ~~(6) verification and monitoring of effectiveness of systems to ensure safe medication~~
 303.21 ~~handling and administration;~~

303.22 ~~(7) coordination of medication refills;~~

303.23 ~~(8) handling changes to prescriptions and implementation of those changes;~~

303.24 ~~(9) communicating with the pharmacy; or~~

303.25 ~~(10) coordination and communication with prescriber.~~

303.26 ~~For the purposes of this chapter, medication management does not mean "medication~~
 303.27 ~~therapy management services" as identified in section 256B.0625, subdivision 13h.~~

303.28 ~~Subd. 20. **Mental health crisis intervention team.** "Mental health crisis~~
 303.29 ~~intervention team" means a mental health crisis response providers provider as identified~~
 303.30 ~~in section 256B.0624, subdivision 2, paragraph (d), for adults, and in section 256B.0944,~~
 303.31 ~~subdivision 1, paragraph (d), for children.~~

303.32 ~~Subd. 20a. **Most integrated setting.** "Most integrated setting" means a setting that~~
 303.33 ~~enables individuals with disabilities to interact with nondisabled persons to the fullest~~
 303.34 ~~extent possible.~~

304.1 Subd. 21. **Over-the-counter drug.** "Over-the-counter drug" means a drug that
304.2 is not required by federal law to bear the statement "Caution: Federal law prohibits
304.3 dispensing without prescription."

304.4 Subd. 21a. **Outcome.** "Outcome" means the behavior, action, or status attained by
304.5 the person that can be observed, measured, and determined reliable and valid.

304.6 Subd. 22. **Person.** "Person" has the meaning given in section 245A.02, subdivision
304.7 11.

304.8 Subd. 23. **Person with a disability.** "Person with a disability" means a person
304.9 determined to have a disability by the commissioner's state medical review team as
304.10 identified in section 256B.055, subdivision 7, the Social Security Administration, or
304.11 the person is determined to have a developmental disability as defined in Minnesota
304.12 Rules, part 9525.0016, subpart 2, item B, or a related condition as defined in section
304.13 252.27, subdivision 1a.

304.14 Subd. 23a. **Physician.** "Physician" means a person who is licensed under chapter
304.15 147.

304.16 Subd. 24. **Prescriber.** ~~"Prescriber" means a licensed practitioner as defined in~~
304.17 ~~section 151.01, subdivision 23, person who is authorized under section 148.235; 151.01,~~
304.18 ~~subdivision 23; or 151.37 to prescribe drugs. For the purposes of this chapter, the term~~
304.19 ~~"prescriber" is used interchangeably with "physician."~~

304.20 Subd. 25. **Prescription drug.** "Prescription drug" has the meaning given in section
304.21 151.01, subdivision ~~17~~ 16.

304.22 Subd. 26. **Program.** "Program" means either the nonresidential or residential
304.23 program as defined in section 245A.02, subdivisions 10 and 14.

304.24 Subd. 27. **Psychotropic medication.** "Psychotropic medication" means any
304.25 medication prescribed to treat the symptoms of mental illness that affect thought processes,
304.26 mood, sleep, or behavior. The major classes of psychotropic medication are antipsychotic
304.27 (neuroleptic), antidepressant, antianxiety, mood stabilizers, anticonvulsants, and
304.28 stimulants and nonstimulants for the treatment of attention deficit/hyperactivity disorder.
304.29 Other miscellaneous medications are considered to be a psychotropic medication when
304.30 they are specifically prescribed to treat a mental illness or to control or alter behavior.

304.31 Subd. 28. **Restraint.** "Restraint" means physical or mechanical limiting of the free
304.32 and normal movement of body or limbs.

304.33 Subd. 29. **Seclusion.** ~~"Seclusion" means separating a person from others in a way~~
304.34 ~~that prevents social contact and prevents the person from leaving the situation if he or she~~
304.35 ~~chooses~~ the placement of a person alone in a room from which exit is prohibited by a staff

305.1 person or a mechanism such as a lock, a device, or an object positioned to hold the door
305.2 closed or otherwise prevent the person from leaving the room.

305.3 Subd. 29a. **Self-determination.** "Self-determination" means the person makes
305.4 decisions independently, plans for the person's own future, determines how money is spent
305.5 for the person's supports, and takes responsibility for making these decisions. If a person
305.6 has a legal representative, the legal representative's decision-making authority is limited to
305.7 the scope of authority granted by the court or allowed in the document authorizing the
305.8 legal representative to act.

305.9 Subd. 29b. **Semi-independent living services.** "Semi-independent living services"
305.10 has the meaning given in section 252.275.

305.11 Subd. 30. **Service.** "Service" means care, training, supervision, counseling,
305.12 consultation, or medication assistance assigned to the license holder in the coordinated
305.13 service and support plan.

305.14 Subd. 31. **Service plan.** "Service plan" means the individual service plan or
305.15 individual care plan identified in sections 256B.0913, 256B.0915, 256B.092, and 256B.49,
305.16 or successor provisions, and includes any support plans or service needs identified as
305.17 a result of long-term care consultation, or a support team meeting that includes the
305.18 participation of the person, the person's legal representative, and case manager, or assigned
305.19 to a license holder through an authorized service agreement.

305.20 Subd. 32. **Service site.** "Service site" means the location where the service is
305.21 provided to the person, including, but not limited to, a facility licensed according to
305.22 chapter 245A; a location where the license holder is the owner, lessor, or tenant; a person's
305.23 own home; or a community-based location.

305.24 Subd. 33. **Staff.** "Staff" means an employee who will have direct contact with a
305.25 person served by the facility, agency, or program.

305.26 Subd. 33a. **Supervised living facility.** "Supervised living facility" has the meaning
305.27 given in Minnesota Rules, part 4665.0100, subpart 10.

305.28 Subd. 33b. **Supervision.** (a) "Supervision" means:

305.29 (1) oversight by direct support staff as specified in the person's coordinated service
305.30 and support plan or coordinated service and support plan addendum and awareness of
305.31 the person's needs and activities;

305.32 (2) responding to situations that present a serious risk to the health, safety, or rights
305.33 of the person while services are being provided; and

305.34 (3) the presence of direct support staff at a service site while services are being
305.35 provided, unless a determination has been made and documented in the person's coordinated

306.1 service and support plan or coordinated service and support plan addendum that the person
 306.2 does not require the presence of direct support staff while services are being provided.

306.3 (b) For the purposes of this definition, "while services are being provided," means
 306.4 any period of time during which the license holder will seek reimbursement for services.

306.5 Subd. 34. **Support team.** "Support team" means the service planning team
 306.6 identified in section 256B.49, subdivision 15, or the interdisciplinary team identified in
 306.7 Minnesota Rules, part 9525.0004, subpart 14.

306.8 Subd. 34a. **Time out.** "Time out" means removing a person involuntarily from an
 306.9 ongoing activity to a room, either locked or unlocked, or otherwise separating a person
 306.10 from others in a way that prevents social contact and prevents the person from leaving
 306.11 the situation if the person chooses. For the purpose of chapter 245D, "time out" does
 306.12 not mean voluntary removal or self-removal for the purpose of calming, prevention of
 306.13 escalation, or de-escalation of behavior for a period of up to 15 minutes. "Time out"
 306.14 does not include a person voluntarily moving from an ongoing activity to an unlocked
 306.15 room or otherwise separating from a situation or social contact with others if the person
 306.16 chooses. For the purposes of this definition, "voluntarily" means without being forced,
 306.17 compelled, or coerced.

306.18 ~~Subd. 35. **Unit of government.** "Unit of government" means every city, county,~~
 306.19 ~~town, school district, other political subdivisions of the state, and any agency of the state~~
 306.20 ~~or the United States, and includes any instrumentality of a unit of government.~~

306.21 Subd. 35a. **Treatment.** "Treatment" means the provision of care, other than
 306.22 medications, ordered or prescribed by a licensed health or mental health professional,
 306.23 provided to a person to cure, rehabilitate, or ease symptoms.

306.24 Subd. 36. **Volunteer.** "Volunteer" means an individual who, under the direction of the
 306.25 license holder, provides direct services without pay to a person served by the license holder.

306.26 **EFFECTIVE DATE.** This section is effective January 1, 2014.

306.27 Sec. 19. Minnesota Statutes 2012, section 245D.03, is amended to read:

306.28 **245D.03 APPLICABILITY AND EFFECT.**

306.29 Subdivision 1. **Applicability.** (a) The commissioner shall regulate the provision of
 306.30 home and community-based services to persons with disabilities and persons age 65 and
 306.31 older pursuant to this chapter. The licensing standards in this chapter govern the provision
 306.32 of ~~the following~~ basic support services; and intensive support services.

306.33 ~~(1) housing access coordination as defined under the current BI, CADI, and DD~~
 306.34 ~~waiver plans or successor plans;~~

307.1 ~~(2) respite services as defined under the current CADI, BI, CAC, DD, and EW~~
 307.2 ~~waiver plans or successor plans when the provider is an individual who is not an employee~~
 307.3 ~~of a residential or nonresidential program licensed by the Department of Human Services~~
 307.4 ~~or the Department of Health that is otherwise providing the respite service;~~

307.5 ~~(3) behavioral programming as defined under the current BI and CADI waiver~~
 307.6 ~~plans or successor plans;~~

307.7 ~~(4) specialist services as defined under the current DD waiver plan or successor plans;~~

307.8 ~~(5) companion services as defined under the current BI, CADI, and EW waiver~~
 307.9 ~~plans or successor plans, excluding companion services provided under the Corporation~~
 307.10 ~~for National and Community Services Senior Companion Program established under the~~
 307.11 ~~Domestic Volunteer Service Act of 1973, Public Law 98-288;~~

307.12 ~~(6) personal support as defined under the current DD waiver plan or successor plans;~~

307.13 ~~(7) 24-hour emergency assistance, on-call and personal emergency response as~~
 307.14 ~~defined under the current CADI and DD waiver plans or successor plans;~~

307.15 ~~(8) night supervision services as defined under the current BI waiver plan or~~
 307.16 ~~successor plans;~~

307.17 ~~(9) homemaker services as defined under the current CADI, BI, CAC, DD, and EW~~
 307.18 ~~waiver plans or successor plans, excluding providers licensed by the Department of Health~~
 307.19 ~~under chapter 144A and those providers providing cleaning services only;~~

307.20 ~~(10) independent living skills training as defined under the current BI and CADI~~
 307.21 ~~waiver plans or successor plans;~~

307.22 ~~(11) prevocational services as defined under the current BI and CADI waiver plans~~
 307.23 ~~or successor plans;~~

307.24 ~~(12) structured day services as defined under the current BI waiver plan or successor~~
 307.25 ~~plans; or~~

307.26 ~~(13) supported employment as defined under the current BI and CADI waiver plans~~
 307.27 ~~or successor plans.~~

307.28 (b) Basic support services provide the level of assistance, supervision, and care that
 307.29 is necessary to ensure the health and safety of the person and do not include services that
 307.30 are specifically directed toward the training, treatment, habilitation, or rehabilitation of
 307.31 the person. Basic support services include:

307.32 (1) in-home and out-of-home respite care services as defined in section 245A.02,
 307.33 subdivision 15, and under the brain injury, community alternative care, community
 307.34 alternatives for disabled individuals, developmental disability, and elderly waiver plans;

307.35 (2) companion services as defined under the brain injury, community alternatives for
 307.36 disabled individuals, and elderly waiver plans, excluding companion services provided

308.1 under the Corporation for National and Community Services Senior Companion Program
308.2 established under the Domestic Volunteer Service Act of 1973, Public Law 98-288;
308.3 (3) personal support as defined under the developmental disability waiver plan;
308.4 (4) 24-hour emergency assistance, personal emergency response as defined under the
308.5 community alternatives for disabled individuals and developmental disability waiver plans;
308.6 (5) night supervision services as defined under the brain injury waiver plan; and
308.7 (6) homemaker services as defined under the community alternatives for disabled
308.8 individuals, brain injury, community alternative care, developmental disability, and elderly
308.9 waiver plans, excluding providers licensed by the Department of Health under chapter
308.10 144A and those providers providing cleaning services only.

308.11 (c) Intensive support services provide assistance, supervision, and care that is
308.12 necessary to ensure the health and safety of the person and services specifically directed
308.13 toward the training, habilitation, or rehabilitation of the person. Intensive support services
308.14 include:

308.15 (1) intervention services, including:

308.16 (i) behavioral support services as defined under the brain injury and community
308.17 alternatives for disabled individuals waiver plans;

308.18 (ii) in-home or out-of-home crisis respite services as defined under the developmental
308.19 disability waiver plan; and

308.20 (iii) specialist services as defined under the current developmental disability waiver
308.21 plan;

308.22 (2) in-home support services, including:

308.23 (i) in-home family support and supported living services as defined under the
308.24 developmental disability waiver plan;

308.25 (ii) independent living services training as defined under the brain injury and
308.26 community alternatives for disabled individuals waiver plans; and

308.27 (iii) semi-independent living services;

308.28 (3) residential supports and services, including:

308.29 (i) supported living services as defined under the developmental disability waiver
308.30 plan provided in a family or corporate child foster care residence, a family adult foster
308.31 care residence, a community residential setting, or a supervised living facility;

308.32 (ii) foster care services as defined in the brain injury, community alternative care,
308.33 and community alternatives for disabled individuals waiver plans provided in a family or
308.34 corporate child foster care residence, a family adult foster care residence, or a community
308.35 residential setting; and

309.1 (iii) residential services provided in a supervised living facility that is certified by
 309.2 the Department of Health as an ICF/DD;

309.3 (4) day services, including:

309.4 (i) structured day services as defined under the brain injury waiver plan;

309.5 (ii) day training and habilitation services under sections 252.40 to 252.46, and as
 309.6 defined under the developmental disability waiver plan; and

309.7 (iii) prevocational services as defined under the brain injury and community
 309.8 alternatives for disabled individuals waiver plans; and

309.9 (5) supported employment as defined under the brain injury, developmental
 309.10 disability, and community alternatives for disabled individuals waiver plans.

309.11 **Subd. 2. Relationship to other standards governing home and community-based**
 309.12 **services.** (a) A license holder governed by this chapter is also subject to the licensure
 309.13 requirements under chapter 245A.

309.14 ~~(b) A license holder concurrently providing child foster care services licensed~~
 309.15 ~~according to Minnesota Rules, chapter 2960, to the same person receiving a service licensed~~
 309.16 ~~under this chapter is exempt from section 245D.04 as it applies to the person. A corporate~~
 309.17 ~~or family child foster care site controlled by a license holder and providing services~~
 309.18 ~~governed by this chapter is exempt from compliance with section 245D.04. This exemption~~
 309.19 ~~applies to foster care homes where at least one resident is receiving residential supports~~
 309.20 ~~and services licensed according to this chapter. This chapter does not apply to corporate or~~
 309.21 ~~family child foster care homes that do not provide services licensed under this chapter.~~

309.22 (c) A family adult foster care site controlled by a license holder and providing
 309.23 services governed by this chapter is exempt from compliance with Minnesota Rules, parts
 309.24 9555.6185; 9555.6225, subpart 8; 9555.6235, item C; 9555.6245; 9555.6255, subpart
 309.25 2; and 9555.6265. These exemptions apply to family adult foster care homes where at
 309.26 least one resident is receiving residential supports and services licensed according to this
 309.27 chapter. This chapter does not apply to family adult foster care homes that do not provide
 309.28 services licensed under this chapter.

309.29 (d) A license holder providing services licensed according to this chapter in a
 309.30 supervised living facility is exempt from compliance with sections 245D.04; 245D.05,
 309.31 subdivision 2; and 245D.06, subdivision 2, clauses (1), (4), and (5).

309.32 (e) A license holder providing residential services to persons in an ICF/DD is exempt
 309.33 from compliance with sections 245D.04; 245D.05, subdivision 1b; 245D.06, subdivision
 309.34 2, clauses (4) and (5); 245D.071, subdivisions 4 and 5; 245D.081, subdivision 2; 245D.09,
 309.35 subdivision 7; 245D.095, subdivision 2; and 245D.11, subdivision 3.

310.1 ~~(e) (f) A license holder concurrently providing home care~~ homemaker services
 310.2 ~~registered licensed~~ according to sections 144A.43 to 144A.49 to the same person receiving
 310.3 ~~home management services licensed under this chapter and registered according to chapter~~
 310.4 144A is exempt from compliance with section 245D.04 as it applies to the person.

310.5 ~~(d) A license holder identified in subdivision 1, clauses (1), (5), and (9), is exempt~~
 310.6 ~~from compliance with sections 245A.65, subdivision 2, paragraph (a), and 626.557,~~
 310.7 ~~subdivision 14, paragraph (b).~~

310.8 ~~(e) Notwithstanding section 245D.06, subdivision 5, a license holder providing~~
 310.9 ~~structured day, prevocational, or supported employment services under this chapter~~
 310.10 ~~and day training and habilitation or supported employment services licensed under~~
 310.11 ~~chapter 245B within the same program is exempt from compliance with this chapter~~
 310.12 ~~when the license holder notifies the commissioner in writing that the requirements under~~
 310.13 ~~chapter 245B will be met for all persons receiving these services from the program. For~~
 310.14 ~~the purposes of this paragraph, if the license holder has obtained approval from the~~
 310.15 ~~commissioner for an alternative inspection status according to section 245B.031, that~~
 310.16 ~~approval will apply to all persons receiving services in the program.~~

310.17 ~~(g) Nothing in this chapter prohibits a license holder from concurrently serving~~
 310.18 ~~persons without disabilities or people who are or are not age 65 and older, provided this~~
 310.19 ~~chapter's standards are met as well as other relevant standards.~~

310.20 ~~(h) The documentation required under sections 245D.07 and 245D.071 must meet~~
 310.21 ~~the individual program plan requirements identified in section 256B.092 or successor~~
 310.22 ~~provisions.~~

310.23 **Subd. 3. Variance.** If the conditions in section 245A.04, subdivision 9, are met,
 310.24 the commissioner may grant a variance to any of the requirements in this chapter, except
 310.25 sections 245D.04, and 245D.10, subdivision 4, paragraph (b) 245D.06, subdivision 4,
 310.26 paragraph (b), and 245D.061, subdivision 3, or provisions governing data practices and
 310.27 information rights of persons.

310.28 **Subd. 4. License holders with multiple 245D licenses.** (a) When a person changes
 310.29 service from one license to a different license held by the same license holder, the license
 310.30 holder is exempt from the requirements in section 245D.10, subdivision 4, paragraph (b).

310.31 (b) When a staff person begins providing direct service under one or more licenses
 310.32 held by the same license holder, other than the license for which staff orientation was
 310.33 initially provided according to section 245D.09, subdivision 4, the license holder is
 310.34 exempt from those staff orientation requirements, except the staff person must review each
 310.35 person's service plan and medication administration procedures in accordance with section
 310.36 245D.09, subdivision 4, paragraph (c), if not previously reviewed by the staff person.

311.1 Subd. 5. **Program certification.** An applicant or a license holder may apply for
 311.2 program certification as identified in section 245D.33.

311.3 **EFFECTIVE DATE.** This section is effective January 1, 2014.

311.4 Sec. 20. Minnesota Statutes 2012, section 245D.04, is amended to read:

311.5 **245D.04 SERVICE RECIPIENT RIGHTS.**

311.6 Subdivision 1. **License holder responsibility for individual rights of persons**
 311.7 **served by the program.** The license holder must:

311.8 (1) provide each person or each person's legal representative with a written notice
 311.9 that identifies the service recipient rights in subdivisions 2 and 3, and an explanation of
 311.10 those rights within five working days of service initiation and annually thereafter;

311.11 (2) make reasonable accommodations to provide this information in other formats
 311.12 or languages as needed to facilitate understanding of the rights by the person and the
 311.13 person's legal representative, if any;

311.14 (3) maintain documentation of the person's or the person's legal representative's
 311.15 receipt of a copy and an explanation of the rights; and

311.16 (4) ensure the exercise and protection of the person's rights in the services provided
 311.17 by the license holder and as authorized in the coordinated service and support plan.

311.18 Subd. 2. **Service-related rights.** A person's service-related rights include the right to:

311.19 (1) participate in the development and evaluation of the services provided to the
 311.20 person;

311.21 (2) have services and supports identified in the coordinated service and support plan
 311.22 and the coordinated service and support plan addendum provided in a manner that respects
 311.23 and takes into consideration the person's preferences according to the requirements in
 311.24 sections 245D.07 and 245D.071;

311.25 (3) refuse or terminate services and be informed of the consequences of refusing
 311.26 or terminating services;

311.27 (4) know, in advance, limits to the services available from the license holder,
 311.28 including the license holder's knowledge, skill, and ability to meet the person's service and
 311.29 support needs based on the information required in section 245D.031, subdivision 2;

311.30 (5) know conditions and terms governing the provision of services, including the
 311.31 license holder's admission criteria and policies and procedures related to temporary
 311.32 service suspension and service termination;

311.33 (6) a coordinated transfer to ensure continuity of care when there will be a change
 311.34 in the provider;

312.1 (7) know what the charges are for services, regardless of who will be paying for the
 312.2 services, and be notified of changes in those charges;

312.3 ~~(7)~~ (8) know, in advance, whether services are covered by insurance, government
 312.4 funding, or other sources, and be told of any charges the person or other private party
 312.5 may have to pay; and

312.6 ~~(8)~~ (9) receive services from an individual who is competent and trained, who has
 312.7 professional certification or licensure, as required, and who meets additional qualifications
 312.8 identified in the person's coordinated service and support plan; ~~or coordinated service and~~
 312.9 support plan addendum.

312.10 Subd. 3. **Protection-related rights.** (a) A person's protection-related rights include
 312.11 the right to:

312.12 (1) have personal, financial, service, health, and medical information kept private,
 312.13 and be advised of disclosure of this information by the license holder;

312.14 (2) access records and recorded information about the person in accordance with
 312.15 applicable state and federal law, regulation, or rule;

312.16 (3) be free from maltreatment;

312.17 (4) be free from restraint, time out, or seclusion ~~used for a purpose other than~~ except
 312.18 for emergency use of manual restraint to protect the person from imminent danger to self
 312.19 or others according to the requirements in section 245D.06;

312.20 (5) receive services in a clean and safe environment when the license holder is the
 312.21 owner, lessor, or tenant of the service site;

312.22 (6) be treated with courtesy and respect and receive respectful treatment of the
 312.23 person's property;

312.24 (7) reasonable observance of cultural and ethnic practice and religion;

312.25 (8) be free from bias and harassment regarding race, gender, age, disability,
 312.26 spirituality, and sexual orientation;

312.27 (9) be informed of and use the license holder's grievance policy and procedures,
 312.28 including knowing how to contact persons responsible for addressing problems and to
 312.29 appeal under section 256.045;

312.30 (10) know the name, telephone number, and the Web site, e-mail, and street
 312.31 addresses of protection and advocacy services, including the appropriate state-appointed
 312.32 ombudsman, and a brief description of how to file a complaint with these offices;

312.33 (11) assert these rights personally, or have them asserted by the person's family,
 312.34 authorized representative, or legal representative, without retaliation;

312.35 (12) give or withhold written informed consent to participate in any research or
 312.36 experimental treatment;

313.1 (13) associate with other persons of the person's choice;

313.2 (14) personal privacy; and

313.3 (15) engage in chosen activities.

313.4 (b) For a person residing in a residential site licensed according to chapter 245A,
313.5 or where the license holder is the owner, lessor, or tenant of the residential service site,
313.6 protection-related rights also include the right to:

313.7 (1) have daily, private access to and use of a non-coin-operated telephone for local
313.8 calls and long-distance calls made collect or paid for by the person;

313.9 (2) receive and send, without interference, uncensored, unopened mail or electronic
313.10 correspondence or communication; ~~and~~

313.11 (3) have use of and free access to common areas in the residence; and

313.12 (4) privacy for visits with the person's spouse, next of kin, legal counsel, religious
313.13 advisor, or others, in accordance with section 363A.09 of the Human Rights Act, including
313.14 privacy in the person's bedroom.

313.15 (c) Restriction of a person's rights under subdivision 2, clause (10), or paragraph (a),
313.16 clauses (13) to (15), or paragraph (b) is allowed only if determined necessary to ensure
313.17 the health, safety, and well-being of the person. Any restriction of those rights must be
313.18 documented in the person's coordinated service and support plan for the person and or
313.19 coordinated service and support plan addendum. The restriction must be implemented
313.20 in the least restrictive alternative manner necessary to protect the person and provide
313.21 support to reduce or eliminate the need for the restriction in the most integrated setting
313.22 and inclusive manner. The documentation must include the following information:

313.23 (1) the justification for the restriction based on an assessment of the person's
313.24 vulnerability related to exercising the right without restriction;

313.25 (2) the objective measures set as conditions for ending the restriction;

313.26 (3) a schedule for reviewing the need for the restriction based on the conditions for
313.27 ending the restriction to occur, ~~at a minimum, every three months for persons who do not~~
313.28 ~~have a legal representative and annually for persons who do have a legal representative~~
313.29 semiannually from the date of initial approval, at a minimum, or more frequently if
313.30 requested by the person, the person's legal representative, if any, and case manager; and

313.31 (4) signed and dated approval for the restriction from the person, or the person's
313.32 legal representative, if any. A restriction may be implemented only when the required
313.33 approval has been obtained. Approval may be withdrawn at any time. If approval is
313.34 withdrawn, the right must be immediately and fully restored.

313.35 **EFFECTIVE DATE.** This section is effective January 1, 2014.

314.1 Sec. 21. Minnesota Statutes 2012, section 245D.05, is amended to read:

314.2 **245D.05 HEALTH SERVICES.**

314.3 Subdivision 1. **Health needs.** (a) The license holder is responsible for ~~providing~~
 314.4 meeting health services service needs assigned in the coordinated service and support plan
 314.5 ~~and or the coordinated service and support plan addendum,~~ consistent with the person's
 314.6 health needs. The license holder is responsible for promptly notifying ~~the person or~~
 314.7 the person's legal representative, if any, and the case manager of changes in a person's
 314.8 physical and mental health needs affecting ~~assigned health services~~ service needs assigned
 314.9 to the license holder in the coordinated service and support plan or the coordinated service
 314.10 and support plan addendum, when discovered by the license holder, unless the license
 314.11 holder has reason to know the change has already been reported. The license holder
 314.12 must document when the notice is provided.

314.13 (b) ~~When assigned in the service plan,~~ If responsibility for meeting the person's
 314.14 health service needs has been assigned to the license holder in the coordinated service and
 314.15 support plan or the coordinated service and support plan addendum, the license holder is
 314.16 ~~required to~~ must maintain documentation on how the person's health needs will be met,
 314.17 including a description of the procedures the license holder will follow in order to:

314.18 (1) provide medication ~~administration, assistance or medication assistance, or~~
 314.19 ~~medication management~~ administration according to this chapter;

314.20 (2) monitor health conditions according to written instructions from ~~the person's~~
 314.21 ~~physician or~~ a licensed health professional;

314.22 (3) assist with or coordinate medical, dental, and other health service appointments; or

314.23 (4) use medical equipment, devices, or adaptive aides or technology safely and
 314.24 correctly according to written instructions from ~~the person's physician or~~ a licensed
 314.25 health professional.

314.26 Subd. 1a. **Medication setup.** For the purposes of this subdivision, "medication
 314.27 setup" means the arranging of medications according to instructions from the pharmacy,
 314.28 the prescriber, or a licensed nurse, for later administration when the license holder
 314.29 is assigned responsibility for medication assistance or medication administration in
 314.30 the coordinated service and support plan or the coordinated service and support plan
 314.31 addendum. A prescription label or the prescriber's written or electronically recorded order
 314.32 for the prescription is sufficient to constitute written instructions from the prescriber. The
 314.33 license holder must document in the person's medication administration record: dates
 314.34 of setup, name of medication, quantity of dose, times to be administered, and route of
 314.35 administration at time of setup; and, when the person will be away from home, to whom
 314.36 the medications were given.

315.1 Subd. 1b. **Medication assistance.** If responsibility for medication assistance
 315.2 is assigned to the license holder in the coordinated service and support plan or the
 315.3 coordinated service and support plan addendum, the license holder must ensure that
 315.4 the requirements of subdivision 2, paragraph (b), have been met when staff provides
 315.5 medication assistance to enable a person to self-administer medication or treatment when
 315.6 the person is capable of directing the person's own care, or when the person's legal
 315.7 representative is present and able to direct care for the person. For the purposes of this
 315.8 subdivision, "medication assistance" means any of the following:

315.9 (1) bringing to the person and opening a container of previously set up medications,
 315.10 emptying the container into the person's hand, or opening and giving the medications in
 315.11 the original container to the person;

315.12 (2) bringing to the person liquids or food to accompany the medication; or

315.13 (3) providing reminders to take regularly scheduled medication or perform regularly
 315.14 scheduled treatments and exercises.

315.15 Subd. 2. **Medication administration.** (a) If responsibility for medication
 315.16 administration is assigned to the license holder in the coordinated service and support plan
 315.17 or the coordinated service and support plan addendum, the license holder must implement
 315.18 the following medication administration procedures to ensure a person takes medications
 315.19 and treatments as prescribed:

315.20 (1) checking the person's medication record;

315.21 (2) preparing the medication as necessary;

315.22 (3) administering the medication or treatment to the person;

315.23 (4) documenting the administration of the medication or treatment or the reason for
 315.24 not administering the medication or treatment; and

315.25 (5) reporting to the prescriber or a nurse any concerns about the medication or
 315.26 treatment, including side effects, effectiveness, or a pattern of the person refusing to
 315.27 take the medication or treatment as prescribed. Adverse reactions must be immediately
 315.28 reported to the prescriber or a nurse.

315.29 (b)(1) The license holder must ensure that the following criteria requirements in
 315.30 clauses (2) to (4) have been met before staff that is not a licensed health professional
 315.31 administers administering medication or treatment;

315.32 (+) (2) The license holder must obtain written authorization has been obtained from
 315.33 the person or the person's legal representative to administer medication or treatment
 315.34 orders; and must obtain reauthorization annually as needed. If the person or the person's
 315.35 legal representative refuses to authorize the license holder to administer medication, the

316.1 medication must not be administered. The refusal to authorize medication administration
 316.2 must be reported to the prescriber as expeditiously as possible.

316.3 ~~(2)~~ (3) The staff person ~~has completed~~ responsible for administering the medication
 316.4 or treatment must complete medication administration training according to section
 316.5 245D.09, subdivision 4, ~~paragraph 4a, paragraphs (a) and (c), clause (2); and, as applicable~~
 316.6 to the person, paragraph (d).

316.7 ~~(3) The medication or treatment will be administered under administration~~
 316.8 ~~procedures established for the person in consultation with a licensed health professional.~~
 316.9 ~~written instruction from the person's physician may constitute the medication~~
 316.10 ~~administration procedures. A prescription label or the prescriber's order for the~~
 316.11 ~~prescription is sufficient to constitute written instructions from the prescriber. A licensed~~
 316.12 ~~health professional may delegate medication administration procedures.~~

316.13 (4) For a license holder providing intensive support services, the medication or
 316.14 treatment must be administered according to the license holder's medication administration
 316.15 policy and procedures as required under section 245D.11, subdivision 2, clause (3).

316.16 ~~(b)~~ (c) The license holder must ensure the following information is documented in
 316.17 the person's medication administration record:

316.18 (1) the information on the current prescription label or the prescriber's current written
 316.19 or electronically recorded order or prescription that includes ~~directions for~~ the person's
 316.20 name, description of the medication or treatment to be provided, and the frequency and
 316.21 other information needed to safely and correctly ~~administering~~ administer the medication
 316.22 or treatment to ensure effectiveness;

316.23 (2) information on any ~~discomforts~~, risks; or other side effects that are reasonable to
 316.24 expect, and any contraindications to its use. This information must be readily available
 316.25 to all staff administering the medication;

316.26 (3) the possible consequences if the medication or treatment is not taken or
 316.27 administered as directed;

316.28 (4) instruction ~~from the prescriber~~ on when and to whom to report the following:

316.29 (i) if ~~the~~ a dose of medication or treatment is not administered or treatment is not
 316.30 performed as prescribed, whether by error by the staff or the person or by refusal by
 316.31 the person; and

316.32 (ii) the occurrence of possible adverse reactions to the medication or treatment;

316.33 (5) notation of any occurrence of a dose of medication not being administered or
 316.34 treatment not performed as prescribed, whether by error by the staff or the person or by
 316.35 refusal by the person, or of adverse reactions, and when and to whom the report was
 316.36 made; and

317.1 (6) notation of when a medication or treatment is started, administered, changed, or
317.2 discontinued.

317.3 ~~(e) The license holder must ensure that the information maintained in the medication~~
317.4 ~~administration record is current and is regularly reviewed with the person or the person's~~
317.5 ~~legal representative and the staff administering the medication to identify medication~~
317.6 ~~administration issues or errors. At a minimum, the review must be conducted every three~~
317.7 ~~months or more often if requested by the person or the person's legal representative.~~
317.8 ~~Based on the review, the license holder must develop and implement a plan to correct~~
317.9 ~~medication administration issues or errors. If issues or concerns are identified related to~~
317.10 ~~the medication itself, the license holder must report those as required under subdivision 4.~~

317.11 ~~Subd. 3. **Medication assistance.** The license holder must ensure that the~~
317.12 ~~requirements of subdivision 2, paragraph (a), have been met when staff provides assistance~~
317.13 ~~to enable a person to self-administer medication when the person is capable of directing~~
317.14 ~~the person's own care, or when the person's legal representative is present and able to~~
317.15 ~~direct care for the person.~~

317.16 ~~Subd. 4. **Reviewing and reporting medication and treatment issues.** The~~
317.17 ~~following medication administration issues must be reported to the person or the person's~~
317.18 ~~legal representative and case manager as they occur or following timelines established~~
317.19 ~~in the person's service plan or as requested in writing by the person or the person's legal~~
317.20 ~~representative, or the case manager: (a) When assigned responsibility for medication~~
317.21 ~~administration, the license holder must ensure that the information maintained in~~
317.22 ~~the medication administration record is current and is regularly reviewed to identify~~
317.23 ~~medication administration errors. At a minimum, the review must be conducted every~~
317.24 ~~three months, or more frequently as directed in the coordinated service and support plan~~
317.25 ~~or coordinated service and support plan addendum or as requested by the person or the~~
317.26 ~~person's legal representative. Based on the review, the license holder must develop and~~
317.27 ~~implement a plan to correct patterns of medication administration errors when identified.~~

317.28 ~~(b) If assigned responsibility for medication assistance or medication administration,~~
317.29 ~~the license holder must report the following to the person's legal representative and case~~
317.30 ~~manager as they occur or as otherwise directed in the coordinated service and support plan~~
317.31 ~~or the coordinated service and support plan addendum:~~

317.32 (1) any reports made to the person's physician or prescriber required under
317.33 subdivision 2, paragraph ~~(b)~~ (c), clause (4);

317.34 (2) a person's refusal or failure to take or receive medication or treatment as
317.35 prescribed; or

317.36 (3) concerns about a person's self-administration of medication or treatment.

318.1 Subd. 5. **Injectable medications.** Injectable medications may be administered
 318.2 according to a prescriber's order and written instructions when one of the following
 318.3 conditions has been met:

318.4 (1) a registered nurse or licensed practical nurse will administer the subcutaneous or
 318.5 intramuscular injection;

318.6 (2) a supervising registered nurse with a physician's order has delegated the
 318.7 administration of subcutaneous injectable medication to an unlicensed staff member
 318.8 and has provided the necessary training; or

318.9 (3) there is an agreement signed by the license holder, the prescriber, and the
 318.10 person or the person's legal representative specifying what subcutaneous injections may
 318.11 be given, when, how, and that the prescriber must retain responsibility for the license
 318.12 holder's giving the injections. A copy of the agreement must be placed in the person's
 318.13 service recipient record.

318.14 Only licensed health professionals are allowed to administer psychotropic
 318.15 medications by injection.

318.16 **EFFECTIVE DATE.** This section is effective January 1, 2014.

318.17 Sec. 22. **[245D.051] PSYCHOTROPIC MEDICATION USE AND**
 318.18 **MONITORING.**

318.19 **Subdivision 1. Conditions for psychotropic medication administration.** (a)
 318.20 When a person is prescribed a psychotropic medication and the license holder is assigned
 318.21 responsibility for administration of the medication in the person's coordinated service
 318.22 and support plan or the coordinated service and support plan addendum, the license
 318.23 holder must ensure that the requirements in paragraphs (b) to (d) and section 245D.05,
 318.24 subdivision 2, are met.

318.25 (b) Use of the medication must be included in the person's coordinated service and
 318.26 support plan or in the coordinated service and support plan addendum and based on a
 318.27 prescriber's current written or electronically recorded prescription.

318.28 (c) The license holder must develop, implement, and maintain the following
 318.29 documentation in the person's coordinated service and support plan addendum according
 318.30 to the requirements in sections 245D.07 and 245D.071:

318.31 (1) a description of the target symptoms that the psychotropic medication is to
 318.32 alleviate; and

318.33 (2) documentation methods the license holder will use to monitor and measure
 318.34 changes in the target symptoms that are to be alleviated by the psychotropic medication if
 318.35 required by the prescriber. The license holder must collect and report on medication and

319.1 symptom-related data as instructed by the prescriber. The license holder must provide
 319.2 the monitoring data to the expanded support team for review every three months, or as
 319.3 otherwise requested by the person or the person's legal representative.

319.4 For the purposes of this section, "target symptom" refers to any perceptible
 319.5 diagnostic criteria for a person's diagnosed mental disorder as defined by the Diagnostic
 319.6 and Statistical Manual of Mental Disorders Fourth Edition Text Revision (DSM-IV-TR) or
 319.7 successive editions that has been identified for alleviation.

319.8 (d) If a person is prescribed a psychotropic medication, monitoring the use of the
 319.9 psychotropic medication must be assigned to the license holder in the coordinated service
 319.10 and support plan or the coordinated service and support plan addendum. The assigned
 319.11 license holder must monitor the psychotropic medication as required by this section.

319.12 Subd. 2. **Refusal to authorize psychotropic medication.** If the person or the
 319.13 person's legal representative refuses to authorize the administration of a psychotropic
 319.14 medication as ordered by the prescriber, the license holder must follow the requirement
 319.15 in section 245D.05, subdivision 2, paragraph (b), clause (2). After reporting the refusal
 319.16 to the prescriber, the license holder must follow any directives or orders given by the
 319.17 prescriber. A court order must be obtained to override the refusal. Refusal to authorize
 319.18 administration of a specific psychotropic medication is not grounds for service termination
 319.19 and does not constitute an emergency. A decision to terminate services must be reached in
 319.20 compliance with section 245D.10, subdivision 3.

319.21 **EFFECTIVE DATE.** This section is effective January 1, 2014.

319.22 Sec. 23. Minnesota Statutes 2012, section 245D.06, is amended to read:

319.23 **245D.06 PROTECTION STANDARDS.**

319.24 Subdivision 1. **Incident response and reporting.** (a) The license holder must
 319.25 respond to all incidents under section 245D.02, subdivision 11, that occur while providing
 319.26 services to protect the health and safety of and minimize risk of harm to the person.

319.27 (b) The license holder must maintain information about and report incidents to the
 319.28 person's legal representative or designated emergency contact and case manager within 24
 319.29 hours of an incident occurring while services are being provided, or within 24 hours of
 319.30 discovery or receipt of information that an incident occurred, unless the license holder
 319.31 has reason to know that the incident has already been reported, or as otherwise directed
 319.32 in a person's coordinated service and support plan or coordinated service and support
 319.33 plan addendum. An incident of suspected or alleged maltreatment must be reported as

320.1 required under paragraph (d), and an incident of serious injury or death must be reported
 320.2 as required under paragraph (e).

320.3 (c) When the incident involves more than one person, the license holder must not
 320.4 disclose personally identifiable information about any other person when making the report
 320.5 to each person and case manager unless the license holder has the consent of the person.

320.6 (d) Within 24 hours of reporting maltreatment as required under section 626.556
 320.7 or 626.557, the license holder must inform the case manager of the report unless there is
 320.8 reason to believe that the case manager is involved in the suspected maltreatment. The
 320.9 license holder must disclose the nature of the activity or occurrence reported and the
 320.10 agency that received the report.

320.11 (e) The license holder must report the death or serious injury of the person to the legal
 320.12 representative, if any, and case manager, as required in paragraph (b) and to the Department
 320.13 of Human Services Licensing Division, and the Office of Ombudsman for Mental Health
 320.14 and Developmental Disabilities as required under section 245.94, subdivision 2a, within
 320.15 24 hours of the death, or receipt of information that the death occurred, unless the license
 320.16 holder has reason to know that the death has already been reported.

320.17 (f) When a death or serious injury occurs in a facility certified as an intermediate
 320.18 care facility for persons with developmental disabilities, the death or serious injury must
 320.19 be reported to the Department of Health, Office of Health Facility Complaints, and the
 320.20 Office of Ombudsman for Mental Health and Developmental Disabilities, as required
 320.21 under sections 245.91 and 245.94, subdivision 2a, unless the license holder has reason to
 320.22 know that the death has already been reported.

320.23 (f) (g) The license holder must conduct a an internal review of incident reports of
 320.24 deaths and serious injuries that occurred while services were being provided and that
 320.25 were not reported by the program as alleged or suspected maltreatment, for identification
 320.26 of incident patterns, and implementation of corrective action as necessary to reduce
 320.27 occurrences. The review must include an evaluation of whether related policies and
 320.28 procedures were followed, whether the policies and procedures were adequate, whether
 320.29 there is a need for additional staff training, whether the reported event is similar to past
 320.30 events with the persons or the services involved, and whether there is a need for corrective
 320.31 action by the license holder to protect the health and safety of persons receiving services.
 320.32 Based on the results of this review, the license holder must develop, document, and
 320.33 implement a corrective action plan designed to correct current lapses and prevent future
 320.34 lapses in performance by staff or the license holder, if any.

320.35 (h) The license holder must verbally report the emergency use of manual restraint of
 320.36 a person as required in paragraph (b), within 24 hours of the occurrence. The license holder

321.1 must ensure the written report and internal review of all incident reports of the emergency
 321.2 use of manual restraints are completed according to the requirements in section 245D.061.

321.3 Subd. 2. **Environment and safety.** The license holder must:

321.4 (1) ensure the following when the license holder is the owner, lessor, or tenant
 321.5 of ~~the~~ an unlicensed service site:

321.6 (i) the service site is a safe and hazard-free environment;

321.7 (ii) ~~doors are locked or toxic substances or dangerous items normally accessible are~~
 321.8 inaccessible to persons served by the program ~~are stored in locked cabinets, drawers, or~~
 321.9 ~~containers~~ only to protect the safety of a person receiving services and not as a substitute
 321.10 for staff supervision or interactions with a person who is receiving services. ~~If doors are~~
 321.11 ~~locked or toxic substances or dangerous items normally accessible to persons served by the~~
 321.12 ~~program are stored in locked cabinets, drawers, or containers~~ are made inaccessible, the
 321.13 license holder must ~~justify and document how this determination was made in consultation~~
 321.14 ~~with the person or person's legal representative, and how access will otherwise be provided~~
 321.15 ~~to the person and all other affected persons receiving services; and~~ document an assessment
 321.16 of the physical plant, its environment, and its population identifying the risk factors which
 321.17 require toxic substances or dangerous items to be inaccessible and a statement of specific
 321.18 measures to be taken to minimize the safety risk to persons receiving services;

321.19 (iii) doors are locked from the inside to prevent a person from exiting only when
 321.20 necessary to protect the safety of a person receiving services and not as a substitute for
 321.21 staff supervision or interactions with the person. If doors are locked from the inside, the
 321.22 license holder must document an assessment of the physical plant, the environment and
 321.23 the population served, identifying the risk factors which require the use of locked doors,
 321.24 and a statement of specific measures to be taken to minimize the safety risk to persons
 321.25 receiving services at the service site; and

321.26 ~~(iii)~~ (iv) a staff person is available on site who is trained in basic first aid and, when
 321.27 required in a person's coordinated service and support plan or coordinated service and
 321.28 support plan addendum, cardiopulmonary resuscitation, "CPR," whenever persons are
 321.29 present and staff are required to be at the site to provide direct service. The CPR training
 321.30 must include in-person instruction, hands-on practice, and an observed skills assessment
 321.31 under the direct supervision of a CPR instructor;

321.32 (2) maintain equipment, vehicles, supplies, and materials owned or leased by the
 321.33 license holder in good condition when used to provide services;

321.34 (3) follow procedures to ensure safe transportation, handling, and transfers of the
 321.35 person and any equipment used by the person, when the license holder is responsible for
 321.36 transportation of a person or a person's equipment;

322.1 (4) be prepared for emergencies and follow emergency response procedures to
 322.2 ensure the person's safety in an emergency; and

322.3 (5) follow universal precautions and sanitary practices, including hand washing, for
 322.4 infection prevention and control, and to prevent communicable diseases.

322.5 ~~Subd. 3. **Compliance with fire and safety codes.** When services are provided at a~~
 322.6 ~~service site licensed according to chapter 245A or where the license holder is the owner,~~
 322.7 ~~lessor, or tenant of the service site, the license holder must document compliance with~~
 322.8 ~~applicable building codes, fire and safety codes, health rules, and zoning ordinances, or~~
 322.9 ~~document that an appropriate waiver has been granted.~~

322.10 Subd. 4. **Funds and property.** (a) Whenever the license holder assists a person
 322.11 with the safekeeping of funds or other property according to section 245A.04, subdivision
 322.12 13, the license holder must have obtain written authorization to do so from the person or
 322.13 the person's legal representative and the case manager. Authorization must be obtained
 322.14 within five working days of service initiation and renewed annually thereafter. At the time
 322.15 initial authorization is obtained, the license holder must survey, document, and implement
 322.16 the preferences of the person or the person's legal representative and the case manager
 322.17 for frequency of receiving a statement that itemizes receipts and disbursements of funds
 322.18 or other property. The license holder must document changes to these preferences when
 322.19 they are requested.

322.20 (b) A license holder or staff person may not accept powers-of-attorney from a
 322.21 person receiving services from the license holder for any purpose, ~~and may not accept an~~
 322.22 ~~appointment as guardian or conservator of a person receiving services from the license~~
 322.23 ~~holder. This does not apply to license holders that are Minnesota counties or other~~
 322.24 ~~units of government or to staff persons employed by license holders who were acting~~
 322.25 ~~as power-of-attorney, guardian, or conservator~~ attorney-in-fact for specific individuals
 322.26 prior to ~~April 23, 2012~~ implementation of this chapter. The license holder must maintain
 322.27 documentation of the power-of-attorney, ~~guardianship, or conservatorship~~ in the service
 322.28 recipient record.

322.29 (c) Upon the transfer or death of a person, any funds or other property of the person
 322.30 must be surrendered to the person or the person's legal representative, or given to the
 322.31 executor or administrator of the estate in exchange for an itemized receipt.

322.32 Subd. 5. **Prohibitions.** (a) The license holder is prohibited from using ~~psychotropic~~
 322.33 ~~medication~~ chemical restraints, mechanical restraint practices, manual restraints, time out,
 322.34 or seclusion as a substitute for adequate staffing, for a behavioral or therapeutic program
 322.35 to reduce or eliminate behavior, as punishment, or ~~for staff convenience, or for any reason~~
 322.36 ~~other than as prescribed.~~

323.1 ~~(b) The license holder is prohibited from using restraints or seclusion under any~~
323.2 ~~circumstance, unless the commissioner has approved a variance request from the license~~
323.3 ~~holder that allows for the emergency use of restraints and seclusion according to terms~~
323.4 ~~and conditions approved in the variance. Applicants and license holders who have~~
323.5 ~~reason to believe they may be serving an individual who will need emergency use of~~
323.6 ~~restraints or seclusion may request a variance on the application or reapplication, and~~
323.7 ~~the commissioner shall automatically review the request for a variance as part of the~~
323.8 ~~application or reapplication process. License holders may also request the variance any~~
323.9 ~~time after issuance of a license. In the event a license holder uses restraint or seclusion for~~
323.10 ~~any reason without first obtaining a variance as required, the license holder must report~~
323.11 ~~the unauthorized use of restraint or seclusion to the commissioner within 24 hours of the~~
323.12 ~~occurrence and request the required variance.~~

323.13 (b) For the purposes of this subdivision, "chemical restraint" means the
323.14 administration of a drug or medication to control the person's behavior or restrict the
323.15 person's freedom of movement and is not a standard treatment of dosage for the person's
323.16 medical or psychological condition.

323.17 (c) For the purposes of this subdivision, "mechanical restraint practice" means the
323.18 use of any adaptive equipment or safety device to control the person's behavior or restrict
323.19 the person's freedom of movement and not as ordered by a licensed health professional.
323.20 Mechanical restraint practices include, but are not limited to, the use of bed rails or similar
323.21 devices on a bed to prevent the person from getting out of bed, chairs that prevent a person
323.22 from rising, or placing a person in a wheelchair so close to a wall that the wall prevents
323.23 the person from rising. Wrist bands or devices on clothing that trigger electronic alarms to
323.24 warn staff that a person is leaving a room or area do not, in and of themselves, restrict
323.25 freedom of movement and should not be considered restraints.

323.26 (d) A license holder must not use manual restraints, time out, or seclusion under any
323.27 circumstance, except for emergency use of manual restraints according to the requirements
323.28 in section 245D.061 or the use of controlled procedures with a person with a developmental
323.29 disability as governed by Minnesota Rules, parts 9525.2700 to 9525.2810, or its successor
323.30 provisions. License holders implementing nonemergency use of manual restraint, or any
323.31 other programmatic use of mechanical restraint, time out, or seclusion with persons who
323.32 do not have a developmental disability that is not subject to the requirements of Minnesota
323.33 Rules, parts 9525.2700 to 9525.2810, must submit a variance request to the commissioner
323.34 for continued use of the procedure within three months of implementation of this chapter.

323.35 **EFFECTIVE DATE.** This section is effective January 1, 2014.

324.1 Sec. 24. **[245D.061] EMERGENCY USE OF MANUAL RESTRAINTS.**

324.2 **Subdivision 1. Standards for emergency use of manual restraints.** Except
324.3 for the emergency use of controlled procedures with a person with a developmental
324.4 disability as governed by Minnesota Rules, part 9525.2770, or its successor provisions,
324.5 the license holder must ensure that emergency use of manual restraints complies with the
324.6 requirements of this chapter and the license holder's policy and procedures as required
324.7 under subdivision 10.

324.8 **Subd. 2. Definitions.** (a) The terms used in this section have the meaning given
324.9 them in this subdivision.

324.10 (b) "Manual restraint" means physical intervention intended to hold a person
324.11 immobile or limit a person's voluntary movement by using body contact as the only source
324.12 of physical restraint.

324.13 (c) "Mechanical restraint" means the use of devices, materials, or equipment attached
324.14 or adjacent to the person's body, or the use of practices which restrict freedom of movement
324.15 or normal access to one's body or body parts, or limits a person's voluntary movement
324.16 or holds a person immobile as an intervention precipitated by a person's behavior. The
324.17 term does apply to mechanical restraint used to prevent injury with persons who engage in
324.18 self-injurious behaviors, such as head-banging, gouging, or other actions resulting in tissue
324.19 damage that have caused or could cause medical problems resulting from the self-injury.

324.20 **Subd. 3. Conditions for emergency use of manual restraint.** Emergency use of
324.21 manual restraint must meet the following conditions:

324.22 (1) immediate intervention must be needed to protect the person or others from
324.23 imminent risk of physical harm; and

324.24 (2) the type of manual restraint used must be the least restrictive intervention to
324.25 eliminate the immediate risk of harm and effectively achieve safety. The manual restraint
324.26 must end when the threat of harm ends.

324.27 **Subd. 4. Permitted instructional techniques and therapeutic conduct.** (a) Use of
324.28 physical contact as therapeutic conduct or as an instructional technique as identified in
324.29 paragraphs (b) and (c), is permitted and is not subject to the requirements of this section
324.30 when such use is addressed in a person's coordinated service and support plan addendum
324.31 and the required conditions have been met. For the purposes of this subdivision,
324.32 "therapeutic conduct" has the meaning given in section 626.5572, subdivision 20.

324.33 (b) Physical contact or instructional techniques must use the least restrictive
324.34 alternative possible to meet the needs of the person and may be used:

324.35 (1) to calm or comfort a person by holding that person with no resistance from
324.36 that person;

325.1 (2) to protect a person known to be at risk of injury due to frequent falls as a result of
 325.2 a medical condition; or

325.3 (3) to position a person with physical disabilities in a manner specified in the
 325.4 person's coordinated service and support plan addendum.

325.5 (c) Restraint may be used as therapeutic conduct:

325.6 (1) to allow a licensed health care professional to safely conduct a medical
 325.7 examination or to provide medical treatment ordered by a licensed health care professional
 325.8 to a person necessary to promote healing or recovery from an acute, meaning short-term,
 325.9 medical condition;

325.10 (2) to facilitate the person's completion of a task or response when the person does
 325.11 not resist or the person's resistance is minimal in intensity and duration;

325.12 (3) to briefly block or redirect a person's limbs or body without holding the person
 325.13 or limiting the person's movement to interrupt the person's behavior that may result in
 325.14 injury to self or others; or

325.15 (4) to assist in the safe evacuation of a person in the event of an emergency or to
 325.16 redirect a person who is at imminent risk of harm in a dangerous situation.

325.17 (d) A plan for using restraint as therapeutic conduct must be developed according to
 325.18 the requirements in sections 245D.07 and 245D.071, and must include methods to reduce
 325.19 or eliminate the use of and need for restraint.

325.20 **Subd. 5. Restrictions when implementing emergency use of manual restraint.**

325.21 (a) Emergency use of manual restraint procedures must not:

325.22 (1) be implemented with a child in a manner that constitutes sexual abuse, neglect,
 325.23 physical abuse, or mental injury, as defined in section 626.556, subdivision 2;

325.24 (2) be implemented with an adult in a manner that constitutes abuse or neglect as
 325.25 defined in section 626.5572, subdivisions 2 and 17;

325.26 (3) be implemented in a manner that violates a person's rights and protections
 325.27 identified in section 245D.04;

325.28 (4) restrict a person's normal access to a nutritious diet, drinking water, adequate
 325.29 ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping
 325.30 conditions, or necessary clothing, or to any protection required by state licensing standards
 325.31 and federal regulations governing the program;

325.32 (5) deny the person visitation or ordinary contact with legal counsel, a legal
 325.33 representative, or next of kin;

325.34 (6) be used as a substitute for adequate staffing, for the convenience of staff, as
 325.35 punishment, or as a consequence if the person refuses to participate in the treatment
 325.36 or services provided by the program; or

326.1 (7) use prone restraint. For the purposes of this section, "prone restraint" means use
326.2 of manual restraint that places a person in a face-down position. This does not include
326.3 brief physical holding of a person who, during an emergency use of manual restraint, rolls
326.4 into a prone position, and the person is restored to a standing, sitting, or side-lying position
326.5 as quickly as possible. Applying back or chest pressure while a person is in the prone or
326.6 supine position or face-up is prohibited.

326.7 Subd. 6. **Monitoring emergency use of manual restraint.** The license holder shall
326.8 monitor a person's health and safety during an emergency use of a manual restraint. Staff
326.9 monitoring the procedure must not be the staff implementing the procedure when possible.
326.10 The license holder shall complete a monitoring form, approved by the commissioner, for
326.11 each incident involving the emergency use of a manual restraint.

326.12 Subd. 7. **Reporting emergency use of manual restraint incident.** (a) Within
326.13 three calendar days after an emergency use of a manual restraint, the staff person who
326.14 implemented the emergency use must report in writing to the designated coordinator the
326.15 following information about the emergency use:

326.16 (1) the staff and persons receiving services who were involved in the incident
326.17 leading up to the emergency use of manual restraint;

326.18 (2) a description of the physical and social environment, including who was present
326.19 before and during the incident leading up to the emergency use of manual restraint;

326.20 (3) a description of what less restrictive alternative measures were attempted to
326.21 de-escalate the incident and maintain safety before the manual restraint was implemented
326.22 that identifies when, how, and how long the alternative measures were attempted before
326.23 manual restraint was implemented;

326.24 (4) a description of the mental, physical, and emotional condition of the person who
326.25 was restrained, and other persons involved in the incident leading up to, during, and
326.26 following the manual restraint;

326.27 (5) whether there was any injury to the person who was restrained or other persons
326.28 involved in the incident, including staff, before or as a result of the use of manual
326.29 restraint; and

326.30 (6) whether there was an attempt to debrief with the staff, and, if not contraindicated,
326.31 with the person who was restrained and other persons who were involved in or who
326.32 witnessed the restraint, following the incident and the outcome of the debriefing. If the
326.33 debriefing was not conducted at the time the incident report was made, the report should
326.34 identify whether a debriefing is planned.

327.1 (b) Each single incident of emergency use of manual restraint must be reported
327.2 separately. For the purposes of this subdivision, an incident of emergency use of manual
327.3 restraint is a single incident when the following conditions have been met:

327.4 (1) after implementing the manual restraint, staff attempt to release the person at the
327.5 moment staff believe the person's conduct no longer poses an imminent risk of physical
327.6 harm to self or others and less restrictive strategies can be implemented to maintain safety;

327.7 (2) upon the attempt to release the restraint, the person's behavior immediately
327.8 re-escalates; and

327.9 (3) staff must immediately reimplement the restraint in order to maintain safety.

327.10 Subd. 8. **Internal review of emergency use of manual restraint.** (a) Within five
327.11 working days of the emergency use of manual restraint, the license holder must complete
327.12 an internal review of each report of emergency use of manual restraint. The review must
327.13 include an evaluation of whether:

327.14 (1) the person's service and support strategies developed according to sections
327.15 245D.07 and 245D.071 need to be revised;

327.16 (2) related policies and procedures were followed;

327.17 (3) the policies and procedures were adequate;

327.18 (4) there is a need for additional staff training;

327.19 (5) the reported event is similar to past events with the persons, staff, or the services
327.20 involved; and

327.21 (6) there is a need for corrective action by the license holder to protect the health
327.22 and safety of persons.

327.23 (b) Based on the results of the internal review, the license holder must develop,
327.24 document, and implement a corrective action plan for the program designed to correct
327.25 current lapses and prevent future lapses in performance by individuals or the license
327.26 holder, if any. The corrective action plan, if any, must be implemented within 30 days of
327.27 the internal review being completed.

327.28 Subd. 9. **Expanded support team review.** Within five working days after the
327.29 completion of the internal review required in subdivision 8, the license holder must consult
327.30 with the expanded support team following the emergency use of manual restraint to:

327.31 (1) discuss the incident reported in subdivision 7, to define the antecedent or event
327.32 that gave rise to the behavior resulting in the manual restraint and identify the perceived
327.33 function the behavior served; and

327.34 (2) determine whether the person's coordinated service and support plan addendum
327.35 needs to be revised according to sections 245D.07 and 245D.071 to positively and

328.1 effectively help the person maintain stability and to reduce or eliminate future occurrences
328.2 requiring emergency use of manual restraint.

328.3 Subd. 10. **Emergency use of manual restraints policy and procedures.** The
328.4 license holder must develop, document, and implement a policy and procedures that
328.5 promote service recipient rights and protect health and safety during the emergency use of
328.6 manual restraints. The policy and procedures must comply with the requirements of this
328.7 section and must specify the following:

328.8 (1) a description of the positive support strategies and techniques staff must use to
328.9 attempt to de-escalate a person's behavior before it poses an imminent risk of physical
328.10 harm to self or others;

328.11 (2) a description of the types of manual restraints the license holder allows staff to
328.12 use on an emergency basis, if any. If the license holder will not allow the emergency use
328.13 of manual restraint, the policy and procedure must identify the alternative measures the
328.14 license holder will require staff to use when a person's conduct poses an imminent risk of
328.15 physical harm to self or others and less restrictive strategies would not achieve safety;

328.16 (3) instructions for safe and correct implementation of the allowed manual restraint
328.17 procedures;

328.18 (4) the training that staff must complete and the timelines for completion, before they
328.19 may implement an emergency use of manual restraint. In addition to the training on this
328.20 policy and procedure and the orientation and annual training required in section 245D.09,
328.21 subdivision 4, the training for emergency use of manual restraint must incorporate the
328.22 following subjects:

328.23 (i) alternatives to manual restraint procedures, including techniques to identify
328.24 events and environmental factors that may escalate conduct that poses an imminent risk of
328.25 physical harm to self or others;

328.26 (ii) de-escalation methods, positive support strategies, and how to avoid power
328.27 struggles;

328.28 (iii) simulated experiences of administering and receiving manual restraint
328.29 procedures allowed by the license holder on an emergency basis;

328.30 (iv) how to properly identify thresholds for implementing and ceasing restrictive
328.31 procedures;

328.32 (v) how to recognize, monitor, and respond to the person's physical signs of distress,
328.33 including positional asphyxia;

328.34 (vi) the physiological and psychological impact on the person and the staff when
328.35 restrictive procedures are used;

328.36 (vii) the communicative intent of behaviors; and

- 329.1 (viii) relationship building;
 329.2 (5) the procedures and forms to be used to monitor the emergency use of manual
 329.3 restraints, including what must be monitored and the frequency of monitoring per
 329.4 each incident of emergency use of manual restraint, and the person or position who is
 329.5 responsible for monitoring the use;
 329.6 (6) the instructions, forms, and timelines required for completing and submitting an
 329.7 incident report by the person or persons who implemented the manual restraint; and
 329.8 (7) the procedures and timelines for conducting the internal review and the expanded
 329.9 support team review, and the person or position responsible for completing the reviews and
 329.10 who is responsible for ensuring that corrective action is taken or the person's coordinated
 329.11 service and support plan addendum is revised, when determined necessary.

329.12 **EFFECTIVE DATE.** This section is effective January 1, 2014.

329.13 Sec. 25. Minnesota Statutes 2012, section 245D.07, is amended to read:

329.14 **245D.07 SERVICE NEEDS PLANNING AND DELIVERY.**

329.15 Subdivision 1. **Provision of services.** The license holder must provide services as
 329.16 ~~specified assigned~~ in the coordinated service and support plan ~~and assigned to the license~~
 329.17 ~~holder.~~ The provision of services must comply with the requirements of this chapter and
 329.18 the federal waiver plans.

329.19 **Subd. 1a. Person-centered planning and service delivery.** (a) The license holder
 329.20 must provide services in response to the person's identified needs, interests, preferences,
 329.21 and desired outcomes as specified in the coordinated service and support plan, the
 329.22 coordinated service and support plan addendum, and in compliance with the requirements
 329.23 of this chapter. License holders providing intensive support services must also provide
 329.24 outcome-based services according to the requirements in section 245D.071.

329.25 (b) Services must be provided in a manner that supports the person's preferences,
 329.26 daily needs, and activities and accomplishment of the person's personal goals and service
 329.27 outcomes, consistent with the principles of:

329.28 (1) person-centered service planning and delivery that:

329.29 (i) identifies and supports what is important to the person as well as what is
 329.30 important for the person, including preferences for when, how, and by whom direct
 329.31 support service is provided;

329.32 (ii) uses that information to identify outcomes the person desires; and

329.33 (iii) respects each person's history, dignity, and cultural background;

329.34 (2) self-determination that supports and provides:

330.1 (i) opportunities for the development and exercise of functional and age-appropriate
 330.2 skills, decision making and choice, personal advocacy, and communication; and

330.3 (ii) the affirmation and protection of each person's civil and legal rights;

330.4 (3) providing the most integrated setting and inclusive service delivery that supports,
 330.5 promotes, and allows:

330.6 (i) inclusion and participation in the person's community as desired by the person
 330.7 in a manner that enables the person to interact with nondisabled persons to the fullest
 330.8 extent possible and supports the person in developing and maintaining a role as a valued
 330.9 community member;

330.10 (ii) opportunities for self-sufficiency as well as developing and maintaining social
 330.11 relationships and natural supports; and

330.12 (iii) a balance between risk and opportunity, meaning the least restrictive supports or
 330.13 interventions necessary are provided in the most integrated settings in the most inclusive
 330.14 manner possible to support the person to engage in activities of the person's own choosing
 330.15 that may otherwise present a risk to the person's health, safety, or rights.

330.16 **Subd. 2. Service planning requirements for basic support services.** (a) License
 330.17 holders providing basic support services must meet the requirements of this subdivision.

330.18 (b) Within 15 days of service initiation the license holder must complete a
 330.19 preliminary coordinated service and support plan addendum based on the coordinated
 330.20 service and support plan.

330.21 (c) Within 60 days of service initiation the license holder must review and revise as
 330.22 needed the preliminary coordinated service and support plan addendum to document the
 330.23 services that will be provided including how, when, and by whom services will be provided,
 330.24 and the person responsible for overseeing the delivery and coordination of services.

330.25 (d) The license holder must participate in service planning and support team
 330.26 meetings related to for the person following stated timelines established in the person's
 330.27 coordinated service and support plan or as requested by the support team, the person, or
 330.28 the person's legal representative, the support team or the expanded support team.

330.29 **Subd. 3. Reports.** The license holder must provide written reports regarding the
 330.30 person's progress or status as requested by the person, the person's legal representative, the
 330.31 case manager, or the team.

330.32 **EFFECTIVE DATE.** This section is effective January 1, 2014.

330.33 **Sec. 26. [245D.071] SERVICE PLANNING AND DELIVERY; INTENSIVE**
 330.34 **SUPPORT SERVICES.**

331.1 Subdivision 1. **Requirements for intensive support services.** A license holder
331.2 providing intensive support services identified in section 245D.03, subdivision 1,
331.3 paragraph (c), must comply with the requirements in section 245D.07, subdivisions 1
331.4 and 3, and this section.

331.5 Subd. 2. **Abuse prevention.** Prior to or upon initiating services, the license holder
331.6 must develop, document, and implement an abuse prevention plan according to section
331.7 245A.65, subdivision 2.

331.8 Subd. 3. **Assessment and initial service planning.** (a) Within 15 days of service
331.9 initiation the license holder must complete a preliminary coordinated service and support
331.10 plan addendum based on the coordinated service and support plan.

331.11 (b) Within 45 days of service initiation the license holder must meet with the person,
331.12 the person's legal representative, the case manager, and other members of the support team
331.13 or expanded support team to assess and determine the following based on the person's
331.14 coordinated service and support plan and the requirements in subdivision 4 and section
331.15 245D.07, subdivision 1a:

331.16 (1) the scope of the services to be provided to support the person's daily needs
331.17 and activities;

331.18 (2) the person's desired outcomes and the supports necessary to accomplish the
331.19 person's desired outcomes;

331.20 (3) the person's preferences for how services and supports are provided;

331.21 (4) whether the current service setting is the most integrated setting available and
331.22 appropriate for the person; and

331.23 (5) how services must be coordinated across other providers licensed under this
331.24 chapter serving the same person to ensure continuity of care for the person.

331.25 (c) Within the scope of services, the license holder must, at a minimum, assess
331.26 the following areas:

331.27 (1) the person's ability to self-manage health and medical needs to maintain or
331.28 improve physical, mental, and emotional well-being, including, when applicable, allergies,
331.29 seizures, choking, special dietary needs, chronic medical conditions, self-administration
331.30 of medication or treatment orders, preventative screening, and medical and dental
331.31 appointments;

331.32 (2) the person's ability to self-manage personal safety to avoid injury or accident in
331.33 the service setting, including, when applicable, risk of falling, mobility, regulating water
331.34 temperature, community survival skills, water safety skills, and sensory disabilities; and

331.35 (3) the person's ability to self-manage symptoms or behavior that may otherwise
331.36 result in an incident as defined in section 245D.02, subdivision 11, clauses (4) to

332.1 (7), suspension or termination of services by the license holder, or other symptoms
332.2 or behaviors that may jeopardize the health and safety of the person or others. The
332.3 assessments must produce information about the person that is descriptive of the person's
332.4 overall strengths, functional skills and abilities, and behaviors or symptoms.

332.5 Subd. 4. **Service outcomes and supports.** (a) Within ten working days of the
332.6 45-day meeting, the license holder must develop and document the service outcomes and
332.7 supports based on the assessments completed under subdivision 3 and the requirements
332.8 in section 245D.07, subdivision 1a. The outcomes and supports must be included in the
332.9 coordinated service and support plan addendum.

332.10 (b) The license holder must document the supports and methods to be implemented
332.11 to support the accomplishment of outcomes related to acquiring, retaining, or improving
332.12 skills. The documentation must include:

332.13 (1) the methods or actions that will be used to support the person and to accomplish
332.14 the service outcomes, including information about:

332.15 (i) any changes or modifications to the physical and social environments necessary
332.16 when the service supports are provided;

332.17 (ii) any equipment and materials required; and

332.18 (iii) techniques that are consistent with the person's communication mode and
332.19 learning style;

332.20 (2) the measurable and observable criteria for identifying when the desired outcome
332.21 has been achieved and how data will be collected;

332.22 (3) the projected starting date for implementing the supports and methods and
332.23 the date by which progress towards accomplishing the outcomes will be reviewed and
332.24 evaluated; and

332.25 (4) the names of the staff or position responsible for implementing the supports
332.26 and methods.

332.27 (c) Within 20 working days of the 45-day meeting, the license holder must obtain
332.28 dated signatures from the person or the person's legal representative and case manager
332.29 to document completion and approval of the assessment and coordinated service and
332.30 support plan addendum.

332.31 Subd. 5. **Progress reviews.** (a) The license holder must give the person or the
332.32 person's legal representative and case manager an opportunity to participate in the ongoing
332.33 review and development of the methods used to support the person and accomplish
332.34 outcomes identified in subdivisions 3 and 4. The license holder, in coordination with
332.35 the person's support team or expanded support team, must meet with the person, the
332.36 person's legal representative, and the case manager, and participate in progress review

333.1 meetings following stated timelines established in the person's coordinated service and
 333.2 support plan or coordinated service and support plan addendum or within 30 days of a
 333.3 written request by the person, the person's legal representative, or the case manager,
 333.4 at a minimum of once per year.

333.5 (b) The license holder must summarize the person's progress toward achieving the
 333.6 identified outcomes and make recommendations and identify the rationale for changing,
 333.7 continuing, or discontinuing implementation of supports and methods identified in
 333.8 subdivision 4 in a written report sent to the person or the person's legal representative
 333.9 and case manager five working days prior to the review meeting, unless the person, the
 333.10 person's legal representative, or the case manager request to receive the report at the
 333.11 time of the meeting.

333.12 (c) Within ten working days of the progress review meeting, the license holder
 333.13 must obtain dated signatures from the person or the person's legal representative and
 333.14 the case manager to document approval of any changes to the coordinated service and
 333.15 support plan addendum.

333.16 **EFFECTIVE DATE.** This section is effective January 1, 2014.

333.17 Sec. 27. **[245D.081] PROGRAM COORDINATION, EVALUATION, AND**
 333.18 **OVERSIGHT.**

333.19 Subdivision 1. **Program coordination and evaluation.** (a) The license holder
 333.20 is responsible for:

333.21 (1) coordination of service delivery and evaluation for each person served by the
 333.22 program as identified in subdivision 2; and

333.23 (2) program management and oversight that includes evaluation of the program
 333.24 quality and program improvement for services provided by the license holder as identified
 333.25 in subdivision 3.

333.26 (b) The same person may perform the functions in paragraph (a) if the work and
 333.27 education qualifications are met in subdivisions 2 and 3.

333.28 Subd. 2. **Coordination and evaluation of individual service delivery.** (a) Delivery
 333.29 and evaluation of services provided by the license holder must be coordinated by a
 333.30 designated staff person. The designated coordinator must provide supervision, support,
 333.31 and evaluation of activities that include:

333.32 (1) oversight of the license holder's responsibilities assigned in the person's
 333.33 coordinated service and support plan and the coordinated service and support plan
 333.34 addendum;

334.1 (2) taking the action necessary to facilitate the accomplishment of the outcomes
334.2 according to the requirements in section 245D.07;

334.3 (3) instruction and assistance to direct support staff implementing the coordinated
334.4 service and support plan and the service outcomes, including direct observation of service
334.5 delivery sufficient to assess staff competency; and

334.6 (4) evaluation of the effectiveness of service delivery, methodologies, and progress on
334.7 the person's outcomes based on the measurable and observable criteria for identifying when
334.8 the desired outcome has been achieved according to the requirements in section 245D.07.

334.9 (b) The license holder must ensure that the designated coordinator is competent to
334.10 perform the required duties identified in paragraph (a) through education and training in
334.11 human services and disability-related fields, and work experience in providing direct care
334.12 services and supports to persons with disabilities. The designated coordinator must have
334.13 the skills and ability necessary to develop effective plans and to design and use data
334.14 systems to measure effectiveness of services and supports. The license holder must verify
334.15 and document competence according to the requirements in section 245D.09, subdivision

334.16 3. The designated coordinator must minimally have:

334.17 (1) a baccalaureate degree in a field related to human services, and one year of
334.18 full-time work experience providing direct care services to persons with disabilities or
334.19 persons age 65 and older;

334.20 (2) an associate degree in a field related to human services, and two years of
334.21 full-time work experience providing direct care services to persons with disabilities or
334.22 persons age 65 and older;

334.23 (3) a diploma in a field related to human services from an accredited postsecondary
334.24 institution and three years of full-time work experience providing direct care services to
334.25 persons with disabilities or persons age 65 and older; or

334.26 (4) a minimum of 50 hours of education and training related to human services
334.27 and disabilities; and

334.28 (5) four years of full-time work experience providing direct care services to persons
334.29 with disabilities or persons age 65 and older under the supervision of a staff person who
334.30 meets the qualifications identified in clauses (1) to (3).

334.31 Subd. 3. **Program management and oversight.** (a) The license holder must
334.32 designate a managerial staff person or persons to provide program management and
334.33 oversight of the services provided by the license holder. The designated manager is
334.34 responsible for the following:

334.35 (1) maintaining a current understanding of the licensing requirements sufficient to
334.36 ensure compliance throughout the program as identified in section 245A.04, subdivision

335.1 1, paragraph (e), and when applicable, as identified in section 256B.04, subdivision 21,
 335.2 paragraph (b);

335.3 (2) ensuring the duties of the designated coordinator are fulfilled according to the
 335.4 requirements in subdivision 2;

335.5 (3) ensuring the program implements corrective action identified as necessary
 335.6 by the program following review of incident and emergency reports according to the
 335.7 requirements in section 245D.11, subdivision 2, clause (7). An internal review of
 335.8 incident reports of alleged or suspected maltreatment must be conducted according to the
 335.9 requirements in section 245A.65, subdivision 1, paragraph (b);

335.10 (4) evaluation of satisfaction of persons served by the program, the person's legal
 335.11 representative, if any, and the case manager, with the service delivery and progress
 335.12 towards accomplishing outcomes identified in sections 245D.07 and 245D.071, and
 335.13 ensuring and protecting each person's rights as identified in section 245D.04;

335.14 (5) ensuring staff competency requirements are met according to the requirements in
 335.15 section 245D.09, subdivision 3, and ensuring staff orientation and training is provided
 335.16 according to the requirements in section 245D.09, subdivisions 4, 4a, and 5;

335.17 (6) ensuring corrective action is taken when ordered by the commissioner and that
 335.18 the terms and condition of the license and any variances are met; and

335.19 (7) evaluating the information identified in clauses (1) to (6) to develop, document,
 335.20 and implement ongoing program improvements.

335.21 (b) The designated manager must be competent to perform the duties as required and
 335.22 must minimally meet the education and training requirements identified in subdivision
 335.23 2, paragraph (b), and have a minimum of three years of supervisory level experience in
 335.24 a program providing direct support services to persons with disabilities or persons age
 335.25 65 and older.

335.26 **EFFECTIVE DATE.** This section is effective January 1, 2014.

335.27 Sec. 28. Minnesota Statutes 2012, section 245D.09, is amended to read:

335.28 **245D.09 STAFFING STANDARDS.**

335.29 Subdivision 1. **Staffing requirements.** The license holder must provide the level of
 335.30 direct service support staff sufficient supervision, assistance, and training necessary:

335.31 (1) to ensure the health, safety, and protection of rights of each person; and

335.32 (2) to be able to implement the responsibilities assigned to the license holder in each
 335.33 person's coordinated service and support plan or identified in the coordinated service and
 335.34 support plan addendum, according to the requirements of this chapter.

336.1 Subd. 2. **Supervision of staff having direct contact.** Except for a license holder
 336.2 who is the sole direct ~~service~~ support staff, the license holder must provide adequate
 336.3 supervision of staff providing direct ~~service~~ support to ensure the health, safety, and
 336.4 protection of rights of each person and implementation of the responsibilities assigned to
 336.5 the license holder in each person's ~~service plan~~ coordinated service and support plan or
 336.6 coordinated service and support plan addendum.

336.7 Subd. 3. **Staff qualifications.** (a) The license holder must ensure that staff is
 336.8 providing direct support, or staff who have responsibilities related to supervising or
 336.9 managing the provision of direct support service, are competent as demonstrated through
 336.10 skills and knowledge training, experience, and education to meet the person's needs
 336.11 and additional requirements as written in the coordinated service and support plan or
 336.12 coordinated service and support plan addendum, or when otherwise required by the case
 336.13 manager or the federal waiver plan. The license holder must verify and maintain evidence
 336.14 of staff competency, including documentation of:

336.15 (1) education and experience qualifications relevant to the job responsibilities
 336.16 assigned to the staff and the needs of the general population of persons served by the
 336.17 program, including a valid degree and transcript, or a current license, registration, or
 336.18 certification, when a degree or licensure, registration, or certification is required by this
 336.19 chapter or in the coordinated service and support plan or coordinated service and support
 336.20 plan addendum;

336.21 (2) ~~completion of required~~ demonstrated competency in the orientation and training
 336.22 areas required under this chapter, including and when applicable, completion of continuing
 336.23 education required to maintain professional licensure, registration, or certification
 336.24 requirements. Competency in these areas is determined by the license holder through
 336.25 knowledge testing and observed skill assessment conducted by the trainer or instructor; and

336.26 (3) except for a license holder who is the sole direct ~~service~~ support staff, periodic
 336.27 performance evaluations completed by the license holder of the direct ~~service~~ support staff
 336.28 person's ability to perform the job functions based on direct observation.

336.29 (b) Staff under 18 years of age may not perform overnight duties or administer
 336.30 medication.

336.31 Subd. 4. **Orientation to program requirements.** (a) Except for a license holder
 336.32 who does not supervise any direct ~~service~~ support staff, within ~~90 days of hiring direct~~
 336.33 ~~service staff~~ 60 days of hire, unless stated otherwise, the license holder must provide
 336.34 and ensure completion of 30 hours of orientation for direct support staff that combines
 336.35 supervised on-the-job training with review of and instruction ~~on~~ in the following areas:

336.36 (1) the job description and how to complete specific job functions, including:

337.1 (i) responding to and reporting incidents as required under section 245D.06,
337.2 subdivision 1; and

337.3 (ii) following safety practices established by the license holder and as required in
337.4 section 245D.06, subdivision 2;

337.5 (2) the license holder's current policies and procedures required under this chapter,
337.6 including their location and access, and staff responsibilities related to implementation
337.7 of those policies and procedures;

337.8 (3) data privacy requirements according to sections 13.01 to 13.10 and 13.46, the
337.9 federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), and staff
337.10 responsibilities related to complying with data privacy practices;

337.11 (4) the service recipient rights ~~under section 245D.04~~, and staff responsibilities
337.12 related to ensuring the exercise and protection of those rights according to the requirements
337.13 in section 245D.04;

337.14 (5) sections 245A.65, 245A.66, 626.556, and 626.557, governing maltreatment
337.15 reporting and service planning for children and vulnerable adults, and staff responsibilities
337.16 related to protecting persons from maltreatment and reporting maltreatment. This
337.17 orientation must be provided within 72 hours of first providing direct contact services and
337.18 annually thereafter according to section 245A.65, subdivision 3;

337.19 (6) ~~what constitutes use of restraints, seclusion, and psychotropic medications,~~
337.20 ~~and staff responsibilities related to the prohibitions of their use~~ the principles of
337.21 person-centered service planning and delivery as identified in section 245D.07, subdivision
337.22 1a, and how they apply to direct support service provided by the staff person; and

337.23 (7) other topics as determined necessary in the person's coordinated service and
337.24 support plan by the case manager or other areas identified by the license holder.

337.25 (b) ~~License holders who provide direct service themselves must complete the~~
337.26 ~~orientation required in paragraph (a), clauses (3) to (7).~~

337.27 Subd. 4a. Orientation to individual service recipient needs. (e) (a) Before
337.28 ~~providing having~~ unsupervised direct service to contact with a person served by the
337.29 program, or for whom the staff person has not previously provided direct service support,
337.30 or any time the plans or procedures identified in ~~clauses (1) and (2)~~ paragraphs (b) to
337.31 (f) are revised, the staff person must review and receive instruction on the ~~following~~
337.32 ~~as it relates~~ requirements in paragraphs (b) to (f) as they relate to the staff person's job
337.33 functions for that person.

337.34 (b) Training and competency evaluations must include the following:

338.1 (1) appropriate and safe techniques in personal hygiene and grooming, including
 338.2 hair care, bathing, care of teeth, gums, oral prosthetic devices, and other activities of daily
 338.3 living (ADLs) as defined under section 256B.0659, subdivision 1;

338.4 (2) an understanding of what constitutes a healthy diet according to data from the
 338.5 Centers for Disease Control and Prevention and the skills necessary to prepare that diet;

338.6 (3) skills necessary to provide appropriate support in instrumental activities of daily
 338.7 living (IADLs) as defined under section 256B.0659, subdivision 1; and

338.8 (4) demonstrated competence in providing first aid.

338.9 ~~(1) (c) The staff person must review and receive instruction on the person's~~
 338.10 ~~coordinated service and support plan or coordinated service and support plan addendum as~~
 338.11 ~~it relates to the responsibilities assigned to the license holder, and when applicable, the~~
 338.12 ~~person's individual abuse prevention plan according to section 245A.65, to achieve and~~
 338.13 ~~demonstrate an understanding of the person as a unique individual, and how to implement~~
 338.14 ~~those plans; and.~~

338.15 ~~(2) (d) The staff person must review and receive instruction on medication~~
 338.16 ~~administration procedures established for the person when medication administration is~~
 338.17 ~~assigned to the license holder according to section 245D.05, subdivision 1, paragraph~~
 338.18 ~~(b). Unlicensed staff may administer medications only after successful completion of a~~
 338.19 ~~medication administration training, from a training curriculum developed by a registered~~
 338.20 ~~nurse, clinical nurse specialist in psychiatric and mental health nursing, certified nurse~~
 338.21 ~~practitioner, physician's assistant, or physician incorporating. The training curriculum~~
 338.22 ~~must incorporate an observed skill assessment conducted by the trainer to ensure staff~~
 338.23 ~~demonstrate the ability to safely and correctly follow medication procedures.~~

338.24 Medication administration must be taught by a registered nurse, clinical nurse
 338.25 specialist, certified nurse practitioner, physician's assistant, or physician if, at the time of
 338.26 service initiation or any time thereafter, the person has or develops a health care condition
 338.27 that affects the service options available to the person because the condition requires:

338.28 ~~(i) (1) specialized or intensive medical or nursing supervision; and~~

338.29 ~~(ii) (2) nonmedical service providers to adapt their services to accommodate the~~
 338.30 ~~health and safety needs of the person; and.~~

338.31 ~~(iii) necessary training in order to meet the health service needs of the person as~~
 338.32 ~~determined by the person's physician.~~

338.33 (e) The staff person must review and receive instruction on the safe and correct
 338.34 operation of medical equipment used by the person to sustain life, including but not
 338.35 limited to ventilators, feeding tubes, or endotracheal tubes. The training must be provided
 338.36 by a licensed health care professional or a manufacturer's representative and incorporate

339.1 an observed skill assessment to ensure staff demonstrate the ability to safely and correctly
 339.2 operate the equipment according to the treatment orders and the manufacturer's instructions.

339.3 (f) The staff person must review and receive instruction on what constitutes use of
 339.4 restraints, time out, and seclusion, including chemical restraint, and staff responsibilities
 339.5 related to the prohibitions of their use according to the requirements in section 245D.06,
 339.6 subdivision 5, why such procedures are not effective for reducing or eliminating symptoms
 339.7 or undesired behavior and why they are not safe, and the safe and correct use of manual
 339.8 restraint on an emergency basis according to the requirements in section 245D.061.

339.9 (g) In the event of an emergency service initiation, the license holder must ensure
 339.10 the training required in this subdivision occurs within 72 hours of the direct support staff
 339.11 person first having unsupervised contact with the person receiving services. The license
 339.12 holder must document the reason for the unplanned or emergency service initiation and
 339.13 maintain the documentation in the person's service recipient record.

339.14 (h) License holders who provide direct support services themselves must complete
 339.15 the orientation required in subdivision 4, clauses (3) to (7).

339.16 Subd. 5. **Annual training.** ~~(a)~~ A license holder must provide annual training
 339.17 to direct ~~service support~~ staff on the topics identified in subdivision 4, ~~paragraph (a),~~
 339.18 clauses (3) to ~~(6)~~ (7), and subdivision 4a. A license holder must provide a minimum of 24
 339.19 hours of annual training to direct service staff with fewer than five years of documented
 339.20 experience and 12 hours of annual training to direct service staff with five or more years
 339.21 of documented experience in topics described in subdivisions 4 and 4a, paragraphs (a)
 339.22 to (h). Training on relevant topics received from sources other than the license holder
 339.23 may count toward training requirements.

339.24 ~~(b) A license holder providing behavioral programming, specialist services, personal~~
 339.25 ~~support, 24-hour emergency assistance, night supervision, independent living skills,~~
 339.26 ~~structured day, prevocational, or supported employment services must provide a minimum~~
 339.27 ~~of eight hours of annual training to direct service staff that addresses:~~

339.28 ~~(1) topics related to the general health, safety, and service needs of the population~~
 339.29 ~~served by the license holder; and~~

339.30 ~~(2) other areas identified by the license holder or in the person's current service plan.~~

339.31 ~~Training on relevant topics received from sources other than the license holder~~
 339.32 ~~may count toward training requirements.~~

339.33 ~~(c) When the license holder is the owner, lessor, or tenant of the service site and~~
 339.34 ~~whenever a person receiving services is present at the site, the license holder must have~~
 339.35 ~~a staff person available on site who is trained in basic first aid and, when required in a~~
 339.36 ~~person's service plan, cardiopulmonary resuscitation.~~

340.1 Subd. 5a. **Alternative sources of training.** Orientation or training received by the
340.2 staff person from sources other than the license holder in the same subjects as identified
340.3 in subdivision 4 may count toward the orientation and annual training requirements if
340.4 received in the 12-month period before the staff person's date of hire. The license holder
340.5 must maintain documentation of the training received from other sources and of each staff
340.6 person's competency in the required area according to the requirements in subdivision 3.

340.7 Subd. 6. **Subcontractors and temporary staff.** If the license holder uses a
340.8 subcontractor or temporary staff to perform services licensed under this chapter on the
340.9 license holder's behalf, the license holder must ensure that the subcontractor or temporary
340.10 staff meets and maintains compliance with all requirements under this chapter that apply
340.11 to the services to be provided, including training, orientation, and supervision necessary
340.12 to fulfill their responsibilities. The license holder must ensure that a background study
340.13 has been completed according to the requirements in sections 245C.03, subdivision 1,
340.14 and 245C.04. Subcontractors and temporary staff hired by the license holder must meet
340.15 the Minnesota licensing requirements applicable to the disciplines in which they are
340.16 providing services. The license holder must maintain documentation that the applicable
340.17 requirements have been met.

340.18 Subd. 7. **Volunteers.** The license holder must ensure that volunteers who provide
340.19 direct support services to persons served by the program receive the training, orientation,
340.20 and supervision necessary to fulfill their responsibilities. The license holder must ensure
340.21 that a background study has been completed according to the requirements in sections
340.22 245C.03, subdivision 1, and 245C.04. The license holder must maintain documentation
340.23 that the applicable requirements have been met.

340.24 Subd. 8. **Staff orientation and training plan.** The license holder must develop
340.25 a staff orientation and training plan documenting when and how compliance with
340.26 subdivisions 4, 4a, and 5 will be met.

340.27 **EFFECTIVE DATE.** This section is effective January 1, 2014.

340.28 Sec. 29. **[245D.091] INTERVENTION SERVICES.**

340.29 Subdivision 1. **Licensure requirements.** An individual meeting the staff
340.30 qualification requirements of this section who is an employee of a program licensed
340.31 according to this chapter and providing behavioral support services, specialist services,
340.32 or crisis respite services is not required to hold a separate license under this chapter.
340.33 An individual meeting the staff qualifications of this section who is not providing these
340.34 services as an employee of a program licensed according to this chapter must obtain a
340.35 license according to this chapter.

341.1 Subd. 2. Behavior professional qualifications. A behavior professional, as defined
341.2 in the brain injury and community alternatives for disabled individuals waiver plans or
341.3 successor plans, must have competencies in areas related to:

341.4 (1) ethical considerations;
341.5 (2) functional assessment;
341.6 (3) functional analysis;
341.7 (4) measurement of behavior and interpretation of data;
341.8 (5) selecting intervention outcomes and strategies;
341.9 (6) behavior reduction and elimination strategies that promote least restrictive
341.10 approved alternatives;

341.11 (7) data collection;
341.12 (8) staff and caregiver training;
341.13 (9) support plan monitoring;
341.14 (10) co-occurring mental disorders or neuro-cognitive disorder;
341.15 (11) demonstrated expertise with populations being served; and
341.16 (12) must be a:

341.17 (i) psychologist licensed under sections 148.88 to 148.98, who has stated to the
341.18 Board of Psychology competencies in the above identified areas;

341.19 (ii) clinical social worker licensed as an independent clinical social worker under
341.20 chapter 148D, or a person with a master's degree in social work from an accredited college
341.21 or university, with at least 4,000 hours of post-master's supervised experience in the
341.22 delivery of clinical services in the areas identified in clauses (1) to (11);

341.23 (iii) physician licensed under chapter 147 and certified by the American Board
341.24 of Psychiatry and Neurology or eligible for board certification in psychiatry with
341.25 competencies in the areas identified in clauses (1) to (11);

341.26 (iv) licensed professional clinical counselor licensed under sections 148B.29 to
341.27 148B.39 with at least 4,000 hours of post-master's supervised experience in the delivery
341.28 of clinical services who has demonstrated competencies in the areas identified in clauses
341.29 (1) to (11);

341.30 (v) person with a master's degree from an accredited college or university in one
341.31 of the behavioral sciences or related fields, with at least 4,000 hours of post-master's
341.32 supervised experience in the delivery of clinical services with demonstrated competencies
341.33 in the areas identified in clauses (1) to (11); or

341.34 (vi) registered nurse who is licensed under sections 148.171 to 148.285, and who is
341.35 certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and
341.36 mental health nursing by a national nurse certification organization, or who has a master's

342.1 degree in nursing or one of the behavioral sciences or related fields from an accredited
 342.2 college or university or its equivalent, with at least 4,000 hours of post-master's supervised
 342.3 experience in the delivery of clinical services.

342.4 Subd. 3. **Behavior analyst qualifications.** (a) A behavior analyst, as defined in
 342.5 the brain injury and community alternatives for disabled individuals waiver plans or
 342.6 successor plans, must:

342.7 (1) have obtained a baccalaureate degree, master's degree, or PhD in a social services
 342.8 discipline; or

342.9 (2) meet the qualifications of a mental health practitioner as defined in section
 342.10 245.462, subdivision 17.

342.11 (b) In addition, a behavior analyst must:

342.12 (1) have four years of supervised experience working with individuals who exhibit
 342.13 challenging behaviors as well as co-occurring mental disorders or neuro-cognitive disorder;

342.14 (2) have received ten hours of instruction in functional assessment and functional
 342.15 analysis;

342.16 (3) have received 20 hours of instruction in the understanding of the function of
 342.17 behavior;

342.18 (4) have received ten hours of instruction on design of positive practices behavior
 342.19 support strategies;

342.20 (5) have received 20 hours of instruction on the use of behavior reduction approved
 342.21 strategies used only in combination with behavior positive practices strategies;

342.22 (6) be determined by a behavior professional to have the training and prerequisite
 342.23 skills required to provide positive practice strategies as well as behavior reduction

342.24 approved and permitted intervention to the person who receives behavioral support; and

342.25 (7) be under the direct supervision of a behavior professional.

342.26 Subd. 4. **Behavior specialist qualifications.** (a) A behavior specialist, as defined
 342.27 in the brain injury and community alternatives for disabled individuals waiver plans or
 342.28 successor plans, must meet the following qualifications:

342.29 (1) have an associate's degree in a social services discipline; or

342.30 (2) have two years of supervised experience working with individuals who exhibit
 342.31 challenging behaviors as well as co-occurring mental disorders or neuro-cognitive disorder.

342.32 (b) In addition, a behavior specialist must:

342.33 (1) have received a minimum of four hours of training in functional assessment;

342.34 (2) have received 20 hours of instruction in the understanding of the function of
 342.35 behavior;

343.1 (3) have received ten hours of instruction on design of positive practices behavioral
 343.2 support strategies;

343.3 (4) be determined by a behavior professional to have the training and prerequisite
 343.4 skills required to provide positive practices strategies as well as behavior reduction
 343.5 approved intervention to the person who receives behavioral support; and

343.6 (5) be under the direct supervision of a behavior professional.

343.7 Subd. 5. **Specialist services qualifications.** An individual providing specialist
 343.8 services, as defined in the developmental disabilities waiver plan or successor plan, must
 343.9 have:

343.10 (1) the specific experience and skills required of the specialist to meet the needs of
 343.11 the person identified by the person's service planning team; and

343.12 (2) the qualifications of the specialist identified in the person's coordinated service
 343.13 and support plan.

343.14 **EFFECTIVE DATE.** This section is effective January 1, 2014.

343.15 Sec. 30. **[245D.095] RECORD REQUIREMENTS.**

343.16 Subdivision 1. **Record-keeping systems.** The license holder must ensure that the
 343.17 content and format of service recipient, personnel, and program records are uniform and
 343.18 legible according to the requirements of this chapter.

343.19 Subd. 2. **Admission and discharge register.** The license holder must keep a written
 343.20 or electronic register, listing in chronological order the dates and names of all persons
 343.21 served by the program who have been admitted, discharged, or transferred, including
 343.22 service terminations initiated by the license holder and deaths.

343.23 Subd. 3. **Service recipient record.** (a) The license holder must maintain a record of
 343.24 current services provided to each person on the premises where the services are provided
 343.25 or coordinated. When the services are provided in a licensed facility, the records must
 343.26 be maintained at the facility, otherwise the records must be maintained at the license
 343.27 holder's program office. The license holder must protect service recipient records against
 343.28 loss, tampering, or unauthorized disclosure according to the requirements in sections
 343.29 13.01 to 13.10 and 13.46.

343.30 (b) The license holder must maintain the following information for each person:
 343.31 (1) an admission form signed by the person or the person's legal representative
 343.32 that includes:

343.33 (i) identifying information, including the person's name, date of birth, address,
 343.34 and telephone number; and

344.1 (ii) the name, address, and telephone number of the person's legal representative, if
344.2 any, and a primary emergency contact, the case manager, and family members or others as
344.3 identified by the person or case manager;

344.4 (2) service information, including service initiation information, verification of the
344.5 person's eligibility for services, documentation verifying that services have been provided
344.6 as identified in the coordinated service and support plan or coordinated service and support
344.7 plan addendum according to paragraph (a), and date of admission or readmission;

344.8 (3) health information, including medical history, special dietary needs, and
344.9 allergies, and when the license holder is assigned responsibility for meeting the person's
344.10 health service needs according to section 245D.05:

344.11 (i) current orders for medication, treatments, or medical equipment and a signed
344.12 authorization from the person or the person's legal representative to administer or assist in
344.13 administering the medication or treatments, if applicable;

344.14 (ii) a signed statement authorizing the license holder to act in a medical emergency
344.15 when the person's legal representative, if any, cannot be reached or is delayed in arriving;

344.16 (iii) medication administration procedures;

344.17 (iv) a medication administration record documenting the implementation of the
344.18 medication administration procedures, and the medication administration record reviews,
344.19 including any agreements for administration of injectable medications by the license
344.20 holder according to the requirements in section 245D.05; and

344.21 (v) a medical appointment schedule when the license holder is assigned
344.22 responsibility for assisting with medical appointments;

344.23 (4) the person's current coordinated service and support plan or that portion of the
344.24 plan assigned to the license holder;

344.25 (5) copies of the individual abuse prevention plan and assessments as required under
344.26 section 245D.071, subdivisions 2 and 3;

344.27 (6) a record of other service providers serving the person when the person's
344.28 coordinated service and support plan or coordinated service and support plan addendum
344.29 identifies the need for coordination between the service providers, that includes a contact
344.30 person and telephone numbers, services being provided, and names of staff responsible for
344.31 coordination;

344.32 (7) documentation of orientation to service recipient rights according to section
344.33 245D.04, subdivision 1, and maltreatment reporting policies and procedures according to
344.34 section 245A.65, subdivision 1, paragraph (c);

344.35 (8) copies of authorizations to handle a person's funds, according to section 245D.06,
344.36 subdivision 4, paragraph (a);

- 345.1 (9) documentation of complaints received and grievance resolution;
345.2 (10) incident reports involving the person, required under section 245D.06,
345.3 subdivision 1;
345.4 (11) copies of written reports regarding the person's status when requested according
345.5 to section 245D.07, subdivision 3, progress review reports as required under section
345.6 245D.071, subdivision 5, progress or daily log notes that are recorded by the program,
345.7 and reports received from other agencies involved in providing services or care to the
345.8 person; and
345.9 (12) discharge summary, including service termination notice and related
345.10 documentation, when applicable.
- 345.11 Subd. 4. **Access to service recipient records.** The license holder must ensure that
345.12 the following people have access to the information in subdivision 1 in accordance with
345.13 applicable state and federal laws, regulations, or rules:
- 345.14 (1) the person, the person's legal representative, and anyone properly authorized
345.15 by the person;
345.16 (2) the person's case manager;
345.17 (3) staff providing services to the person unless the information is not relevant to
345.18 carrying out the coordinated service and support plan or coordinated service and support
345.19 plan addendum; and
345.20 (4) the county child or adult foster care licenser, when services are also licensed as
345.21 child or adult foster care.
- 345.22 Subd. 5. **Personnel records.** (a) The license holder must maintain a personnel
345.23 record of each employee to document and verify staff qualifications, orientation, and
345.24 training. The personnel record must include:
- 345.25 (1) the employee's date of hire, completed application, an acknowledgement signed
345.26 by the employee that job duties were reviewed with the employee and the employee
345.27 understands those duties, and documentation that the employee meets the position
345.28 requirements as determined by the license holder;
345.29 (2) documentation of staff qualifications, orientation, training, and performance
345.30 evaluations as required under section 245D.09, subdivisions 3 to 5, including the date
345.31 the training was completed, the number of hours per subject area, and the name of the
345.32 trainer or instructor; and
345.33 (3) a completed background study as required under chapter 245C.
345.34 (b) For employees hired after January 1, 2014, the license holder must maintain
345.35 documentation in the personnel record or elsewhere, sufficient to determine the date of the

346.1 employee's first supervised direct contact with a person served by the program, and the
 346.2 date of first unsupervised direct contact with a person served by the program.

346.3 **EFFECTIVE DATE.** This section is effective January 1, 2014.

346.4 Sec. 31. Minnesota Statutes 2012, section 245D.10, is amended to read:

346.5 **245D.10 POLICIES AND PROCEDURES.**

346.6 Subdivision 1. **Policy and procedure requirements.** The A license holder
 346.7 providing either basic or intensive supports and services must establish, enforce, and
 346.8 maintain policies and procedures as required in this chapter, chapter 245A, and other
 346.9 applicable state and federal laws and regulations governing the provision of home and
 346.10 community-based services licensed according to this chapter.

346.11 Subd. 2. **Grievances.** The license holder must establish policies and procedures
 346.12 that ~~provide~~ promote service recipient rights by providing a simple complaint process for
 346.13 persons served by the program and their authorized representatives to bring a grievance that:

346.14 (1) provides staff assistance with the complaint process when requested, and the
 346.15 addresses and telephone numbers of outside agencies to assist the person;

346.16 (2) allows the person to bring the complaint to the highest level of authority in the
 346.17 program if the grievance cannot be resolved by other staff members, and that provides
 346.18 the name, address, and telephone number of that person;

346.19 (3) requires the license holder to promptly respond to all complaints affecting a
 346.20 person's health and safety. For all other complaints, the license holder must provide an
 346.21 initial response within 14 calendar days of receipt of the complaint. All complaints must
 346.22 be resolved within 30 calendar days of receipt or the license holder must document the
 346.23 reason for the delay and a plan for resolution;

346.24 (4) requires a complaint review that includes an evaluation of whether:

346.25 (i) related policies and procedures were followed and adequate;

346.26 (ii) there is a need for additional staff training;

346.27 (iii) the complaint is similar to past complaints with the persons, staff, or services
 346.28 involved; and

346.29 (iv) there is a need for corrective action by the license holder to protect the health
 346.30 and safety of persons receiving services;

346.31 (5) based on the review in clause (4), requires the license holder to develop,
 346.32 document, and implement a corrective action plan designed to correct current lapses and
 346.33 prevent future lapses in performance by staff or the license holder, if any;

347.1 (6) provides a written summary of the complaint and a notice of the complaint
 347.2 resolution to the person and case manager that:

347.3 (i) identifies the nature of the complaint and the date it was received;

347.4 (ii) includes the results of the complaint review;

347.5 (iii) identifies the complaint resolution, including any corrective action; and

347.6 (7) requires that the complaint summary and resolution notice be maintained in the
 347.7 service recipient record.

347.8 Subd. 3. **Service suspension and service termination.** (a) The license holder must
 347.9 establish policies and procedures for temporary service suspension and service termination
 347.10 that promote continuity of care and service coordination with the person and the case
 347.11 manager and with other licensed caregivers, if any, who also provide support to the person.

347.12 (b) The policy must include the following requirements:

347.13 (1) the license holder must notify the person or the person's legal representative and
 347.14 case manager in writing of the intended termination or temporary service suspension, and
 347.15 the person's right to seek a temporary order staying the termination of service according to
 347.16 the procedures in section 256.045, subdivision 4a, or 6, paragraph (c);

347.17 (2) notice of the proposed termination of services, including those situations
 347.18 that began with a temporary service suspension, must be given at least 60 days before
 347.19 the proposed termination is to become effective when a license holder is providing
 347.20 ~~independent living skills training, structured day, prevocational or supported employment~~
 347.21 ~~services to the person~~ intensive supports and services identified in section 245D.03,
 347.22 subdivision 1, paragraph (c), and 30 days prior to termination for all other services
 347.23 licensed under this chapter;

347.24 (3) the license holder must provide information requested by the person or case
 347.25 manager when services are temporarily suspended or upon notice of termination;

347.26 (4) prior to giving notice of service termination or temporary service suspension,
 347.27 the license holder must document actions taken to minimize or eliminate the need for
 347.28 service suspension or termination;

347.29 (5) during the temporary service suspension or service termination notice period,
 347.30 the license holder will work with the appropriate county agency to develop reasonable
 347.31 alternatives to protect the person and others;

347.32 (6) the license holder must maintain information about the service suspension or
 347.33 termination, including the written termination notice, in the service recipient record; and

347.34 (7) the license holder must restrict temporary service suspension to situations in
 347.35 which the person's ~~behavior causes immediate and serious danger to the health and safety~~

348.1 ~~of the person or others~~ conduct poses an imminent risk of physical harm to self or others
 348.2 and less restrictive or positive support strategies would not achieve safety.

348.3 Subd. 4. **Availability of current written policies and procedures.** (a) The license
 348.4 holder must review and update, as needed, the written policies and procedures required
 348.5 under this chapter.

348.6 (b)(1) The license holder must inform the person and case manager of the policies
 348.7 and procedures affecting a person's rights under section 245D.04, and provide copies of
 348.8 those policies and procedures, within five working days of service initiation.

348.9 (2) If a license holder only provides basic services and supports, this includes the:

348.10 (i) grievance policy and procedure required under subdivision 2; and

348.11 (ii) service suspension and termination policy and procedure required under
 348.12 subdivision 3.

348.13 (3) For all other license holders this includes the:

348.14 (i) policies and procedures in clause (2);

348.15 (ii) emergency use of manual restraints policy and procedure required under
 348.16 subdivision 3a; and

348.17 (iii) data privacy requirements under section 245D.11, subdivision 3.

348.18 (c) The license holder must provide a written notice to all persons or their legal
 348.19 representatives and case managers at least 30 days before implementing any ~~revised~~
 348.20 ~~policies and procedures~~ procedural revisions to policies affecting a person's service-related
 348.21 or protection-related rights under section 245D.04 and maltreatment reporting policies and
 348.22 procedures. The notice must explain the revision that was made and include a copy of the
 348.23 revised policy and procedure. The license holder must document the ~~reason~~ reasonable
 348.24 cause for not providing the notice at least 30 days before implementing the revisions.

348.25 (d) Before implementing revisions to required policies and procedures, the license
 348.26 holder must inform all employees of the revisions and provide training on implementation
 348.27 of the revised policies and procedures.

348.28 (e) The license holder must annually notify all persons, or their legal representatives,
 348.29 and case managers of any procedural revisions to policies required under this chapter,
 348.30 other than those in paragraph (c). Upon request, the license holder must provide the
 348.31 person, or the person's legal representative, and case manager with copies of the revised
 348.32 policies and procedures.

348.33 **EFFECTIVE DATE.** This section is effective January 1, 2014.

348.34 Sec. 32. **[245D.11] POLICIES AND PROCEDURES; INTENSIVE SUPPORT**
 348.35 **SERVICES.**

349.1 Subdivision 1. **Policy and procedure requirements.** A license holder providing
349.2 intensive support services as identified in section 245D.03, subdivision 1, paragraph (c),
349.3 must establish, enforce, and maintain policies and procedures as required in this section.

349.4 Subd. 2. **Health and safety.** The license holder must establish policies and
349.5 procedures that promote health and safety by ensuring:

349.6 (1) use of universal precautions and sanitary practices in compliance with section
349.7 245D.06, subdivision 2, clause (5);

349.8 (2) if the license holder operates a residential program, health service coordination
349.9 and care according to the requirements in section 245D.05, subdivision 1;

349.10 (3) safe medication assistance and administration according to the requirements
349.11 in sections 245D.05, subdivisions 1a, 2, and 5, and 245D.051, that are established in
349.12 consultation with a registered nurse, nurse practitioner, physician's assistant, or medical
349.13 doctor and require completion of medication administration training according to the
349.14 requirements in section 245D.09, subdivision 4a, paragraph (c). Medication assistance
349.15 and administration includes, but is not limited to:

349.16 (i) providing medication-related services for a person;

349.17 (ii) medication setup;

349.18 (iii) medication administration;

349.19 (iv) medication storage and security;

349.20 (v) medication documentation and charting;

349.21 (vi) verification and monitoring of effectiveness of systems to ensure safe medication
349.22 handling and administration;

349.23 (vii) coordination of medication refills;

349.24 (viii) handling changes to prescriptions and implementation of those changes;

349.25 (ix) communicating with the pharmacy; and

349.26 (x) coordination and communication with prescriber;

349.27 (4) safe transportation, when the license holder is responsible for transportation of
349.28 persons, with provisions for handling emergency situations according to the requirements
349.29 in section 245D.06, subdivision 2, clauses (2) to (4);

349.30 (5) a plan for ensuring the safety of persons served by the program in emergencies as
349.31 defined in section 245D.02, subdivision 8, and procedures for staff to report emergencies
349.32 to the license holder. A license holder with a community residential setting or a day service
349.33 facility license must ensure the policy and procedures comply with the requirements in
349.34 section 245D.22, subdivision 4;

350.1 (6) a plan for responding to all incidents as defined in section 245D.02, subdivision
350.2 11; and reporting all incidents required to be reported according to section 245D.06,
350.3 subdivision 1. The plan must:

350.4 (i) provide the contact information of a source of emergency medical care and
350.5 transportation; and

350.6 (ii) require staff to first call 911 when the staff believes a medical emergency may be
350.7 life threatening, or to call the mental health crisis intervention team when the person is
350.8 experiencing a mental health crisis; and

350.9 (7) a procedure for the review of incidents and emergencies to identify trends or
350.10 patterns, and corrective action if needed. The license holder must establish and maintain
350.11 a record-keeping system for the incident and emergency reports. Each incident and
350.12 emergency report file must contain a written summary of the incident. The license holder
350.13 must conduct a review of incident reports for identification of incident patterns, and
350.14 implementation of corrective action as necessary to reduce occurrences. Each incident
350.15 report must include:

350.16 (i) the name of the person or persons involved in the incident. It is not necessary
350.17 to identify all persons affected by or involved in an emergency unless the emergency
350.18 resulted in an incident;

350.19 (ii) the date, time, and location of the incident or emergency;

350.20 (iii) a description of the incident or emergency;

350.21 (iv) a description of the response to the incident or emergency and whether a person's
350.22 coordinated service and support plan addendum or program policies and procedures were
350.23 implemented as applicable;

350.24 (v) the name of the staff person or persons who responded to the incident or
350.25 emergency; and

350.26 (vi) the determination of whether corrective action is necessary based on the results
350.27 of the review.

350.28 Subd. 3. **Data privacy.** The license holder must establish policies and procedures that
350.29 promote service recipient rights by ensuring data privacy according to the requirements in:

350.30 (1) the Minnesota Government Data Practices Act, section 13.46, and all other
350.31 applicable Minnesota laws and rules in handling all data related to the services provided;
350.32 and

350.33 (2) the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to the
350.34 extent that the license holder performs a function or activity involving the use of protected
350.35 health information as defined under Code of Federal Regulations, title 45, section 164.501,
350.36 including, but not limited to, providing health care services; health care claims processing

351.1 or administration; data analysis, processing, or administration; utilization review; quality
 351.2 assurance; billing; benefit management; practice management; repricing; or as otherwise
 351.3 provided by Code of Federal Regulations, title 45, section 160.103. The license holder
 351.4 must comply with the Health Insurance Portability and Accountability Act of 1996 and
 351.5 its implementing regulations, Code of Federal Regulations, title 45, parts 160 to 164,
 351.6 and all applicable requirements.

351.7 Subd. 4. **Admission criteria.** The license holder must establish policies and
 351.8 procedures that promote continuity of care by ensuring that admission or service initiation
 351.9 criteria:

351.10 (1) is consistent with the license holder's registration information identified in the
 351.11 requirements in section 245D.031, subdivision 2, and with the service-related rights
 351.12 identified in section 245D.04, subdivisions 2, clauses (4) to (7), and 3, clause (8);

351.13 (2) identifies the criteria to be applied in determining whether the license holder
 351.14 can develop services to meet the needs specified in the person's coordinated service and
 351.15 support plan;

351.16 (3) requires a license holder providing services in a health care facility to comply
 351.17 with the requirements in section 243.166, subdivision 4b, to provide notification to
 351.18 residents when a registered predatory offender is admitted into the program or to a
 351.19 potential admission when the facility was already serving a registered predatory offender.
 351.20 For purposes of this clause, "health care facility" means a facility licensed by the
 351.21 commissioner as a residential facility under chapter 245A to provide adult foster care or
 351.22 residential services to persons with disabilities; and

351.23 (4) requires that when a person or the person's legal representative requests services
 351.24 from the license holder, a refusal to admit the person must be based on an evaluation of
 351.25 the person's assessed needs and the license holder's lack of capacity to meet the needs of
 351.26 the person. The license holder must not refuse to admit a person based solely on the
 351.27 type of residential services the person is receiving, or solely on the person's severity of
 351.28 disability, orthopedic or neurological handicaps, sight or hearing impairments, lack of
 351.29 communication skills, physical disabilities, toilet habits, behavioral disorders, or past
 351.30 failure to make progress. Documentation of the basis for refusal must be provided to the
 351.31 person or the person's legal representative and case manager upon request.

351.32 **EFFECTIVE DATE.** This section is effective January 1, 2014.

351.33 Sec. 33. **[245D.21] FACILITY LICENSURE REQUIREMENTS AND**
 351.34 **APPLICATION PROCESS.**

352.1 Subdivision 1. **Community residential settings and day service facilities.** For
352.2 purposes of this section, "facility" means both a community residential setting and day
352.3 service facility and the physical plant.

352.4 Subd. 2. **Inspections and code compliance.** (a) Physical plants must comply with
352.5 applicable state and local fire, health, building, and zoning codes.

352.6 (b)(1) The facility must be inspected by a fire marshal or their delegate within
352.7 12 months before initial licensure to verify that it meets the applicable occupancy
352.8 requirements as defined in the State Fire Code and that the facility complies with the fire
352.9 safety standards for that occupancy code contained in the State Fire Code.

352.10 (2) The fire marshal inspection of a community residential setting must verify the
352.11 residence is a dwelling unit within a residential occupancy as defined in section 9.117 of
352.12 the State Fire Code. A home safety checklist, approved by the commissioner, must be
352.13 completed for a community residential setting by the license holder and the commissioner
352.14 before the satellite license is reissued.

352.15 (3) The facility shall be inspected according to the facility capacity specified on the
352.16 initial application form.

352.17 (4) If the commissioner has reasonable cause to believe that a potentially hazardous
352.18 condition may be present or the licensed capacity is increased, the commissioner shall
352.19 request a subsequent inspection and written report by a fire marshal to verify the absence
352.20 of hazard.

352.21 (5) Any condition cited by a fire marshal, building official, or health authority as
352.22 hazardous or creating an immediate danger of fire or threat to health and safety must be
352.23 corrected before a license is issued by the department, and for community residential
352.24 settings, before a license is reissued.

352.25 (c) The facility must maintain in a permanent file the reports of health, fire, and
352.26 other safety inspections.

352.27 (d) The facility's plumbing, ventilation, heating, cooling, lighting, and other
352.28 fixtures and equipment, including elevators or food service, if provided, must conform to
352.29 applicable health, sanitation, and safety codes and regulations.

352.30 **EFFECTIVE DATE.** This section is effective January 1, 2014.

352.31 Sec. 34. **[245D.22] FACILITY SANITATION AND HEALTH.**

352.32 Subdivision 1. **General maintenance.** The license holder must maintain the interior
352.33 and exterior of buildings, structures, or enclosures used by the facility, including walls,
352.34 floors, ceilings, registers, fixtures, equipment, and furnishings in good repair and in a
352.35 sanitary and safe condition. The facility must be clean and free from accumulations of

353.1 dirt, grease, garbage, peeling paint, mold, vermin, and insects. The license holder must
353.2 correct building and equipment deterioration, safety hazards, and unsanitary conditions.

353.3 Subd. 2. **Hazards and toxic substances.** The license holder must ensure that
353.4 service sites owned or leased by the license holder are free from hazards that would
353.5 threaten the health or safety of a person receiving services by ensuring the requirements
353.6 in paragraphs (a) to (g) are met.

353.7 (a) Chemicals, detergents, and other hazardous or toxic substances must not be
353.8 stored with food products or in any way that poses a hazard to persons receiving services.

353.9 (b) The license holder must install handrails and nonslip surfaces on interior and
353.10 exterior runways, stairways, and ramps according to the applicable building code.

353.11 (c) If there are elevators in the facility, the license holder must have elevators
353.12 inspected each year. The date of the inspection, any repairs needed, and the date the
353.13 necessary repairs were made must be documented.

353.14 (d) The license holder must keep stairways, ramps, and corridors free of obstructions.

353.15 (e) Outside property must be free from debris and safety hazards. Exterior stairs and
353.16 walkways must be kept free of ice and snow.

353.17 (f) Heating, ventilation, air conditioning units, and other hot surfaces and moving
353.18 parts of machinery must be shielded or enclosed.

353.19 (g) Use of dangerous items or equipment by persons served by the program must be
353.20 allowed in accordance with the person's coordinated service and support plan addendum
353.21 or the program abuse prevention plan, if not addressed in the coordinated service and
353.22 support plan addendum.

353.23 Subd. 3. **Storage and disposal of medication.** Schedule II controlled substances in
353.24 the facility that are named in section 152.02, subdivision 3, must be stored in a locked
353.25 storage area permitting access only by persons and staff authorized to administer the
353.26 medication. This must be incorporated into the license holder's medication administration
353.27 policy and procedures required under section 245D.11, subdivision 2, clause (3).
353.28 Medications must be disposed of according to the Environmental Protection Agency
353.29 recommendations.

353.30 Subd. 4. **First aid must be available on site.** (a) A staff person trained in first
353.31 aid must be available on site and, when required in a person's coordinated service and
353.32 support plan or coordinated service and support plan addendum, be able to provide
353.33 cardiopulmonary resuscitation, whenever persons are present and staff are required to be
353.34 at the site to provide direct service. The CPR training must include in-person instruction,
353.35 hands-on practice, and an observed skills assessment under the direct supervision of a
353.36 CPR instructor.

354.1 (b) A facility must have first aid kits readily available for use by, and that meet
354.2 the needs of, persons receiving services and staff. At a minimum, the first aid kit must
354.3 be equipped with accessible first aid supplies including bandages, sterile compresses,
354.4 scissors, an ice bag or cold pack, an oral or surface thermometer, mild liquid soap,
354.5 adhesive tape, and first aid manual.

354.6 Subd. 5. **Emergencies.** (a) The license holder must have a written plan for
354.7 responding to emergencies as defined in section 245D.02, subdivision 8, to ensure the
354.8 safety of persons served in the facility. The plan must include:

354.9 (1) procedures for emergency evacuation and emergency sheltering, including:

354.10 (i) how to report a fire or other emergency;

354.11 (ii) procedures to notify, relocate, and evacuate occupants, including use of adaptive
354.12 procedures or equipment to assist with the safe evacuation of persons with physical or
354.13 sensory disabilities; and

354.14 (iii) instructions on closing off the fire area, using fire extinguishers, and activating
354.15 and responding to alarm systems;

354.16 (2) a floor plan that identifies:

354.17 (i) the location of fire extinguishers;

354.18 (ii) the location of audible or visual alarm systems, including but not limited to
354.19 manual fire alarm boxes, smoke detectors, fire alarm enunciators and controls, and
354.20 sprinkler systems;

354.21 (iii) the location of exits, primary and secondary evacuation routes, and accessible
354.22 egress routes, if any; and

354.23 (iv) the location of emergency shelter within the facility;

354.24 (3) a site plan that identifies:

354.25 (i) designated assembly points outside the facility;

354.26 (ii) the locations of fire hydrants; and

354.27 (iii) the routes of fire department access;

354.28 (4) the responsibilities each staff person must assume in case of emergency;

354.29 (5) procedures for conducting quarterly drills each year and recording the date of
354.30 each drill in the file of emergency plans;

354.31 (6) procedures for relocation or service suspension when services are interrupted
354.32 for more than 24 hours;

354.33 (7) for a community residential setting with three or more dwelling units, a floor
354.34 plan that identifies the location of enclosed exit stairs; and

354.35 (8) an emergency escape plan for each resident.

354.36 (b) The license holder must:

- 355.1 (1) maintain a log of quarterly fire drills on file in the facility;
355.2 (2) provide an emergency response plan that is readily available to staff and persons
355.3 receiving services;
355.4 (3) inform each person of a designated area within the facility where the person
355.5 should go for emergency shelter during severe weather and the designated assembly points
355.6 outside the facility; and
355.7 (4) maintain emergency contact information for persons served at the facility that
355.8 can be readily accessed in an emergency.

355.9 Subd. 6. **Emergency equipment.** The facility must have a flashlight and a portable
355.10 radio or television set that do not require electricity and can be used if a power failure
355.11 occurs.

355.12 Subd. 7. **Telephone and posted numbers.** A facility must have a non-coin operated
355.13 telephone that is readily accessible. A list of emergency numbers must be posted in a
355.14 prominent location. When an area has a 911 number or a mental health crisis intervention
355.15 team number, both numbers must be posted and the emergency number listed must be
355.16 911. In areas of the state without a 911 number, the numbers listed must be those of the
355.17 local fire department, police department, emergency transportation, and poison control
355.18 center. The names and telephone numbers of each person's representative, physician, and
355.19 dentist must be readily available.

355.20 **EFFECTIVE DATE.** This section is effective January 1, 2014.

355.21 Sec. 35. **[245D.23] COMMUNITY RESIDENTIAL SETTINGS; SATELLITE**
355.22 **LICENSURE REQUIREMENTS AND APPLICATION PROCESS.**

355.23 Subdivision 1. **Separate satellite license required for separate sites.** (a) A license
355.24 holder providing residential support services must obtain a separate satellite license for
355.25 each community residential setting located at separate addresses when the community
355.26 residential settings are to be operated by the same license holder. For purposes of this
355.27 chapter, a community residential setting is a satellite of the home and community-based
355.28 services license.

355.29 (b) Community residential settings are permitted single-family use homes. After a
355.30 license has been issued, the commissioner shall notify the local municipality where the
355.31 residence is located of the approved license.

355.32 Subd. 2. **Notification to local agency.** The license holder must notify the local
355.33 agency within 24 hours of the onset of changes in a residence resulting from construction,
355.34 remodeling, or damages requiring repairs that require a building permit or may affect a
355.35 licensing requirement in this chapter.

356.1 Subd. 3. **Alternate overnight supervision.** A license holder granted an alternate
356.2 overnight supervision technology adult foster care license according to section 245A.11,
356.3 subdivision 7a, that converts to a community residential setting satellite license according
356.4 to this chapter, must retain that designation.

356.5 **EFFECTIVE DATE.** This section is effective January 1, 2014.

356.6 Sec. 36. **[245D.24] COMMUNITY RESIDENTIAL SETTINGS; PHYSICAL**
356.7 **PLANT AND ENVIRONMENT.**

356.8 Subdivision 1. **Occupancy.** The residence must meet the definition of a dwelling
356.9 unit in a residential occupancy.

356.10 Subd. 2. **Common area requirements.** The living area must be provided with an
356.11 adequate number of furnishings for the usual functions of daily living and social activities.
356.12 The dining area must be furnished to accommodate meals shared by all persons living in
356.13 the residence. These furnishings must be in good repair and functional to meet the daily
356.14 needs of the persons living in the residence.

356.15 Subd. 3. **Bedrooms.** (a) People receiving services must mutually consent, in
356.16 writing, to sharing a bedroom with one another. No more than two people receiving
356.17 services may share one bedroom.

356.18 (b) A single occupancy bedroom must have at least 80 square feet of floor space with
356.19 a 7-1/2 foot ceiling. A double occupancy room must have at least 120 square feet of floor
356.20 space with a 7-1/2 foot ceiling. Bedrooms must be separated from halls, corridors, and
356.21 other habitable rooms by floor to ceiling walls containing no openings except doorways
356.22 and must not serve as a corridor to another room used in daily living.

356.23 (c) A person's personal possessions and items for the person's own use are the only
356.24 items permitted to be stored in a person's bedroom.

356.25 (d) Unless otherwise documented through assessment as a safety concern for the
356.26 person, each person must be provided with the following furnishings:

356.27 (1) a separate bed of proper size and height for the convenience and comfort of the
356.28 person, with a clean mattress in good repair;

356.29 (2) clean bedding appropriate for the season for each person;

356.30 (3) an individual cabinet, or dresser, shelves, and a closet, for storage of personal
356.31 possessions and clothing; and

356.32 (4) a mirror for grooming.

356.33 (e) When possible, a person must be allowed to have items of furniture that the
356.34 person personally owns in the bedroom, unless doing so would interfere with safety
356.35 precautions, violate a building or fire code, or interfere with another person's use of the

357.1 bedroom. A person may choose not to have a cabinet, dresser, shelves, or a mirror in the
 357.2 bedroom, as otherwise required under paragraph (d), clause (3) or (4). A person may
 357.3 choose to use a mattress other than an innerspring mattress and may choose not to have
 357.4 the mattress on a mattress frame or support. If a person chooses not to have a piece of
 357.5 required furniture, the license holder must document this choice and is not required to
 357.6 provide the item. If a person chooses to use a mattress other than an innerspring mattress
 357.7 or chooses not to have a mattress frame or support, the license holder must document this
 357.8 choice and allow the alternative desired by the person.

357.9 (f) A person must be allowed to bring personal possessions into the bedroom
 357.10 and other designated storage space, if such space is available, in the residence. The
 357.11 person must be allowed to accumulate possessions to the extent the residence is able to
 357.12 accommodate them, unless doing so is contraindicated for the person's physical or mental
 357.13 health, would interfere with safety precautions or another person's use of the bedroom, or
 357.14 would violate a building or fire code. The license holder must allow for locked storage
 357.15 of personal items. Any restriction on the possession or locked storage of personal items,
 357.16 including requiring a person to use a lock provided by the license holder, must comply
 357.17 with section 245D.04, subdivision 3, paragraph (c), and allow the person to be present if
 357.18 and when the license holder opens the lock.

357.19 **EFFECTIVE DATE.** This section is effective January 1, 2014.

357.20 Sec. 37. **[245D.25] COMMUNITY RESIDENTIAL SETTINGS; FOOD AND**
 357.21 **WATER.**

357.22 Subdivision 1. **Water.** Potable water from privately owned wells must be tested
 357.23 annually by a Department of Health-certified laboratory for coliform bacteria and nitrate
 357.24 nitrogens to verify safety. The health authority may require retesting and corrective
 357.25 measures if results exceed state water standards in Minnesota Rules, chapter 4720, or in
 357.26 the event of flooding or an incident which may put the well at risk of contamination. To
 357.27 prevent scalding, the water temperature of faucets must not exceed 120 degrees Fahrenheit.

357.28 Subd. 2. **Food.** Food served must meet any special dietary needs of a person as
 357.29 prescribed by the person's physician or dietitian. Three nutritionally balanced meals a day
 357.30 must be served or made available to persons, and nutritious snacks must be available
 357.31 between meals.

357.32 Subd. 3. **Food safety.** Food must be obtained, handled, and properly stored to
 357.33 prevent contamination, spoilage, or a threat to the health of a person.

357.34 **EFFECTIVE DATE.** This section is effective January 1, 2014.

358.1 Sec. 38. **[245D.26] COMMUNITY RESIDENTIAL SETTINGS; SANITATION**
358.2 **AND HEALTH.**

358.3 **Subdivision 1. Goods provided by the license holder.** Individual clean bed linens
358.4 appropriate for the season and the person's comfort, including towels and wash cloths,
358.5 must be available for each person. Usual or customary goods for the operation of a
358.6 residence which are communally used by all persons receiving services living in the
358.7 residence must be provided by the license holder, including household items for meal
358.8 preparation, cleaning supplies to maintain the cleanliness of the residence, window
358.9 coverings on windows for privacy, toilet paper, and hand soap.

358.10 **Subd. 2. Personal items.** Personal health and hygiene items must be stored in a
358.11 safe and sanitary manner.

358.12 **Subd. 3. Pets and service animals.** Pets and service animals housed within
358.13 the residence must be immunized and maintained in good health as required by local
358.14 ordinances and state law. The license holder must ensure that the person and the person's
358.15 representative are notified before admission of the presence of pets in the residence.

358.16 **Subd. 4. Smoking in the residence.** License holders must comply with the
358.17 requirements of the Minnesota Clean Indoor Air Act, sections 144.411 to 144.417, when
358.18 smoking is permitted in the residence.

358.19 **Subd. 5. Weapons.** Weapons and ammunition must be stored separately in locked
358.20 areas that are inaccessible to a person receiving services. For purposes of this subdivision,
358.21 "weapons" means firearms and other instruments or devices designed for and capable of
358.22 producing bodily harm.

358.23 **EFFECTIVE DATE.** This section is effective January 1, 2014.

358.24 Sec. 39. **[245D.27] DAY SERVICES FACILITIES; SATELLITE LICENSURE**
358.25 **REQUIREMENTS AND APPLICATION PROCESS.**

358.26 **Except for day service facilities on the same or adjoining lot, the license holder**
358.27 **providing day services must apply for a separate license for each facility-based service**
358.28 **site when the license holder is the owner, lessor, or tenant of the service site at which**
358.29 **persons receive day services and the license holder's employees who provide day services**
358.30 **are present for a cumulative total of more than 30 days within any 12-month period. For**
358.31 **purposes of this chapter, a day services facility license is a satellite license of the day**
358.32 **services program. A day services program may operate multiple licensed day service**
358.33 **facilities in one or more counties in the state. For the purposes of this section, "adjoining**
358.34 **lot" means day services facilities that are next door to or across the street from one another.**

359.1 **EFFECTIVE DATE.** This section is effective January 1, 2014.

359.2 Sec. 40. **[245D.28] DAY SERVICES FACILITIES; PHYSICAL PLANT AND**
359.3 **SPACE REQUIREMENTS.**

359.4 Subdivision 1. **Facility capacity and useable space requirements.** (a) The facility
359.5 capacity of each day service facility must be determined by the amount of primary space
359.6 available, the scheduling of activities at other service sites, and the space requirements of
359.7 all persons receiving services at the facility, not just the licensed services. The facility
359.8 capacity must specify the maximum number of persons that may receive services on
359.9 site at any one time.

359.10 (b) When a facility is located in a multifunctional organization, the facility may
359.11 share common space with the multifunctional organization if the required available
359.12 primary space for use by persons receiving day services is maintained while the facility is
359.13 operating. The license holder must comply at all times with all applicable fire and safety
359.14 codes under section 245A.04, subdivision 2a, and adequate supervision requirements
359.15 under section 245D.31 for all persons receiving day services.

359.16 (c) A day services facility must have a minimum of 40 square feet of primary space
359.17 available for each person receiving services who is present at the site at any one time.

359.18 Primary space does not include:

359.19 (1) common areas, such as hallways, stairways, closets, utility areas, bathrooms,
359.20 and kitchens;

359.21 (2) floor areas beneath stationary equipment; or

359.22 (3) any space occupied by persons associated with the multifunctional organization
359.23 while persons receiving day services are using common space.

359.24 Subd. 2. **Individual personal articles.** Each person must be provided space in a
359.25 closet, cabinet, on a shelf, or a coat hook for storage of personal items for the person's own
359.26 use while receiving services at the facility, unless doing so would interfere with safety
359.27 precautions, another person's work space, or violate a building or fire code.

359.28 **EFFECTIVE DATE.** This section is effective January 1, 2014.

359.29 Sec. 41. **[245D.29] DAY SERVICES FACILITIES; HEALTH AND SAFETY**
359.30 **REQUIREMENTS.**

359.31 Subdivision 1. **Refrigeration.** If the license holder provides refrigeration at service
359.32 sites owned or leased by the license holder for storing perishable foods and perishable
359.33 portions of bag lunches, whether the foods are supplied by the license holder or the

360.1 persons receiving services, the refrigeration must have a temperature of 40 degrees
360.2 Fahrenheit or less.

360.3 Subd. 2. **Drinking water.** Drinking water must be available to all persons
360.4 receiving services. If a person is unable to request or obtain drinking water, it must be
360.5 provided according to that person's individual needs. Drinking water must be provided in
360.6 single-service containers or from drinking fountains accessible to all persons.

360.7 Subd. 3. **Individuals who become ill during the day.** There must be an area in
360.8 which a person receiving services can rest if:

360.9 (1) the person becomes ill during the day;

360.10 (2) the person does not live in a licensed residential site;

360.11 (3) the person requires supervision; and

360.12 (4) there is not a caretaker immediately available. Supervision must be provided
360.13 until the caretaker arrives to bring the person home.

360.14 Subd. 4. **Safety procedures.** The license holder must establish general written
360.15 safety procedures that include criteria for selecting, training, and supervising persons who
360.16 work with hazardous machinery, tools, or substances. Safety procedures specific to each
360.17 person's activities must be explained and be available in writing to all staff members
360.18 and persons receiving services.

360.19 **EFFECTIVE DATE.** This section is effective January 1, 2014.

360.20 Sec. 42. **[245D.31] DAY SERVICES FACILITIES; STAFF RATIO AND**
360.21 **FACILITY COVERAGE.**

360.22 Subdivision 1. **Scope.** This section applies only to facility-based day services.

360.23 Subd. 2. **Factors.** (a) The number of direct support service staff members that a
360.24 license holder must have on duty at the facility at a given time to meet the minimum
360.25 staffing requirements established in this section varies according to:

360.26 (1) the number of persons who are enrolled and receiving direct support services
360.27 at that given time;

360.28 (2) the staff ratio requirement established under subdivision 3 for each person who
360.29 is present; and

360.30 (3) whether the conditions described in subdivision 8 exist and warrant additional
360.31 staffing beyond the number determined to be needed under subdivision 7.

360.32 (b) The commissioner must consider the factors in paragraph (a) in determining a
360.33 license holder's compliance with the staffing requirements and must further consider
360.34 whether the staff ratio requirement established under subdivision 3 for each person
360.35 receiving services accurately reflects the person's need for staff time.

361.1 Subd. 3. Staff ratio requirement for each person receiving services. The case
361.2 manager, in consultation with the interdisciplinary team, must determine at least once each
361.3 year which of the ratios in subdivisions 4, 5, and 6 is appropriate for each person receiving
361.4 services on the basis of the characteristics described in subdivisions 4, 5, and 6. The ratio
361.5 assigned each person and the documentation of how the ratio was arrived at must be kept
361.6 in each person's individual service plan. Documentation must include an assessment of the
361.7 person with respect to the characteristics in subdivisions 4, 5, and 6 recorded on a standard
361.8 assessment form required by the commissioner.

361.9 Subd. 4. Person requiring staff ratio of one to four. A person must be assigned a
361.10 staff ratio requirement of one to four if:

361.11 (1) on a daily basis the person requires total care and monitoring or constant
361.12 hand-over-hand physical guidance to successfully complete at least three of the following
361.13 activities: toileting, communicating basic needs, eating, ambulating; or is not capable of
361.14 taking appropriate action for self-preservation under emergency conditions; or

361.15 (2) the person engages in conduct that poses an imminent risk of physical harm to
361.16 self or others at a documented level of frequency, intensity, or duration requiring frequent
361.17 daily ongoing intervention and monitoring as established in the person's coordinated
361.18 service and support plan or coordinated service and support plan addendum.

361.19 Subd. 5. Person requiring staff ratio of one to eight. A person must be assigned a
361.20 staff ratio requirement of one to eight if:

361.21 (1) the person does not meet the requirements in subdivision 4; and

361.22 (2) on a daily basis the person requires verbal prompts or spot checks and minimal
361.23 or no physical assistance to successfully complete at least four of the following activities:
361.24 toileting, communicating basic needs, eating, ambulating, or taking appropriate action for
361.25 self-preservation under emergency conditions.

361.26 Subd. 6. Person requiring staff ratio of one to six. A person who does not have
361.27 any of the characteristics described in subdivision 4 or 5 must be assigned a staff ratio
361.28 requirement of one to six.

361.29 Subd. 7. Determining number of direct support service staff required. The
361.30 minimum number of direct support service staff members required at any one time to
361.31 meet the combined staff ratio requirements of the persons present at that time can be
361.32 determined by the following steps:

361.33 (1) assign to each person in attendance the three-digit decimal below that corresponds
361.34 to the staff ratio requirement assigned to that person. A staff ratio requirement of one to
361.35 four equals 0.250. A staff ratio requirement of one to eight equals 0.125. A staff ratio
361.36 requirement of one to six equals 0.166. A staff ratio requirement of one to ten equals 0.100;

362.1 (2) add all of the three-digit decimals (one three-digit decimal for every person in
 362.2 attendance) assigned in clause (1);

362.3 (3) when the sum in clause (2) falls between two whole numbers, round off the sum
 362.4 to the larger of the two whole numbers; and

362.5 (4) the larger of the two whole numbers in clause (3) equals the number of direct
 362.6 support service staff members needed to meet the staff ratio requirements of the persons
 362.7 in attendance.

362.8 **Subd. 8. Staff to be included in calculating minimum staffing requirement.**

362.9 Only staff providing direct support must be counted as staff members in calculating
 362.10 the staff-to-participant ratio. A volunteer may be counted as a direct support staff in
 362.11 calculating the staff to participant ratio if the volunteer meets the same standards and
 362.12 requirements as paid staff. No person receiving services must be counted as or be
 362.13 substituted for a staff member in calculating the staff-to-participant ratio.

362.14 **Subd. 9. Conditions requiring additional direct support staff.** The license holder
 362.15 must increase the number of direct support staff members present at any one time beyond
 362.16 the number arrived at in subdivision 4 if necessary when any one or combination of the
 362.17 following circumstances can be documented by the commissioner as existing:

362.18 (1) the health and safety needs of the persons receiving services cannot be met by
 362.19 the number of staff members available under the staffing pattern in effect even though the
 362.20 number has been accurately calculated under subdivision 7; or

362.21 (2) the person's conduct frequently presents an imminent risk of physical harm to
 362.22 self or others.

362.23 **Subd. 10. Supervision requirements.** (a) At no time must one direct support
 362.24 staff member be assigned responsibility for supervision and training of more than ten
 362.25 persons receiving supervision and training, except as otherwise stated in each person's risk
 362.26 management plan.

362.27 (b) In the temporary absence of the director or a supervisor, a direct support staff
 362.28 member must be designated to supervise the center.

362.29 **Subd. 11. Multifunctional programs.** A multifunctional program may count other
 362.30 employees of the organization besides direct support staff of the day service facility in
 362.31 calculating the staff-to-participant ratio if the employee is assigned to the day services
 362.32 facility for a specified amount of time, during which the employee is not assigned to
 362.33 another organization or program.

362.34 **EFFECTIVE DATE.** This section is effective January 1, 2014.

362.35 **Sec. 43. [245D.32] ALTERNATIVE LICENSING INSPECTIONS.**

363.1 Subdivision 1. **Eligibility for an alternative licensing inspection.** (a) A license
363.2 holder providing services licensed under this chapter, with a qualifying accreditation and
363.3 meeting the eligibility criteria in paragraphs (b) and (c), may request approval for an
363.4 alternative licensing inspection when all services provided under the license holder's
363.5 license are accredited. A license holder with a qualifying accreditation and meeting
363.6 the eligibility criteria in paragraphs (b) and (c) may request approval for an alternative
363.7 licensing inspection for individual community residential settings or day services facilities
363.8 licensed under this chapter.

363.9 (b) In order to be eligible for an alternative licensing inspection, the program must
363.10 have had at least one inspection by the commissioner following issuance of the initial
363.11 license. For programs operating a day services facility, each facility must have had at least
363.12 one on-site inspection by the commissioner following issuance of the initial license.

363.13 (c) In order to be eligible for an alternative licensing inspection, the program must
363.14 have been in substantial and consistent compliance at the time of the last licensing
363.15 inspection and during the current licensing period. For purposes of this section,
363.16 "substantial and consistent compliance" means:

363.17 (1) the license holder's license was not made conditional, suspended, or revoked;

363.18 (2) there have been no substantiated allegations of maltreatment against the license
363.19 holder;

363.20 (3) there were no program deficiencies identified that would jeopardize the health,
363.21 safety, or rights of persons being served; and

363.22 (4) the license holder maintained substantial compliance with the other requirements
363.23 of chapters 245A and 245C and other applicable laws and rules.

363.24 (d) For the purposes of this section, the license holder's license includes services
363.25 licensed under this chapter that were previously licensed under chapter 245B until
363.26 December 31, 2013.

363.27 Subd. 2. **Qualifying accreditation.** The commissioner must accept a three-year
363.28 accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF)
363.29 as a qualifying accreditation.

363.30 Subd. 3. **Request for approval of an alternative inspection status.** (a) A request
363.31 for an alternative inspection must be made on the forms and in the manner prescribed
363.32 by the commissioner. When submitting the request, the license holder must submit all
363.33 documentation issued by the accrediting body verifying that the license holder has obtained
363.34 and maintained the qualifying accreditation and has complied with recommendations
363.35 or requirements from the accrediting body during the period of accreditation. Based

364.1 on the request and the additional required materials, the commissioner may approve
364.2 an alternative inspection status.

364.3 (b) The commissioner must notify the license holder in writing that the request for
364.4 an alternative inspection status has been approved. Approval must be granted until the
364.5 end of the qualifying accreditation period.

364.6 (c) The license holder must submit a written request for approval to be renewed
364.7 one month before the end of the current approval period according to the requirements
364.8 in paragraph (a). If the license holder does not submit a request to renew approval as
364.9 required, the commissioner must conduct a licensing inspection.

364.10 Subd. 4. **Programs approved for alternative licensing inspection; deemed**
364.11 **compliance licensing requirements.** (a) A license holder approved for alternative
364.12 licensing inspection under this section is required to maintain compliance with all
364.13 licensing standards according to this chapter.

364.14 (b) A license holder approved for alternative licensing inspection under this section
364.15 must be deemed to be in compliance with all the requirements of this chapter, and the
364.16 commissioner must not perform routine licensing inspections.

364.17 (c) Upon receipt of a complaint regarding the services of a license holder approved
364.18 for alternative licensing inspection under this section, the commissioner must investigate
364.19 the complaint and may take any action as provided under section 245A.06 or 245A.07.

364.20 Subd. 5. **Investigations of alleged or suspected maltreatment.** Nothing in this
364.21 section changes the commissioner's responsibilities to investigate alleged or suspected
364.22 maltreatment of a minor under section 626.556 or a vulnerable adult under section 626.557.

364.23 Subd. 6. **Termination or denial of subsequent approval.** Following approval of
364.24 an alternative licensing inspection, the commissioner may terminate or deny subsequent
364.25 approval of an alternative licensing inspection if the commissioner determines that:

364.26 (1) the license holder has not maintained the qualifying accreditation;

364.27 (2) the commissioner has substantiated maltreatment for which the license holder or
364.28 facility is determined to be responsible during the qualifying accreditation period; or

364.29 (3) during the qualifying accreditation period, the license holder has been issued
364.30 an order for conditional license, fine, suspension, or license revocation that has not been
364.31 reversed upon appeal.

364.32 Subd. 7. **Appeals.** The commissioner's decision that the conditions for approval for
364.33 an alternative licensing inspection have not been met is final and not subject to appeal
364.34 under the provisions of chapter 14.

365.1 Subd. 8. Commissioner's programs. Home and community-based services licensed
365.2 under this chapter for which the commissioner is the license holder with a qualifying
365.3 accreditation are excluded from being approved for an alternative licensing inspection.

365.4 EFFECTIVE DATE. This section is effective January 1, 2014.

365.5 Sec. 44. [245D.33] ADULT MENTAL HEALTH CERTIFICATION STANDARDS.

365.6 (a) The commissioner of human services shall issue a mental health certification
365.7 for services licensed under this chapter when a license holder is determined to have met
365.8 the requirements under paragraph (b). This certification is voluntary for license holders.
365.9 The certification shall be printed on the license and identified on the commissioner's
365.10 public Web site.

365.11 (b) The requirements for certification are:

365.12 (1) all staff have received at least seven hours of annual training covering all of
365.13 the following topics:

365.14 (i) mental health diagnoses;

365.15 (ii) mental health crisis response and de-escalation techniques;

365.16 (iii) recovery from mental illness;

365.17 (iv) treatment options, including evidence-based practices;

365.18 (v) medications and their side effects;

365.19 (vi) co-occurring substance abuse and health conditions; and

365.20 (vii) community resources;

365.21 (2) a mental health professional, as defined in section 245.462, subdivision 18, or a
365.22 mental health practitioner as defined in section 245.462, subdivision 17, is available
365.23 for consultation and assistance;

365.24 (3) there is a plan and protocol in place to address a mental health crisis; and

365.25 (4) each person's individual service and support plan identifies who is providing
365.26 clinical services and their contact information, and includes an individual crisis prevention
365.27 and management plan developed with the person.

365.28 (c) License holders seeking certification under this section must request this
365.29 certification on forms and in the manner prescribed by the commissioner.

365.30 (d) If the commissioner finds that the license holder has failed to comply with the
365.31 certification requirements under paragraph (b), the commissioner may issue a correction
365.32 order and an order of conditional license in accordance with section 245A.06 or may
365.33 issue a sanction in accordance with section 245A.07, including and up to removal of
365.34 the certification.

366.1 (e) A denial of the certification or the removal of the certification based on a
 366.2 determination that the requirements under paragraph (b) have not been met is not subject to
 366.3 appeal. A license holder that has been denied a certification or that has had a certification
 366.4 removed may again request certification when the license holder is in compliance with the
 366.5 requirements of paragraph (b).

366.6 **EFFECTIVE DATE.** This section is effective January 1, 2014.

366.7 Sec. 45. Minnesota Statutes 2012, section 256B.092, subdivision 11, is amended to read:

366.8 Subd. 11. **Residential support services.** (a) Upon federal approval, there is
 366.9 established a new service called residential support that is available on the community
 366.10 alternative care, community alternatives for disabled individuals, developmental
 366.11 disabilities, and brain injury waivers. Existing waiver service descriptions must be
 366.12 modified to the extent necessary to ensure there is no duplication between other services.
 366.13 Residential support services must be provided by vendors licensed as a community
 366.14 residential setting as defined in section 245A.11, subdivision 8, a foster care setting
 366.15 licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or an adult foster care
 366.16 setting licensed under Minnesota Rules, parts 9555.5105 to 9555.6265.

366.17 (b) Residential support services must meet the following criteria:

366.18 ~~(1) providers of residential support services must own or control the residential site;~~

366.19 ~~(2) the residential site must not be the primary residence of the license holder;~~

366.20 ~~(3)~~ (1) the residential site must have a designated program supervisor person
 366.21 responsible for program management, oversight, development, and implementation of
 366.22 policies and procedures;

366.23 ~~(4)~~ (2) the provider of residential support services must provide supervision, training,
 366.24 and assistance as described in the person's coordinated service and support plan; and

366.25 ~~(5)~~ (3) the provider of residential support services must meet the requirements of
 366.26 licensure and additional requirements of the person's coordinated service and support plan.

366.27 (c) Providers of residential support services that meet the definition in paragraph (a)
 366.28 ~~must be registered using a process determined by the commissioner beginning July 1, 2009~~
 366.29 must be licensed according to chapter 245D. Providers licensed to provide child foster care
 366.30 under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under
 366.31 Minnesota Rules, parts 9555.5105 to 9555.6265, and that meet the requirements in section
 366.32 245A.03, subdivision 7, paragraph (g), are considered registered under this section.

366.33 Sec. 46. Minnesota Statutes 2012, section 256B.4912, subdivision 1, is amended to read:

367.1 Subdivision 1. **Provider qualifications.** (a) For the home and community-based
 367.2 waivers providing services to seniors and individuals with disabilities under sections
 367.3 256B.0913, 256B.0915, 256B.092, and 256B.49, the commissioner shall establish:

367.4 (1) agreements with enrolled waiver service providers to ensure providers meet
 367.5 Minnesota health care program requirements;

367.6 (2) regular reviews of provider qualifications, and including requests of proof of
 367.7 documentation; and

367.8 (3) processes to gather the necessary information to determine provider qualifications.

367.9 (b) Beginning July 1, 2012, staff that provide direct contact, as defined in section
 367.10 245C.02, subdivision 11, for services specified in the federally approved waiver plans
 367.11 must meet the requirements of chapter 245C prior to providing waiver services and as
 367.12 part of ongoing enrollment. Upon federal approval, this requirement must also apply to
 367.13 consumer-directed community supports.

367.14 (c) Beginning January 1, 2014, service owners and managerial officials overseeing
 367.15 the management or policies of services that provide direct contact as specified in the
 367.16 federally approved waiver plans must meet the requirements of chapter 245C prior to
 367.17 reenrollment or, for new providers, prior to initial enrollment if they have not already done
 367.18 so as a part of service licensure requirements.

367.19 Sec. 47. Minnesota Statutes 2012, section 256B.4912, subdivision 7, is amended to read:

367.20 Subd. 7. **Applicant and license holder training.** An applicant or license holder
 367.21 for the home and community-based waivers providing services to seniors and individuals
 367.22 with disabilities under sections 256B.0913, 256B.0915, 256B.092, and 256B.49 that is
 367.23 not enrolled as a Minnesota health care program home and community-based services
 367.24 waiver provider at the time of application must ensure that at least one controlling
 367.25 individual completes a onetime training on the requirements for providing home and
 367.26 community-based services ~~from a qualified source~~ as determined by the commissioner,
 367.27 before a provider is enrolled or license is issued. Within six months of enrollment, a newly
 367.28 enrolled home and community-based waiver service provider must ensure that at least one
 367.29 controlling individual has completed training on waiver and related program billing.

367.30 Sec. 48. Minnesota Statutes 2012, section 256B.4912, is amended by adding a
 367.31 subdivision to read:

367.32 Subd. 8. **Data on use of emergency use of manual restraint.** Beginning July 1,
 367.33 2013, facilities and services to be licensed under chapter 245D shall submit data regarding

368.1 the use of emergency use of manual restraint as identified in section 245D.061 in a format
368.2 and at a frequency identified by the commissioner.

368.3 Sec. 49. Minnesota Statutes 2012, section 256B.4912, is amended by adding a
368.4 subdivision to read:

368.5 Subd. 9. **Definitions.** (a) For the purposes of this section, the following terms
368.6 have the meanings given them.

368.7 (b) "Controlling individual" means a public body, governmental agency, business
368.8 entity, officer, owner, or managerial official whose responsibilities include the direction of
368.9 the management or policies of a program.

368.10 (c) "Managerial official" means an individual who has decision-making authority
368.11 related to the operation of the program and responsibility for the ongoing management of
368.12 or direction of the policies, services, or employees of the program.

368.13 (d) "Owner" means an individual who has direct or indirect ownership interest in
368.14 a corporation or partnership, or business association enrolling with the Department of
368.15 Human Services as a provider of waiver services.

368.16 Sec. 50. Minnesota Statutes 2012, section 256B.4912, is amended by adding a
368.17 subdivision to read:

368.18 Subd. 10. **Enrollment requirements.** All home and community-based waiver
368.19 providers must provide, at the time of enrollment and within 30 days of a request, in a
368.20 format determined by the commissioner, information and documentation that includes, but
368.21 is not limited to, the following:

368.22 (1) proof of surety bond coverage in the amount of \$50,000 or ten percent of the
368.23 provider's payments from Medicaid in the previous calendar year, whichever is greater;

368.24 (2) proof of fidelity bond coverage in the amount of \$20,000; and

368.25 (3) proof of liability insurance.

368.26 Sec. 51. Minnesota Statutes 2012, section 626.557, subdivision 9a, is amended to read:

368.27 **Subd. 9a. Evaluation and referral of reports made to common entry point unit.**

368.28 The common entry point must screen the reports of alleged or suspected maltreatment for
368.29 immediate risk and make all necessary referrals as follows:

368.30 (1) if the common entry point determines that there is an immediate need for
368.31 adult protective services, the common entry point agency shall immediately notify the
368.32 appropriate county agency;

369.1 (2) if the report contains suspected criminal activity against a vulnerable adult, the
 369.2 common entry point shall immediately notify the appropriate law enforcement agency;

369.3 (3) the common entry point shall refer all reports of alleged or suspected
 369.4 maltreatment to the appropriate lead investigative agency as soon as possible, but in any
 369.5 event no longer than two working days; and

369.6 ~~(4) if the report involves services licensed by the Department of Human Services~~
 369.7 ~~and subject to chapter 245D, the common entry point shall refer the report to the county as~~
 369.8 ~~the lead agency according to clause (3), but shall also notify the Department of Human~~
 369.9 ~~Services of the report; and~~

369.10 ~~(5)~~ (4) if the report contains information about a suspicious death, the common
 369.11 entry point shall immediately notify the appropriate law enforcement agencies, the local
 369.12 medical examiner, and the ombudsman for mental health and developmental disabilities
 369.13 established under section 245.92. Law enforcement agencies shall coordinate with the
 369.14 local medical examiner and the ombudsman as provided by law.

369.15 Sec. 52. Minnesota Statutes 2012, section 626.5572, subdivision 13, is amended to read:

369.16 Subd. 13. **Lead investigative agency.** "Lead investigative agency" is the primary
 369.17 administrative agency responsible for investigating reports made under section 626.557.

369.18 (a) The Department of Health is the lead investigative agency for facilities or
 369.19 services licensed or required to be licensed as hospitals, home care providers, nursing
 369.20 homes, boarding care homes, hospice providers, residential facilities that are also federally
 369.21 certified as intermediate care facilities that serve people with developmental disabilities,
 369.22 or any other facility or service not listed in this subdivision that is licensed or required to
 369.23 be licensed by the Department of Health for the care of vulnerable adults. "Home care
 369.24 provider" has the meaning provided in section 144A.43, subdivision 4, and applies when
 369.25 care or services are delivered in the vulnerable adult's home, whether a private home or a
 369.26 housing with services establishment registered under chapter 144D, including those that
 369.27 offer assisted living services under chapter 144G.

369.28 ~~(b) Except as provided under paragraph (c), for services licensed according to~~
 369.29 ~~chapter 245D, The Department of Human Services is the lead investigative agency for~~
 369.30 facilities or services licensed or required to be licensed as adult day care, adult foster care,
 369.31 programs for people with developmental disabilities, family adult day services, mental
 369.32 health programs, mental health clinics, chemical dependency programs, the Minnesota
 369.33 sex offender program, or any other facility or service not listed in this subdivision that is
 369.34 licensed or required to be licensed by the Department of Human Services.

370.1 (c) The county social service agency or its designee is the lead investigative agency
370.2 for all other reports, including, but not limited to, reports involving vulnerable adults
370.3 receiving services from a personal care provider organization under section 256B.0659;
370.4 ~~or receiving home and community-based services licensed by the Department of Human~~
370.5 ~~Services and subject to chapter 245D.~~

370.6 Sec. 53. **INTEGRATED LICENSING SYSTEM FOR HOME CARE AND HOME**
370.7 **AND COMMUNITY-BASED SERVICES.**

370.8 (a) The Department of Health Compliance Monitoring Division and the Department
370.9 of Human Services Licensing Division shall jointly develop an integrated licensing system
370.10 for providers of both home care services subject to licensure under Minnesota Statutes,
370.11 chapter 144A, and for home and community-based services subject to licensure under
370.12 Minnesota Statutes, chapter 245D. The integrated licensing system shall:

370.13 (1) require only one license of any provider of services under Minnesota Statutes,
370.14 sections 144A.43 to 144A.482, and 245D.03, subdivision 1;

370.15 (2) promote quality services that recognize a person's individual needs and protect
370.16 the person's health, safety, rights, and well-being;

370.17 (3) promote provider accountability through application requirements, compliance
370.18 inspections, investigations, and enforcement actions;

370.19 (4) reference other applicable requirements in existing state and federal laws,
370.20 including the federal Affordable Care Act;

370.21 (5) establish internal procedures to facilitate ongoing communications between the
370.22 agencies and with providers and services recipients about the regulatory activities;

370.23 (6) create a link between the agency Web sites so that providers and the public can
370.24 access the same information regardless of which Web site is accessed initially; and

370.25 (7) collect data on identified outcome measures as necessary for the agencies to
370.26 report to the Centers for Medicare and Medicaid Services.

370.27 (b) The joint recommendations for legislative changes to implement the integrated
370.28 licensing system are due to the legislature by February 15, 2014.

370.29 (c) Before implementation of the integrated licensing system, providers licensed as
370.30 home care providers under Minnesota Statutes, chapter 144A, may also provide home
370.31 and community-based services subject to licensure under Minnesota Statutes, chapter
370.32 245D, without obtaining a home and community-based services license under Minnesota
370.33 Statutes, chapter 245D. During this time, the conditions under clauses (1) to (3) shall
370.34 apply to these providers:

371.1 (1) the provider must comply with all requirements under Minnesota Statutes, chapter
 371.2 245D, for services otherwise subject to licensure under Minnesota Statutes, chapter 245D;

371.3 (2) a violation of requirements under Minnesota Statutes, chapter 245D, may be
 371.4 enforced by the Department of Health under the enforcement authority set forth in
 371.5 Minnesota Statutes, section 144A.475; and

371.6 (3) the Department of Health will provide information to the Department of Human
 371.7 Services about each provider licensed under this section, including the provider's license
 371.8 application, licensing documents, inspections, information about complaints received, and
 371.9 investigations conducted for possible violations of Minnesota Statutes, chapter 245D.

371.10 Sec. 54. **REPEALER.**

371.11 (a) Minnesota Statutes 2012, sections 245B.01; 245B.02; 245B.03; 245B.031;
 371.12 245B.04; 245B.05, subdivisions 1, 2, 3, 5, 6, and 7; 245B.055; 245B.06; 245B.07; and
 371.13 245B.08, are repealed effective January 1, 2014.

371.14 (b) Minnesota Statutes 2012, section 245D.08, is repealed.

371.15 **ARTICLE 9**

371.16 **WAIVER PROVIDER STANDARDS TECHNICAL CHANGES**

371.17 Section 1. Minnesota Statutes 2012, section 16C.10, subdivision 5, is amended to read:

371.18 Subd. 5. **Specific purchases.** The solicitation process described in this chapter is
 371.19 not required for acquisition of the following:

371.20 (1) merchandise for resale purchased under policies determined by the commissioner;

371.21 (2) farm and garden products which, as determined by the commissioner, may be
 371.22 purchased at the prevailing market price on the date of sale;

371.23 (3) goods and services from the Minnesota correctional facilities;

371.24 (4) goods and services from rehabilitation facilities and extended employment
 371.25 providers that are certified by the commissioner of employment and economic
 371.26 development, and day ~~training and habilitation~~ services licensed under ~~sections 245B.01~~
 371.27 ~~to 245B.08~~ chapter 245D;

371.28 (5) goods and services for use by a community-based facility operated by the
 371.29 commissioner of human services;

371.30 (6) goods purchased at auction or when submitting a sealed bid at auction provided
 371.31 that before authorizing such an action, the commissioner consult with the requesting
 371.32 agency to determine a fair and reasonable value for the goods considering factors
 371.33 including, but not limited to, costs associated with submitting a bid, travel, transportation,
 371.34 and storage. This fair and reasonable value must represent the limit of the state's bid;

- 372.1 (7) utility services where no competition exists or where rates are fixed by law or
 372.2 ordinance; and
 372.3 (8) goods and services from Minnesota sex offender program facilities.

372.4 **EFFECTIVE DATE.** This section is effective January 1, 2014.

372.5 Sec. 2. Minnesota Statutes 2012, section 16C.155, subdivision 1, is amended to read:

372.6 Subdivision 1. **Service contracts.** The commissioner of administration shall
 372.7 ensure that a portion of all contracts for janitorial services; document imaging;
 372.8 document shredding; and mailing, collating, and sorting services be awarded by the
 372.9 state to rehabilitation programs and extended employment providers that are certified
 372.10 by the commissioner of employment and economic development, and day ~~training and~~
 372.11 ~~habilitation~~ services licensed under ~~sections 245B.01 to 245B.08~~ chapter 245D. The
 372.12 amount of each contract awarded under this section may exceed the estimated fair market
 372.13 price as determined by the commissioner for the same goods and services by up to six
 372.14 percent. The aggregate value of the contracts awarded to eligible providers under this
 372.15 section in any given year must exceed 19 percent of the total value of all contracts for
 372.16 janitorial services; document imaging; document shredding; and mailing, collating, and
 372.17 sorting services entered into in the same year. For the 19 percent requirement to be
 372.18 applicable in any given year, the contract amounts proposed by eligible providers must be
 372.19 within six percent of the estimated fair market price for at least 19 percent of the contracts
 372.20 awarded for the corresponding service area.

372.21 **EFFECTIVE DATE.** This section is effective January 1, 2014.

372.22 Sec. 3. Minnesota Statutes 2012, section 144D.01, subdivision 4, is amended to read:

372.23 Subd. 4. **Housing with services establishment or establishment.** (a) "Housing
 372.24 with services establishment" or "establishment" means:

372.25 (1) an establishment providing sleeping accommodations to one or more adult
 372.26 residents, at least 80 percent of which are 55 years of age or older, and offering or
 372.27 providing, for a fee, one or more regularly scheduled health-related services or two or
 372.28 more regularly scheduled supportive services, whether offered or provided directly by the
 372.29 establishment or by another entity arranged for by the establishment; or

372.30 (2) an establishment that registers under section 144D.025.

372.31 (b) Housing with services establishment does not include:

372.32 (1) a nursing home licensed under chapter 144A;

- 373.1 (2) a hospital, certified boarding care home, or supervised living facility licensed
 373.2 under sections 144.50 to 144.56;
- 373.3 (3) a board and lodging establishment licensed under chapter 157 and Minnesota
 373.4 Rules, parts 9520.0500 to 9520.0670, 9525.0215 to 9525.0355, 9525.0500 to 9525.0660,
 373.5 or 9530.4100 to 9530.4450, or under chapter ~~245B~~ 245D;
- 373.6 (4) a board and lodging establishment which serves as a shelter for battered women
 373.7 or other similar purpose;
- 373.8 (5) a family adult foster care home licensed by the Department of Human Services;
- 373.9 (6) private homes in which the residents are related by kinship, law, or affinity with
 373.10 the providers of services;
- 373.11 (7) residential settings for persons with developmental disabilities in which the
 373.12 services are licensed under Minnesota Rules, parts 9525.2100 to 9525.2140, or applicable
 373.13 successor rules or laws;
- 373.14 (8) a home-sharing arrangement such as when an elderly or disabled person or
 373.15 single-parent family makes lodging in a private residence available to another person
 373.16 in exchange for services or rent, or both;
- 373.17 (9) a duly organized condominium, cooperative, common interest community, or
 373.18 owners' association of the foregoing where at least 80 percent of the units that comprise the
 373.19 condominium, cooperative, or common interest community are occupied by individuals
 373.20 who are the owners, members, or shareholders of the units; or
- 373.21 (10) services for persons with developmental disabilities that are provided under
 373.22 a license according to Minnesota Rules, parts 9525.2000 to 9525.2140 in effect until
 373.23 January 1, 1998, or under chapter ~~245B~~ 245D.

373.24 **EFFECTIVE DATE.** This section is effective January 1, 2014.

373.25 Sec. 4. Minnesota Statutes 2012, section 174.30, subdivision 1, is amended to read:

373.26 Subdivision 1. **Applicability.** (a) The operating standards for special transportation
 373.27 service adopted under this section do not apply to special transportation provided by:

- 373.28 (1) a common carrier operating on fixed routes and schedules;
- 373.29 (2) a volunteer driver using a private automobile;
- 373.30 (3) a school bus as defined in section 169.011, subdivision 71; or
- 373.31 (4) an emergency ambulance regulated under chapter 144.

373.32 (b) The operating standards adopted under this section only apply to providers
 373.33 of special transportation service who receive grants or other financial assistance from
 373.34 either the state or the federal government, or both, to provide or assist in providing that
 373.35 service; except that the operating standards adopted under this section do not apply

374.1 to any nursing home licensed under section 144A.02, to any board and care facility
374.2 licensed under section 144.50, or to any day training and habilitation services, day care,
374.3 or group home facility licensed under sections 245A.01 to 245A.19 unless the facility or
374.4 program provides transportation to nonresidents on a regular basis and the facility receives
374.5 reimbursement, other than per diem payments, for that service under rules promulgated
374.6 by the commissioner of human services.

374.7 (c) Notwithstanding paragraph (b), the operating standards adopted under this
374.8 section do not apply to any vendor of services licensed under chapter ~~245B~~ 245D that
374.9 provides transportation services to consumers or residents of other vendors licensed under
374.10 chapter ~~245B~~ 245D and transports 15 or fewer persons, including consumers or residents
374.11 and the driver.

374.12 **EFFECTIVE DATE.** This section is effective January 1, 2014.

374.13 Sec. 5. Minnesota Statutes 2012, section 245A.02, subdivision 1, is amended to read:

374.14 Subdivision 1. **Scope.** The terms used in this chapter ~~and chapter 245B~~ have the
374.15 meanings given them in this section.

374.16 **EFFECTIVE DATE.** This section is effective January 1, 2014.

374.17 Sec. 6. Minnesota Statutes 2012, section 245A.02, subdivision 9, is amended to read:

374.18 Subd. 9. **License holder.** "License holder" means an individual, corporation,
374.19 partnership, voluntary association, or other organization that is legally responsible for the
374.20 operation of the program, has been granted a license by the commissioner under this chapter
374.21 or chapter ~~245B~~ 245D and the rules of the commissioner, and is a controlling individual.

374.22 **EFFECTIVE DATE.** This section is effective January 1, 2014.

374.23 Sec. 7. Minnesota Statutes 2012, section 245A.03, subdivision 9, is amended to read:

374.24 Subd. 9. **Permitted services by an individual who is related.** Notwithstanding
374.25 subdivision 2, paragraph (a), clause (1), and subdivision 7, an individual who is related to a
374.26 person receiving supported living services may provide licensed services to that person if:

374.27 (1) the person who receives supported living services received these services in a
374.28 residential site on July 1, 2005;

374.29 (2) the services under clause (1) were provided in a corporate foster care setting for
374.30 adults and were funded by the developmental disabilities home and community-based
374.31 services waiver defined in section 256B.092;

375.1 (3) the individual who is related obtains and maintains both a license under chapter
 375.2 ~~245B~~ 245D and an adult foster care license under Minnesota Rules, parts 9555.5105
 375.3 to 9555.6265; and

375.4 (4) the individual who is related is not the guardian of the person receiving supported
 375.5 living services.

375.6 **EFFECTIVE DATE.** This section is effective January 1, 2014.

375.7 Sec. 8. Minnesota Statutes 2012, section 245A.04, subdivision 13, is amended to read:

375.8 Subd. 13. **Funds and property; other requirements.** (a) A license holder must
 375.9 ensure that persons served by the program retain the use and availability of personal funds
 375.10 or property unless restrictions are justified in the person's individual plan. ~~This subdivision~~
 375.11 ~~does not apply to programs governed by the provisions in section 245B.07, subdivision 10.~~

375.12 (b) The license holder must ensure separation of funds of persons served by the
 375.13 program from funds of the license holder, the program, or program staff.

375.14 (c) Whenever the license holder assists a person served by the program with the
 375.15 safekeeping of funds or other property, the license holder must:

375.16 (1) immediately document receipt and disbursement of the person's funds or other
 375.17 property at the time of receipt or disbursement, including the person's signature, or the
 375.18 signature of the conservator or payee; and

375.19 (2) return to the person upon the person's request, funds and property in the license
 375.20 holder's possession subject to restrictions in the person's treatment plan, as soon as
 375.21 possible, but no later than three working days after the date of request.

375.22 (d) License holders and program staff must not:

375.23 (1) borrow money from a person served by the program;

375.24 (2) purchase personal items from a person served by the program;

375.25 (3) sell merchandise or personal services to a person served by the program;

375.26 (4) require a person served by the program to purchase items for which the license
 375.27 holder is eligible for reimbursement; or

375.28 (5) use funds of persons served by the program to purchase items for which the
 375.29 facility is already receiving public or private payments.

375.30 **EFFECTIVE DATE.** This section is effective January 1, 2014.

375.31 Sec. 9. Minnesota Statutes 2012, section 245A.07, subdivision 3, is amended to read:

375.32 Subd. 3. **License suspension, revocation, or fine.** (a) The commissioner may
 375.33 suspend or revoke a license, or impose a fine if:

376.1 (1) a license holder fails to comply fully with applicable laws or rules;

376.2 (2) a license holder, a controlling individual, or an individual living in the household
376.3 where the licensed services are provided or is otherwise subject to a background study has
376.4 a disqualification which has not been set aside under section 245C.22;

376.5 (3) a license holder knowingly withholds relevant information from or gives false
376.6 or misleading information to the commissioner in connection with an application for
376.7 a license, in connection with the background study status of an individual, during an
376.8 investigation, or regarding compliance with applicable laws or rules; or

376.9 (4) after July 1, 2012, and upon request by the commissioner, a license holder fails
376.10 to submit the information required of an applicant under section 245A.04, subdivision 1,
376.11 paragraph (f) or (g).

376.12 A license holder who has had a license suspended, revoked, or has been ordered
376.13 to pay a fine must be given notice of the action by certified mail or personal service. If
376.14 mailed, the notice must be mailed to the address shown on the application or the last
376.15 known address of the license holder. The notice must state the reasons the license was
376.16 suspended, revoked, or a fine was ordered.

376.17 (b) If the license was suspended or revoked, the notice must inform the license
376.18 holder of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts
376.19 1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking
376.20 a license. The appeal of an order suspending or revoking a license must be made in writing
376.21 by certified mail or personal service. If mailed, the appeal must be postmarked and sent to
376.22 the commissioner within ten calendar days after the license holder receives notice that the
376.23 license has been suspended or revoked. If a request is made by personal service, it must be
376.24 received by the commissioner within ten calendar days after the license holder received
376.25 the order. Except as provided in subdivision 2a, paragraph (c), if a license holder submits
376.26 a timely appeal of an order suspending or revoking a license, the license holder may
376.27 continue to operate the program as provided in section 245A.04, subdivision 7, paragraphs
376.28 (g) and (h), until the commissioner issues a final order on the suspension or revocation.

376.29 (c)(1) If the license holder was ordered to pay a fine, the notice must inform the
376.30 license holder of the responsibility for payment of fines and the right to a contested case
376.31 hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The appeal
376.32 of an order to pay a fine must be made in writing by certified mail or personal service. If
376.33 mailed, the appeal must be postmarked and sent to the commissioner within ten calendar
376.34 days after the license holder receives notice that the fine has been ordered. If a request is
376.35 made by personal service, it must be received by the commissioner within ten calendar
376.36 days after the license holder received the order.

377.1 (2) The license holder shall pay the fines assessed on or before the payment date
377.2 specified. If the license holder fails to fully comply with the order, the commissioner
377.3 may issue a second fine or suspend the license until the license holder complies. If the
377.4 license holder receives state funds, the state, county, or municipal agencies or departments
377.5 responsible for administering the funds shall withhold payments and recover any payments
377.6 made while the license is suspended for failure to pay a fine. A timely appeal shall stay
377.7 payment of the fine until the commissioner issues a final order.

377.8 (3) A license holder shall promptly notify the commissioner of human services,
377.9 in writing, when a violation specified in the order to forfeit a fine is corrected. If upon
377.10 reinspection the commissioner determines that a violation has not been corrected as
377.11 indicated by the order to forfeit a fine, the commissioner may issue a second fine. The
377.12 commissioner shall notify the license holder by certified mail or personal service that a
377.13 second fine has been assessed. The license holder may appeal the second fine as provided
377.14 under this subdivision.

377.15 (4) Fines shall be assessed as follows: the license holder shall forfeit \$1,000 for
377.16 each determination of maltreatment of a child under section 626.556 or the maltreatment
377.17 of a vulnerable adult under section 626.557 for which the license holder is determined
377.18 responsible for the maltreatment under section 626.556, subdivision 10e, paragraph (i),
377.19 or 626.557, subdivision 9c, paragraph (c); the license holder shall forfeit \$200 for each
377.20 occurrence of a violation of law or rule governing matters of health, safety, or supervision,
377.21 including but not limited to the provision of adequate staff-to-child or adult ratios, and
377.22 failure to comply with background study requirements under chapter 245C; and the license
377.23 holder shall forfeit \$100 for each occurrence of a violation of law or rule other than
377.24 those subject to a \$1,000 or \$200 fine above. For purposes of this section, "occurrence"
377.25 means each violation identified in the commissioner's fine order. Fines assessed against a
377.26 license holder that holds a license to provide ~~the residential-based habilitation home and~~
377.27 community-based services, as defined under identified in section 245B.02, subdivision
377.28 ~~20~~ 245D.03, subdivision 1, and a community residential setting or day services facility
377.29 ~~license to provide foster care under chapter 245D where the services are provided,~~ may be
377.30 assessed against both licenses for the same occurrence, but the combined amount of the
377.31 fines shall not exceed the amount specified in this clause for that occurrence.

377.32 (5) When a fine has been assessed, the license holder may not avoid payment by
377.33 closing, selling, or otherwise transferring the licensed program to a third party. In such an
377.34 event, the license holder will be personally liable for payment. In the case of a corporation,
377.35 each controlling individual is personally and jointly liable for payment.

378.1 (d) Except for background study violations involving the failure to comply with an
 378.2 order to immediately remove an individual or an order to provide continuous, direct
 378.3 supervision, the commissioner shall not issue a fine under paragraph (c) relating to a
 378.4 background study violation to a license holder who self-corrects a background study
 378.5 violation before the commissioner discovers the violation. A license holder who has
 378.6 previously exercised the provisions of this paragraph to avoid a fine for a background
 378.7 study violation may not avoid a fine for a subsequent background study violation unless at
 378.8 least 365 days have passed since the license holder self-corrected the earlier background
 378.9 study violation.

378.10 **EFFECTIVE DATE.** This section is effective January 1, 2014.

378.11 Sec. 10. Minnesota Statutes 2012, section 256B.0625, subdivision 19c, is amended to
 378.12 read:

378.13 Subd. 19c. **Personal care.** Medical assistance covers personal care assistance
 378.14 services provided by an individual who is qualified to provide the services according to
 378.15 subdivision 19a and sections 256B.0651 to 256B.0656, provided in accordance with a
 378.16 plan, and supervised by a qualified professional.

378.17 "Qualified professional" means a mental health professional as defined in section
 378.18 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6);
 378.19 or a registered nurse as defined in sections 148.171 to 148.285, a licensed social worker
 378.20 as defined in sections 148E.010 and 148E.055, or a qualified ~~developmental disabilities~~
 378.21 ~~specialist under section 245B.07, subdivision 4~~ designated coordinator under section
 378.22 245D.081, subdivision 2. The qualified professional shall perform the duties required in
 378.23 section 256B.0659.

378.24 **EFFECTIVE DATE.** This section is effective January 1, 2014.

378.25 Sec. 11. Minnesota Statutes 2012, section 256B.5011, subdivision 2, is amended to read:

378.26 Subd. 2. **Contract provisions.** (a) The service contract with each intermediate
 378.27 care facility must include provisions for:

- 378.28 (1) modifying payments when significant changes occur in the needs of the
 378.29 consumers;
- 378.30 (2) appropriate and necessary statistical information required by the commissioner;
- 378.31 (3) annual aggregate facility financial information; and
- 378.32 (4) additional requirements for intermediate care facilities not meeting the standards
 378.33 set forth in the service contract.

379.1 (b) The commissioner of human services and the commissioner of health, in
 379.2 consultation with representatives from counties, advocacy organizations, and the provider
 379.3 community, shall review ~~the consolidated standards under chapter 245B and the home and~~
 379.4 community-based services standards under chapter 245D and the supervised living facility
 379.5 rule under Minnesota Rules, chapter 4665, to determine what provisions in Minnesota
 379.6 Rules, chapter 4665, may be waived by the commissioner of health for intermediate care
 379.7 facilities in order to enable facilities to implement the performance measures in their
 379.8 contract and provide quality services to residents without a duplication of or increase in
 379.9 regulatory requirements.

379.10 **EFFECTIVE DATE.** This section is effective January 1, 2014.

379.11 Sec. 12. Minnesota Statutes 2012, section 471.59, subdivision 1, is amended to read:

379.12 Subdivision 1. **Agreement.** Two or more governmental units, by agreement entered
 379.13 into through action of their governing bodies, may jointly or cooperatively exercise
 379.14 any power common to the contracting parties or any similar powers, including those
 379.15 which are the same except for the territorial limits within which they may be exercised.
 379.16 The agreement may provide for the exercise of such powers by one or more of the
 379.17 participating governmental units on behalf of the other participating units. The term
 379.18 "governmental unit" as used in this section includes every city, county, town, school
 379.19 district, independent nonprofit firefighting corporation, other political subdivision of
 379.20 this or another state, another state, federally recognized Indian tribe, the University
 379.21 of Minnesota, the Minnesota Historical Society, nonprofit hospitals licensed under
 379.22 sections 144.50 to 144.56, rehabilitation facilities and extended employment providers
 379.23 that are certified by the commissioner of employment and economic development, ~~day~~
 379.24 ~~training and habilitation services licensed under sections 245B.01 to 245B.08,~~ day and
 379.25 supported employment services licensed under chapter 245D, and any agency of the state
 379.26 of Minnesota or the United States, and includes any instrumentality of a governmental
 379.27 unit. For the purpose of this section, an instrumentality of a governmental unit means an
 379.28 instrumentality having independent policy-making and appropriating authority.

379.29 **EFFECTIVE DATE.** This section is effective January 1, 2014.

379.30 Sec. 13. Minnesota Statutes 2012, section 626.556, subdivision 2, is amended to read:

379.31 Subd. 2. **Definitions.** As used in this section, the following terms have the meanings
 379.32 given them unless the specific content indicates otherwise:

380.1 (a) "Family assessment" means a comprehensive assessment of child safety, risk
380.2 of subsequent child maltreatment, and family strengths and needs that is applied to a
380.3 child maltreatment report that does not allege substantial child endangerment. Family
380.4 assessment does not include a determination as to whether child maltreatment occurred
380.5 but does determine the need for services to address the safety of family members and the
380.6 risk of subsequent maltreatment.

380.7 (b) "Investigation" means fact gathering related to the current safety of a child
380.8 and the risk of subsequent maltreatment that determines whether child maltreatment
380.9 occurred and whether child protective services are needed. An investigation must be used
380.10 when reports involve substantial child endangerment, and for reports of maltreatment in
380.11 facilities required to be licensed under chapter 245A or 245B; under sections 144.50 to
380.12 144.58 and 241.021; in a school as defined in sections 120A.05, subdivisions 9, 11, and
380.13 13, and 124D.10; or in a nonlicensed personal care provider association as defined in
380.14 sections 256B.04, subdivision 16, and 256B.0625, subdivision 19a.

380.15 (c) "Substantial child endangerment" means a person responsible for a child's care,
380.16 and in the case of sexual abuse includes a person who has a significant relationship to the
380.17 child as defined in section 609.341, or a person in a position of authority as defined in
380.18 section 609.341, who by act or omission commits or attempts to commit an act against a
380.19 child under their care that constitutes any of the following:

380.20 (1) egregious harm as defined in section 260C.007, subdivision 14;

380.21 (2) sexual abuse as defined in paragraph (d);

380.22 (3) abandonment under section 260C.301, subdivision 2;

380.23 (4) neglect as defined in paragraph (f), clause (2), that substantially endangers the
380.24 child's physical or mental health, including a growth delay, which may be referred to as
380.25 failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

380.26 (5) murder in the first, second, or third degree under section 609.185, 609.19, or
380.27 609.195;

380.28 (6) manslaughter in the first or second degree under section 609.20 or 609.205;

380.29 (7) assault in the first, second, or third degree under section 609.221, 609.222, or
380.30 609.223;

380.31 (8) solicitation, inducement, and promotion of prostitution under section 609.322;

380.32 (9) criminal sexual conduct under sections 609.342 to 609.3451;

380.33 (10) solicitation of children to engage in sexual conduct under section 609.352;

380.34 (11) malicious punishment or neglect or endangerment of a child under section
380.35 609.377 or 609.378;

380.36 (12) use of a minor in sexual performance under section 617.246; or

381.1 (13) parental behavior, status, or condition which mandates that the county attorney
381.2 file a termination of parental rights petition under section 260C.301, subdivision 3,
381.3 paragraph (a).

381.4 (d) "Sexual abuse" means the subjection of a child by a person responsible for the
381.5 child's care, by a person who has a significant relationship to the child, as defined in
381.6 section 609.341, or by a person in a position of authority, as defined in section 609.341,
381.7 subdivision 10, to any act which constitutes a violation of section 609.342 (criminal sexual
381.8 conduct in the first degree), 609.343 (criminal sexual conduct in the second degree),
381.9 609.344 (criminal sexual conduct in the third degree), 609.345 (criminal sexual conduct
381.10 in the fourth degree), or 609.3451 (criminal sexual conduct in the fifth degree). Sexual
381.11 abuse also includes any act which involves a minor which constitutes a violation of
381.12 prostitution offenses under sections 609.321 to 609.324 or 617.246. Sexual abuse includes
381.13 threatened sexual abuse which includes the status of a parent or household member
381.14 who has committed a violation which requires registration as an offender under section
381.15 243.166, subdivision 1b, paragraph (a) or (b), or required registration under section
381.16 243.166, subdivision 1b, paragraph (a) or (b).

381.17 (e) "Person responsible for the child's care" means (1) an individual functioning
381.18 within the family unit and having responsibilities for the care of the child such as a
381.19 parent, guardian, or other person having similar care responsibilities, or (2) an individual
381.20 functioning outside the family unit and having responsibilities for the care of the child
381.21 such as a teacher, school administrator, other school employees or agents, or other lawful
381.22 custodian of a child having either full-time or short-term care responsibilities including,
381.23 but not limited to, day care, babysitting whether paid or unpaid, counseling, teaching,
381.24 and coaching.

381.25 (f) "Neglect" means the commission or omission of any of the acts specified under
381.26 clauses (1) to (9), other than by accidental means:

381.27 (1) failure by a person responsible for a child's care to supply a child with necessary
381.28 food, clothing, shelter, health, medical, or other care required for the child's physical or
381.29 mental health when reasonably able to do so;

381.30 (2) failure to protect a child from conditions or actions that seriously endanger the
381.31 child's physical or mental health when reasonably able to do so, including a growth delay,
381.32 which may be referred to as a failure to thrive, that has been diagnosed by a physician and
381.33 is due to parental neglect;

381.34 (3) failure to provide for necessary supervision or child care arrangements
381.35 appropriate for a child after considering factors as the child's age, mental ability, physical

382.1 condition, length of absence, or environment, when the child is unable to care for the
382.2 child's own basic needs or safety, or the basic needs or safety of another child in their care;

382.3 (4) failure to ensure that the child is educated as defined in sections 120A.22 and
382.4 260C.163, subdivision 11, which does not include a parent's refusal to provide the parent's
382.5 child with sympathomimetic medications, consistent with section 125A.091, subdivision 5;

382.6 (5) nothing in this section shall be construed to mean that a child is neglected solely
382.7 because the child's parent, guardian, or other person responsible for the child's care in
382.8 good faith selects and depends upon spiritual means or prayer for treatment or care of
382.9 disease or remedial care of the child in lieu of medical care; except that a parent, guardian,
382.10 or caretaker, or a person mandated to report pursuant to subdivision 3, has a duty to report
382.11 if a lack of medical care may cause serious danger to the child's health. This section does
382.12 not impose upon persons, not otherwise legally responsible for providing a child with
382.13 necessary food, clothing, shelter, education, or medical care, a duty to provide that care;

382.14 (6) prenatal exposure to a controlled substance, as defined in section 253B.02,
382.15 subdivision 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal
382.16 symptoms in the child at birth, results of a toxicology test performed on the mother at
382.17 delivery or the child at birth, medical effects or developmental delays during the child's
382.18 first year of life that medically indicate prenatal exposure to a controlled substance, or the
382.19 presence of a fetal alcohol spectrum disorder;

382.20 (7) "medical neglect" as defined in section 260C.007, subdivision 6, clause (5);

382.21 (8) chronic and severe use of alcohol or a controlled substance by a parent or
382.22 person responsible for the care of the child that adversely affects the child's basic needs
382.23 and safety; or

382.24 (9) emotional harm from a pattern of behavior which contributes to impaired
382.25 emotional functioning of the child which may be demonstrated by a substantial and
382.26 observable effect in the child's behavior, emotional response, or cognition that is not
382.27 within the normal range for the child's age and stage of development, with due regard to
382.28 the child's culture.

382.29 (g) "Physical abuse" means any physical injury, mental injury, or threatened injury,
382.30 inflicted by a person responsible for the child's care on a child other than by accidental
382.31 means, or any physical or mental injury that cannot reasonably be explained by the child's
382.32 history of injuries, or any aversive or deprivation procedures, or regulated interventions,
382.33 that have not been authorized under section 121A.67 or 245.825.

382.34 Abuse does not include reasonable and moderate physical discipline of a child
382.35 administered by a parent or legal guardian which does not result in an injury. Abuse does
382.36 not include the use of reasonable force by a teacher, principal, or school employee as

383.1 allowed by section 121A.582. Actions which are not reasonable and moderate include,
383.2 but are not limited to, any of the following that are done in anger or without regard to the
383.3 safety of the child:

383.4 (1) throwing, kicking, burning, biting, or cutting a child;

383.5 (2) striking a child with a closed fist;

383.6 (3) shaking a child under age three;

383.7 (4) striking or other actions which result in any nonaccidental injury to a child
383.8 under 18 months of age;

383.9 (5) unreasonable interference with a child's breathing;

383.10 (6) threatening a child with a weapon, as defined in section 609.02, subdivision 6;

383.11 (7) striking a child under age one on the face or head;

383.12 (8) purposely giving a child poison, alcohol, or dangerous, harmful, or controlled
383.13 substances which were not prescribed for the child by a practitioner, in order to control or
383.14 punish the child; or other substances that substantially affect the child's behavior, motor
383.15 coordination, or judgment or that results in sickness or internal injury, or subjects the
383.16 child to medical procedures that would be unnecessary if the child were not exposed
383.17 to the substances;

383.18 (9) unreasonable physical confinement or restraint not permitted under section
383.19 609.379, including but not limited to tying, caging, or chaining; or

383.20 (10) in a school facility or school zone, an act by a person responsible for the child's
383.21 care that is a violation under section 121A.58.

383.22 (h) "Report" means any report received by the local welfare agency, police
383.23 department, county sheriff, or agency responsible for assessing or investigating
383.24 maltreatment pursuant to this section.

383.25 (i) "Facility" means:

383.26 (1) a licensed or unlicensed day care facility, residential facility, agency, hospital,
383.27 sanitarium, or other facility or institution required to be licensed under sections 144.50 to
383.28 144.58, 241.021, or 245A.01 to 245A.16, or chapter ~~245B~~ 245D;

383.29 (2) a school as defined in sections 120A.05, subdivisions 9, 11, and 13; and
383.30 124D.10; or

383.31 (3) a nonlicensed personal care provider organization as defined in sections 256B.04,
383.32 subdivision 16, and 256B.0625, subdivision 19a.

383.33 (j) "Operator" means an operator or agency as defined in section 245A.02.

383.34 (k) "Commissioner" means the commissioner of human services.

384.1 (l) "Practice of social services," for the purposes of subdivision 3, includes but is
384.2 not limited to employee assistance counseling and the provision of guardian ad litem and
384.3 parenting time expeditor services.

384.4 (m) "Mental injury" means an injury to the psychological capacity or emotional
384.5 stability of a child as evidenced by an observable or substantial impairment in the child's
384.6 ability to function within a normal range of performance and behavior with due regard to
384.7 the child's culture.

384.8 (n) "Threatened injury" means a statement, overt act, condition, or status that
384.9 represents a substantial risk of physical or sexual abuse or mental injury. Threatened
384.10 injury includes, but is not limited to, exposing a child to a person responsible for the
384.11 child's care, as defined in paragraph (e), clause (1), who has:

384.12 (1) subjected a child to, or failed to protect a child from, an overt act or condition
384.13 that constitutes egregious harm, as defined in section 260C.007, subdivision 14, or a
384.14 similar law of another jurisdiction;

384.15 (2) been found to be palpably unfit under section 260C.301, paragraph (b), clause
384.16 (4), or a similar law of another jurisdiction;

384.17 (3) committed an act that has resulted in an involuntary termination of parental rights
384.18 under section 260C.301, or a similar law of another jurisdiction; or

384.19 (4) committed an act that has resulted in the involuntary transfer of permanent
384.20 legal and physical custody of a child to a relative under Minnesota Statutes 2010, section
384.21 260C.201, subdivision 11, paragraph (d), clause (1), section 260C.515, subdivision 4, or a
384.22 similar law of another jurisdiction.

384.23 A child is the subject of a report of threatened injury when the responsible social
384.24 services agency receives birth match data under paragraph (o) from the Department of
384.25 Human Services.

384.26 (o) Upon receiving data under section 144.225, subdivision 2b, contained in a
384.27 birth record or recognition of parentage identifying a child who is subject to threatened
384.28 injury under paragraph (n), the Department of Human Services shall send the data to the
384.29 responsible social services agency. The data is known as "birth match" data. Unless the
384.30 responsible social services agency has already begun an investigation or assessment of the
384.31 report due to the birth of the child or execution of the recognition of parentage and the
384.32 parent's previous history with child protection, the agency shall accept the birth match
384.33 data as a report under this section. The agency may use either a family assessment or
384.34 investigation to determine whether the child is safe. All of the provisions of this section
384.35 apply. If the child is determined to be safe, the agency shall consult with the county
384.36 attorney to determine the appropriateness of filing a petition alleging the child is in need

385.1 of protection or services under section 260C.007, subdivision 6, clause (16), in order to
385.2 deliver needed services. If the child is determined not to be safe, the agency and the county
385.3 attorney shall take appropriate action as required under section 260C.301, subdivision 3.

385.4 (p) Persons who conduct assessments or investigations under this section shall take
385.5 into account accepted child-rearing practices of the culture in which a child participates
385.6 and accepted teacher discipline practices, which are not injurious to the child's health,
385.7 welfare, and safety.

385.8 (q) "Accidental" means a sudden, not reasonably foreseeable, and unexpected
385.9 occurrence or event which:

385.10 (1) is not likely to occur and could not have been prevented by exercise of due
385.11 care; and

385.12 (2) if occurring while a child is receiving services from a facility, happens when the
385.13 facility and the employee or person providing services in the facility are in compliance
385.14 with the laws and rules relevant to the occurrence or event.

385.15 (r) "Nonmaltreatment mistake" means:

385.16 (1) at the time of the incident, the individual was performing duties identified in the
385.17 center's child care program plan required under Minnesota Rules, part 9503.0045;

385.18 (2) the individual has not been determined responsible for a similar incident that
385.19 resulted in a finding of maltreatment for at least seven years;

385.20 (3) the individual has not been determined to have committed a similar
385.21 nonmaltreatment mistake under this paragraph for at least four years;

385.22 (4) any injury to a child resulting from the incident, if treated, is treated only with
385.23 remedies that are available over the counter, whether ordered by a medical professional or
385.24 not; and

385.25 (5) except for the period when the incident occurred, the facility and the individual
385.26 providing services were both in compliance with all licensing requirements relevant to the
385.27 incident.

385.28 This definition only applies to child care centers licensed under Minnesota
385.29 Rules, chapter 9503. If clauses (1) to (5) apply, rather than making a determination of
385.30 substantiated maltreatment by the individual, the commissioner of human services shall
385.31 determine that a nonmaltreatment mistake was made by the individual.

385.32 **EFFECTIVE DATE.** This section is effective January 1, 2014.

385.33 Sec. 14. Minnesota Statutes 2012, section 626.556, subdivision 3, is amended to read:

385.34 Subd. 3. **Persons mandated to report.** (a) A person who knows or has reason
385.35 to believe a child is being neglected or physically or sexually abused, as defined in

386.1 subdivision 2, or has been neglected or physically or sexually abused within the preceding
386.2 three years, shall immediately report the information to the local welfare agency, agency
386.3 responsible for assessing or investigating the report, police department, or the county
386.4 sheriff if the person is:

386.5 (1) a professional or professional's delegate who is engaged in the practice of
386.6 the healing arts, social services, hospital administration, psychological or psychiatric
386.7 treatment, child care, education, correctional supervision, probation and correctional
386.8 services, or law enforcement; or

386.9 (2) employed as a member of the clergy and received the information while
386.10 engaged in ministerial duties, provided that a member of the clergy is not required by
386.11 this subdivision to report information that is otherwise privileged under section 595.02,
386.12 subdivision 1, paragraph (c).

386.13 The police department or the county sheriff, upon receiving a report, shall
386.14 immediately notify the local welfare agency or agency responsible for assessing or
386.15 investigating the report, orally and in writing. The local welfare agency, or agency
386.16 responsible for assessing or investigating the report, upon receiving a report, shall
386.17 immediately notify the local police department or the county sheriff orally and in writing.
386.18 The county sheriff and the head of every local welfare agency, agency responsible
386.19 for assessing or investigating reports, and police department shall each designate a
386.20 person within their agency, department, or office who is responsible for ensuring that
386.21 the notification duties of this paragraph and paragraph (b) are carried out. Nothing in
386.22 this subdivision shall be construed to require more than one report from any institution,
386.23 facility, school, or agency.

386.24 (b) Any person may voluntarily report to the local welfare agency, agency responsible
386.25 for assessing or investigating the report, police department, or the county sheriff if the
386.26 person knows, has reason to believe, or suspects a child is being or has been neglected or
386.27 subjected to physical or sexual abuse. The police department or the county sheriff, upon
386.28 receiving a report, shall immediately notify the local welfare agency or agency responsible
386.29 for assessing or investigating the report, orally and in writing. The local welfare agency or
386.30 agency responsible for assessing or investigating the report, upon receiving a report, shall
386.31 immediately notify the local police department or the county sheriff orally and in writing.

386.32 (c) A person mandated to report physical or sexual child abuse or neglect occurring
386.33 within a licensed facility shall report the information to the agency responsible for
386.34 licensing the facility under sections 144.50 to 144.58; 241.021; 245A.01 to 245A.16; or
386.35 chapter ~~245B~~ 245D; or a nonlicensed personal care provider organization as defined in
386.36 sections 256B.04, subdivision 16; and 256B.0625, subdivision 19. A health or corrections

387.1 agency receiving a report may request the local welfare agency to provide assistance
387.2 pursuant to subdivisions 10, 10a, and 10b. A board or other entity whose licensees
387.3 perform work within a school facility, upon receiving a complaint of alleged maltreatment,
387.4 shall provide information about the circumstances of the alleged maltreatment to the
387.5 commissioner of education. Section 13.03, subdivision 4, applies to data received by the
387.6 commissioner of education from a licensing entity.

387.7 (d) Any person mandated to report shall receive a summary of the disposition of
387.8 any report made by that reporter, including whether the case has been opened for child
387.9 protection or other services, or if a referral has been made to a community organization,
387.10 unless release would be detrimental to the best interests of the child. Any person who is
387.11 not mandated to report shall, upon request to the local welfare agency, receive a concise
387.12 summary of the disposition of any report made by that reporter, unless release would be
387.13 detrimental to the best interests of the child.

387.14 (e) For purposes of this section, "immediately" means as soon as possible but in
387.15 no event longer than 24 hours.

387.16 **EFFECTIVE DATE.** This section is effective January 1, 2014.

387.17 Sec. 15. Minnesota Statutes 2012, section 626.556, subdivision 10d, is amended to read:

387.18 Subd. 10d. **Notification of neglect or abuse in facility.** (a) When a report is
387.19 received that alleges neglect, physical abuse, sexual abuse, or maltreatment of a child while
387.20 in the care of a licensed or unlicensed day care facility, residential facility, agency, hospital,
387.21 sanitarium, or other facility or institution required to be licensed according to sections
387.22 144.50 to 144.58; 241.021; or 245A.01 to 245A.16; or chapter ~~245B~~ 245D, or a school as
387.23 defined in sections 120A.05, subdivisions 9, 11, and 13; and 124D.10; or a nonlicensed
387.24 personal care provider organization as defined in section 256B.04, subdivision 16, and
387.25 256B.0625, subdivision 19a, the commissioner of the agency responsible for assessing
387.26 or investigating the report or local welfare agency investigating the report shall provide
387.27 the following information to the parent, guardian, or legal custodian of a child alleged to
387.28 have been neglected, physically abused, sexually abused, or the victim of maltreatment
387.29 of a child in the facility: the name of the facility; the fact that a report alleging neglect,
387.30 physical abuse, sexual abuse, or maltreatment of a child in the facility has been received;
387.31 the nature of the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child
387.32 in the facility; that the agency is conducting an assessment or investigation; any protective
387.33 or corrective measures being taken pending the outcome of the investigation; and that a
387.34 written memorandum will be provided when the investigation is completed.

388.1 (b) The commissioner of the agency responsible for assessing or investigating the
388.2 report or local welfare agency may also provide the information in paragraph (a) to the
388.3 parent, guardian, or legal custodian of any other child in the facility if the investigative
388.4 agency knows or has reason to believe the alleged neglect, physical abuse, sexual
388.5 abuse, or maltreatment of a child in the facility has occurred. In determining whether
388.6 to exercise this authority, the commissioner of the agency responsible for assessing
388.7 or investigating the report or local welfare agency shall consider the seriousness of the
388.8 alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility; the
388.9 number of children allegedly neglected, physically abused, sexually abused, or victims of
388.10 maltreatment of a child in the facility; the number of alleged perpetrators; and the length
388.11 of the investigation. The facility shall be notified whenever this discretion is exercised.

388.12 (c) When the commissioner of the agency responsible for assessing or investigating
388.13 the report or local welfare agency has completed its investigation, every parent, guardian,
388.14 or legal custodian previously notified of the investigation by the commissioner or
388.15 local welfare agency shall be provided with the following information in a written
388.16 memorandum: the name of the facility investigated; the nature of the alleged neglect,
388.17 physical abuse, sexual abuse, or maltreatment of a child in the facility; the investigator's
388.18 name; a summary of the investigation findings; a statement whether maltreatment was
388.19 found; and the protective or corrective measures that are being or will be taken. The
388.20 memorandum shall be written in a manner that protects the identity of the reporter and
388.21 the child and shall not contain the name, or to the extent possible, reveal the identity of
388.22 the alleged perpetrator or of those interviewed during the investigation. If maltreatment
388.23 is determined to exist, the commissioner or local welfare agency shall also provide the
388.24 written memorandum to the parent, guardian, or legal custodian of each child in the facility
388.25 who had contact with the individual responsible for the maltreatment. When the facility is
388.26 the responsible party for maltreatment, the commissioner or local welfare agency shall also
388.27 provide the written memorandum to the parent, guardian, or legal custodian of each child
388.28 who received services in the population of the facility where the maltreatment occurred.
388.29 This notification must be provided to the parent, guardian, or legal custodian of each child
388.30 receiving services from the time the maltreatment occurred until either the individual
388.31 responsible for maltreatment is no longer in contact with a child or children in the facility
388.32 or the conclusion of the investigation. In the case of maltreatment within a school facility,
388.33 as defined in sections 120A.05, subdivisions 9, 11, and 13, and 124D.10, the commissioner
388.34 of education need not provide notification to parents, guardians, or legal custodians of
388.35 each child in the facility, but shall, within ten days after the investigation is completed,
388.36 provide written notification to the parent, guardian, or legal custodian of any student

389.1 alleged to have been maltreated. The commissioner of education may notify the parent,
389.2 guardian, or legal custodian of any student involved as a witness to alleged maltreatment.

389.3 **EFFECTIVE DATE.** This section is effective January 1, 2014.

389.4 Sec. 16. **REPEALER.**

389.5 Minnesota Statutes 2012, section 256B.49, subdivision 16a, is repealed effective
389.6 January 1, 2014.

389.7 **ARTICLE 10**

389.8 **HEALTH-RELATED LICENSING BOARDS**

389.9 Section 1. Minnesota Statutes 2012, section 13.411, subdivision 7, is amended to read:

389.10 Subd. 7. **Examining and licensing boards.** (a) **Health licensing boards.** Data
389.11 held by health licensing boards are classified under sections 214.10, subdivision 8, and
389.12 214.25, subdivision 1.

389.13 (b) **Combined boards data.** Data held by licensing boards participating in a health
389.14 professional services program are classified under sections 214.34 and 214.35.

389.15 (c) **Criminal background checks.** Criminal history record information obtained by
389.16 a health-related licensing board is classified under section 214.075, subdivision 7.

389.17 Sec. 2. Minnesota Statutes 2012, section 148B.17, subdivision 2, is amended to read:

389.18 Subd. 2. **Licensure and application fees.** Nonrefundable licensure and application
389.19 fees ~~charged~~ established by the board ~~are as follows~~ shall not exceed the following amounts:

389.20 (1) application fee for national examination is ~~\$220~~ \$110;

389.21 (2) application fee for Licensed Marriage and Family Therapist (LMFT) state
389.22 examination is \$110;

389.23 (3) initial LMFT license fee is prorated, but cannot exceed \$125;

389.24 (4) annual renewal fee for LMFT license is \$125;

389.25 (5) late fee for ~~initial Licensed Associate Marriage and Family Therapist LAMFT~~
389.26 LMFT license renewal is \$50;

389.27 (6) application fee for LMFT licensure by reciprocity is ~~\$340~~ \$220;

389.28 (7) fee for initial Licensed Associate Marriage and Family Therapist (LAMFT)
389.29 license is \$75;

389.30 (8) annual renewal fee for LAMFT license is \$75;

389.31 (9) late fee for LAMFT renewal is ~~\$50~~ \$25;

389.32 (10) fee for reinstatement of license is \$150; and

390.1 (11) fee for emeritus status is \$125.

390.2 Sec. 3. Minnesota Statutes 2012, section 151.01, subdivision 27, is amended to read:

390.3 Subd. 27. **Practice of pharmacy.** "Practice of pharmacy" means:

390.4 (1) interpretation and evaluation of prescription drug orders;

390.5 (2) compounding, labeling, and dispensing drugs and devices (except labeling by
390.6 a manufacturer or packager of nonprescription drugs or commercially packaged legend
390.7 drugs and devices);

390.8 (3) participation in clinical interpretations and monitoring of drug therapy for
390.9 assurance of safe and effective use of drugs;

390.10 (4) participation in drug and therapeutic device selection; drug administration for first
390.11 dosage and medical emergencies; drug regimen reviews; and drug or drug-related research;

390.12 (5) participation in administration of influenza vaccines to all eligible individuals ten
390.13 years of age and older and all other vaccines to patients 18 years of age and older under
390.14 standing orders from a physician licensed under chapter 147 or by written protocol with a
390.15 physician licensed under chapter 147 provided that:

390.16 (i) the standing orders or protocol include, at a minimum, the name, dosage, and
390.17 route of each vaccine that may be given, the patient population to whom the vaccine may
390.18 be given, contraindications and precautions to the vaccine, the procedure for handling an
390.19 adverse reaction, the name and signature of the physician, the address of the physician, a
390.20 phone number at which the physician can be contacted, and the date and time period for
390.21 which the standing orders or protocol are valid;

390.22 ~~(i)~~ (ii) the pharmacist is trained in has successfully completed a program approved
390.23 by the American Accreditation Council of Pharmaceutical for Pharmacy Education,
390.24 specifically for the administration of immunizations, or graduated from a college of
390.25 pharmacy in 2001 or thereafter; and a program approved according to rules adopted by
390.26 the board;

390.27 (iii) the pharmacist completes continuing education concerning the administration of
390.28 immunizations, as required by Minnesota Rules;

390.29 (iv) the pharmacist has a current cardiopulmonary resuscitation certificate;

390.30 ~~(ii)~~ (v) the pharmacist reports the administration of the immunization to the patient's
390.31 primary physician or clinic or to the Minnesota Immunization Information Connection;

390.32 (vi) the pharmacist complies with guidelines for vaccines and immunizations
390.33 established by the federal Advisory Committee on Immunization Practices (ACIP), except
390.34 that a pharmacist does not need to comply with those guidelines if administering a vaccine
390.35 pursuant to a valid, patient-specific order issued by a physician licensed under chapter 147

391.1 when the order is consistent with United States Food and Drug Administration-approved
 391.2 labeling of the vaccine; and

391.3 (vii) the pharmacist complies with Centers for Disease Control and Prevention
 391.4 guidelines relating to immunization schedules, vaccine storage and handling, and vaccine
 391.5 administration and documentation;

391.6 (6) participation in the practice of managing drug therapy and modifying drug
 391.7 therapy, ~~according to section 151.21, subdivision 1,~~ according to a written protocol
 391.8 between the specific pharmacist and the individual dentist, optometrist, physician,
 391.9 podiatrist, or veterinarian who is responsible for the patient's care and authorized to
 391.10 independently prescribe drugs. Any significant changes in drug therapy must be reported
 391.11 by the pharmacist to the patient's medical record;

391.12 (7) participation in the storage of drugs and the maintenance of records;

391.13 (8) ~~responsibility for participation in~~ patient counseling on therapeutic values,
 391.14 content, hazards, and uses of drugs and devices; and

391.15 (9) offering or performing those acts, services, operations, or transactions necessary
 391.16 in the conduct, operation, management, and control of a pharmacy.

391.17 Sec. 4. Minnesota Statutes 2012, section 151.19, subdivision 1, is amended to read:

391.18 Subdivision 1. **Pharmacy registration licensure requirements.** ~~The board shall~~
 391.19 ~~require and provide for the annual registration of every pharmacy now or hereafter doing~~
 391.20 ~~business within this state. Upon the payment of any applicable fee specified in section~~
 391.21 ~~151.065, the board shall issue a registration certificate in such form as it may prescribe to~~
 391.22 ~~such persons as may be qualified by law to conduct a pharmacy. Such certificate shall~~
 391.23 ~~be displayed in a conspicuous place in the pharmacy for which it is issued and expire on~~
 391.24 ~~the 30th day of June following the date of issue. It shall be unlawful for any person to~~
 391.25 ~~conduct a pharmacy unless such certificate has been issued to the person by the board. (a)~~
 391.26 No person shall operate a pharmacy without first obtaining a license from the board and
 391.27 paying any applicable fee specified in section 151.065. The license shall be displayed in a
 391.28 conspicuous place in the pharmacy for which it is issued and expires on June 30 following
 391.29 the date of issue. It is unlawful for any person to operate a pharmacy unless the license
 391.30 has been issued to the person by the board.

391.31 (b) Application for a pharmacy license under this section shall be made in a manner
 391.32 specified by the board.

391.33 (c) No license shall be issued or renewed for a pharmacy located within the state
 391.34 unless the applicant agrees to operate the pharmacy in a manner prescribed by federal and
 391.35 state law and according to rules adopted by the board. No license shall be issued for a

392.1 pharmacy located outside of the state unless the applicant agrees to operate the pharmacy
392.2 in a manner prescribed by federal law and, when dispensing medications for residents of
392.3 this state, the laws of this state, and Minnesota Rules.

392.4 (d) No license shall be issued or renewed for a pharmacy that is required to be
392.5 licensed or registered by the state in which it is physically located unless the applicant
392.6 supplies the board with proof of such licensure or registration.

392.7 (e) The board shall require a separate license for each pharmacy located within
392.8 the state and for each pharmacy located outside of the state at which any portion of the
392.9 dispensing process occurs for drugs dispensed to residents of this state.

392.10 (f) The board shall not issue an initial or renewed license for a pharmacy unless the
392.11 pharmacy passes an inspection conducted by an authorized representative of the board. In
392.12 the case of a pharmacy located outside of the state, the board may require the applicant to
392.13 pay the cost of the inspection, in addition to the license fee in section 151.065, unless the
392.14 applicant furnishes the board with a report, issued by the appropriate regulatory agency of
392.15 the state in which the facility is located, of an inspection that has occurred within the 24
392.16 months immediately preceding receipt of the license application by the board. The board
392.17 may deny licensure unless the applicant submits documentation satisfactory to the board
392.18 that any deficiencies noted in an inspection report have been corrected.

392.19 (g) The board shall not issue an initial or renewed license for a pharmacy located
392.20 outside of the state unless the applicant discloses and certifies:

392.21 (1) the location, names, and titles of all principal corporate officers and all
392.22 pharmacists who are involved in dispensing drugs to residents of this state;

392.23 (2) that it maintains its records of drugs dispensed to residents of this state so that the
392.24 records are readily retrievable from the records of other drugs dispensed;

392.25 (3) that it agrees to cooperate with, and provide information to, the board concerning
392.26 matters related to dispensing drugs to residents of this state;

392.27 (4) that, during its regular hours of operation, but no less than six days per week, for
392.28 a minimum of 40 hours per week, a toll-free telephone service is provided to facilitate
392.29 communication between patients in this state and a pharmacist at the pharmacy who has
392.30 access to the patients' records; the toll-free number must be disclosed on the label affixed
392.31 to each container of drugs dispensed to residents of this state; and

392.32 (5) that, upon request of a resident of a long-term care facility located in this
392.33 state, the resident's authorized representative, or a contract pharmacy or licensed health
392.34 care facility acting on behalf of the resident, the pharmacy will dispense medications
392.35 prescribed for the resident in unit-dose packaging or, alternatively, comply with section
392.36 151.415, subdivision 5.

393.1 Sec. 5. Minnesota Statutes 2012, section 151.19, subdivision 3, is amended to read:

393.2 Subd. 3. **Sale of federally restricted medical gases.** ~~The board shall require and~~
393.3 ~~provide for the annual registration of every person or establishment not licensed as a~~
393.4 ~~pharmacy or a practitioner engaged in the retail sale or distribution of federally restricted~~
393.5 ~~medical gases. Upon the payment of any applicable fee specified in section 151.065, the~~
393.6 ~~board shall issue a registration certificate in such form as it may prescribe to those persons~~
393.7 ~~or places that may be qualified to sell or distribute federally restricted medical gases. The~~
393.8 ~~certificate shall be displayed in a conspicuous place in the business for which it is issued~~
393.9 ~~and expire on the date set by the board. It is unlawful for a person to sell or distribute~~
393.10 ~~federally restricted medical gases unless a certificate has been issued to that person by the~~
393.11 ~~board.~~ (a) A person or establishment not licensed as a pharmacy or a practitioner shall not
393.12 engage in the retail sale or distribution of federally restricted medical gases without first
393.13 obtaining a registration from the board and paying the applicable fee specified in section
393.14 151.065. The registration shall be displayed in a conspicuous place in the business for
393.15 which it is issued and expires on the date set by the board. It is unlawful for a person to
393.16 sell or distribute federally restricted medical gases unless a certificate has been issued to
393.17 that person by the board.

393.18 (b) Application for a medical gas distributor registration under this section shall be
393.19 made in a manner specified by the board.

393.20 (c) No registration shall be issued or renewed for a medical gas distributor located
393.21 within the state unless the applicant agrees to operate in a manner prescribed by federal
393.22 and state law and according to the rules adopted by the board. No license shall be issued
393.23 for a medical gas distributor located outside of the state unless the applicant agrees to
393.24 operate in a manner prescribed by federal law and, when distributing medical gases for
393.25 residents of this state, the laws of this state and Minnesota Rules.

393.26 (d) No registration shall be issued or renewed for a medical gas distributor that is
393.27 required to be licensed or registered by the state in which it is physically located unless the
393.28 applicant supplies the board with proof of the licensure or registration. The board may, by
393.29 rule, establish standards for the registration of a medical gas distributor that is not required
393.30 to be licensed or registered by the state in which it is physically located.

393.31 (e) The board shall require a separate registration for each medical gas distributor
393.32 located within the state and for each facility located outside of the state from which
393.33 medical gases are distributed to residents of this state.

393.34 (f) The board shall not issue an initial or renewed registration for a medical gas
393.35 distributor unless the medical gas distributor passes an inspection conducted by an
393.36 authorized representative of the board. In the case of a medical gas distributor located

394.1 outside of the state, the board may require the applicant to pay the cost of the inspection,
394.2 in addition to the license fee in section 151.065, unless the applicant furnishes the board
394.3 with a report, issued by the appropriate regulatory agency of the state in which the facility
394.4 is located, of an inspection that has occurred within the 24 months immediately preceding
394.5 receipt of the license application by the board. The board may deny licensure unless the
394.6 applicant submits documentation satisfactory to the board that any deficiencies noted in
394.7 an inspection report have been corrected.

394.8 **Sec. 6. [151.252] LICENSING OF DRUG MANUFACTURERS; FEES;**
394.9 **PROHIBITIONS.**

394.10 Subdivision 1. **Requirements.** (a) No person shall act as a manufacturer without
394.11 first obtaining a license from the board and paying any applicable fee specified in section
394.12 151.065.

394.13 (b) Application for a manufacturer license under this section shall be made in a
394.14 manner specified by the board.

394.15 (c) No license shall be issued or renewed for a manufacturer unless the applicant
394.16 agrees to operate in a manner prescribed by federal and state law and according to
394.17 Minnesota Rules.

394.18 (d) No license shall be issued or renewed for a manufacturer that is required to
394.19 be registered pursuant to United State Code, title 21, section 360, unless the applicant
394.20 supplies the board with proof of registration. The board may establish by rule the
394.21 standards for licensure of manufacturers that are not required to be registered under United
394.22 States Code, title 21, section 360.

394.23 (e) No license shall be issued or renewed for a manufacturer that is required to be
394.24 licensed or registered by the state in which it is physically located unless the applicant
394.25 supplies the board with proof of licensure or registration. The board may establish, by
394.26 rule, standards for the licensure of a manufacturer that is not required to be licensed or
394.27 registered by the state in which it is physically located.

394.28 (f) The board shall require a separate license for each facility located within the state
394.29 at which manufacturing occurs and for each facility located outside of the state at which
394.30 drugs that are shipped into the state are manufactured.

394.31 (g) The board shall not issue an initial or renewed license for a manufacturing
394.32 facility unless the facility passes an inspection conducted by an authorized representative
394.33 of the board. In the case of a manufacturing facility located outside of the state, the board
394.34 may require the applicant to pay the cost of the inspection, in addition to the license fee
394.35 in section 151.065, unless the applicant furnishes the board with a report, issued by the

395.1 appropriate regulatory agency of the state in which the facility is located or by the United
395.2 States Food and Drug Administration, of an inspection that has occurred within the 24
395.3 months immediately preceding receipt of the license application by the board. The board
395.4 may deny licensure unless the applicant submits documentation satisfactory to the board
395.5 that any deficiencies noted in an inspection report have been corrected.

395.6 Subd. 2. **Prohibition.** It is unlawful for any person engaged in manufacturing to sell
395.7 legend drugs to anyone located in this state except as provided in this chapter.

395.8 Sec. 7. Minnesota Statutes 2012, section 151.26, subdivision 1, is amended to read:

395.9 Subdivision 1. **Generally.** Nothing in this chapter shall subject a person duly
395.10 licensed in this state to practice medicine, dentistry, or veterinary medicine, to inspection
395.11 by the State Board of Pharmacy, nor prevent the person from administering drugs,
395.12 medicines, chemicals, or poisons in the person's practice, nor prevent a duly licensed
395.13 practitioner from furnishing to a patient properly packaged and labeled drugs, medicines,
395.14 chemicals, or poisons as may be considered appropriate in the treatment of such patient;
395.15 unless the person is engaged in the dispensing, sale, or distribution of drugs and the board
395.16 provides reasonable notice of an inspection.

395.17 Except for the provisions of section 151.37, nothing in this chapter applies to or
395.18 interferes with the dispensing, in its original package and at no charge to the patient, of
395.19 a legend drug, ~~other than a controlled substance,~~ that was packaged by a manufacturer
395.20 and provided to the dispenser for ~~distribution~~ dispensing as a professional sample, so
395.21 long as the sample is prepared and distributed pursuant to Code of Federal Regulations,
395.22 title 21, section 203, subpart D.

395.23 Nothing in this chapter shall prevent the sale of drugs, medicines, chemicals, or
395.24 poisons at wholesale to licensed physicians, dentists and veterinarians for use in their
395.25 practice, nor to hospitals for use therein.

395.26 Nothing in this chapter shall prevent the sale of drugs, chemicals, or poisons either
395.27 at wholesale or retail for use for commercial purposes, or in the arts, nor interfere with the
395.28 sale of insecticides, as defined in Minnesota Statutes 1974, section 24.069, and nothing in
395.29 this chapter shall prevent the sale of common household preparations and other drugs,
395.30 chemicals, and poisons sold exclusively for use for nonmedicinal purposes.

395.31 Nothing in this chapter shall apply to or interfere with the vending or retailing
395.32 of any nonprescription medicine or drug not otherwise prohibited by statute which is
395.33 prepackaged, fully prepared by the manufacturer or producer for use by the consumer, and
395.34 labeled in accordance with the requirements of the state or federal Food and Drug Act; nor
395.35 to the manufacture, wholesaling, vending, or retailing of flavoring extracts, toilet articles,

396.1 cosmetics, perfumes, spices, and other commonly used household articles of a chemical
396.2 nature, for use for nonmedicinal purposes. Nothing in this chapter shall prevent the sale of
396.3 drugs or medicines by licensed pharmacists at a discount to persons over 65 years of age.

396.4 Sec. 8. Minnesota Statutes 2012, section 151.37, subdivision 4, is amended to read:

396.5 Subd. 4. **Research.** (a) Any qualified person may use legend drugs in the course
396.6 of a bona fide research project, but cannot administer or dispense such drugs to human
396.7 beings unless such drugs are prescribed, dispensed, and administered by a person lawfully
396.8 authorized to do so.

396.9 (b) Drugs may be dispensed or distributed by a pharmacy licensed by the board for
396.10 use by, or administration to, patients enrolled in a bona fide research study that is being
396.11 conducted pursuant to either an investigational new drug application approved by the
396.12 United States Food and Drug Administration or that has been approved by an institutional
396.13 review board. For the purposes of this subdivision only:

396.14 (1) a prescription drug order is not required for a pharmacy to dispense a research
396.15 drug, unless the study protocol requires the pharmacy to receive such an order;

396.16 (2) notwithstanding the prescription labeling requirements found in this chapter or
396.17 the rules promulgated by the board, a research drug may be labeled as required by the
396.18 study protocol; and

396.19 (3) dispensing and distribution of research drugs by pharmacies shall not be
396.20 considered compounding, manufacturing, or wholesaling under this chapter.

396.21 (c) An entity that is under contract to a federal agency for the purpose of distributing
396.22 drugs for bona fide research studies is exempt from the drug wholesaler licensing
396.23 requirements of this chapter. Any other entity is exempt from the drug wholesaler
396.24 licensing requirements of this chapter if the board finds that the entity is licensed or
396.25 registered according to the laws of the state in which it is physically located and it is
396.26 distributing drugs for use by, or administration to, patients enrolled in a bona fide research
396.27 study that is being conducted pursuant to either an investigational new drug application
396.28 approved by the United States Food and Drug Administration or that has been approved
396.29 by an institutional review board.

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

396.31 Sec. 9. Minnesota Statutes 2012, section 151.47, subdivision 1, is amended to read:

396.32 Subdivision 1. **Requirements.** (a) All wholesale drug distributors are subject to the
396.33 requirements ~~in paragraphs (a) to (f)~~ of this subdivision.

397.1 ~~(a)~~ (b) No person or distribution outlet shall act as a wholesale drug distributor
397.2 without first obtaining a license from the board and paying any applicable fee specified
397.3 in section 151.065.

397.4 (c) Application for a wholesale drug distributor license under this section shall be
397.5 made in a manner specified by the board.

397.6 ~~(b)~~ (d) No license shall be issued or renewed for a wholesale drug distributor to
397.7 operate unless the applicant agrees to operate in a manner prescribed by federal and state
397.8 law and according to the rules adopted by the board.

397.9 ~~(e) The board may require a separate license for each facility directly or indirectly~~
397.10 ~~owned or operated by the same business entity within the state, or for a parent entity~~
397.11 ~~with divisions, subsidiaries, or affiliate companies within the state, when operations~~
397.12 ~~are conducted at more than one location and joint ownership and control exists among~~
397.13 ~~all the entities.~~

397.14 (e) No license may be issued or renewed for a drug wholesale distributor that is
397.15 required to be licensed or registered by the state in which it is physically located unless
397.16 the applicant supplies the board with proof of licensure or registration. The board may
397.17 establish, by rule, standards for the licensure of a drug wholesale distributor that is not
397.18 required to be licensed or registered by the state in which it is physically located.

397.19 (f) The board shall require a separate license for each drug wholesale distributor
397.20 facility located within the state and for each drug wholesale distributor facility located
397.21 outside of the state from which drugs are shipped into the state or to which drugs are
397.22 reverse distributed.

397.23 (g) The board shall not issue an initial or renewed license for a drug wholesale
397.24 distributor facility unless the facility passes an inspection conducted by an authorized
397.25 representative of the board. In the case of a drug wholesale distributor facility located
397.26 outside of the state, the board may require the applicant to pay the cost of the inspection,
397.27 in addition to the license fee in section 151.065, unless the applicant furnishes the board
397.28 with a report, issued by the appropriate regulatory agency of the state in which the facility
397.29 is located, of an inspection that has occurred within the 24 months immediately preceding
397.30 receipt of the license application by the board. The board may deny licensure unless the
397.31 applicant submits documentation satisfactory to the board that any deficiencies noted in
397.32 an inspection report have been corrected.

397.33 ~~(d)~~ (h) As a condition for receiving and retaining a wholesale drug distributor license
397.34 issued under sections 151.42 to 151.51, an applicant shall satisfy the board that it has
397.35 and will continuously maintain:

397.36 (1) adequate storage conditions and facilities;

398.1 (2) minimum liability and other insurance as may be required under any applicable
398.2 federal or state law;

398.3 (3) a viable security system that includes an after hours central alarm, or comparable
398.4 entry detection capability; restricted access to the premises; comprehensive employment
398.5 applicant screening; and safeguards against all forms of employee theft;

398.6 (4) a system of records describing all wholesale drug distributor activities set forth
398.7 in section 151.44 for at least the most recent two-year period, which shall be reasonably
398.8 accessible as defined by board regulations in any inspection authorized by the board;

398.9 (5) principals and persons, including officers, directors, primary shareholders,
398.10 and key management executives, who must at all times demonstrate and maintain their
398.11 capability of conducting business in conformity with sound financial practices as well
398.12 as state and federal law;

398.13 (6) complete, updated information, to be provided to the board as a condition for
398.14 obtaining and retaining a license, about each wholesale drug distributor to be licensed,
398.15 including all pertinent corporate licensee information, if applicable, or other ownership,
398.16 principal, key personnel, and facilities information found to be necessary by the board;

398.17 (7) written policies and procedures that assure reasonable wholesale drug distributor
398.18 preparation for, protection against, and handling of any facility security or operation
398.19 problems, including, but not limited to, those caused by natural disaster or government
398.20 emergency, inventory inaccuracies or product shipping and receiving, outdated product
398.21 or other unauthorized product control, appropriate disposition of returned goods, and
398.22 product recalls;

398.23 (8) sufficient inspection procedures for all incoming and outgoing product
398.24 shipments; and

398.25 (9) operations in compliance with all federal requirements applicable to wholesale
398.26 drug distribution.

398.27 ~~(e) (i) An agent or employee of any licensed wholesale drug distributor need not~~
398.28 ~~seek licensure under this section.~~

398.29 ~~(f) A wholesale drug distributor shall file with the board an annual report, in a~~
398.30 ~~form and on the date prescribed by the board, identifying all payments, honoraria,~~
398.31 ~~reimbursement or other compensation authorized under section 151.461, clauses (3) to~~
398.32 ~~(5), paid to practitioners in Minnesota during the preceding calendar year. The report~~
398.33 ~~shall identify the nature and value of any payments totaling \$100 or more, to a particular~~
398.34 ~~practitioner during the year, and shall identify the practitioner. Reports filed under this~~
398.35 ~~provision are public data.~~

399.1 Sec. 10. Minnesota Statutes 2012, section 151.47, is amended by adding a subdivision
399.2 to read:

399.3 Subd. 3. **Prohibition.** It is unlawful for any person engaged in wholesale drug
399.4 distribution to sell drugs to anyone located within the state or to receive drugs in reverse
399.5 distribution from anyone located within the state except as provided in this chapter.

399.6 Sec. 11. Minnesota Statutes 2012, section 151.49, is amended to read:

399.7 **151.49 LICENSE RENEWAL APPLICATION PROCEDURES.**

399.8 Application blanks or notices for renewal of a license required by sections 151.42
399.9 to 151.51 shall be mailed or otherwise provided to each licensee on or before the first
399.10 day of the month prior to the month in which the license expires and, if application for
399.11 renewal of the license with the required fee and supporting documents is not made before
399.12 the expiration date, the existing license or renewal shall lapse and become null and void
399.13 upon the date of expiration.

399.14 Sec. 12. Minnesota Statutes 2012, section 152.126, is amended to read:

399.15 **152.126 ~~CONTROLLED SUBSTANCES PRESCRIPTION ELECTRONIC~~**
399.16 **~~REPORTING SYSTEM PRESCRIPTION MONITORING PROGRAM.~~**

399.17 Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in
399.18 this subdivision have the meanings given.

399.19 ~~(a)~~ (b) "Board" means the Minnesota State Board of Pharmacy established under
399.20 chapter 151.

399.21 ~~(b)~~ (c) "Controlled substances" means those substances listed in section 152.02,
399.22 subdivisions 3 to ~~5~~ 6, and those substances defined by the board pursuant to section
399.23 152.02, subdivisions 7, 8, and 12. For the purpose of this section only, "controlled
399.24 substances" includes tramadol and butalbital.

399.25 ~~(c)~~ (d) "Dispense" or "dispensing" has the meaning given in section 151.01,
399.26 subdivision 30. Dispensing does not include the direct administering of a controlled
399.27 substance to a patient by a licensed health care professional.

399.28 ~~(d)~~ (e) "Dispenser" means a person authorized by law to dispense a controlled
399.29 substance, pursuant to a valid prescription. For the purposes of this section, a dispenser does
399.30 not include a licensed hospital pharmacy that distributes controlled substances for inpatient
399.31 hospital care or a veterinarian who is dispensing prescriptions under section 156.18.

399.32 ~~(e)~~ (f) "Prescriber" means a licensed health care professional who is authorized to
399.33 prescribe a controlled substance under section 152.12, subdivision 1.

399.34 ~~(f)~~ (g) "Prescription" has the meaning given in section 151.01, subdivision 16.

400.1 Subd. 1a. **Treatment of intractable pain.** This section is not intended to limit or
400.2 interfere with the legitimate prescribing of controlled substances for pain. No prescriber
400.3 shall be subject to disciplinary action by a health-related licensing board for prescribing a
400.4 controlled substance according to the provisions of section 152.125.

400.5 Subd. 2. **Prescription electronic reporting system.** (a) The board shall establish
400.6 by January 1, 2010, an electronic system for reporting the information required under
400.7 subdivision 4 for all controlled substances dispensed within the state.

400.8 (b) The board may contract with a vendor for the purpose of obtaining technical
400.9 assistance in the design, implementation, operation, and maintenance of the electronic
400.10 reporting system.

400.11 Subd. 3. **Prescription Electronic Reporting Monitoring Program Advisory**
400.12 **Committee.** (a) The board shall convene an advisory committee. The committee must
400.13 include at least one representative of:

400.14 (1) the Department of Health;

400.15 (2) the Department of Human Services;

400.16 (3) each health-related licensing board that licenses prescribers;

400.17 (4) a professional medical association, which may include an association of pain
400.18 management and chemical dependency specialists;

400.19 (5) a professional pharmacy association;

400.20 (6) a professional nursing association;

400.21 (7) a professional dental association;

400.22 (8) a consumer privacy or security advocate; ~~and~~

400.23 (9) a consumer or patient rights organization; and

400.24 (10) an association of medical examiners and coroners.

400.25 (b) The advisory committee shall advise the board on the development and operation
400.26 of the ~~electronic reporting system~~ prescription monitoring program, including, but not
400.27 limited to:

400.28 (1) technical standards for electronic prescription drug reporting;

400.29 (2) proper analysis and interpretation of prescription monitoring data; and

400.30 (3) an evaluation process for the program.

400.31 Subd. 4. **Reporting requirements; notice.** (a) Each dispenser must submit the
400.32 following data to the board or its designated vendor, ~~subject to the notice required under~~
400.33 ~~paragraph (d):~~

400.34 (1) name of the prescriber;

400.35 (2) national provider identifier of the prescriber;

400.36 (3) name of the dispenser;

- 401.1 (4) national provider identifier of the dispenser;
- 401.2 (5) prescription number;
- 401.3 (6) name of the patient for whom the prescription was written;
- 401.4 (7) address of the patient for whom the prescription was written;
- 401.5 (8) date of birth of the patient for whom the prescription was written;
- 401.6 (9) date the prescription was written;
- 401.7 (10) date the prescription was filled;
- 401.8 (11) name and strength of the controlled substance;
- 401.9 (12) quantity of controlled substance prescribed;
- 401.10 (13) quantity of controlled substance dispensed; and
- 401.11 (14) number of days supply.

401.12 (b) The dispenser must submit the required information by a procedure and in a
 401.13 format established by the board. The board may allow dispensers to omit data listed in this
 401.14 subdivision or may require the submission of data not listed in this subdivision provided
 401.15 the omission or submission is necessary for the purpose of complying with the electronic
 401.16 reporting or data transmission standards of the American Society for Automation in
 401.17 Pharmacy, the National Council on Prescription Drug Programs, or other relevant national
 401.18 standard-setting body.

401.19 (c) A dispenser is not required to submit this data for those controlled substance
 401.20 prescriptions dispensed for:

- 401.21 ~~(1) individuals residing in licensed skilled nursing or intermediate care facilities;~~
- 401.22 ~~(2) individuals receiving assisted living services under chapter 144G or through a~~
 401.23 ~~medical assistance home and community-based waiver;~~
- 401.24 ~~(3) individuals receiving medication intravenously;~~
- 401.25 ~~(4) individuals receiving hospice and other palliative or end-of-life care; and~~
- 401.26 ~~(5) individuals receiving services from a home care provider regulated under~~
 401.27 ~~chapter 144A. individuals residing in a health care facility as defined in section 151.58,~~
 401.28 ~~subdivision 2, paragraph (b), when a drug is distributed through the use of an automated~~
 401.29 ~~drug distribution system according to section 151.58; and~~
- 401.30 (2) individuals receiving a drug sample that was packaged by a manufacturer and
 401.31 provided to the dispenser for dispensing as a professional sample pursuant to Code of
 401.32 Federal Regulations, title 21, section 203, subpart D.

401.33 (d) A dispenser must ~~not submit data under this subdivision unless~~ provide a
 401.34 conspicuous notice of the reporting requirements of this section is ~~given~~ to the patient for
 401.35 whom the prescription was written.

402.1 Subd. 5. **Use of data by board.** (a) The board shall develop and maintain a database
402.2 of the data reported under subdivision 4. The board shall maintain data that could identify
402.3 an individual prescriber or dispenser in encrypted form. The database may be used by
402.4 permissible users identified under subdivision 6 for the identification of:

402.5 (1) individuals receiving prescriptions for controlled substances from prescribers
402.6 who subsequently obtain controlled substances from dispensers in quantities or with a
402.7 frequency inconsistent with generally recognized standards of use for those controlled
402.8 substances, including standards accepted by national and international pain management
402.9 associations; and

402.10 (2) individuals presenting forged or otherwise false or altered prescriptions for
402.11 controlled substances to dispensers.

402.12 (b) No permissible user identified under subdivision 6 may access the database
402.13 for the sole purpose of identifying prescribers of controlled substances for unusual or
402.14 excessive prescribing patterns without a valid search warrant or court order.

402.15 (c) No personnel of a state or federal occupational licensing board or agency may
402.16 access the database for the purpose of obtaining information to be used to initiate or
402.17 substantiate a disciplinary action against a prescriber.

402.18 (d) Data reported under subdivision 4 shall be retained by the board in ~~the~~ an active
402.19 database for a 12-month period, and shall be removed from the active database no later
402.20 than 12 months from the last day of the month during which the data was received. The
402.21 board may transfer the data into a database that may only be used by the authorized staff
402.22 of the board for the purposes of administering, operating, and maintaining the prescription
402.23 monitoring program and conducting trend analyses and other studies as necessary to
402.24 evaluate the effectiveness of the program. No data that can be used to identify an
402.25 individual may be transferred into this database.

402.26 Subd. 6. **Access to reporting system data.** (a) Except as indicated in this
402.27 subdivision, the data submitted to the board under subdivision 4 is private data on
402.28 individuals as defined in section 13.02, subdivision 12, and not subject to public disclosure.

402.29 (b) Except as specified in subdivision 5, the following persons shall be considered
402.30 permissible users and may access the data submitted under subdivision 4 in the same or
402.31 similar manner, and for the same or similar purposes, as those persons who are authorized
402.32 to access similar private data on individuals under federal and state law:

402.33 (1) a prescriber or an agent or employee of the prescriber to whom the prescriber has
402.34 delegated the task of accessing the data, to the extent the information relates specifically to
402.35 a current patient, to whom the prescriber is prescribing or considering prescribing any
402.36 controlled substance or to whom the prescriber is providing other medical treatment for

403.1 which access to the data may be necessary and with the provision that the prescriber remains
 403.2 responsible for the use or misuse of data accessed by a delegated agent or employee;

403.3 (2) a dispenser or an agent or employee of the dispenser to whom the dispenser has
 403.4 delegated the task of accessing the data, to the extent the information relates specifically
 403.5 to a current patient to whom that dispenser is dispensing or considering dispensing any
 403.6 controlled substance or to whom the dispenser is providing other pharmaceutical care for
 403.7 which access to the data may be necessary and with the provision that the dispenser remains
 403.8 responsible for the use or misuse of data accessed by a delegated agent or employee;

403.9 (3) a licensed pharmacist who is providing pharmaceutical care for which access to
 403.10 the data may be necessary or when consulted by a prescriber who is requesting data in
 403.11 accordance with clause (1);

403.12 ~~(3)~~ (4) an individual who is the recipient of a controlled substance prescription for
 403.13 which data was submitted under subdivision 4, or a guardian of the individual, parent or
 403.14 guardian of a minor, or health care agent of the individual acting under a health care
 403.15 directive under chapter 145C;

403.16 ~~(4)~~ (5) personnel of the board specifically assigned to conduct a bona fide
 403.17 investigation of a specific licensee;

403.18 ~~(5)~~ (6) personnel of the board engaged in the collection of controlled substance
 403.19 prescription information as part of the assigned duties and responsibilities under this
 403.20 section;

403.21 ~~(6)~~ (7) authorized personnel of a vendor under contract with the board who are
 403.22 engaged in the design, implementation, operation, and maintenance of the ~~electronic~~
 403.23 ~~reporting system~~ prescription monitoring program as part of the assigned duties and
 403.24 responsibilities of their employment, provided that access to data is limited to the
 403.25 minimum amount necessary to carry out such duties and responsibilities;

403.26 ~~(7)~~ (8) federal, state, and local law enforcement authorities acting pursuant to a
 403.27 valid search warrant; ~~and~~

403.28 ~~(8)~~ (9) personnel of the ~~medical assistance program~~ Minnesota health care programs
 403.29 assigned to use the data collected under this section to identify and manage recipients
 403.30 whose usage of controlled substances may warrant restriction to a single primary care
 403.31 ~~physician provider~~, a single outpatient pharmacy, ~~or~~ and a single hospital; and

403.32 (10) a coroner or medical examiner, or an agent or employee of the coroner or
 403.33 medical examiner to whom the coroner or medical examiner has delegated the task of
 403.34 accessing the data, conducting an investigation pursuant to section 390.11, and with the
 403.35 provision that the coroner or medical examiner remains responsible for the use or misuse
 403.36 of data accessed by a delegated agent or employee.

404.1 For purposes of clause ~~(3)~~ (4), access by an individual includes persons in the
404.2 definition of an individual under section 13.02.

404.3 (c) Any permissible user identified in paragraph (b), who directly accesses
404.4 the data electronically, shall implement and maintain a comprehensive information
404.5 security program that contains administrative, technical, and physical safeguards that
404.6 are appropriate to the user's size and complexity, and the sensitivity of the personal
404.7 information obtained. The permissible user shall identify reasonably foreseeable internal
404.8 and external risks to the security, confidentiality, and integrity of personal information
404.9 that could result in the unauthorized disclosure, misuse, or other compromise of the
404.10 information and assess the sufficiency of any safeguards in place to control the risks.

404.11 (d) The board shall not release data submitted under this section unless it is provided
404.12 with evidence, satisfactory to the board, that the person requesting the information is
404.13 entitled to receive the data.

404.14 ~~(e) The board shall not release the name of a prescriber without the written consent
404.15 of the prescriber or a valid search warrant or court order. The board shall provide a
404.16 mechanism for a prescriber to submit to the board a signed consent authorizing the release
404.17 of the prescriber's name when data containing the prescriber's name is requested.~~

404.18 ~~(f)~~ (f) The board shall maintain a log of all persons who access the data for a period of
404.19 at least five years and shall ensure that any permissible user complies with paragraph (c)
404.20 prior to attaining direct access to the data.

404.21 ~~(g)~~ (f) Section 13.05, subdivision 6, shall apply to any contract the board enters into
404.22 pursuant to subdivision 2. A vendor shall not use data collected under this section for
404.23 any purpose not specified in this section.

404.24 (g) The board may participate in an interstate prescription monitoring program data
404.25 exchange system provided that permissible users in other states may have access to the data
404.26 only as allowed under this section and that section 13.05, subdivision 6, shall apply to any
404.27 contract or memorandum of understanding that the board enters into under this paragraph.

404.28 **Subd. 7. Disciplinary action.** (a) A dispenser who knowingly fails to submit data to
404.29 the board as required under this section is subject to disciplinary action by the appropriate
404.30 health-related licensing board.

404.31 (b) A prescriber or dispenser authorized to access the data who knowingly discloses
404.32 the data in violation of state or federal laws relating to the privacy of health care data
404.33 shall be subject to disciplinary action by the appropriate health-related licensing board,
404.34 and appropriate civil penalties.

404.35 ~~**Subd. 8. Evaluation and reporting.** (a) The board shall evaluate the prescription~~
404.36 ~~electronic reporting system to determine if the system is negatively impacting appropriate~~

405.1 ~~prescribing practices of controlled substances. The board may contract with a vendor to~~
 405.2 ~~design and conduct the evaluation.~~

405.3 ~~(b) The board shall submit the evaluation of the system to the legislature by July~~
 405.4 ~~15, 2011.~~

405.5 Subd. 9. **Immunity from liability; no requirement to obtain information.** (a) A
 405.6 pharmacist, prescriber, or other dispenser making a report to the program in good faith
 405.7 under this section is immune from any civil, criminal, or administrative liability, which
 405.8 might otherwise be incurred or imposed as a result of the report, or on the basis that the
 405.9 pharmacist or prescriber did or did not seek or obtain or use information from the program.

405.10 (b) Nothing in this section shall require a pharmacist, prescriber, or other dispenser
 405.11 to obtain information about a patient from the program, and the pharmacist, prescriber,
 405.12 or other dispenser, if acting in good faith, is immune from any civil, criminal, or
 405.13 administrative liability that might otherwise be incurred or imposed for requesting,
 405.14 receiving, or using information from the program.

405.15 Subd. 10. **Funding.** (a) The board may seek grants and private funds from nonprofit
 405.16 charitable foundations, the federal government, and other sources to fund the enhancement
 405.17 and ongoing operations of the prescription ~~electronic reporting system~~ monitoring
 405.18 program established under this section. Any funds received shall be appropriated to the
 405.19 board for this purpose. The board may not expend funds to enhance the program in a way
 405.20 that conflicts with this section without seeking approval from the legislature.

405.21 (b) Notwithstanding any other section, the administrative services unit for the
 405.22 health-related licensing boards shall apportion between the Board of Medical Practice, the
 405.23 Board of Nursing, the Board of Dentistry, the Board of Podiatric Medicine, the Board of
 405.24 Optometry, the Board of Veterinary Medicine, and the Board of Pharmacy an amount to
 405.25 be paid through fees by each respective board. The amount apportioned to each board
 405.26 shall equal each board's share of the annual appropriation to the Board of Pharmacy
 405.27 from the state government special revenue fund for operating the prescription ~~electronic~~
 405.28 ~~reporting system~~ monitoring program under this section. Each board's apportioned share
 405.29 shall be based on the number of prescribers or dispensers that each board identified in
 405.30 this paragraph licenses as a percentage of the total number of prescribers and dispensers
 405.31 licensed collectively by these boards. Each respective board may adjust the fees that the
 405.32 boards are required to collect to compensate for the amount apportioned to each board by
 405.33 the administrative services unit.

405.34 Sec. 13. **[214.075] HEALTH-RELATED LICENSING BOARDS; CRIMINAL**
 405.35 **BACKGROUND CHECKS.**

406.1 Subdivision 1. **Applications.** (a) By January 1, 2018, each health-related licensing
406.2 board, as defined in section 214.01, subdivision 2, shall require applicants for initial
406.3 licensure, licensure by endorsement, or reinstatement or other relicensure after a lapse
406.4 in licensure, as defined by the individual health-related licensing boards, to submit to
406.5 a criminal history records check of state data completed by the Bureau of Criminal
406.6 Apprehension (BCA) and a national criminal history records check, including a search of
406.7 the records of the Federal Bureau of Investigation (FBI).

406.8 (b) An applicant must complete a criminal background check if more than one year
406.9 has elapsed since the applicant last submitted a background check to the board.

406.10 Subd. 2. **Investigations.** If a health-related licensing board has reasonable cause
406.11 to believe a licensee has been charged with or convicted of a crime in this or any other
406.12 jurisdiction, the health-related licensing board may require the licensee to submit to a
406.13 criminal history records check of state data completed by the BCA and a national criminal
406.14 history records check, including a search of the records of the FBI.

406.15 Subd. 3. **Consent form; fees; fingerprints.** (a) In order to effectuate the federal
406.16 and state level, fingerprint-based criminal background check, the applicant or licensee
406.17 must submit a completed criminal history records check consent form and a full set of
406.18 fingerprints to the respective health-related licensing board or a designee in the manner
406.19 and form specified by the board.

406.20 (b) The applicant or licensee is responsible for all fees associated with preparation of
406.21 the fingerprints, the criminal records check consent form, and the criminal background
406.22 check. The fees for the criminal records background check shall be set by the BCA and
406.23 the FBI and are not refundable. The fees shall be submitted to the respective health-related
406.24 licensing board by the applicant or licensee as prescribed by the respective board.

406.25 (c) All fees received by the health-related licensing boards under this subdivision
406.26 shall be deposited in a dedicated account in the special revenue fund and are appropriated
406.27 to the Board of Nursing Home Administrators for the administrative services unit to pay
406.28 for the criminal background checks conducted by the Bureau of Criminal Apprehension
406.29 and Federal Bureau of Investigation.

406.30 Subd. 4. **Refusal to consent.** (a) The health-related licensing boards shall not issue
406.31 a license to any applicant who refuses to consent to a criminal background check or fails
406.32 to submit fingerprints within 90 days after submission of an application for licensure. Any
406.33 fees paid by the applicant to the board shall be forfeited if the applicant refuses to consent
406.34 to the criminal background check or fails to submit the required fingerprints.

406.35 (b) The failure of a licensee to submit to a criminal background check as provided in
406.36 subdivision 3 is grounds for disciplinary action by the respective health licensing board.

407.1 Subd. 5. **Submission of fingerprints to the Bureau of Criminal Apprehension.**

407.2 The health-related licensing board or designee shall submit applicant or licensee
407.3 fingerprints to the BCA. The BCA shall perform a check for state criminal justice
407.4 information and shall forward the applicant's or licensee's fingerprints to the FBI to
407.5 perform a check for national criminal justice information regarding the applicant or
407.6 licensee. The BCA shall report to the board the results of the state and national criminal
407.7 justice information checks.

407.8 Subd. 6. **Alternatives to fingerprint-based criminal background checks.** The
407.9 health-related licensing board may require an alternative method of criminal history
407.10 checks for an applicant or licensee who has submitted at least three sets of fingerprints in
407.11 accordance with this section that have been unreadable by the BCA or the FBI.

407.12 Subd. 7. **Data practices.** Criminal history record information obtained by the
407.13 health-related licensing board under this section is private data on individuals under
407.14 section 13.02, subdivision 12.

407.15 Subd. 8. **Opportunity to challenge accuracy of report.** Prior to taking disciplinary
407.16 action against an applicant or a licensee based on a criminal conviction, the health-related
407.17 licensing board shall provide the applicant or the licensee an opportunity to complete or
407.18 challenge the accuracy of the criminal history information reported to the board. The
407.19 applicant or licensee shall have 30 calendar days following notice from the board of
407.20 the intent to deny licensure or to take disciplinary action to request an opportunity to
407.21 correct or complete the record prior to the board taking disciplinary action based on the
407.22 information reported to the board. The board shall provide the applicant up to 180 days to
407.23 challenge the accuracy or completeness of the report with the agency responsible for the
407.24 record. This subdivision does not affect the right of the subject of the data to contest the
407.25 accuracy or completeness under section 13.04, subdivision 4.

407.26 Subd. 9. **Instructions to the board; plans.** The health-related licensing boards, in
407.27 collaboration with the commissioner of human services and the BCA, shall establish a
407.28 plan for completing criminal background checks of all licensees who were licensed before
407.29 the effective date requirement under subdivision 1. The plan must seek to minimize
407.30 duplication of requirements for background checks of licensed health professionals. The
407.31 plan for background checks of current licensees shall be developed no later than January
407.32 1, 2017, and may be contingent upon the implementation of a system by the BCA or FBI
407.33 in which any new crimes that an applicant or licensee commits after an initial background
407.34 check are flagged in the BCA's or FBI's database and reported back to the board. The plan
407.35 shall include recommendations for any necessary statutory changes.

408.1 Sec. 14. Minnesota Statutes 2012, section 214.12, is amended by adding a subdivision
408.2 to read:

408.3 Subd. 4. **Parental depression.** The health-related licensing boards that regulate
408.4 professions that serve caregivers at risk of depression, or their children, including
408.5 behavioral health and therapy, chiropractic, marriage and family therapy, medical practice,
408.6 nursing, psychology, and social work, shall provide educational materials to licensees on
408.7 the subject of parental depression and its potential effects on children if unaddressed,
408.8 including how to:

408.9 (1) screen mothers for depression;

408.10 (2) identify children who are affected by their mother's depression; and

408.11 (3) provide treatment or referral information on needed services.

408.12 Sec. 15. Minnesota Statutes 2012, section 214.40, subdivision 1, is amended to read:

408.13 Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this
408.14 section.

408.15 (b) "Administrative services unit" means the administrative services unit for the
408.16 health-related licensing boards.

408.17 (c) "Charitable organization" means a charitable organization within the meaning of
408.18 section 501(c)(3) of the Internal Revenue Code that has as a purpose the sponsorship or
408.19 support of programs designed to improve the quality, awareness, and availability of health
408.20 care services and that serves as a funding mechanism for providing those services.

408.21 (d) "Health care facility or organization" means a health care facility licensed under
408.22 chapter 144 or 144A, or a charitable organization.

408.23 (e) "Health care provider" means a physician licensed under chapter 147, physician
408.24 assistant ~~registered~~ licensed and practicing under chapter 147A, nurse licensed and
408.25 registered to practice under chapter 148, ~~or dentist or~~ dental hygienist, or dental therapist
408.26 licensed under chapter 150A, or an advanced dental therapist licensed and certified under
408.27 chapter 150A.

408.28 (f) "Health care services" means health promotion, health monitoring, health
408.29 education, diagnosis, treatment, minor surgical procedures, the administration of local
408.30 anesthesia for the stitching of wounds, and primary dental services, including preventive,
408.31 diagnostic, restorative, and emergency treatment. Health care services do not include the
408.32 administration of general anesthesia or surgical procedures other than minor surgical
408.33 procedures.

408.34 (g) "Medical professional liability insurance" means medical malpractice insurance
408.35 as defined in section 62F.03.

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

409.2 Sec. 16. **INCLUSION OF OTHER HEALTH-RELATED OCCUPATIONS TO**
 409.3 **CRIMINAL BACKGROUND CHECKS.**

409.4 (a) If the Department of Health is not reviewed by the Sunset Advisory Commission
 409.5 according to the schedule in Minnesota Statutes, section 3D.21, the commissioner
 409.6 of health, as the regulator for occupational therapy practitioners, speech-language
 409.7 pathologists, audiologists, and hearing instrument dispensers, shall require applicants
 409.8 for licensure or renewal to submit to a criminal history records check as required under
 409.9 Minnesota Statutes, section 214.075, for other health-related licensed occupations
 409.10 regulated by the health-related licensing boards.

409.11 (b) Any statutory changes necessary to include the commissioner of health to
 409.12 Minnesota Statutes, section 214.075, shall be included in the plan required in Minnesota
 409.13 Statutes, section 214.075, subdivision 9.

409.14 Sec. 17. **REPEALER.**

409.15 Minnesota Statutes 2012, sections 151.19, subdivision 2; 151.25; 151.45; 151.47,
 409.16 subdivision 2; and 151.48, are repealed.

409.17 **ARTICLE 11**

409.18 **HOME CARE PROVIDERS**

409.19 Section 1. Minnesota Statutes 2012, section 13.381, subdivision 2, is amended to read:

409.20 Subd. 2. **Health occupations data.** (a) **Health-related licensees and registrants.**

409.21 The collection, analysis, reporting, and use of data on individuals licensed or registered by
 409.22 the commissioner of health or health-related licensing boards are governed by sections
 409.23 144.051, ~~subdivision 2~~ subdivisions 2 to 6, and 144.052.

409.24 (b) **Health services personnel.** Data collected by the commissioner of health for the
 409.25 database on health services personnel are classified under section 144.1485.

409.26 Sec. 2. Minnesota Statutes 2012, section 13.381, subdivision 10, is amended to read:

409.27 Subd. 10. **Home care and hospice provider.** Data regarding a home care provider
 409.28 under sections 144A.43 to 144A.47 are governed by section 144A.45. Data regarding
 409.29 home care provider background studies are governed by section 144A.476, subdivision 1.
 409.30 Data regarding a hospice provider under sections 144A.75 to 144A.755 are governed by
 409.31 sections 144A.752 and 144A.754.

410.1 Sec. 3. Minnesota Statutes 2012, section 144.051, is amended by adding a subdivision
410.2 to read:

410.3 Subd. 3. **Data classification; private data.** For providers regulated pursuant to
410.4 sections 144A.43 to 144A.482, the following data collected, created, or maintained by
410.5 the commissioner are classified as private data on individuals as defined in section 13.02,
410.6 subdivision 12:

410.7 (1) data submitted by or on behalf of applicants for licenses prior to issuance of
410.8 the license;

410.9 (2) the identity of complainants who have made reports concerning licensees or
410.10 applicants unless the complainant consents to the disclosure;

410.11 (3) the identity of individuals who provide information as part of surveys and
410.12 investigations;

410.13 (4) Social Security numbers; and

410.14 (5) health record data.

410.15 Sec. 4. Minnesota Statutes 2012, section 144.051, is amended by adding a subdivision
410.16 to read:

410.17 Subd. 4. **Data classification; public data.** For providers regulated pursuant to
410.18 sections 144A.43 to 144A.482, the following data collected, created, or maintained by the
410.19 commissioner are public:

410.20 (1) all application data on licensees, license numbers, license status;

410.21 (2) licensing information about licenses previously held under this chapter;

410.22 (3) correction orders, including information about compliance with the order and
410.23 whether the fine was paid;

410.24 (4) final enforcement actions pursuant to chapter 14;

410.25 (5) orders for hearing, findings of fact and conclusions of law; and

410.26 (6) when the licensee and department agree to resolve the matter without a hearing,
410.27 the agreement and specific reasons for the agreement are public data.

410.28 Sec. 5. Minnesota Statutes 2012, section 144.051, is amended by adding a subdivision
410.29 to read:

410.30 Subd. 5. **Data classification; confidential data.** For providers regulated pursuant to
410.31 sections 144A.43 to 144A.482, the following data collected, created, or maintained by
410.32 the Department of Health are classified as confidential data on individuals as defined in
410.33 section 13.02, subdivision 3: active investigative data relating to the investigation of

411.1 potential violations of law by a licensee including data from the survey process before the
 411.2 correction order is issued by the department.

411.3 Sec. 6. Minnesota Statutes 2012, section 144.051, is amended by adding a subdivision
 411.4 to read:

411.5 Subd. 6. **Release of private or confidential data.** For providers regulated pursuant
 411.6 to sections 144A.43 to 144A.482, the department may release private or confidential data,
 411.7 except Social Security numbers, to the appropriate state, federal, or local agency and law
 411.8 enforcement office to facilitate investigative or enforcement efforts or further the public
 411.9 health protective process. Types of offices include Adult Protective Services, Office of the
 411.10 Ombudsmen for Long-Term Care and Office of the Ombudsmen for Mental Health and
 411.11 Developmental Disabilities, health licensing boards, the Department of Human Services,
 411.12 county or city attorney's offices, police, and local or county public health offices.

411.13 Sec. 7. Minnesota Statutes 2012, section 144A.43, is amended to read:

411.14 **144A.43 DEFINITIONS.**

411.15 Subdivision 1. **Applicability.** The definitions in this section apply to sections
 411.16 144.699, subdivision 2, and 144A.43 to ~~144A.47~~ 144A.482.

411.17 Subd. 1a. **Agent.** "Agent" means the person upon whom all notices and orders shall
 411.18 be served and who is authorized to accept service of notices and orders on behalf of
 411.19 the home care provider.

411.20 Subd. 1b. **Applicant.** "Applicant" means an individual, organization, association,
 411.21 corporation, unit of government, or other entity that applies for a temporary license,
 411.22 license, or renewal of their home care provider license under section 144A.472.

411.23 Subd. 1c. **Client.** "Client" means a person to whom home care services are provided.

411.24 Subd. 1d. **Client record.** "Client record" means all records that document
 411.25 information about the home care services provided to the client by the home care provider.

411.26 Subd. 1e. **Client representative.** "Client representative" means a person who,
 411.27 because of the client's needs, makes decisions about the client's care on behalf of the
 411.28 client. A client representative may be a guardian, health care agent, family member, or
 411.29 other agent of the client. Nothing in this section expands or diminishes the rights of
 411.30 persons to act on behalf of clients under other law.

411.31 Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

411.32 Subd. 2a. **Controlled substance.** "Controlled substance" has the meaning given
 411.33 in section 152.01, subdivision 4.

411.34 Subd. 2b. **Department.** "Department" means the Minnesota Department of Health.

412.1 Subd. 2c. **Dietary supplement.** "Dietary supplement" means a product taken by
 412.2 mouth that contains a "dietary ingredient" intended to supplement the diet. Dietary
 412.3 ingredients may include vitamins, minerals, herbs or other botanicals, amino acids, and
 412.4 substances such as enzymes, organ tissue, glandulars, or metabolites.

412.5 Subd. 2d. **Dietitian.** "Dietitian" is a person licensed under sections 148.621 to
 412.6 148.633.

412.7 Subd. 2e. **Dietetics or nutrition practice.** "Dietetics or nutrition practice" is
 412.8 performed by a licensed dietitian or licensed nutritionist and includes the activities of
 412.9 assessment, setting priorities and objectives, providing nutrition counseling, developing
 412.10 and implementing nutrition care services, and evaluating and maintaining appropriate
 412.11 standards of quality of nutrition care under sections 148.621 to 148.633.

412.12 Subd. 3. **Home care service.** "Home care service" means any of the following
 412.13 services when delivered in a place of residence to the home of a person whose illness,
 412.14 disability, or physical condition creates a need for the service:

412.15 ~~(1) nursing services, including the services of a home health aide;~~

412.16 ~~(2) personal care services not included under sections 148.171 to 148.285;~~

412.17 ~~(3) physical therapy;~~

412.18 ~~(4) speech therapy;~~

412.19 ~~(5) respiratory therapy;~~

412.20 ~~(6) occupational therapy;~~

412.21 ~~(7) nutritional services;~~

412.22 ~~(8) home management services when provided to a person who is unable to perform~~
 412.23 ~~these activities due to illness, disability, or physical condition. Home management~~
 412.24 ~~services include at least two of the following services: housekeeping, meal preparation,~~
 412.25 ~~and shopping;~~

412.26 ~~(9) medical social services;~~

412.27 ~~(10) the provision of medical supplies and equipment when accompanied by the~~
 412.28 ~~provision of a home care service; and~~

412.29 ~~(11) other similar medical services and health-related support services identified by~~
 412.30 ~~the commissioner in rule.~~

412.31 ~~"Home care service" does not include the following activities conducted by the~~
 412.32 ~~commissioner of health or a board of health as defined in section 145A.02, subdivision 2:~~
 412.33 ~~communicable disease investigations or testing; administering or monitoring a prescribed~~
 412.34 ~~therapy necessary to control or prevent a communicable disease; or the monitoring~~
 412.35 ~~of an individual's compliance with a health directive as defined in section 144.4172,~~
 412.36 ~~subdivision 6.~~

413.1 (1) assistive tasks as defined in section 144A.471, subdivision 6, provided by
 413.2 unlicensed personnel;

413.3 (2) services provided by a registered nurse or licensed practical nurse, physical
 413.4 therapist, respiratory therapist, occupational therapist, speech-language pathologist,
 413.5 dietitian or nutritionist, or social worker;

413.6 (3) medication and treatment management services; or

413.7 (4) the provision of durable medical equipment services when provided with any of
 413.8 the home care services listed in clauses (1) to (3).

413.9 Subd. 3a. **Hands-on-assistance.** "Hands-on-assistance" means physical help by
 413.10 another person without which the client is not able to perform the activity.

413.11 Subd. 3b. **Home.** "Home" means the client's temporary or permanent place of
 413.12 residence.

413.13 Subd. 4. **Home care provider.** "Home care provider" means an individual,
 413.14 organization, association, corporation, unit of government, or other entity that is regularly
 413.15 engaged in the delivery of at least one home care service, directly or by contractual
 413.16 arrangement, of home care services in a client's home for a fee and who has a valid current
 413.17 temporary license or license issued under sections 144A.43 to 144A.482. At least one
 413.18 home care service must be provided directly, although additional home care services may
 413.19 be provided by contractual arrangements. "Home care provider" does not include:

413.20 (1) any home care or nursing services conducted by and for the adherents of any
 413.21 recognized church or religious denomination for the purpose of providing care and
 413.22 services for those who depend upon spiritual means, through prayer alone, for healing;

413.23 (2) an individual who only provides services to a relative;

413.24 (3) an individual not connected with a home care provider who provides assistance
 413.25 with home management services or personal care needs if the assistance is provided
 413.26 primarily as a contribution and not as a business;

413.27 (4) an individual not connected with a home care provider who shares housing with
 413.28 and provides primarily housekeeping or homemaking services to an elderly or disabled
 413.29 person in return for free or reduced-cost housing;

413.30 (5) an individual or agency providing home-delivered meal services;

413.31 (6) an agency providing senior companion services and other older American
 413.32 volunteer programs established under the Domestic Volunteer Service Act of 1973,
 413.33 Public Law 98-288;

413.34 (7) an employee of a nursing home licensed under this chapter or an employee of a
 413.35 boarding care home licensed under sections 144.50 to 144.56 who responds to occasional

414.1 emergency calls from individuals residing in a residential setting that is attached to or
414.2 located on property contiguous to the nursing home or boarding care home;

414.3 (8) a member of a professional corporation organized under chapter 319B that does
414.4 not regularly offer or provide home care services as defined in subdivision 3;

414.5 (9) the following organizations established to provide medical or surgical services
414.6 that do not regularly offer or provide home care services as defined in subdivision 3:
414.7 a business trust organized under sections 318.01 to 318.04, a nonprofit corporation
414.8 organized under chapter 317A, a partnership organized under chapter 323, or any other
414.9 entity determined by the commissioner;

414.10 (10) an individual or agency that provides medical supplies or durable medical
414.11 equipment, except when the provision of supplies or equipment is accompanied by a
414.12 home care service;

414.13 (11) an individual licensed under chapter 147; or

414.14 (12) an individual who provides home care services to a person with a developmental
414.15 disability who lives in a place of residence with a family, foster family, or primary caregiver.

414.16 Subd. 5. **Medication reminder.** "Medication reminder" means providing a verbal
414.17 or visual reminder to a client to take medication. This includes bringing the medication
414.18 to the client and providing liquids or nutrition to accompany medication that a client is
414.19 self-administering.

414.20 Subd. 6. **License.** "License" means a basic or comprehensive home care license
414.21 issued by the commissioner to a home care provider.

414.22 Subd. 7. **Licensed health professional.** "Licensed health professional" means a
414.23 person, other than a registered nurse or licensed practical nurse, who provides home care
414.24 services within the scope of practice of the person's health occupation license, registration,
414.25 or certification as regulated and who is licensed by the appropriate Minnesota state board
414.26 or agency.

414.27 Subd. 8. **Licensee.** "Licensee" means a home care provider that is licensed under
414.28 this chapter.

414.29 Subd. 9. **Managerial official.** "Managerial official" means an administrator,
414.30 director, officer, trustee, or employee of a home care provider, however designated, who
414.31 has the authority to establish or control business policy.

414.32 Subd. 10. **Medication.** "Medication" means a prescription or over-the-counter drug.
414.33 For purposes of this chapter only, medication includes dietary supplements.

414.34 Subd. 11. **Medication administration.** "Medication administration" means
414.35 performing a set of tasks to ensure a client takes medications, and includes the following:

414.36 (1) checking the client's medication record;

- 415.1 (2) preparing the medication as necessary;
 415.2 (3) administering the medication to the client;
 415.3 (4) documenting the administration or reason for not administering the medication;
 415.4 and
 415.5 (5) reporting to a nurse any concerns about the medication, the client, or the client's
 415.6 refusal to take the medication.

415.7 Subd. 12. **Medication management.** "Medication management" means the
 415.8 provision of any of the following medication-related services to a client:

- 415.9 (1) performing medication setup;
 415.10 (2) administering medication;
 415.11 (3) storing and securing medications;
 415.12 (4) documenting medication activities;
 415.13 (5) verifying and monitoring effectiveness of systems to ensure safe handling and
 415.14 administration;
 415.15 (6) coordinating refills;
 415.16 (7) handling and implementing changes to prescriptions;
 415.17 (8) communicating with the pharmacy about the client's medications; and
 415.18 (9) coordinating and communicating with the prescriber.

415.19 Subd. 13. **Medication setup.** "Medication setup" means arranging medications by a
 415.20 nurse, pharmacy, or authorized prescriber for later administration by the client or by
 415.21 comprehensive home care staff.

415.22 Subd. 14. **Nurse.** "Nurse" means a person who is licensed under sections 148.171 to
 415.23 148.285.

415.24 Subd. 15. **Occupational therapist.** "Occupational therapist" means a person who is
 415.25 licensed under sections 148.6401 to 148.6450.

415.26 Subd. 16. **Over-the-counter drug.** "Over-the-counter drug" means a drug that is
 415.27 not required by federal law to bear the symbol "Rx only."

415.28 Subd. 17. **Owner.** "Owner" means a proprietor, general partner, limited partner who
 415.29 has five percent or more of equity interest in a limited partnership, a person who owns or
 415.30 controls voting stock in a corporation in an amount equal to or greater than five percent of
 415.31 the shares issued and outstanding, or a corporation that owns equity interest in a licensee
 415.32 or applicant for a license.

415.33 Subd. 18. **Pharmacist.** "Pharmacist" has the meaning given in section 151.01,
 415.34 subdivision 3.

415.35 Subd. 19. **Physical therapist.** "Physical therapist" means a person who is licensed
 415.36 under sections 148.65 to 148.78.

- 416.1 Subd. 20. **Physician.** "Physician" means a person who is licensed under chapter 147.
- 416.2 Subd. 21. **Prescriber.** "Prescriber" means a person who is authorized by sections
- 416.3 148.235; 151.01, subdivision 23; and 151.37, to prescribe prescription drugs.
- 416.4 Subd. 22. **Prescription.** "Prescription" has the meaning given in section 151.01,
- 416.5 subdivision 16.
- 416.6 Subd. 23. **Regularly scheduled.** "Regularly scheduled" means ordered or planned
- 416.7 to be completed at predetermined times or according to a predetermined routine.
- 416.8 Subd. 24. **Reminder.** "Reminder" means providing a verbal or visual reminder
- 416.9 to a client.
- 416.10 Subd. 25. **Respiratory therapist.** "Respiratory therapist" means a person who
- 416.11 is licensed under chapter 147C.
- 416.12 Subd. 26. **Revenues.** "Revenues" means all money received by a licensee derived
- 416.13 from the provisions of home care services, including fees for services and appropriations
- 416.14 of public money for home care services.
- 416.15 Subd. 27. **Service plan.** "Service plan" means the written plan between the client or
- 416.16 client's representative and the temporary licensee or licensee about the services that will
- 416.17 be provided to the client.
- 416.18 Subd. 28. **Social worker.** "Social worker" means a person who is licensed under
- 416.19 chapter 148D or 148E.
- 416.20 Subd. 29. **Speech language pathologist.** "Speech language pathologist" has the
- 416.21 meaning given in section 148.512.
- 416.22 Subd. 30. **Standby assistance.** "Standby assistance" means the presence of another
- 416.23 person within arm's reach to minimize the risk of injury while performing daily activities
- 416.24 through physical intervention or cuing.
- 416.25 Subd. 31. **Substantial compliance.** "Substantial compliance" means complying
- 416.26 with the requirements in this chapter sufficiently to prevent unacceptable health or safety
- 416.27 risks to the home care client.
- 416.28 Subd. 32. **Survey.** "Survey" means an inspection of a licensee or applicant for
- 416.29 licensure for compliance with this chapter.
- 416.30 Subd. 33. **Surveyor.** "Surveyor" means a staff person of the department authorized
- 416.31 to conduct surveys of home care providers and applicants.
- 416.32 Subd. 34. **Temporary license.** "Temporary license" means the initial basic or
- 416.33 comprehensive home care license the department issues after approval of a complete
- 416.34 written application and before the department completes the temporary license survey and
- 416.35 determines that the temporary licensee is in substantial compliance.

417.1 Subd. 35. **Treatment or therapy.** "Treatment" or "therapy" means the provision
 417.2 of care, other than medications, ordered or prescribed by a licensed health professional
 417.3 provided to a client to cure, rehabilitate, or ease symptoms.

417.4 Subd. 36. **Unit of government.** "Unit of government" means every city, county,
 417.5 town, school district, other political subdivisions of the state, and any agency of the state
 417.6 or federal government, which includes any instrumentality of a unit of government.

417.7 Subd. 37. **Unlicensed personnel.** "Unlicensed personnel" are individuals not
 417.8 otherwise licensed or certified by a governmental health board or agency who provide
 417.9 home care services in the client's home.

417.10 Subd. 38. **Verbal.** "Verbal" means oral and not in writing.

417.11 Sec. 8. Minnesota Statutes 2012, section 144A.44, is amended to read:

417.12 **144A.44 HOME CARE BILL OF RIGHTS.**

417.13 Subdivision 1. **Statement of rights.** A person who receives home care services
 417.14 has these rights:

417.15 (1) the right to receive written information about rights ~~in advance of~~ before
 417.16 ~~receiving care or during the initial evaluation visit before the initiation of treatment~~
 417.17 services, including what to do if rights are violated;

417.18 (2) the right to receive care and services according to a suitable and up-to-date plan,
 417.19 and subject to accepted health care, medical or nursing standards, to take an active part
 417.20 ~~in creating and changing the plan~~ developing, modifying, and evaluating care the plan
 417.21 and services;

417.22 (3) the right to be told ~~in advance of~~ before receiving care ~~about the services that will~~
 417.23 ~~be provided, the disciplines that will furnish care~~ the type and disciplines of staff who will
 417.24 be providing the services, the frequency of visits proposed to be furnished, other choices
 417.25 that are available for addressing home care needs, and ~~the consequences of these choices~~
 417.26 ~~including~~ the potential consequences of refusing these services;

417.27 (4) the right to be told in advance of any ~~change~~ recommended changes by the
 417.28 provider in the service plan of care and to take an active part in any ~~change~~ decisions
 417.29 about changes to the service plan;

417.30 (5) the right to refuse services or treatment;

417.31 (6) the right to know, ~~in advance~~ before receiving services or during the initial
 417.32 visit, any limits to the services available from a home care provider, ~~and the provider's~~
 417.33 ~~grounds for a termination of services~~;

418.1 ~~(7) the right to know in advance of receiving care whether the services are covered~~
 418.2 ~~by health insurance, medical assistance, or other health programs, the charges for services~~
 418.3 ~~that will not be covered by Medicare, and the charges that the individual may have to pay;~~

418.4 ~~(8) (7) the right to know~~ be told before services are initiated what the provider
 418.5 charges are for the services, no matter who will be paying the bill and if known, to what
 418.6 extent payment may be expected from health insurance, public programs or other sources,
 418.7 and what charges the client may be responsible for paying;

418.8 ~~(9) (8) the right to know that there may be other services available in the community,~~
 418.9 ~~including other home care services and providers, and to know where to go for find~~
 418.10 ~~information about these services;~~

418.11 ~~(10) (9) the right to choose freely among available providers and to change providers~~
 418.12 ~~after services have begun, within the limits of health insurance, long-term care insurance,~~
 418.13 ~~medical assistance, or other health programs;~~

418.14 ~~(11) (10) the right to have personal, financial, and medical information kept private,~~
 418.15 ~~and to be advised of the provider's policies and procedures regarding disclosure of such~~
 418.16 ~~information;~~

418.17 ~~(12) (11) the right to be allowed access to the client's own records and written~~
 418.18 ~~information from those records in accordance with sections 144.291 to 144.298;~~

418.19 ~~(13) (12) the right to be served by people who are properly trained and competent~~
 418.20 ~~to perform their duties;~~

418.21 ~~(14) (13) the right to be treated with courtesy and respect, and to have the patient's~~
 418.22 ~~client's property treated with respect;~~

418.23 ~~(15) (14) the right to be free from physical and verbal abuse, neglect, financial~~
 418.24 ~~exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and~~
 418.25 ~~the Maltreatment of Minors Act;~~

418.26 ~~(16) (15) the right to reasonable, advance notice of changes in services or charges;~~
 418.27 ~~including;~~

418.28 ~~(16) the right to know the provider's reason for termination of services;~~

418.29 ~~(17) the right to~~ at least ten days' advance notice of the termination of a service by a
 418.30 provider, except in cases where:

418.31 ~~(i) the recipient of services~~ client ~~engages in conduct that significantly alters the~~
 418.32 ~~conditions of employment as specified in the employment contract between terms of~~
 418.33 ~~the service plan with the home care provider and the individual providing home care~~
 418.34 ~~services, or creates;~~

418.35 ~~(ii) the client, person who lives with the client, or others create an abusive or unsafe~~
 418.36 ~~work environment for the individual person providing home care services; or~~

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

419.4 ~~(17)~~ (18) the right to a coordinated transfer when there will be a change in the
 419.5 provider of services;

419.6 ~~(18)~~ (19) the right to ~~voice grievances regarding treatment or care that is complain~~
 419.7 ~~about services that are provided, or fails to be, furnished, or regarding fail to be provided,~~
 419.8 ~~and the lack of courtesy or respect to the patient~~ client or the ~~patient's~~ client's property;

419.9 ~~(19)~~ (20) the right to know how to contact an individual associated with the home
 419.10 care provider who is responsible for handling problems and to have the home care provider
 419.11 investigate and attempt to resolve the grievance or complaint;

419.12 ~~(20)~~ (21) the right to know the name and address of the state or county agency to
 419.13 contact for additional information or assistance; and

419.14 ~~(21)~~ (22) the right to assert these rights personally, or have them asserted by
 419.15 the ~~patient's family or guardian when the patient has been judged incompetent,~~ client's
 419.16 representative or by anyone on behalf of the client, without retaliation.

419.17 Subd. 2. **Interpretation and enforcement of rights.** These rights are established
 419.18 for the benefit of ~~persons~~ clients who receive home care services. "~~Home care services~~"
 419.19 ~~means home care services as defined in section 144A.43, subdivision 3, and unlicensed~~
 419.20 ~~personal care assistance services, including services covered by medical assistance under~~
 419.21 ~~section 256B.0625, subdivision 19a.~~ All home care providers, including those exempted
 419.22 under section 144A.471, must comply with this section. The commissioner shall enforce
 419.23 this section and the home care bill of rights requirement against home care providers
 419.24 exempt from licensure in the same manner as for licensees. A home care provider may
 419.25 not request or require a person client to surrender any of these rights as a condition of
 419.26 receiving services. ~~A guardian or conservator or, when there is no guardian or conservator,~~
 419.27 ~~a designated person, may seek to enforce these rights.~~ This statement of rights does not
 419.28 replace or diminish other rights and liberties that may exist relative to ~~persons~~ clients
 419.29 receiving home care services, persons providing home care services, or providers licensed
 419.30 under ~~Laws 1987, chapter 378.~~ A copy of these rights must be provided to an individual
 419.31 at the time home care services, including personal care assistance services, are initiated.
 419.32 The copy shall also contain the address and phone number of the Office of Health Facility
 419.33 Complaints and the Office of Ombudsman for Long-Term Care and a brief statement
 419.34 describing how to file a complaint with these offices. ~~Information about how to contact~~
 419.35 ~~the Office of Ombudsman for Long-Term Care shall be included in notices of change in~~

420.1 ~~client fees and in notices where home care providers initiate transfer or discontinuation of~~
 420.2 ~~services sections 144A.43 to 144A.482.~~

420.3 Sec. 9. Minnesota Statutes 2012, section 144A.45, is amended to read:

420.4 **144A.45 REGULATION OF HOME CARE SERVICES.**

420.5 Subdivision 1. **Rules Regulations.** The commissioner shall ~~adopt rules for the~~
 420.6 ~~regulation of~~ regulate home care providers pursuant to sections 144A.43 to ~~144A.47~~
 420.7 144A.482. The ~~rules~~ regulations shall include the following:

420.8 (1) provisions to assure, to the extent possible, the health, safety and well-being,
 420.9 and appropriate treatment of persons who receive home care services while respecting
 420.10 clients' autonomy and choice;

420.11 (2) requirements that home care providers furnish the commissioner with specified
 420.12 information necessary to implement sections 144A.43 to ~~144A.47~~ 144A.482;

420.13 (3) standards of training of home care provider personnel, ~~which may vary according~~
 420.14 ~~to the nature of the services provided or the health status of the consumer~~;

420.15 (4) standards for provision of home care services;

420.16 ~~(4) (5) standards for medication management which may vary according to the~~
 420.17 ~~nature of the services provided, the setting in which the services are provided, or the~~
 420.18 ~~status of the consumer. Medication management includes the central storage, handling,~~
 420.19 ~~distribution, and administration of medications~~;

420.20 ~~(5) (6) standards for supervision of home care services requiring supervision by a~~
 420.21 ~~registered nurse or other appropriate health care professional which must occur on site~~
 420.22 ~~at least every 62 days, or more frequently if indicated by a clinical assessment, and in~~
 420.23 ~~accordance with sections 148.171 to 148.285 and rules adopted thereunder, except that a~~
 420.24 ~~person performing home care aide tasks for a class B licensee providing paraprofessional~~
 420.25 ~~services does not require nursing supervision~~;

420.26 ~~(6) (7) standards for client evaluation or assessment which may vary according to~~
 420.27 ~~the nature of the services provided or the status of the consumer~~;

420.28 ~~(7) (8) requirements for the involvement of a consumer's physician~~ client's health
 420.29 care provider, the documentation of ~~physicians'~~ health care providers' orders, if required,
 420.30 and the ~~consumer's treatment~~ client's service plan, and;

420.31 (9) the maintenance of accurate, current ~~clinical~~ client records;

420.32 ~~(8) (10) the establishment of different classes~~ basic and comprehensive levels of
 420.33 ~~licenses for different types of providers and different standards and requirements for~~
 420.34 ~~different kinds of home care~~ based on services provided; and

421.1 ~~(9) operating procedures required to implement (11) provisions to enforce these~~
 421.2 ~~regulations and the home care bill of rights.~~

421.3 ~~Subd. 1a. **Home care aide tasks.** Notwithstanding the provisions of Minnesota~~
 421.4 ~~Rules, part 4668.0110, subpart 1, item E, home care aide tasks also include assisting~~
 421.5 ~~toileting, transfers, and ambulation if the client is ambulatory and if the client has no~~
 421.6 ~~serious acute illness or infectious disease.~~

421.7 ~~Subd. 1b. **Home health aide qualifications.** Notwithstanding the provisions of~~
 421.8 ~~Minnesota Rules, part 4668.0100, subpart 5, a person may perform home health aide tasks~~
 421.9 ~~if the person maintains current registration as a nursing assistant on the Minnesota nursing~~
 421.10 ~~assistant registry. Maintaining current registration on the Minnesota nursing assistant~~
 421.11 ~~registry satisfies the documentation requirements of Minnesota Rules, part 4668.0110,~~
 421.12 ~~subpart 3.~~

421.13 ~~Subd. 2. **Regulatory functions.** (a) The commissioner shall:~~

421.14 ~~(1) evaluate, monitor, and license, survey, and monitor without advance notice, home~~
 421.15 ~~care providers in accordance with sections 144A.45 to 144A.47 144A.43 to 144A.482;~~

421.16 ~~(2) inspect the office and records of a provider during regular business hours without~~
 421.17 ~~advance notice to the home care provider;~~

421.18 ~~(2) survey every temporary licensee within one year of the temporary license issuance~~
 421.19 ~~date subject to the temporary licensee providing home care services to a client or clients;~~

421.20 ~~(3) survey all licensed home care providers on an interval that will promote the~~
 421.21 ~~health and safety of clients;~~

421.22 ~~(3) (4) with the consent of the consumer client, visit the home where services are~~
 421.23 ~~being provided;~~

421.24 ~~(4) (5) issue correction orders and assess civil penalties in accordance with section~~
 421.25 ~~144.653, subdivisions 5 to 8, for violations of sections 144A.43 to 144A.47 or the rules~~
 421.26 ~~adopted under those sections 144A.482;~~

421.27 ~~(5) (6) take action as authorized in section 144A.46, subdivision 3 144A.475; and~~

421.28 ~~(6) (7) take other action reasonably required to accomplish the purposes of sections~~
 421.29 ~~144A.43 to 144A.47 144A.482.~~

421.30 ~~(b) In the exercise of the authority granted in sections 144A.43 to 144A.47, the~~
 421.31 ~~commissioner shall comply with the applicable requirements of section 144.122, the~~
 421.32 ~~Government Data Practices Act, and the Administrative Procedure Act.~~

421.33 ~~Subd. 4. **Medicaid reimbursement.** Notwithstanding the provisions of section~~
 421.34 ~~256B.37 or state plan requirements to the contrary, certification by the federal Medicare~~
 421.35 ~~program must not be a requirement of Medicaid payment for services delivered under~~
 421.36 ~~section 144A.4605.~~

422.1 ~~Subd. 5. **Home care providers; services for Alzheimer's disease or related**~~
 422.2 ~~**disorder.** (a) If a home care provider licensed under section 144A.46 or 144A.4605 markets~~
 422.3 ~~or otherwise promotes services for persons with Alzheimer's disease or related disorders,~~
 422.4 ~~the facility's direct care staff and their supervisors must be trained in dementia care.~~

422.5 ~~(b) Areas of required training include:~~

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

422.7 ~~(2) assistance with activities of daily living;~~

422.8 ~~(3) problem solving with challenging behaviors; and~~

422.9 ~~(4) communication skills.~~

422.10 ~~(c) The licensee shall provide to consumers in written or electronic form a~~
 422.11 ~~description of the training program, the categories of employees trained, the frequency~~
 422.12 ~~of training, and the basic topics covered.~~

422.13 Sec. 10. [144A.471] HOME CARE PROVIDER AND HOME CARE SERVICES.

422.14 Subdivision 1. **License required.** A home care provider may not open, operate,
 422.15 manage, conduct, maintain, or advertise itself as a home care provider or provide home
 422.16 care services in Minnesota without a temporary or current home care provider license
 422.17 issued by the commissioner of health.

422.18 Subd. 2. **Determination of direct home care service.** "Direct home care service"
 422.19 means a home care service provided to a client by the home care provider or its employees,
 422.20 and not by contract. Factors that must be considered in determining whether an individual
 422.21 or a business entity provides at least one home care service directly include, but are not
 422.22 limited to, whether the individual or business entity:

422.23 (1) has the right to control, and does control, the types of services provided;

422.24 (2) has the right to control, and does control, when and how the services are provided;

422.25 (3) establishes the charges;

422.26 (4) collects fees from the clients or receives payment from third-party payers on
 422.27 the clients' behalf;

422.28 (5) pays individuals providing services compensation on an hourly, weekly, or
 422.29 similar basis;

422.30 (6) treats the individuals providing services as employees for the purposes of payroll
 422.31 taxes and workers' compensation insurance; and

422.32 (7) holds itself out as a provider of home care services or acts in a manner that
 422.33 leads clients or potential clients to believe that it is a home care provider providing home
 422.34 care services.

422.35 None of the factors listed in this subdivision is solely determinative.

423.1 Subd. 3. **Determination of regularly engaged.** "Regularly engaged" means
423.2 providing, or offering to provide, home care services as a regular part of a business. The
423.3 following factors must be considered by the commissioner in determining whether an
423.4 individual or a business entity is regularly engaged in providing home care services:

423.5 (1) whether the individual or business entity states or otherwise promotes that the
423.6 individual or business entity provides home care services;

423.7 (2) whether persons receiving home care services constitute a substantial part of the
423.8 individual's or the business entity's clientele; and

423.9 (3) whether the home care services provided are other than occasional or incidental
423.10 to the provision of services other than home care services.

423.11 None of the factors listed in this subdivision is solely determinative.

423.12 Subd. 4. **Penalties for operating without license.** A person involved in the
423.13 management, operation, or control of a home care provider that operates without an
423.14 appropriate license is guilty of a misdemeanor. This section does not apply to a person
423.15 who has no legal authority to affect or change decisions related to the management,
423.16 operation, or control of a home care provider.

423.17 Subd. 5. **Basic and comprehensive levels of licensure.** An applicant seeking
423.18 to become a home care provider must apply for either a basic or comprehensive home
423.19 care license.

423.20 Subd. 6. **Basic home care license provider.** Home care services that can be
423.21 provided with a basic home care license are assistive tasks provided by licensed or
423.22 unlicensed personnel that include:

423.23 (1) assisting with dressing, self-feeding, oral hygiene, hair care, grooming, toileting,
423.24 and bathing;

423.25 (2) providing standby assistance;

423.26 (3) providing verbal or visual reminders to the client to take regularly scheduled
423.27 medication which includes bringing the client previously set-up medication, medication in
423.28 original containers, or liquid or food to accompany the medication;

423.29 (4) providing verbal or visual reminders to the client to perform regularly scheduled
423.30 treatments and exercises;

423.31 (5) preparing modified diets ordered by a licensed health professional; and

423.32 (6) assisting with laundry, housekeeping, meal preparation, shopping, or other
423.33 household chores and services if the provider is also providing at least one of the activities
423.34 in clauses (1) to (5)

424.1 Subd. 7. **Comprehensive home care license provider.** Home care services that
 424.2 may be provided with a comprehensive home care license include any of the basic home
 424.3 care services listed in subdivision 6, and one or more of the following:

424.4 (1) services of an advanced practice nurse, registered nurse, licensed practical
 424.5 nurse, physical therapist, respiratory therapist, occupational therapist, speech-language
 424.6 pathologist, dietitian or nutritionist, or social worker;

424.7 (2) tasks delegated to unlicensed personnel by a registered nurse or assigned by a
 424.8 licensed health professional within the person's scope of practice;

424.9 (3) medication management services;

424.10 (4) hands-on assistance with transfers and mobility;

424.11 (5) assisting clients with eating when the clients have complicating eating problems
 424.12 as identified in the client record or through an assessment such as difficulty swallowing,
 424.13 recurrent lung aspirations, or requiring the use of a tube or parenteral or intravenous
 424.14 instruments to be fed; or

424.15 (6) providing other complex or specialty health care services.

424.16 Subd. 8. **Exemptions from home care services licensure.** (a) Except as otherwise
 424.17 provided in this chapter, home care services that are provided by the state, counties, or
 424.18 other units of government must be licensed under this chapter.

424.19 (b) An exemption under this subdivision does not excuse the exempted individual or
 424.20 organization from complying with applicable provisions of the home care bill of rights
 424.21 in section 144A.44. The following individuals or organizations are exempt from the
 424.22 requirement to obtain a home care provider license:

424.23 (1) an individual or organization that offers, provides, or arranges for personal care
 424.24 assistance services under the medical assistance program as authorized under sections
 424.25 256B.04, subdivision 16; 256B.0625, subdivision 19a; and 256B.0659;

424.26 (2) a provider that is licensed by the commissioner of human services to provide
 424.27 semi-independent living services for persons with developmental disabilities under section
 424.28 252.275 and Minnesota Rules, parts 9525.0900 to 9525.1020;

424.29 (3) a provider that is licensed by the commissioner of human services to provide
 424.30 home and community-based services for persons with developmental disabilities under
 424.31 section 256B.092 and Minnesota Rules, parts 9525.1800 to 9525.1930;

424.32 (4) an individual or organization that provides only home management services, if
 424.33 the individual or organization is registered under section 144A.482; or

424.34 (5) an individual who is licensed in this state as a nurse, dietitian, social worker,
 424.35 occupational therapist, physical therapist, or speech-language pathologist who provides

425.1 health care services in the home independently and not through any contractual or
425.2 employment relationship with a home care provider or other organization.

425.3 Subd. 9. Exclusions from home care licensure. The following are excluded from
425.4 home care licensure and are not required to provide the home care bill of rights:

425.5 (1) an individual or business entity providing only coordination of home care that
425.6 includes one or more of the following:

425.7 (i) determination of whether a client needs home care services, or assisting a client
425.8 in determining what services are needed;

425.9 (ii) referral of clients to a home care provider;

425.10 (iii) administration of payments for home care services; or

425.11 (iv) administration of a health care home established under section 256B.0751;

425.12 (2) an individual who is not an employee of a licensed home care provider if the
425.13 individual:

425.14 (i) only provides services as an independent contractor to one or more licensed
425.15 home care providers;

425.16 (ii) provides no services under direct agreements or contracts with clients; and

425.17 (iii) is contractually bound to perform services in compliance with the contracting
425.18 home care provider's policies and service plans;

425.19 (3) a business that provides staff to home care providers, such as a temporary
425.20 employment agency, if the business:

425.21 (i) only provides staff under contract to licensed or exempt providers;

425.22 (ii) provides no services under direct agreements with clients; and

425.23 (iii) is contractually bound to perform services under the contracting home care
425.24 provider's direction and supervision;

425.25 (4) any home care services conducted by and for the adherents of any recognized
425.26 church or religious denomination for its members through spiritual means, or by prayer
425.27 for healing;

425.28 (5) an individual who only provides home care services to a relative;

425.29 (6) an individual not connected with a home care provider that provides assistance
425.30 with basic home care needs if the assistance is provided primarily as a contribution and
425.31 not as a business;

425.32 (7) an individual not connected with a home care provider that shares housing with
425.33 and provides primarily housekeeping or homemaking services to an elderly or disabled
425.34 person in return for free or reduced-cost housing;

425.35 (8) an individual or provider providing home-delivered meal services;

426.1 (9) an individual providing senior companion services and other Older American
426.2 Volunteer Programs (OAVP) established under the Domestic Volunteer Service Act of
426.3 1973, United States Code, title 42, chapter 66;

426.4 (10) an employee of a nursing home licensed under this chapter or an employee of a
426.5 boarding care home licensed under sections 144.50 to 144.56 who responds to occasional
426.6 emergency calls from individuals residing in a residential setting that is attached to or
426.7 located on property contiguous to the nursing home or boarding care home;

426.8 (11) a member of a professional corporation organized under chapter 319B that
426.9 does not regularly offer or provide home care services as defined in section 144A.43,
426.10 subdivision 3;

426.11 (12) the following organizations established to provide medical or surgical services
426.12 that do not regularly offer or provide home care services as defined in section 144A.43,
426.13 subdivision 3: a business trust organized under sections 318.01 to 318.04, a nonprofit
426.14 corporation organized under chapter 317A, a partnership organized under chapter 323, or
426.15 any other entity determined by the commissioner;

426.16 (13) an individual or agency that provides medical supplies or durable medical
426.17 equipment, except when the provision of supplies or equipment is accompanied by a
426.18 home care service;

426.19 (14) a physician licensed under chapter 147;

426.20 (15) an individual who provides home care services to a person with a developmental
426.21 disability who lives in a place of residence with a family, foster family, or primary caregiver;

426.22 (16) a business that only provides services that are primarily instructional and not
426.23 medical services or health-related support services;

426.24 (17) an individual who performs basic home care services for no more than 14 hours
426.25 each calendar week to no more than one client;

426.26 (18) an individual or business licensed as hospice as defined in sections 144A.75 to
426.27 144A.755 who is not providing home care services independent of hospice service;

426.28 (19) activities conducted by the commissioner of health or a board of health as
426.29 defined in section 145A.02, subdivision 2, including communicable disease investigations
426.30 or testing; or

426.31 (20) administering or monitoring a prescribed therapy necessary to control or
426.32 prevent a communicable disease, or the monitoring of an individual's compliance with a
426.33 health directive as defined in section 144.4172, subdivision 6.

426.34 **Sec. 11. [144A.472] HOME CARE PROVIDER LICENSE; APPLICATION**
426.35 **AND RENEWAL.**

427.1 Subdivision 1. License applications. Each application for a home care provider
427.2 license must include information sufficient to show that the applicant meets the
427.3 requirements of licensure, including:

427.4 (1) the applicant's name, e-mail address, physical address, and mailing address,
427.5 including the name of the county in which the applicant resides and has a principal
427.6 place of business;

427.7 (2) the initial license fee in the amount specified in subdivision 7;

427.8 (3) e-mail address, physical address, mailing address, and telephone number of the
427.9 principal administrative office;

427.10 (4) e-mail address, physical address, mailing address, and telephone number of
427.11 each branch office, if any;

427.12 (5) names, e-mail and mailing addresses, and telephone numbers of all owners
427.13 and managerial officials;

427.14 (6) documentation of compliance with the background study requirements of section
427.15 144A.476 for all persons involved in the management, operation, or control of the home
427.16 care provider;

427.17 (7) documentation of a background study as required by section 144.057 for any
427.18 individual seeking employment, paid or volunteer, with the home care provider;

427.19 (8) evidence of workers' compensation coverage as required by sections 176.181
427.20 and 176.182;

427.21 (9) documentation of liability coverage, if the provider has it;

427.22 (10) identification of the license level the provider is seeking;

427.23 (11) documentation that identifies the managerial official who is in charge of
427.24 day-to-day operations and attestation that the person has reviewed and understands the
427.25 home care provider regulations;

427.26 (12) documentation that the applicant has designated one or more owners,
427.27 managerial officials, or employees as an agent or agents, which shall not affect the legal
427.28 responsibility of any other owner or managerial official under this chapter;

427.29 (13) the signature of the officer or managing agent on behalf of an entity, corporation,
427.30 association, or unit of government;

427.31 (14) verification that the applicant has the following policies and procedures in place
427.32 so that if a license is issued, the applicant will implement the policies and procedures
427.33 and keep them current:

427.34 (i) requirements in sections 626.556, reporting of maltreatment of minors, and
427.35 626.557, reporting of maltreatment of vulnerable adults;

427.36 (ii) conducting and handling background studies on employees;

- 428.1 (iii) orientation, training, and competency evaluations of home care staff, and a
428.2 process for evaluating staff performance;
- 428.3 (iv) handling complaints from clients, family members, or client representatives
428.4 regarding staff or services provided by staff;
- 428.5 (v) conducting initial evaluation of clients' needs and the providers' ability to provide
428.6 those services;
- 428.7 (vi) conducting initial and ongoing client evaluations and assessments and how
428.8 changes in a client's condition are identified, managed, and communicated to staff and
428.9 other health care providers as appropriate;
- 428.10 (vii) orientation to and implementation of the home care client bill of rights;
- 428.11 (viii) infection control practices;
- 428.12 (ix) reminders for medications, treatments, or exercises, if provided; and
- 428.13 (x) conducting appropriate screenings, or documentation of prior screenings, to
428.14 show that staff are free of tuberculosis, consistent with current United States Centers for
428.15 Disease Control standards; and
- 428.16 (15) other information required by the department.

428.17 **Subd. 2. Comprehensive home care license applications.** In addition to the
428.18 information and fee required in subdivision 1, applicants applying for a comprehensive
428.19 home care license must also provide verification that the applicant has the following
428.20 policies and procedures in place so that if a license is issued, the applicant will implement
428.21 the policies and procedures in this subdivision and keep them current:

428.22 (1) conducting initial and ongoing assessments of the client's needs by a registered
428.23 nurse or appropriate licensed health professional, including how changes in the client's
428.24 conditions are identified, managed, and communicated to staff and other health care
428.25 providers, as appropriate;

428.26 (2) ensuring that nurses and licensed health professionals have current and valid
428.27 licenses to practice;

428.28 (3) medication and treatment management;

428.29 (4) delegation of home care tasks by registered nurses or licensed health professionals;

428.30 (5) supervision of registered nurses and licensed health professionals; and

428.31 (6) supervision of unlicensed personnel performing delegated home care tasks.

428.32 **Subd. 3. License renewal.** (a) Except as provided in section 144A.475, a license
428.33 may be renewed for a period of one year if the licensee satisfies the following:

428.34 (1) submits an application for renewal in the format provided by the commissioner
428.35 at least 30 days before expiration of the license;

428.36 (2) submits the renewal fee in the amount specified in subdivision 7;

429.1 (3) has provided home care services within the past 12 months;

429.2 (4) complies with sections 144A.43 to 144A.4799;

429.3 (5) provides information sufficient to show that the applicant meets the requirements
429.4 of licensure, including items required under subdivision 1;

429.5 (6) provides verification that all policies under subdivision 1 are current; and

429.6 (7) provides any other information deemed necessary by the commissioner.

429.7 (b) A renewal applicant who holds a comprehensive home care license must also
429.8 provide verification that policies listed under subdivision 2 are current.

429.9 Subd. 4. **Multiple units.** Multiple units or branches of a licensee must be separately
429.10 licensed if the commissioner determines that the units cannot adequately share supervision
429.11 and administration of services from the main office.

429.12 Subd. 5. **Transfers prohibited; changes in ownership.** Any home care license
429.13 issued by the commissioner may not be transferred to another party. Before acquiring
429.14 ownership of a home care provider business, a prospective applicant must apply for a
429.15 new temporary license. A change of ownership is a transfer of operational control to
429.16 a different business entity, and includes:

429.17 (1) transfer of the business to a different or new corporation;

429.18 (2) in the case of a partnership, the dissolution or termination of the partnership under
429.19 chapter 323A, with the business continuing by a successor partnership or other entity;

429.20 (3) relinquishment of control of the provider to another party, including to a contract
429.21 management firm that is not under the control of the owner of the business' assets;

429.22 (4) transfer of the business by a sole proprietor to another party or entity; or

429.23 (5) in the case of a privately held corporation, the change in ownership or control of
429.24 50 percent or more of the outstanding voting stock.

429.25 Subd. 6. **Notification of changes of information.** The temporary licensee or
429.26 licensee shall notify the commissioner in writing within ten working days after any
429.27 change in the information required in subdivision 1, except the information required in
429.28 subdivision 1, clause (5), is required at the time of license renewal.

429.29 Subd. 7. **Fees; application, change of ownership, and renewal.** (a) An applicant
429.30 seeking a temporary home care licensure must submit the following application fee to the
429.31 commissioner along with a completed application:

429.32 (1) basic home care provider, \$2,100; or

429.33 (2) comprehensive home care provider, \$4,200.

429.34 (b) A home care provider who is filing a change of ownership as required under
429.35 subdivision 5 must submit the following application fee to the commissioner, along with
429.36 the documentation required for the change of ownership:

- 430.1 (1) basic home care provider, \$2,100; or
 430.2 (2) comprehensive home care provider, \$4,200.
 430.3 (c) A home care provider who is seeking to renew the provider's license shall pay a
 430.4 fee to the commissioner based on revenues derived from the provision of home care
 430.5 services during the calendar year prior to the year in which the application is submitted,
 430.6 according to the following schedule:

<u>License Renewal Fee</u>	
<u>Provider Annual Revenue</u>	<u>Fee</u>
430.8 <u>greater than \$1,500,000</u>	<u>\$6,625</u>
430.9 <u>greater than \$1,275,000 and no more</u> 430.10 <u>than \$1,500,000</u>	<u>\$5,797</u>
430.11 <u>greater than \$1,100,000 and no more</u> 430.12 <u>than \$1,275,000</u>	<u>\$4,969</u>
430.13 <u>greater than \$950,000 and no more</u> 430.14 <u>than \$1,100,000</u>	<u>\$4,141</u>
430.15 <u>greater than \$850,000 and no more</u> 430.16 <u>than \$950,000</u>	<u>\$3,727</u>
430.17 <u>greater than \$750,000 and no more</u> 430.18 <u>than \$850,000</u>	<u>\$3,313</u>
430.19 <u>greater than \$650,000 and no more</u> 430.20 <u>than \$750,000</u>	<u>\$2,898</u>
430.21 <u>greater than \$550,000 and no more</u> 430.22 <u>than \$650,000</u>	<u>\$2,485</u>
430.23 <u>greater than \$450,000 and no more</u> 430.24 <u>than \$550,000</u>	<u>\$2,070</u>
430.25 <u>greater than \$350,000 and no more</u> 430.26 <u>than \$450,000</u>	<u>\$1,656</u>
430.27 <u>greater than \$250,000 and no more</u> 430.28 <u>than \$350,000</u>	<u>\$1,242</u>
430.29 <u>greater than \$100,000 and no more</u> 430.30 <u>than \$250,000</u>	<u>\$828</u>
430.31 <u>greater than \$50,000 and no more than</u> 430.32 <u>\$100,000</u>	<u>\$500</u>
430.33 <u>greater than \$25,000 and no more than</u> 430.34 <u>\$50,000</u>	<u>\$400</u>
430.35 <u>no more than \$25,000</u>	<u>\$200</u>

- 430.36 (d) If requested, the home care provider shall provide the commissioner information
 430.37 to verify the provider's annual revenues or other information as needed, including copies
 430.38 of documents submitted to the Department of Revenue.

- 430.39 (e) At each annual renewal, a home care provider may elect to pay the highest
 430.40 renewal fee for its license category, and not provide annual revenue information to the
 430.41 commissioner.
 430.42

431.1 (f) A temporary license or license applicant, or temporary licensee or licensee that
 431.2 knowingly provides the commissioner incorrect revenue amounts for the purpose of
 431.3 paying a lower license fee, shall be subject to a civil penalty in the amount of double the
 431.4 fee the provider should have paid.

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

431.7 Sec. 12. **[144A.473] ISSUANCE OF TEMPORARY LICENSE AND LICENSE**
 431.8 **RENEWAL.**

431.9 Subdivision 1. **Temporary license and renewal of license.** (a) The department
 431.10 shall review each application to determine the applicant's knowledge of and compliance
 431.11 with Minnesota home care regulations. Before granting a temporary license or renewing a
 431.12 license, the commissioner may further evaluate the applicant or licensee by requesting
 431.13 additional information or documentation or by conducting an on-site survey of the
 431.14 applicant to determine compliance with sections 144A.43 to 144A.482.

431.15 (b) Within 14 calendar days after receiving an application for a license,
 431.16 the commissioner shall acknowledge receipt of the application in writing. The
 431.17 acknowledgment must indicate whether the application appears to be complete or whether
 431.18 additional information is required before the application will be considered complete.

431.19 (c) Within 90 days after receiving a complete application, the commissioner shall
 431.20 issue a temporary license, renew the license, or deny the license.

431.21 (d) The commissioner shall issue a license that contains the home care provider's
 431.22 name, address, license level, expiration date of the license, and unique license number. All
 431.23 licenses are valid for one year from the date of issuance.

431.24 Subd. 2. **Temporary license.** (a) For new license applicants, the commissioner
 431.25 shall issue a temporary license for either the basic or comprehensive home care level. A
 431.26 temporary license is effective for one year from the date of issuance. Temporary licensees
 431.27 must comply with sections 144A.43 to 144A.482.

431.28 (b) During the temporary license year, the commissioner shall survey the temporary
 431.29 licensee after the commissioner is notified or has evidence that the temporary licensee
 431.30 is providing home care services.

431.31 (c) Within five days of beginning the provision of services, the temporary
 431.32 licensee must notify the commissioner that it is serving clients. The notification to the
 431.33 commissioner may be mailed or e-mailed to the commissioner at the address provided by
 431.34 the commissioner. If the temporary licensee does not provide home care services during

432.1 the temporary license year, then the temporary license expires at the end of the year and
432.2 the applicant must reapply for a temporary home care license.

432.3 (d) A temporary licensee may request a change in the level of licensure prior to
432.4 being surveyed and granted a license by notifying the commissioner in writing and
432.5 providing additional documentation or materials required to update or complete the
432.6 changed temporary license application. The applicant must pay the difference between the
432.7 application fees when changing from the basic to the comprehensive level of licensure.
432.8 No refund will be made if the provider chooses to change the license application to the
432.9 basic level.

432.10 (e) If the temporary licensee notifies the commissioner that the licensee has clients
432.11 within 45 days prior to the temporary license expiration, the commissioner may extend the
432.12 temporary license for up to 60 days in order to allow the commissioner to complete the
432.13 on-site survey required under this section and follow-up survey visits.

432.14 Subd. 3. **Temporary licensee survey.** (a) If the temporary licensee is in substantial
432.15 compliance with the survey, the commissioner shall issue either a basic or comprehensive
432.16 home care license. If the temporary licensee is not in substantial compliance with the
432.17 survey, the commissioner shall not issue a basic or comprehensive license and there will
432.18 be no contested hearing right under chapter 14.

432.19 (b) If the temporary licensee whose basic or comprehensive license has been denied
432.20 disagrees with the conclusions of the commissioner, then the licensee may request a
432.21 reconsideration by the commissioner or commissioner's designee. The reconsideration
432.22 request process will be conducted internally by the commissioner or commissioner's
432.23 designee, and chapter 14 does not apply.

432.24 (c) The temporary licensee requesting reconsideration must make the request in
432.25 writing and must list and describe the reasons why the licensee disagrees with the decision
432.26 to deny the basic or comprehensive home care license.

432.27 (d) A temporary licensee whose license is denied must comply with the requirements
432.28 for notification and transfer of clients in section 144A.475, subdivision 5.

432.29 **Sec. 13. [144A.474] SURVEYS AND INVESTIGATIONS.**

432.30 Subdivision 1. **Surveys.** The commissioner shall conduct surveys of each home
432.31 care provider. By June 30, 2016, the commissioner shall conduct a survey of home care
432.32 providers on a frequency of at least once every three years. Survey frequency may be
432.33 based on the license level, the provider's compliance history, number of clients served,
432.34 or other factors as determined by the department deemed necessary to ensure the health,
432.35 safety, and welfare of clients and compliance with the law.

433.1 Subd. 2. Types of home care surveys. (a) "Initial full survey" is the survey
 433.2 conducted of a new temporary licensee after the department is notified or has evidence that
 433.3 the licensee is providing home care services to determine if the provider is in compliance
 433.4 with home care requirements. Initial surveys must be completed within 14 months after
 433.5 the department's issuance of a temporary basic or comprehensive license.

433.6 (b) "Core survey" means periodic inspection of home care providers to determine
 433.7 ongoing compliance with the home care requirements focusing on the essential health and
 433.8 safety requirements. Core surveys are available to licensed home care providers who have
 433.9 been licensed for three years, and been surveyed at least once in the past three years,
 433.10 with the latest survey having no widespread violation or violations beyond Level 1 as
 433.11 provided in subdivision 11. Providers must also have not had any substantiated licensing
 433.12 complaints, substantiated complaints against the agency under the Vulnerable Adults
 433.13 Act or Maltreatment of Minors Act, or an enforcement action as authorized in section
 433.14 144A.475 in the past three years. The core survey for basic license level providers will
 433.15 review compliance in the following areas:

- 433.16 (1) reporting of maltreatment;
- 433.17 (2) orientation to and implementation of home care client bill of rights;
- 433.18 (3) statement of home care services;
- 433.19 (4) initial evaluation of clients and initiation of services;
- 433.20 (5) basic license level client review and monitoring;
- 433.21 (6) service plan implementation and changes to the service plan;
- 433.22 (7) client complaint and investigative process;
- 433.23 (8) competency of unlicensed personnel; and
- 433.24 (9) infection control.

433.25 For comprehensive license level providers, the core survey will include everything
 433.26 in the basic license level core survey plus these areas:

- 433.27 (1) assessment, monitoring, and reassessments of clients; and
- 433.28 (2) medication, treatment, and therapy management.

433.29 (c) "Full survey" means the periodic inspection of home care providers to determine
 433.30 ongoing compliance with the home care requirements that cover the core survey areas and
 433.31 all the legal requirements for home care providers. A full survey will be conducted for
 433.32 all temporary licensees, providers who do not meet the requirements needed for a core
 433.33 survey, and when a surveyor identifies unacceptable client health or safety risks during a
 433.34 core survey. A full survey will include all the tasks identified as part of the core survey
 433.35 and any additional review deemed necessary by the department, including additional
 433.36 observation, interviewing, or records review of additional clients and staff.

434.1 (d) "Follow-up surveys" are conducted to determine if a home care provider has
434.2 corrected deficient issues and systems identified during a core survey, full survey, or
434.3 complaint investigation. Follow-up surveys may be conducted via phone, e-mail, fax,
434.4 mail, or on-site reviews. Follow-up surveys, other than complaint surveys, shall be
434.5 concluded with an exit conference and written information provided on the process for
434.6 requesting a reconsideration of the survey results.

434.7 (e) Upon receiving information alleging that a home care provider has violated or
434.8 is currently violating a requirement of sections 144A.43 to 144A.482, the commissioner
434.9 shall investigate the complaint according to sections 144A.51 to 144A.54.

434.10 Subd. 3. **Survey process.** The survey process for core surveys shall include the
434.11 following as applicable to the particular licensee and setting surveyed:

434.12 (1) presurvey review of pertinent documents and notification to the ombudsman
434.13 for long-term care;

434.14 (2) an entrance conference with available staff;

434.15 (3) communication with managerial officials or the RN in charge, if available, and
434.16 ongoing communication with key staff throughout the survey regarding information
434.17 needed by the surveyor, clarifications regarding home care requirements, and applicable
434.18 standards of practice;

434.19 (4) presentation of written contact information to the provider about the survey staff
434.20 conducting the survey, the supervisor, and the process for requesting a reconsideration of
434.21 the survey results;

434.22 (5) a brief tour of a sampling of the housing with services establishments in which
434.23 the provider is providing home care services;

434.24 (6) a sample selection of home care clients;

434.25 (7) information gathering through client and staff observations, client and staff
434.26 interviews, and reviews of records, policies, procedures, practices, and other agency
434.27 information;

434.28 (8) interviews of client's family members, if available, with client's consent when the
434.29 client can legally give consent;

434.30 (9) except for complaint surveys conducted by the Office of Health Facilities
434.31 Complaints, an on-site exit conference with preliminary findings shared and discussed
434.32 with the provider, documentation that an exit conference occurred, and written information
434.33 on the process for requesting a reconsideration of the survey results; and

434.34 (10) postsurvey analysis of findings and formulation of survey results, including
434.35 correction orders when applicable.

435.1 Subd. 4. **Scheduling surveys.** Surveys and investigations shall be conducted
435.2 without advance notice to home care providers. Surveyors may contact the home care
435.3 provider on the day of a survey to arrange for someone to be available at the survey site.
435.4 The contact does not constitute advance notice.

435.5 Subd. 5. **Information provided by home care provider.** The home care provider
435.6 shall provide accurate and truthful information to the department during a survey,
435.7 investigation, or other licensing activities.

435.8 Subd. 6. **Providing client records.** Upon request of a surveyor, home care providers
435.9 shall provide a list of current and past clients or client representatives that includes
435.10 addresses and telephone numbers and any other information requested about the services
435.11 to clients within a reasonable period of time.

435.12 Subd. 7. **Contacting and visiting clients.** Surveyors may contact or visit a home
435.13 care provider's clients to gather information without notice to the home care provider.
435.14 Before visiting a client, a surveyor shall obtain the client's or client's representative's
435.15 permission by telephone, mail, or in person. Surveyors shall inform all clients or client's
435.16 representatives of their right to decline permission for a visit.

435.17 Subd. 8. **Correction orders.** (a) A correction order may be issued whenever the
435.18 commissioner finds upon survey or during a complaint investigation that a home care
435.19 provider, managerial official, or an employee of the provider is not in compliance with
435.20 sections 144A.43 to 144A.482. The correction order shall cite the specific statute and
435.21 document areas of noncompliance and the time allowed for correction.

435.22 (b) The commissioner shall mail copies of any correction order to the last known
435.23 address of the home care provider. A copy of each correction order and copies of any
435.24 documentation supplied to the commissioner shall be kept on file by the home care
435.25 provider, and public documents shall be made available for viewing by any person upon
435.26 request. Copies may be kept electronically.

435.27 (c) By the correction order date, the home care provider must document in the
435.28 provider's records any action taken to comply with the correction order. The commissioner
435.29 may request a copy of this documentation and the home care provider's action to respond
435.30 to the correction order in future surveys, upon a complaint investigation, and as otherwise
435.31 needed.

435.32 Subd. 9. **Follow-up surveys.** For providers that have Level III or Level IV
435.33 violations or any violations determined to be widespread, the department shall conduct a
435.34 follow-up survey within 90 calendar days of the survey. When conducting a follow-up
435.35 survey, the surveyor will focus on whether the previous violations have been corrected and
435.36 may also address any new violations that are observed while evaluating the corrections

436.1 that have been made. If a new violation is identified on a follow-up survey, no fine will be
436.2 imposed unless it is not corrected on the next follow-up survey.

436.3 Subd. 10. **Performance incentive.** A licensee is eligible for a performance
436.4 incentive if there are no violations identified in a core or full survey. The performance
436.5 incentive is a ten percent discount on the licensee's next home care renewal license fee.

436.6 Subd. 11. **Fines.** (a) Fines and enforcement actions under this subdivision may be
436.7 assessed based on the level and scope of the violations described in paragraph (c) as follows:

436.8 (1) Level I, no fines or enforcement;

436.9 (2) Level II, fines ranging from \$0 to \$500, in addition to any of the enforcement
436.10 mechanisms authorized in section 144A.475 for widespread violations;

436.11 (3) Level III, fines ranging from \$500 to \$1,000, in addition to any of the
436.12 enforcement mechanisms authorized in section 144A.475; and

436.13 (4) Level IV, fines ranging from \$1,000 to \$5,000, in addition to any of the
436.14 enforcement mechanisms authorized in section 144A.475.

436.15 (b) Correction orders for violations will be categorized by both level and scope as
436.16 follows, and fines will be assessed accordingly:

436.17 (1) level of violation:

436.18 (i) Level I, a violation that has no potential to cause more than a minimal impact on
436.19 the client and does not affect health or safety;

436.20 (ii) Level II, a violation that did not harm the client's health or safety, but had the
436.21 potential to have harmed a client's health or safety, but not likely to cause serious injury,
436.22 impairment, or death;

436.23 (iii) Level III, a violation that harmed a client's health or safety, not including serious
436.24 injury, impairment, or death, or a violation that has the potential to lead to serious injury,
436.25 impairment, or death; and

436.26 (iv) Level IV, a violation that results in serious injury, impairment or death.

436.27 (2) scope of violation:

436.28 (i) isolated, when one or a limited number of clients are affected, or one or a limited
436.29 number of staff are involved, or the situation has occurred only occasionally;

436.30 (ii) pattern, when more than a limited number of clients are affected, more than a
436.31 limited number of staff are involved, or the situation has had repeated occurrences but
436.32 is not found to be pervasive; or

436.33 (iii) widespread; when problems are pervasive or represent a systemic failure that
436.34 has affected or has the potential to affect a large portion or all of the clients.

436.35 (c) If the commissioner finds that the applicant or a home care provider required
436.36 to be licensed under sections 144A.43 to 144A.482 has not corrected violations by the

437.1 date specified in the correction order or conditional license resulting from a survey or
437.2 complaint investigation, the commissioner may impose a fine. A notice of noncompliance
437.3 with a correction order must be mailed to the applicant's or provider's last known address.
437.4 The noncompliance notice must list the violations not corrected.

437.5 (d) The license holder must pay the fines assessed on or before the payment date
437.6 specified. If the license holder fails to fully comply with the order, the commissioner
437.7 may issue a second fine or suspend the license until the license holder complies by
437.8 paying the fine. A timely appeal shall stay payment of the fine until the commissioner
437.9 issues a final order.

437.10 (e) A license holder shall promptly notify the commissioner in writing when a
437.11 violation specified in the order is corrected. If upon reinspection, the commissioner
437.12 determines that a violation has not been corrected as indicated by the order, the
437.13 commissioner may issue a second fine. The commissioner shall notify the license holder by
437.14 mail to the last known address in the licensing record that a second fine has been assessed.
437.15 The license holder may appeal the second fine as provided under this subdivision.

437.16 (f) A home care provider that has been assessed a fine under this subdivision has a
437.17 right to a reconsideration or a hearing under this section and chapter 14.

437.18 (g) When a fine has been assessed, the license holder may not avoid payment by
437.19 closing, selling, or otherwise transferring the licensed program to a third party. In such an
437.20 event, the license holder shall be liable for payment of the fine.

437.21 (h) In addition to any fine imposed under this section, the commissioner may assess
437.22 costs related to an investigation that results in a final order assessing a fine or other
437.23 enforcement action authorized by this chapter.

437.24 (i) Fines collected under this subdivision shall be deposited in the state government
437.25 special revenue fund and credited to an account separate from the revenue collected under
437.26 section 144A.472. Subject to an appropriation by the legislature, the revenue from the
437.27 fines collected may be used by the commissioner for special projects to improve home care
437.28 in Minnesota as recommended by the advisory council established in section 144A.4799.

437.29 Subd. 12. **Reconsideration.** (a) The commissioner shall make available to home
437.30 care providers a correction order reconsideration process. This process may be used
437.31 to challenge the correction order issued, including the level and scope described in
437.32 subdivision 11, and any fine assessed. During the correction order reconsideration
437.33 request, the issuance of the correction orders under reconsideration are not stayed, but
437.34 the department will post information on the Web site with the correction order that the
437.35 licensee has requested a reconsideration review and that the review is pending.

438.1 (b) A licensed home care provider may request from the commissioner, in writing,
 438.2 a correction order reconsideration regarding any correction order issued to the provider.
 438.3 The correction order reconsideration shall not be reviewed by any surveyor, investigator,
 438.4 or supervisor that participated in the writing or reviewing of the correction order being
 438.5 disputed. The correction order reconsiderations may be conducted in person by telephone,
 438.6 by another electronic form, or in writing, as determined by the commissioner. The
 438.7 commissioner shall respond in writing to the request from a home care provider for
 438.8 a correction order reconsideration within 60 days of the date the provider requests a
 438.9 reconsideration. The commissioner's response shall identify the commissioner's decision
 438.10 regarding each citation challenged by the home care provider.

438.11 (c) The findings of a correction order reconsideration process shall be one or more of
 438.12 the following:

438.13 (1) supported in full: the correction order is supported in full, with no deletion of
 438.14 findings to the citation;

438.15 (2) supported in substance: the correction order is supported, but one or more
 438.16 findings are deleted or modified without any change in the citation;

438.17 (3) correction order cited an incorrect home care licensing requirement: the correction
 438.18 order is amended by changing the correction order to the appropriate statutory reference;

438.19 (4) correction order was issued under an incorrect citation: the correction order is
 438.20 amended to be issued under the more appropriate correction order citation;

438.21 (5) the correction order is rescinded;

438.22 (6) fine is amended: it is determined the fine assigned to the correction order was
 438.23 applied incorrectly; or

438.24 (7) the level or scope of the citation is modified based on the reconsideration.

438.25 (d) If the correction order findings are changed by the commissioner, the
 438.26 commissioner shall update the correction order on the Web site accordingly.

438.27 Subd. 13. **Home care surveyor training.** Before conducting a home care survey,
 438.28 each home care surveyor must receive training on the following topics:

438.29 (1) Minnesota home care licensure requirements;

438.30 (2) Minnesota home care client bill of rights;

438.31 (3) Minnesota Vulnerable Adults Act and Reporting of Maltreatment of Minors;

438.32 (4) principles of documentation;

438.33 (5) survey protocol and processes;

438.34 (6) Offices of the Ombudsman roles;

438.35 (7) Office of Health Facility Complaints;

438.36 (8) Minnesota landlord and tenant, and housing with services laws;

439.1 (9) types of payors for home care services; and
 439.2 (10) Minnesota Nurse Practice Act for nurse surveyors.
 439.3 Materials used for this training will be posted on the Department of Health Web
 439.4 site. Requisite understanding of these topics will be reviewed as part of the quality
 439.5 improvement plan in section 30.

439.6 Sec. 14. **[144A.475] ENFORCEMENT.**

439.7 Subdivision 1. **Conditions.** (a) The commissioner may refuse to grant a temporary
 439.8 license or refuse to renew a license, may suspend or revoke a license, or may impose a
 439.9 conditional license if the home care provider or owner or managerial official of the home
 439.10 care provider:

439.11 (1) is in violation of, or during the term of the license has violated, any of the
 439.12 requirements in sections 144A.471 to 144A.482;

439.13 (2) permits, aids, or abets the commission of any illegal act in the provision of
 439.14 home care;

439.15 (3) performs any act detrimental to the health, safety, and welfare of a client;

439.16 (4) obtains the license by fraud or misrepresentation;

439.17 (5) knowingly made or makes a false statement of a material fact in the application
 439.18 for a license or in any other record or report required by this chapter;

439.19 (6) denies representatives of the department access to any part of the home care
 439.20 provider's books, records, files, or employees;

439.21 (7) interferes with or impedes a representative of the department in contacting the
 439.22 home care provider's clients;

439.23 (8) interferes with or impedes a representative of the department in the enforcement
 439.24 of this chapter or has failed to fully cooperate with an inspection, survey, or investigation
 439.25 by the department;

439.26 (9) destroys or makes unavailable any records or other evidence relating to the home
 439.27 care provider's compliance with this chapter;

439.28 (10) refuses to initiate a background study under section 144.057 or 245A.04;

439.29 (11) fails to timely pay any fines assessed by the department;

439.30 (12) violates any local, city, or township ordinance relating to home care services;

439.31 (13) has repeated incidents of personnel performing services beyond their
 439.32 competency level; or

439.33 (14) has operated beyond the scope of the home care provider's license level.

439.34 (b) A violation by a contractor providing the home care services of the home care
 439.35 provider is a violation by the home care provider.

440.1 Subd. 2. **Terms to suspension or conditional license.** A suspension or conditional
440.2 license designation may include terms that must be completed or met before a suspension
440.3 or conditional license designation is lifted. A conditional license designation may include
440.4 restrictions or conditions that are imposed on the provider. Terms for a suspension or
440.5 conditional license may include one or more of the following and the scope of each will be
440.6 determined by the commissioner:

440.7 (1) requiring a consultant to review, evaluate, and make recommended changes to
440.8 the home care provider's practices and submit reports to the commissioner at the cost of
440.9 the home care provider;

440.10 (2) requiring supervision of the home care provider or staff practices at the cost
440.11 of the home care provider by an unrelated person who has sufficient knowledge and
440.12 qualifications to oversee the practices and who will submit reports to the commissioner;

440.13 (3) requiring the home care provider or employees to obtain training at the cost of
440.14 the home care provider;

440.15 (4) requiring the home care provider to submit reports to the commissioner;

440.16 (5) prohibiting the home care provider from taking any new clients for a period
440.17 of time; or

440.18 (6) any other action reasonably required to accomplish the purpose of this
440.19 subdivision and section 144A.45, subdivision 2.

440.20 Subd. 3. **Notice.** Prior to any suspension, revocation, or refusal to renew a license,
440.21 the home care provider shall be entitled to notice and a hearing as provided by sections
440.22 14.57 to 14.69. In addition to any other remedy provided by law, the commissioner may,
440.23 without a prior contested case hearing, temporarily suspend a license or prohibit delivery
440.24 of services by a provider for not more than 90 days if the commissioner determines that
440.25 the health or safety of a consumer is in imminent danger, provided:

440.26 (1) advance notice is given to the home care provider;

440.27 (2) after notice, the home care provider fails to correct the problem;

440.28 (3) the commissioner has reason to believe that other administrative remedies are not
440.29 likely to be effective; and

440.30 (4) there is an opportunity for a contested case hearing within the 90 days.

440.31 Subd. 4. **Time limits for appeals.** To appeal the assessment of civil penalties
440.32 under section 144A.45, subdivision 2, clause (5), and an action against a license under
440.33 this section, a provider must request a hearing no later than 15 days after the provider
440.34 receives notice of the action.

440.35 Subd. 5. **Plan required.** (a) The process of suspending or revoking a license
440.36 must include a plan for transferring affected clients to other providers by the home care

441.1 provider, which will be monitored by the commissioner. Within three business days of
441.2 being notified of the final revocation or suspension action, the home care provider shall
441.3 provide the commissioner, the lead agencies as defined in section 256B.0911, and the
441.4 ombudsman for long-term care with the following information:

441.5 (1) a list of all clients, including full names and all contact information on file;

441.6 (2) a list of each client's representative or emergency contact person, including full
441.7 names and all contact information on file;

441.8 (3) the location or current residence of each client;

441.9 (4) the payor sources for each client, including payor source identification numbers;

441.10 and

441.11 (5) for each client, a copy of the client's service plan, and a list of the types of
441.12 services being provided.

441.13 (b) The revocation or suspension notification requirement is satisfied by mailing the
441.14 notice to the address in the license record. The home care provider shall cooperate with
441.15 the commissioner and the lead agencies during the process of transferring care of clients to
441.16 qualified providers. Within three business days of being notified of the final revocation or
441.17 suspension action, the home care provider must notify and disclose to each of the home
441.18 care provider's clients, or the client's representative or emergency contact persons, that
441.19 the commissioner is taking action against the home care provider's license by providing a
441.20 copy of the revocation or suspension notice issued by the commissioner.

441.21 Subd. 6. **Owners and managerial officials; refusal to grant license.** (a) The owner
441.22 and managerial officials of a home care provider whose Minnesota license has not been
441.23 renewed or that has been revoked because of noncompliance with applicable laws or rules
441.24 shall not be eligible to apply for and shall not be granted a home care license, including
441.25 other licenses under this chapter, or be given status as an enrolled personal care assistance
441.26 provider agency or personal care assistant by the Department of Human Services under
441.27 section 256B.0659 for five years following the effective date of the nonrenewal or
441.28 revocation. If the owner and managerial officials already have enrollment status, their
441.29 enrollment will be terminated by the Department of Human Services.

441.30 (b) The commissioner shall not issue a license to a home care provider for five
441.31 years following the effective date of license nonrenewal or revocation if the owner or
441.32 managerial official, including any individual who was an owner or managerial official
441.33 of another home care provider, had a Minnesota license that was not renewed or was
441.34 revoked as described in paragraph (a).

441.35 (c) Notwithstanding subdivision 1, the commissioner shall not renew, or shall
441.36 suspend or revoke, the license of any home care provider that includes any individual

442.1 as an owner or managerial official who was an owner or managerial official of a home
442.2 care provider whose Minnesota license was not renewed or was revoked as described in
442.3 paragraph (a) for five years following the effective date of the nonrenewal or revocation.

442.4 (d) The commissioner shall notify the home care provider 30 days in advance of
442.5 the date of nonrenewal, suspension, or revocation of the license. Within ten days after
442.6 the receipt of the notification, the home care provider may request, in writing, that the
442.7 commissioner stay the nonrenewal, revocation, or suspension of the license. The home
442.8 care provider shall specify the reasons for requesting the stay; the steps that will be taken
442.9 to attain or maintain compliance with the licensure laws and regulations; any limits on the
442.10 authority or responsibility of the owners or managerial officials whose actions resulted in
442.11 the notice of nonrenewal, revocation, or suspension; and any other information to establish
442.12 that the continuing affiliation with these individuals will not jeopardize client health, safety,
442.13 or well-being. The commissioner shall determine whether the stay will be granted within
442.14 30 days of receiving the provider's request. The commissioner may propose additional
442.15 restrictions or limitations on the provider's license and require that the granting of the stay
442.16 be contingent upon compliance with those provisions. The commissioner shall take into
442.17 consideration the following factors when determining whether the stay should be granted:

442.18 (1) the threat that continued involvement of the owners and managerial officials with
442.19 the home care provider poses to client health, safety, and well-being;

442.20 (2) the compliance history of the home care provider; and

442.21 (3) the appropriateness of any limits suggested by the home care provider.

442.22 If the commissioner grants the stay, the order shall include any restrictions or
442.23 limitation on the provider's license. The failure of the provider to comply with any
442.24 restrictions or limitations shall result in the immediate removal of the stay and the
442.25 commissioner shall take immediate action to suspend, revoke, or not renew the license.

442.26 Subd. 7. **Request for hearing.** A request for a hearing must be in writing and must:

442.27 (1) be mailed or delivered to the department or the commissioner's designee;

442.28 (2) contain a brief and plain statement describing every matter or issue contested; and

442.29 (3) contain a brief and plain statement of any new matter that the applicant or home
442.30 care provider believes constitutes a defense or mitigating factor.

442.31 Subd. 8. **Informal conference.** At any time, the applicant or home care provider
442.32 and the commissioner may hold an informal conference to exchange information, clarify
442.33 issues, or resolve issues.

442.34 Subd. 9. **Injunctive relief.** In addition to any other remedy provided by law, the
442.35 commissioner may bring an action in district court to enjoin a person who is involved in
442.36 the management, operation, or control of a home care provider or an employee of the

443.1 home care provider from illegally engaging in activities regulated by sections 144A.43 to
443.2 144A.482. The commissioner may bring an action under this subdivision in the district
443.3 court in Ramsey County or in the district in which a home care provider is providing
443.4 services. The court may grant a temporary restraining order in the proceeding if continued
443.5 activity by the person who is involved in the management, operation, or control of a home
443.6 care provider, or by an employee of the home care provider, would create an imminent
443.7 risk of harm to a recipient of home care services.

443.8 Subd. 10. **Subpoena.** In matters pending before the commissioner under sections
443.9 144A.43 to 144A.482, the commissioner may issue subpoenas and compel the attendance
443.10 of witnesses and the production of all necessary papers, books, records, documents, and
443.11 other evidentiary material. If a person fails or refuses to comply with a subpoena or
443.12 order of the commissioner to appear or testify regarding any matter about which the
443.13 person may be lawfully questioned or to produce any papers, books, records, documents,
443.14 or evidentiary materials in the matter to be heard, the commissioner may apply to the
443.15 district court in any district, and the court shall order the person to comply with the
443.16 commissioner's order or subpoena. The commissioner of health may administer oaths to
443.17 witnesses or take their affirmation. Depositions may be taken in or outside the state in the
443.18 manner provided by law for the taking of depositions in civil actions. A subpoena or other
443.19 process or paper may be served on a named person anywhere in the state by an officer
443.20 authorized to serve subpoenas in civil actions, with the same fees and mileage and in the
443.21 same manner as prescribed by law for a process issued out of a district court. A person
443.22 subpoenaed under this subdivision shall receive the same fees, mileage, and other costs
443.23 that are paid in proceedings in district court.

443.24 Sec. 15. **[144A.476] BACKGROUND STUDIES.**

443.25 Subdivision 1. **Prior criminal convictions; owner and managerial officials.** (a)
443.26 Before the commissioner issues a temporary license or renews a license, an owner or
443.27 managerial official is required to complete a background study under section 144.057. No
443.28 person may be involved in the management, operation, or control of a home care provider
443.29 if the person has been disqualified under chapter 245C. If an individual is disqualified
443.30 under section 144.057 or chapter 245C, the individual may request reconsideration of
443.31 the disqualification. If the individual requests reconsideration and the commissioner
443.32 sets aside or rescinds the disqualification, the individual is eligible to be involved in the
443.33 management, operation, or control of the provider. If an individual has a disqualification
443.34 under section 245C.15, subdivision 1, and the disqualification is affirmed, the individual's

444.1 disqualification is barred from a set aside, and the individual must not be involved in the
444.2 management, operation, or control of the provider.

444.3 (b) For purposes of this section, owners of a home care provider subject to the
444.4 background check requirement are those individuals whose ownership interest provides
444.5 sufficient authority or control to affect or change decisions related to the operation of the
444.6 home care provider. An owner includes a sole proprietor, a general partner, or any other
444.7 individual whose individual ownership interest can affect the management and direction
444.8 of the policies of the home care provider.

444.9 (c) For the purposes of this section, managerial officials subject to the background
444.10 check requirement are individuals who provide direct contact as defined in section
444.11 245C.02, subdivision 11, or individuals who have the responsibility for the ongoing
444.12 management or direction of the policies, services, or employees of the home care provider.
444.13 Data collected under this subdivision shall be classified as private data on individuals as
444.14 defined in section 13.02, subdivision 12.

444.15 (d) The department shall not issue any license if the applicant, owner, or managerial
444.16 official has been unsuccessful in having a background study disqualification set aside
444.17 under section 144.057 and chapter 245C; if the owner or managerial official, as an owner
444.18 or managerial official of another home care provider, was substantially responsible for
444.19 the other home care provider's failure to substantially comply with sections 144A.43 to
444.20 144A.482; or if an owner that has ceased doing business, either individually or as an
444.21 owner of a home care provider, was issued a correction order for failing to assist clients in
444.22 violation of this chapter.

444.23 Subd. 2. **Employees, contractors, and volunteers.** (a) Employees, contractors,
444.24 and volunteers of a home care provider are subject to the background study required by
444.25 section 144.057, and may be disqualified under chapter 245C. Nothing in this section shall
444.26 be construed to prohibit a home care provider from requiring self-disclosure of criminal
444.27 conviction information.

444.28 (b) Termination of an employee in good faith reliance on information or records
444.29 obtained under paragraph (a) or subdivision 1, regarding a confirmed conviction does not
444.30 subject the home care provider to civil liability or liability for unemployment benefits.

444.31 Sec. 16. **[144A.477] COMPLIANCE.**

444.32 Subdivision 1. **Medicare-certified providers; coordination of surveys.** If feasible,
444.33 the commissioner shall survey licensees to determine compliance with this chapter at the
444.34 same time as surveys for certification for Medicare if Medicare certification is based on
444.35 compliance with the federal conditions of participation and on survey and enforcement

445.1 by the Department of Health as agent for the United States Department of Health and
 445.2 Human Services.

445.3 Subd. 2. **Medicare-certified providers; equivalent requirements.** For home care
 445.4 providers licensed to provide comprehensive home care services that are also certified for
 445.5 participation in Medicare as a home health agency under Code of Federal Regulations,
 445.6 title 42, part 484, the following state licensure regulations are considered equivalent to
 445.7 the federal requirements:

445.8 (1) quality management, section 144A.479, subdivision 3;

445.9 (2) personnel records, section 144A.479, subdivision 7;

445.10 (3) acceptance of clients, section 144A.4791, subdivision 4;

445.11 (4) referrals, section 144A.4791, subdivision 5;

445.12 (5) client assessment, sections 144A.4791, subdivision 8, and 144A.4792,

445.13 subdivisions 2 and 3;

445.14 (6) individualized monitoring and reassessment, sections 144A.4791, subdivision
 445.15 8, and 144A.4792, subdivisions 2 and 3;

445.16 (7) individualized service plan, sections 144A.4791, subdivision 9, 144A.4792,
 445.17 subdivision 5, and 144A.4793, subdivision 3;

445.18 (8) client complaint and investigation process, section 144A.4791, subdivision 11;

445.19 (9) prescription orders, section 144A.4792, subdivisions 13 to 16;

445.20 (10) client records, section 144A.4794, subdivisions 1 to 3;

445.21 (11) qualifications for unlicensed personnel performing delegated tasks, section
 445.22 144A.4795;

445.23 (12) training and competency staff, section 144A.4795;

445.24 (13) training and competency for unlicensed personnel, section 144A.4795,
 445.25 subdivision 7;

445.26 (14) delegation of home care services, section 144A.4795, subdivision 4;

445.27 (15) availability of contact person, section 144A.4797, subdivision 1; and

445.28 (16) supervision of staff, section 144A.4797, subdivisions 2 and 3.

445.29 Violations of the requirements in clauses (1) to (16) may lead to enforcement actions
 445.30 under section 144A.474.

445.31 Sec. 17. **[144A.478] INNOVATION VARIANCE.**

445.32 Subdivision 1. **Definition.** For purposes of this section, "innovation variance"
 445.33 means a specified alternative to a requirement of this chapter. An innovation variance may
 445.34 be granted to allow a home care provider to offer home care services of a type or in a
 445.35 manner that is innovative, will not impair the services provided, will not adversely affect

446.1 the health, safety, or welfare of the clients, and is likely to improve the services provided.

446.2 The innovative variance cannot change any of the client's rights under section 144A.44.

446.3 Subd. 2. **Conditions.** The commissioner may impose conditions on the granting of
446.4 an innovation variance that the commissioner considers necessary.

446.5 Subd. 3. **Duration and renewal.** The commissioner may limit the duration of any
446.6 innovation variance and may renew a limited innovation variance.

446.7 Subd. 4. **Applications; innovation variance.** An application for innovation
446.8 variance from the requirements of this chapter may be made at any time, must be made in
446.9 writing to the commissioner, and must specify the following:

446.10 (1) the statute or law from which the innovation variance is requested;

446.11 (2) the time period for which the innovation variance is requested;

446.12 (3) the specific alternative action that the licensee proposes;

446.13 (4) the reasons for the request; and

446.14 (5) justification that an innovation variance will not impair the services provided;

446.15 will not adversely affect the health, safety, or welfare of clients; and is likely to improve
446.16 the services provided.

446.17 The commissioner may require additional information from the home care provider before
446.18 acting on the request.

446.19 Subd. 5. **Grants and denials.** The commissioner shall grant or deny each request
446.20 for an innovation variance in writing within 45 days of receipt of a complete request.

446.21 Notice of a denial shall contain the reasons for the denial. The terms of a requested
446.22 innovation variance may be modified upon agreement between the commissioner and
446.23 the home care provider.

446.24 Subd. 6. **Violation of innovation variances.** A failure to comply with the terms of
446.25 an innovation variance shall be deemed to be a violation of this chapter.

446.26 Subd. 7. **Revocation or denial of renewal.** The commissioner shall revoke or
446.27 deny renewal of an innovation variance if:

446.28 (1) it is determined that the innovation variance is adversely affecting the health,
446.29 safety, or welfare of the licensee's clients;

446.30 (2) the home care provider has failed to comply with the terms of the innovation
446.31 variance;

446.32 (3) the home care provider notifies the commissioner in writing that it wishes to
446.33 relinquish the innovation variance and be subject to the statute previously varied; or

446.34 (4) the revocation or denial is required by a change in law.

447.1 Sec. 18. **[144A.479] HOME CARE PROVIDER RESPONSIBILITIES;**
447.2 **BUSINESS OPERATION.**

447.3 Subdivision 1. **Display of license.** The original current license must be displayed
447.4 in the home care provider's principal business office and copies must be displayed in
447.5 any branch office. The home care provider must provide a copy of the license to any
447.6 person who requests it.

447.7 Subd. 2. **Advertising.** Home care providers shall not use false, fraudulent,
447.8 or misleading advertising in the marketing of services. For purposes of this section,
447.9 advertising includes any verbal, written, or electronic means of communicating to
447.10 potential clients about the availability, nature, or terms of home care services.

447.11 Subd. 3. **Quality management.** The home care provider shall engage in quality
447.12 management appropriate to the size of the home care provider and relevant to the type
447.13 of services the home care provider provides. The quality management activity means
447.14 evaluating the quality of care by periodically reviewing client services, complaints made,
447.15 and other issues that have occurred and determining whether changes in services, staffing,
447.16 or other procedures need to be made in order to ensure safe and competent services to
447.17 clients. Documentation about quality management activity must be available for two
447.18 years. Information about quality management must be available to the commissioner at
447.19 the time of the survey, investigation, or renewal.

447.20 Subd. 4. **Provider restrictions.** (a) This subdivision does not apply to licensees
447.21 that are Minnesota counties or other units of government.

447.22 (b) A home care provider or staff cannot accept powers-of-attorney from clients for
447.23 any purpose, and may not accept appointments as guardians or conservators of clients.

447.24 (c) A home care provider cannot serve as a client's representative.

447.25 Subd. 5. **Handling of client's finances and property.** (a) A home care provider
447.26 may assist clients with household budgeting, including paying bills and purchasing
447.27 household goods, but may not otherwise manage a client's property. A home care provider
447.28 must provide a client with receipts for all transactions and purchases paid with the client's
447.29 funds. When receipts are not available, the transaction or purchase must be documented.
447.30 A home care provider must maintain records of all such transactions.

447.31 (b) A home care provider or staff may not borrow a client's funds or personal or
447.32 real property, nor in any way convert a client's property to the home care provider's or
447.33 staff's possession.

447.34 (c) Nothing in this section precludes a home care provider or staff from accepting
447.35 gifts of minimal value, or precludes the acceptance of donations or bequests made to a

448.1 home care provider that are exempt from income tax under section 501(c) of the Internal
448.2 Revenue Code of 1986.

448.3 Subd. 6. **Reporting maltreatment of vulnerable adults and minors.** (a) All
448.4 home care providers must comply with requirements for the reporting of maltreatment
448.5 of minors in section 626.556 and the requirements for the reporting of maltreatment
448.6 of vulnerable adults in section 626.557. Home care providers must report suspected
448.7 maltreatment of minors and vulnerable adults to the common entry point. Each home
448.8 care provider must establish and implement a written procedure to ensure that all cases
448.9 of suspected maltreatment are reported.

448.10 (b) Each home care provider must develop and implement an individual abuse
448.11 prevention plan for each vulnerable minor or adult for whom home care services are
448.12 provided by a home care provider. The plan shall contain an individualized review or
448.13 assessment of the person's susceptibility to abuse by another individual, including other
448.14 vulnerable adults or minors; the person's risk of abusing other vulnerable adults or minors;
448.15 and statements of the specific measures to be taken to minimize the risk of abuse to that
448.16 person and other vulnerable adults or minors. For purposes of the abuse prevention plan,
448.17 the term abuse includes self-abuse.

448.18 Subd. 7. **Employee records.** The home care provider must maintain current records
448.19 of each paid employee, regularly scheduled volunteers providing home care services,
448.20 and each individual contractor providing home care services. The records must include
448.21 the following information:

448.22 (1) evidence of current professional licensure, registration, or certification, if
448.23 licensure, registration, or certification is required by this statute, or other rules;

448.24 (2) records of orientation, required annual training and infection control training,
448.25 and competency evaluations;

448.26 (3) current job description, including qualifications, responsibilities, and
448.27 identification of staff providing supervision;

448.28 (4) documentation of annual performance reviews which identify areas of
448.29 improvement needed and training needs;

448.30 (5) for individuals providing home care services, verification that required health
448.31 screenings under section 144A.4798 have taken place and the dates of those screenings; and

448.32 (6) documentation of the background study as required under section 144.057.

448.33 Each employee record must be retained for at least three years after a paid employee,
448.34 home care volunteer, or contractor ceases to be employed by or under contract with the
448.35 home care provider. If a home care provider ceases operation, employee records must be
448.36 maintained for three years.

449.1 Sec. 19. **[144A.4791] HOME CARE PROVIDER RESPONSIBILITIES WITH**
449.2 **RESPECT TO CLIENTS.**

449.3 Subdivision 1. Home care bill of rights; notification to client. (a) The home care
449.4 provider shall make all reasonable efforts to provide the client or the client's representative
449.5 a written notice of the rights under section 144A.44 before the initiation of services. The
449.6 home care provider shall make all reasonable efforts to provide the notice in a language
449.7 the client or client's representative understands. If a written version is not effective or
449.8 available, the notice may be provided verbally.

449.9 (b) In addition to the text of the home care bill of rights in section 144A.44,
449.10 subdivision 1, the notice shall also contain the following statement describing how to file
449.11 a complaint with these offices.

449.12 "If you have a complaint about the provider or the person providing your
449.13 home care services, you may call, write, or visit the Office of Health Facility
449.14 Complaints, Minnesota Department of Health. You may also contact the Office of
449.15 Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health
449.16 and Developmental Disabilities."

449.17 The statement should include the telephone number, Web site address, e-mail
449.18 address, mailing address, and street address of the Office of Health Facility Complaints at
449.19 the Minnesota Department of Health, the Office of the Ombudsman for Long-Term Care,
449.20 and the Office of the Ombudsman for Mental Health and Developmental Disabilities. The
449.21 statement should also include the home care provider's name, address, e-mail, telephone
449.22 number, and name or title of the person at the provider to whom problems or complaints
449.23 may be directed. It must also include a statement that the home care provider will not
449.24 retaliate because of a complaint.

449.25 (c) The home care provider shall obtain written acknowledgment of the client's
449.26 receipt of the home care bill of rights or shall document why an acknowledgment cannot
449.27 be obtained. The acknowledgment may be obtained from the client or the client's
449.28 representative. Acknowledgment of receipt shall be retained in the client's record.

449.29 Subd. 2. Notice of services for dementia, Alzheimer's disease, or related
449.30 disorders. The home care provider that provides services to clients with dementia shall
449.31 provide in written or electronic form, to clients and families or other persons who request
449.32 it, a description of the training program and related training it provides, including the
449.33 categories of employees trained, the frequency of training, and the basic topics covered.
449.34 This information satisfies the disclosure requirements in section 325F.72, subdivision
449.35 2, clause (4).

450.1 Subd. 3. **Statement of home care services.** Prior to the initiation of services,
450.2 a home care provider must provide to the client or the client's representative a written
450.3 statement which identifies if they have a basic or comprehensive home care license, the
450.4 services they are authorized to provide, and which services they cannot provide under the
450.5 scope of their license. The home care provider shall obtain written acknowledgment
450.6 from the clients that they have provided the statement or must document why they could
450.7 not obtain the acknowledgment.

450.8 Subd. 4. **Acceptance of clients.** No home care provider may accept a person as a
450.9 client unless the home care provider has staff, sufficient in qualifications, competency,
450.10 and numbers, to adequately provide the services agreed to in the service plan and that
450.11 are within the provider's scope of practice.

450.12 Subd. 5. **Referrals.** If a home care provider reasonably believes that a client is in
450.13 need of another medical or health service, including a licensed health professional, or
450.14 social service provider, the home care provider shall:

450.15 (1) determine the client's preferences with respect to obtaining the service; and

450.16 (2) inform the client of resources available, if known, to assist the client in obtaining
450.17 services.

450.18 Subd. 6. **Initiation of services.** When a provider initiates services and the
450.19 individualized review or assessment required in subdivisions 7 and 8 has not been
450.20 completed, the provider must complete a temporary plan and agreement with the client for
450.21 services.

450.22 Subd. 7. **Basic individualized client review and monitoring.** (a) When services
450.23 being provided are basic home care services, an individualized initial review of the client's
450.24 needs and preferences must be conducted at the client's residence with the client or client's
450.25 representative. This initial review must be completed within 30 days after the initiation of
450.26 the home care services.

450.27 (b) Client monitoring and review must be conducted as needed based on changes
450.28 in the needs of the client and cannot exceed 90 days from the date of the last review.
450.29 The monitoring and review may be conducted at the client's residence or through the
450.30 utilization of telecommunication methods based on practice standards that meet the
450.31 individual client's needs.

450.32 Subd. 8. **Comprehensive assessment, monitoring, and reassessment.** (a) When
450.33 the services being provided are comprehensive home care services, an individualized
450.34 initial assessment must be conducted in-person by a registered nurse. When the services
450.35 are provided by other licensed health professionals, the assessment must be conducted by

451.1 the appropriate health professional. This initial assessment must be completed within five
451.2 days after initiation of home care services.

451.3 (b) Client monitoring and reassessment must be conducted in the client's home no
451.4 more than 14 days after initiation of services.

451.5 (c) Ongoing client monitoring and reassessment must be conducted as needed based
451.6 on changes in the needs of the client and cannot exceed 90 days from the last date of the
451.7 assessment. The monitoring and reassessment may be conducted at the client's residence
451.8 or through the utilization of telecommunication methods based on practice standards that
451.9 meet the individual client's needs.

451.10 Subd. 9. **Service plan, implementation, and revisions to service plan.** (a) No later
451.11 than 14 days after the initiation of services, a home care provider shall finalize a current
451.12 written service plan.

451.13 (b) The service plan and any revisions must include a signature or other
451.14 authentication by the home care provider and by the client or the client's representative
451.15 documenting agreement on the services to be provided. The service plan must be revised,
451.16 if needed, based on client review or reassessment under subdivisions 7 and 8. The provider
451.17 must provide information to the client about changes to the provider's fee for services and
451.18 how to contact the Office of the Ombudsman for Long-Term Care.

451.19 (c) The home care provider must implement and provide all services required by
451.20 the current service plan.

451.21 (d) The service plan and revised service plan must be entered into the client's record,
451.22 including notice of a change in a client's fees when applicable.

451.23 (e) Staff providing home care services must be informed of the current written
451.24 service plan.

451.25 (f) The service plan must include:

451.26 (1) a description of the home care services to be provided, the fees for services, and
451.27 the frequency of each service, according to the client's current review or assessment and
451.28 client preferences;

451.29 (2) the identification of the staff or categories of staff who will provide the services;

451.30 (3) the schedule and methods of monitoring reviews or assessments of the client;

451.31 (4) the frequency of sessions of supervision of staff and type of personnel who
451.32 will supervise staff; and

451.33 (5) a contingency plan that includes:

451.34 (i) the action to be taken by the home care provider and by the client or client's
451.35 representative if the scheduled service cannot be provided;

452.1 (ii) information and method for a client or client's representative to contact the
452.2 home care provider;

452.3 (iii) names and contact information of persons the client wishes to have notified
452.4 in an emergency or if there is a significant adverse change in the client's condition,
452.5 including identification of and information as to who has authority to sign for the client in
452.6 an emergency; and

452.7 (iv) the circumstances in which emergency medical services are not to be summoned
452.8 consistent with chapters 145B and 145C, and declarations made by the client under those
452.9 chapters.

452.10 Subd. 10. **Termination of service plan.** (a) If a home care provider terminates a
452.11 service plan with a client, and the client continues to need home care services, the home
452.12 care provider shall provide the client and the client's representative, if any, with a written
452.13 notice of termination which includes the following information:

452.14 (1) the effective date of termination;

452.15 (2) the reason for termination;

452.16 (3) a list of known licensed home care providers in the client's immediate geographic
452.17 area;

452.18 (4) a statement that the home care provider will participate in a coordinated transfer
452.19 of care of the client to another home care provider, health care provider, or caregiver, as
452.20 required by the home care bill of rights, section 144A.44, subdivision 1, clause (17);

452.21 (5) the name and contact information of a person employed by the home care
452.22 provider with whom the client may discuss the notice of termination; and

452.23 (6) if applicable, a statement that the notice of termination of home care services
452.24 does not constitute notice of termination of the housing with services contract with a
452.25 housing with services establishment.

452.26 (b) When the home care provider voluntarily discontinues services to all clients, the
452.27 home care provider must notify the commissioner, lead agencies, and the ombudsman for
452.28 long-term care about its clients and comply with the requirements in this subdivision.

452.29 Subd. 11. **Client complaint and investigative process.** (a) The home care
452.30 provider must have a written policy and system for receiving, investigating, reporting,
452.31 and attempting to resolve complaints from its clients or clients' representatives. The
452.32 policy should clearly identify the process by which clients may file a complaint or concern
452.33 about home care services and an explicit statement that the home care provider will not
452.34 discriminate or retaliate against a client for expressing concerns or complaints. A home
452.35 care provider must have a process in place to conduct investigations of complaints made
452.36 by the client or the client's representative about the services in the client's plan that are or

453.1 are not being provided or other items covered in the client's home care bill of rights. This
453.2 complaint system must provide reasonable accommodations for any special needs of the
453.3 client or client's representative if requested.

453.4 (b) The home care provider must document the complaint, name of the client,
453.5 investigation, and resolution of each complaint filed. The home care provider must
453.6 maintain a record of all activities regarding complaints received, including the date the
453.7 complaint was received, and the home care provider's investigation and resolution of the
453.8 complaint. This complaint record must be kept for each event for at least two years after
453.9 the date of entry and must be available to the commissioner for review.

453.10 (c) The required complaint system must provide for written notice to each client or
453.11 client's representative that includes:

453.12 (1) the client's right to complain to the home care provider about the services received;

453.13 (2) the name or title of the person or persons with the home care provider to contact
453.14 with complaints;

453.15 (3) the method of submitting a complaint to the home care provider; and

453.16 (4) a statement that the provider is prohibited against retaliation according to
453.17 paragraph (d).

453.18 (d) A home care provider must not take any action that negatively affects a client
453.19 in retaliation for a complaint made or a concern expressed by the client or the client's
453.20 representative.

453.21 Subd. 12. **Disaster planning and emergency preparedness plan.** The home care
453.22 provider must have a written plan of action to facilitate the management of the client's care
453.23 and services in response to a natural disaster, such as flood and storms, or other emergencies
453.24 that may disrupt the home care provider's ability to provide care or services. The licensee
453.25 must provide adequate orientation and training of staff on emergency preparedness.

453.26 Subd. 13. **Request for discontinuation of life-sustaining treatment.** (a) If a
453.27 client, family member, or other caregiver of the client requests that an employee or other
453.28 agent of the home care provider discontinue a life-sustaining treatment, the employee or
453.29 agent receiving the request:

453.30 (1) shall take no action to discontinue the treatment; and

453.31 (2) shall promptly inform their supervisor or other agent of the home care provider
453.32 of the client's request.

453.33 (b) Upon being informed of a request for termination of treatment, the home care
453.34 provider shall promptly:

453.35 (1) inform the client that the request will be made known to the physician who
453.36 ordered the client's treatment;

454.1 (2) inform the physician of the client's request; and
454.2 (3) work with the client and the client's physician to comply with the provisions of
454.3 the Health Care Directive Act in chapter 145C.

454.4 (c) This section does not require the home care provider to discontinue treatment,
454.5 except as may be required by law or court order.

454.6 (d) This section does not diminish the rights of clients to control their treatments,
454.7 refuse services, or terminate their relationships with the home care provider.

454.8 (e) This section shall be construed in a manner consistent with chapter 145B or
454.9 145C, whichever applies, and declarations made by clients under those chapters.

454.10 Sec. 20. **[144A.4792] MEDICATION MANAGEMENT.**

454.11 **Subdivision 1. Medication management services; comprehensive home care**
454.12 **license.** (a) This subdivision applies only to home care providers with a comprehensive
454.13 home care license that provides medication management services to clients. Medication
454.14 management services may not be provided by a home care provider that has a basic
454.15 home care license.

454.16 (b) A comprehensive home care provider who provides medication management
454.17 services must develop, implement, and maintain current written medication management
454.18 policies and procedures. The policies and procedures must be developed under the
454.19 supervision and direction of a registered nurse, licensed health professional, or pharmacist
454.20 consistent with current practice standards and guidelines.

454.21 (c) The written policies and procedures must address requesting and receiving
454.22 prescriptions for medications; preparing and giving medications; verifying that
454.23 prescription drugs are administered as prescribed; documenting medication management
454.24 activities; controlling and storing medications; monitoring and evaluating medication use;
454.25 resolving medication errors; communicating with the prescriber, pharmacist, client, and
454.26 client representative, if any; disposing of unused medications; and educating clients and
454.27 client representatives about medications. When controlled substances are being managed,
454.28 the policies and procedures must also identify how the provider will ensure security and
454.29 accountability for the overall management, control, and disposition of those substances in
454.30 compliance with state and federal regulations and with subdivision 22.

454.31 **Subd. 2. Provision of medication management services.** (a) For each client who
454.32 requests medication management services, the comprehensive home care provider shall,
454.33 prior to providing medication management services, have a registered nurse, licensed
454.34 health professional, or authorized prescriber under section 151.37 conduct an assessment
454.35 to determine what medication management services will be provided and how the services

455.1 will be provided. This assessment must be conducted face-to-face with the client. The
455.2 assessment must include an identification and review of all medications the client is known
455.3 to be taking. The review and identification must include indications for medications, side
455.4 effects, contraindications, allergic or adverse reactions, and actions to address these issues.

455.5 (b) The assessment must identify interventions needed in management of
455.6 medications to prevent diversion of medication by the client or others who may have
455.7 access to the medications. Diversion of medications means the misuse, theft, or illegal
455.8 or improper disposition of medications.

455.9 Subd. 3. **Individualized medication monitoring and reassessment.** The
455.10 comprehensive home care provider must monitor and reassess the client's medication
455.11 management services as needed under subdivision 14 when the client presents with
455.12 symptoms or other issues that may be medication-related and, at a minimum, annually.

455.13 Subd. 4. **Client refusal.** The home care provider must document in the client's
455.14 record any refusal for an assessment for medication management by the client. The
455.15 provider must discuss with the client the possible consequences of the client's refusal and
455.16 document the discussion in the client's record.

455.17 Subd. 5. **Individualized medication management plan.** (a) For each client
455.18 receiving medication management services, the comprehensive home care provider must
455.19 prepare and include in the service plan a written statement of the medication management
455.20 services that will be provided to the client. The provider must develop and maintain a
455.21 current individualized medication management record for each client based on the client's
455.22 assessment that contains the following:

455.23 (1) a statement describing the medication management services that will be provided;

455.24 (2) a description of storage of medications based on the client's needs and
455.25 preferences, risk of diversion, and consistent with the manufacturer's directions;

455.26 (3) documentation of specific client instructions relating to the administration
455.27 of medications;

455.28 (4) identification of persons responsible for monitoring medication supplies and
455.29 ensuring that medication refills are ordered on a timely basis;

455.30 (5) identification of medication management tasks that may be delegated to
455.31 unlicensed personnel;

455.32 (6) procedures for staff notifying a registered nurse or appropriate licensed health
455.33 professional when a problem arises with medication management services; and

455.34 (7) any client-specific requirements relating to documenting medication
455.35 administration, verification that all medications are administered as prescribed, and
455.36 monitoring of medication use to prevent possible complications or adverse reactions.

456.1 (b) The medication management record must be current and updated when there are
456.2 any changes.

456.3 Subd. 6. **Administration of medication.** Medications may be administered by a
456.4 nurse, physician, or other licensed health practitioner authorized to administer medications
456.5 or by unlicensed personnel who have been delegated medication administration tasks by
456.6 a registered nurse.

456.7 Subd. 7. **Delegation of medication administration.** When administration of
456.8 medications is delegated to unlicensed personnel, the comprehensive home care provider
456.9 must ensure that the registered nurse has:

456.10 (1) instructed the unlicensed personnel in the proper methods to administer the
456.11 medications, and the unlicensed personnel has demonstrated ability to competently follow
456.12 the procedures;

456.13 (2) specified, in writing, specific instructions for each client and documented those
456.14 instructions in the client's records; and

456.15 (3) communicated with the unlicensed personnel about the individual needs of
456.16 the client.

456.17 Subd. 8. **Documentation of administration of medications.** Each medication
456.18 administered by comprehensive home care provider staff must be documented in the
456.19 client's record. The documentation must include the signature and title of the person
456.20 who administered the medication. The documentation must include the medication
456.21 name, dosage, date and time administered, and method and route of administration. The
456.22 staff must document the reason why medication administration was not completed as
456.23 prescribed and document any follow-up procedures that were provided to meet the client's
456.24 needs when medication was not administered as prescribed and in compliance with the
456.25 client's medication management plan.

456.26 Subd. 9. **Documentation of medication set up.** Documentation of dates of
456.27 medication set up, name of medication, quantity of dose, times to be administered, route
456.28 of administration, and name of person completing medication set up must be done at
456.29 time of set up.

456.30 Subd. 10. **Medications management for clients who will be away from home.**
456.31 (a) A home care provider that is providing medication management services to the client
456.32 and controls the client's access to the medications must develop and implement policies
456.33 and procedures for giving accurate and current medications to clients for planned or
456.34 unplanned times away from home according to the client's individualized medication
456.35 management plan.

456.36 The policy and procedures must state that:

457.1 (1) for planned time away, the medications must be obtained from the pharmacy or
457.2 set up by the registered nurse according to appropriate state and federal laws and nursing
457.3 standards of practice;

457.4 (2) for unplanned time away, when the pharmacy is not able to provide the
457.5 medications, a licensed nurse or unlicensed personnel shall give the client or the client's
457.6 representative medications in amounts and dosages needed for the length of the anticipated
457.7 absence, not to exceed 120 hours;

457.8 (3) the client, or the client's representative, must be provided written information
457.9 on medications, including any special instructions for administering or handling the
457.10 medications, including controlled substances;

457.11 (4) the medications must be placed in a medication container or containers
457.12 appropriate to the provider's medication system and must be labeled with the client's name
457.13 and the dates and times that the medications are scheduled; and

457.14 (5) the client or client's representative must be provided in writing the home care
457.15 provider's name and information on how to contact them.

457.16 (b) For unplanned time away when the licensed nurse is not available, the registered
457.17 nurse may delegate this task to unlicensed personnel if:

457.18 (1) the registered nurse has trained and determined the unlicensed staff to be
457.19 competent to follow the procedures for giving medications to clients;

457.20 (2) the registered nurse has developed written procedures for the unlicensed
457.21 personnel, including any special instructions or procedures regarding controlled substances
457.22 that are prescribed for the client. The procedures must address:

457.23 (i) the type of container or containers to be used for the medications appropriate to
457.24 the provider's medication system;

457.25 (ii) how the container or containers must be labeled;

457.26 (iii) the written information about the medications to be given to the client or the
457.27 client's representative;

457.28 (iv) how the unlicensed staff will document in the client's record that medications
457.29 have been given to the client or the client's responsible person, including documenting the
457.30 date the medications were given to the client or the client's responsible person and who
457.31 received the medications, the person who gave the medications to the client, the number of
457.32 medications that were given to the client, and other required information;

457.33 (v) how the registered nurse will be notified that medications have been given to
457.34 the client or the client's responsible person and whether the registered nurse needs to
457.35 be contacted before the medications are given to the client or the client's responsible
457.36 person; and

458.1 (vi) a review by the registered nurse of the completion of this task to verify that this
458.2 task was completed accurately by the unlicensed personnel.

458.3 Subd. 11. **Prescribed and nonprescribed medication.** The comprehensive home
458.4 care provider must determine whether it will require a prescription for all medications it
458.5 manages. The comprehensive home care provider must inform the client or the client's
458.6 representative whether the comprehensive home care provider requires a prescription
458.7 for all over-the-counter and dietary supplements before the comprehensive home care
458.8 provider will agree to manage those medications.

458.9 Subd. 12. **Medications; over-the-counter; dietary supplements not prescribed.**
458.10 A comprehensive home care provider providing medication management services for
458.11 over-the-counter drugs or dietary supplements must retain those items in the original labeled
458.12 container with directions for use prior to setting up for immediate or later administration.
458.13 The provider must verify that the medications are up-to-date and stored as appropriate.

458.14 Subd. 13. **Prescriptions.** There must be a current written or electronically recorded
458.15 prescription as defined in Minnesota Rules, part 6800.0100, subpart 11a, for all prescribed
458.16 medications that the comprehensive home care provider is managing for the client.

458.17 Subd. 14. **Renewal of prescriptions.** Prescriptions must be renewed at least
458.18 every 12 months or more frequently as indicated by the assessment in subdivision 2.
458.19 Prescriptions for controlled substances must comply with chapter 152.

458.20 Subd. 15. **Verbal prescription orders.** Verbal prescription orders from an
458.21 authorized prescriber must be received by a nurse or pharmacist. The order must be
458.22 handled according to Minnesota Rules, part 6800.6200.

458.23 Subd. 16. **Written or electronic prescription.** When a written or electronic
458.24 prescription is received, it must be communicated to the registered nurse in charge and
458.25 recorded or placed in the client's record.

458.26 Subd. 17. **Records confidential.** A prescription or order received verbally, in
458.27 writing, or electronically must be kept according to sections 144.291 to 144.298 and
458.28 144A.44.

458.29 Subd. 18. **Medications provided by client or family members.** When the
458.30 comprehensive home care provider is aware of any medications or dietary supplements
458.31 that are being used by the client and are not included in the assessment for medication
458.32 management services, the staff must advise the registered nurse and document that in
458.33 the client's record.

458.34 Subd. 19. **Storage of drugs.** A comprehensive home care provider providing
458.35 storage of medications outside of the client's private living space must store all prescription

459.1 drugs in securely locked and substantially constructed compartments according to the
459.2 manufacturer's directions and permit only authorized personnel to have access.

459.3 Subd. 20. **Prescription drugs.** A prescription drug, prior to being set up for
459.4 immediate or later administration, must be kept in the original container in which it was
459.5 dispensed by the pharmacy bearing the original prescription label with legible information
459.6 including the expiration or beyond-use date of a time-dated drug.

459.7 Subd. 21. **Prohibitions.** No prescription drug supply for one client may be used or
459.8 saved for use by anyone other than the client.

459.9 Subd. 22. **Disposition of drugs.** (a) Any current medications being managed by the
459.10 comprehensive home care provider must be given to the client or the client's representative
459.11 when the client's service plan ends or medication management services are no longer part
459.12 of the service plan. Medications that have been stored in the client's private living space
459.13 for a client that is deceased or that have been discontinued or that have expired may be
459.14 given to the client or the client's representative for disposal.

459.15 (b) The comprehensive home care provider will dispose of any medications
459.16 remaining with the comprehensive home care provider that are discontinued or expired or
459.17 upon the termination of the service contract or the client's death according to state and
459.18 federal regulations for disposition of drugs and controlled substances.

459.19 (c) Upon disposition, the comprehensive home care provider must document in the
459.20 client's record the disposition of the medications including the medication's name, strength,
459.21 prescription number as applicable, quantity, to whom the medications were given, date of
459.22 disposition, and names of staff and other individuals involved in the disposition.

459.23 Subd. 23. **Loss or spillage.** (a) Comprehensive home care providers providing
459.24 medication management must develop and implement procedures for loss or spillage of all
459.25 controlled substances defined in Minnesota Rules, part 6800.4220. These procedures must
459.26 require that when a spillage of a controlled substance occurs, a notation must be made
459.27 in the client's record explaining the spillage and the actions taken. The notation must
459.28 be signed by the person responsible for the spillage and include verification that any
459.29 contaminated substance was disposed of according to state or federal regulations.

459.30 (b) The procedures must require the comprehensive home care provider of
459.31 medication management to investigate any known loss or unaccounted for prescription
459.32 drugs and take appropriate action required under state or federal regulations and document
459.33 the investigation in required records.

459.34 Sec. 21. **[144A.4793] TREATMENT AND THERAPY MANAGEMENT**
459.35 **SERVICES.**

460.1 Subdivision 1. **Providers with a comprehensive home care license.** This section
460.2 applies only to home care providers with a comprehensive home care license that provide
460.3 treatment or therapy management services to clients. Treatment or therapy management
460.4 services cannot be provided by a home care provider that has a basic home care license.

460.5 Subd. 2. **Policies and procedures.** (a) A comprehensive home care provider who
460.6 provides treatment and therapy management services must develop, implement, and
460.7 maintain up-to-date written treatment or therapy management policies and procedures.
460.8 The policies and procedures must be developed under the supervision and direction of
460.9 a registered nurse or appropriate licensed health professional consistent with current
460.10 practice standards and guidelines.

460.11 (b) The written policies and procedures must address requesting and receiving
460.12 orders or prescriptions for treatments or therapies, providing the treatment or therapy,
460.13 documenting of treatment or therapy activities, educating and communicating with clients
460.14 about treatments or therapy they are receiving, monitoring and evaluating the treatment
460.15 and therapy, and communicating with the prescriber.

460.16 Subd. 3. **Individualized treatment or therapy management plan.** For each
460.17 client receiving management of ordered or prescribed treatments or therapy services, the
460.18 comprehensive home care provider must prepare and include in the service plan a written
460.19 statement of the treatment or therapy services that will be provided to the client. The
460.20 provider must also develop and maintain a current individualized treatment and therapy
460.21 management record for each client that contains at least the following:

460.22 (1) a statement of the type of services that will be provided;

460.23 (2) documentation of specific client instructions relating to the treatments or therapy
460.24 administration;

460.25 (3) identification of treatment or therapy tasks that will be delegated to unlicensed
460.26 personnel;

460.27 (4) procedures for notifying a registered nurse or appropriate licensed health
460.28 professional when a problem arises with treatments or therapy services; and

460.29 (5) any client-specific requirements relating to documentation of treatment and
460.30 therapy received, verification that all treatments and therapy was administered as
460.31 prescribed, and monitoring of treatment or therapy to prevent possible complications or
460.32 adverse reactions. The treatment or therapy management record must be current and
460.33 updated when there are any changes.

460.34 Subd. 4. **Administration of treatments and therapy.** Ordered or prescribed
460.35 treatments or therapies must be administered by a nurse, physician, or other licensed health
460.36 professional authorized to perform the treatment or therapy, or may be delegated or assigned

461.1 to unlicensed personnel by the licensed health professional according to the appropriate
 461.2 practice standards for delegation or assignment. When administration of a treatment or
 461.3 therapy is delegated or assigned to unlicensed personnel, the home care provider must
 461.4 ensure that the registered nurse or authorized licensed health professional has:

461.5 (1) instructed the unlicensed personnel in the proper methods with respect to each
 461.6 client and has demonstrated their ability to competently follow the procedures;

461.7 (2) specified, in writing, specific instructions for each client and documented those
 461.8 instructions in the client's record; and

461.9 (3) communicated with the unlicensed personnel about the individual needs of
 461.10 the client.

461.11 Subd. 5. **Documentation of administration of treatments and therapies.** Each
 461.12 treatment or therapy administered by a comprehensive home care provider must be
 461.13 documented in the client's record. The documentation must include the signature and title
 461.14 of the person who administered the treatment or therapy and must include the date and
 461.15 time of administration. When treatment or therapies are not administered as ordered or
 461.16 prescribed, the provider must document the reason why it was not administered and any
 461.17 follow-up procedures that were provided to meet the client's needs.

461.18 Subd. 6. **Orders or prescriptions.** There must be an up-to-date written or
 461.19 electronically recorded order or prescription for all treatments and therapies. The order
 461.20 must contain the name of the client, description of the treatment or therapy to be provided,
 461.21 and the frequency and other information needed to administer the treatment or therapy.

461.22 Sec. 22. **[144A.4794] CLIENT RECORD REQUIREMENTS.**

461.23 Subdivision 1. **Client record.** (a) The home care provider must maintain records
 461.24 for each client to whom it is providing services. Entries in the client records must be
 461.25 current, legible, permanently recorded, dated, and authenticated with the name and title
 461.26 of the person making the entry.

461.27 (b) Client records, whether written or electronic, must be protected against loss,
 461.28 tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable
 461.29 relevant federal and state laws. The home care provider shall establish and implement
 461.30 written procedures to control use, storage, and security of client's records and establish
 461.31 criteria for release of client information.

461.32 (c) The home care provider may not disclose to any other person any personal,
 461.33 financial, medical, or other information about the client, except:

461.34 (1) as may be required by law;

462.1 (2) to employees or contractors of the home care provider, another home care
 462.2 provider, other health care practitioner or provider, or inpatient facility needing
 462.3 information in order to provide services to the client, but only such information that
 462.4 is necessary for the provision of services;

462.5 (3) to persons authorized in writing by the client or the client's representative to
 462.6 receive the information, including third-party payers; and

462.7 (4) to representatives of the commissioner authorized to survey or investigate home
 462.8 care providers under this chapter or federal laws.

462.9 Subd. 2. **Access to records.** The home care provider must ensure that the
 462.10 appropriate records are readily available to employees or contractors authorized to access
 462.11 the records. Client records must be maintained in a manner that allows for timely access,
 462.12 printing, or transmission of the records.

462.13 Subd. 3. **Contents of client record.** Contents of a client record include the
 462.14 following for each client:

462.15 (1) identifying information, including the client's name, date of birth, address, and
 462.16 telephone number;

462.17 (2) the name, address, and telephone number of an emergency contact, family
 462.18 members, client's representative, if any, or others as identified;

462.19 (3) names, addresses, and telephone numbers of the client's health and medical
 462.20 service providers and other home care providers, if known;

462.21 (4) health information, including medical history, allergies, and when the provider
 462.22 is managing medications, treatments or therapies that require documentation, and other
 462.23 relevant health records;

462.24 (5) client's advance directives, if any;

462.25 (6) the home care provider's current and previous assessments and service plans;

462.26 (7) all records of communications pertinent to the client's home care services;

462.27 (8) documentation of significant changes in the client's status and actions taken in
 462.28 response to the needs of the client including reporting to the appropriate supervisor or
 462.29 health care professional;

462.30 (9) documentation of incidents involving the client and actions taken in response
 462.31 to the needs of the client including reporting to the appropriate supervisor or health
 462.32 care professional;

462.33 (10) documentation that services have been provided as identified in the service plan;

462.34 (11) documentation that the client has received and reviewed the home care bill
 462.35 of rights;

463.1 (12) documentation that the client has been provided the statement of disclosure on
463.2 limitations of services under section 144A.4791, subdivision 3;

463.3 (13) documentation of complaints received and resolution;

463.4 (14) discharge summary, including service termination notice and related
463.5 documentation, when applicable; and

463.6 (15) other documentation required under this chapter and relevant to the client's
463.7 services or status.

463.8 Subd. 4. **Transfer of client records.** If a client transfers to another home care
463.9 provider or other health care practitioner or provider, or is admitted to an inpatient facility,
463.10 the home care provider, upon request of the client or the client's representative, shall take
463.11 steps to ensure a coordinated transfer including sending a copy or summary of the client's
463.12 record to the new home care provider, facility, or the client, as appropriate.

463.13 Subd. 5. **Record retention.** Following the client's discharge or termination of
463.14 services, a home care provider must retain a client's record for at least five years, or as
463.15 otherwise required by state or federal regulations. Arrangements must be made for secure
463.16 storage and retrieval of client records if the home care provider ceases business.

463.17 **Sec. 23. [144A.4795] HOME CARE PROVIDER RESPONSIBILITIES; STAFF.**

463.18 Subdivision 1. **Qualifications, training, and competency.** All staff providing
463.19 home care services must be trained and competent in the provision of home care services
463.20 consistent with current practice standards appropriate to the client's needs.

463.21 Subd. 2. **Licensed health professionals and nurses.** (a) Licensed health
463.22 professionals and nurses providing home care services as an employee of a licensed home
463.23 care provider must possess current Minnesota license or registration to practice.

463.24 (b) Licensed health professionals and registered nurses must be competent in
463.25 assessing client needs, planning appropriate home care services to meet client needs,
463.26 implementing services, and supervising staff if assigned.

463.27 (c) Nothing in this section limits or expands the rights of nurses or licensed health
463.28 professionals to provide services within the scope of their licenses or registrations, as
463.29 provided by law.

463.30 Subd. 3. **Unlicensed personnel.** (a) Unlicensed personnel providing basic home
463.31 care services must have:

463.32 (1) successfully completed a training and competency evaluation appropriate to
463.33 the services provided by the home care provider and the topics listed in subdivision 7,
463.34 paragraph (b); or

464.1 (2) demonstrated competency by satisfactorily completing a written or oral test on
 464.2 the tasks the unlicensed personnel will perform and in the topics listed in subdivision
 464.3 7, paragraph (b); and successfully demonstrate competency of topics in subdivision 7,
 464.4 paragraph (b), clauses (5), (7), and (8), by a practical skills test.

464.5 Unlicensed personnel providing home care services for a basic home care provider may
 464.6 not perform delegated nursing or therapy tasks.

464.7 (b) Unlicensed personnel performing delegated nursing tasks for a comprehensive
 464.8 home care provider must have:

464.9 (1) successfully completed training and demonstrated competency by successfully
 464.10 completing a written or oral test of the topics in subdivision 7, paragraphs (b) and (c), and
 464.11 a practical skills test on tasks listed in subdivision 7, paragraphs (b), clauses (5) and (7),
 464.12 and (c), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; or

464.13 (2) satisfy the current requirements of Medicare for training or competency of home
 464.14 health aides or nursing assistants, as provided by Code of Federal Regulations, title 42,
 464.15 section 483 or section 484.36; or

464.16 (3) before April 19, 1993, completed a training course for nursing assistants that was
 464.17 approved by the commissioner.

464.18 (c) Unlicensed personnel performing therapy or treatment tasks delegated or
 464.19 assigned by a licensed health professional must meet the requirements for delegated
 464.20 tasks in subdivision 4 and any other training or competency requirements within the
 464.21 licensed health professional scope of practice relating to delegation or assignment of tasks
 464.22 to unlicensed personnel.

464.23 Subd. 4. **Delegation of home care tasks.** A registered nurse or licensed health
 464.24 professional may delegate tasks only to staff that are competent and possess the knowledge
 464.25 and skills consistent with the complexity of the tasks and according to the appropriate
 464.26 Minnesota Practice Act. The comprehensive home care provider must establish and
 464.27 implement a system to communicate up-to-date information to the registered nurse or
 464.28 licensed health professional regarding the current available staff and their competency so
 464.29 the registered nurse or licensed health professional has sufficient information to determine
 464.30 the appropriateness of delegating tasks to meet individual client needs and preferences.

464.31 Subd. 5. **Individual contractors.** When a home care provider contracts with an
 464.32 individual contractor excluded from licensure under section 144A.471 to provide home
 464.33 care services, the contractor must meet the same requirements required by this section for
 464.34 personnel employed by the home care provider.

464.35 Subd. 6. **Temporary staff.** When a home care provider contracts with a temporary
 464.36 staffing agency excluded from licensure under section 144A.471, those individuals must

465.1 meet the same requirements required by this section for personnel employed by the home
465.2 care provider and shall be treated as if they are staff of the home care provider.

465.3 Subd. 7. Requirements for instructors, training content, and competency

465.4 evaluations for unlicensed personnel. (a) Instructors and competency evaluators must
465.5 meet the following requirements:

465.6 (1) training and competency evaluations of unlicensed personnel providing basic
465.7 home care services must be conducted by individuals with work experience and training in
465.8 providing home care services listed in section 144A.471, subdivisions 6 and 7; and

465.9 (2) training and competency evaluations of unlicensed personnel providing
465.10 comprehensive home care services must be conducted by a registered nurse, or another
465.11 instructor may provide training in conjunction with the registered nurse. If the home care
465.12 provider is providing services by licensed health professionals only, then that specific
465.13 training and competency evaluation may be conducted by the licensed health professionals
465.14 as appropriate.

465.15 (b) Training and competency evaluations for all unlicensed personnel must include
465.16 the following:

465.17 (1) documentation requirements for all services provided;

465.18 (2) reports of changes in the client's condition to the supervisor designated by the
465.19 home care provider;

465.20 (3) basic infection control, including blood-borne pathogens;

465.21 (4) maintenance of a clean and safe environment;

465.22 (5) appropriate and safe techniques in personal hygiene and grooming, including:

465.23 (i) hair care and bathing;

465.24 (ii) care of teeth, gums, and oral prosthetic devices;

465.25 (iii) care and use of hearing aids; and

465.26 (iv) dressing and assisting with toileting;

465.27 (6) training on the prevention of falls for providers working with the elderly or
465.28 individuals at risk of falls;

465.29 (7) standby assistance techniques and how to perform them;

465.30 (8) medication, exercise, and treatment reminders;

465.31 (9) basic nutrition, meal preparation, food safety, and assistance with eating;

465.32 (10) preparation of modified diets as ordered by a licensed health professional;

465.33 (11) communication skills that include preserving the dignity of the client and

465.34 showing respect for the client and the client's preferences, cultural background, and family;

465.35 (12) awareness of confidentiality and privacy;

466.1 (13) understanding appropriate boundaries between staff and clients and the client's
 466.2 family;
 466.3 (14) procedures to utilize in handling various emergency situations; and
 466.4 (15) awareness of commonly used health technology equipment and assistive devices.
 466.5 (c) In addition to paragraph (b), training and competency evaluation for unlicensed
 466.6 personnel providing comprehensive home care services must include:
 466.7 (1) observation, reporting, and documenting of client status;
 466.8 (2) basic knowledge of body functioning and changes in body functioning, injuries,
 466.9 or other observed changes that must be reported to appropriate personnel;
 466.10 (3) reading and recording temperature, pulse, and respirations of the client;
 466.11 (4) recognizing physical, emotional, cognitive, and developmental needs of the client;
 466.12 (5) safe transfer techniques and ambulation;
 466.13 (6) range of motioning and positioning; and
 466.14 (7) administering medications or treatments as required.
 466.15 (d) When the registered nurse or licensed health professional delegates tasks, they
 466.16 must ensure that prior to the delegation the unlicensed personnel is trained in the proper
 466.17 methods to perform the tasks or procedures for each client and are able to demonstrate
 466.18 the ability to competently follow the procedures and perform the tasks. If an unlicensed
 466.19 personnel has not regularly performed the delegated home care task for a period of 24
 466.20 consecutive months, the unlicensed personnel must demonstrate competency in the task
 466.21 to the registered nurse or appropriate licensed health professional. The registered nurse
 466.22 or licensed health professional must document instructions for the delegated tasks in
 466.23 the client's record.

466.24 **Sec. 24. [144A.4796] ORIENTATION AND ANNUAL TRAINING**
 466.25 **REQUIREMENTS.**

466.26 Subdivision 1. **Orientation of staff and supervisors to home care.** All staff
 466.27 providing and supervising direct home care services must complete an orientation to home
 466.28 care licensing requirements and regulations before providing home care services to clients.
 466.29 The orientation may be incorporated into the training required under subdivision 6. The
 466.30 orientation need only be completed once for each staff person and is not transferable
 466.31 to another home care provider.

466.32 Subd. 2. **Content.** The orientation must contain the following topics:

466.33 (1) an overview of sections 144A.43 to 144A.4798;
 466.34 (2) introduction and review of all the provider's policies and procedures related to
 466.35 the provision of home care services;

467.1 (3) handling of emergencies and use of emergency services;

467.2 (4) compliance with and reporting the maltreatment of minors or vulnerable adults
 467.3 under sections 626.556 and 626.557;

467.4 (5) home care bill of rights, under section 144A.44;

467.5 (6) handling of clients' complaints, reporting of complaints, and where to report
 467.6 complaints including information on the Office of Health Facility Complaints and the
 467.7 Common Entry Point;

467.8 (7) consumer advocacy services of the Office of Ombudsman for Long-Term Care,
 467.9 Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care
 467.10 Ombudsman at the Department of Human Services, county managed care advocates,
 467.11 or other relevant advocacy services; and

467.12 (8) review of the types of home care services the employee will be providing and
 467.13 the provider's scope of licensure.

467.14 Subd. 3. **Verification and documentation of orientation.** Each home care provider
 467.15 shall retain evidence in the employee record of each staff person having completed the
 467.16 orientation required by this section.

467.17 Subd. 4. **Orientation to client.** Staff providing home care services must be oriented
 467.18 specifically to each individual client and the services to be provided. This orientation may
 467.19 be provided in person, orally, in writing, or electronically.

467.20 Subd. 5. **Training required relating to Alzheimer's disease and related disorders.**
 467.21 For home care providers that provide services for persons with Alzheimer's or related
 467.22 disorders, all direct care staff and supervisors working with these clients must receive
 467.23 training that includes a current explanation of Alzheimer's disease and related disorders,
 467.24 effective approaches to use to problem solve when working with a client's challenging
 467.25 behaviors, and how to communicate with clients who have Alzheimer's or related disorders.

467.26 Subd. 6. **Required annual training.** All staff that perform direct home care
 467.27 services must complete at least eight hours of annual training for each 12 months of
 467.28 employment. The training may be obtained from the home care provider or another source
 467.29 and must include topics relevant to the provision of home care services. The annual
 467.30 training must include:

467.31 (1) training on reporting of maltreatment of minors under section 626.556 and
 467.32 maltreatment of vulnerable adults under section 626.557, whichever is applicable to the
 467.33 services provided;

467.34 (2) review of the home care bill of rights in section 144A.44;

467.35 (3) review of infection control techniques used in the home and implementation of
 467.36 infection control standards including a review of hand washing techniques; the need for

468.1 and use of protective gloves, gowns, and masks; appropriate disposal of contaminated
468.2 materials and equipment, such as dressings, needles, syringes, and razor blades;
468.3 disinfecting reusable equipment; disinfecting environmental surfaces; and reporting of
468.4 communicable diseases; and

468.5 (4) review of the provider's policies and procedures relating to the provision of home
468.6 care services and how to implement those policies and procedures.

468.7 Subd. 7. **Documentation.** A home care provider must retain documentation in the
468.8 employee records of the staff that have satisfied the orientation and training requirements
468.9 of this section.

468.10 Sec. 25. **[144A.4797] PROVISION OF SERVICES.**

468.11 Subdivision 1. **Availability of contact person to staff.** (a) A home care provider
468.12 with a basic home care license must have a person available to staff for consultation on
468.13 items relating to the provision of services or about the client.

468.14 (b) A home care provider with a comprehensive home care license must have a
468.15 registered nurse available for consultation to staff performing delegated nursing tasks
468.16 and must have an appropriate licensed health professional available if performing other
468.17 delegated services such as therapies.

468.18 (c) The appropriate contact person must be readily available either in person, by
468.19 telephone, or by other means to the staff at times when the staff is providing services.

468.20 Subd. 2. **Supervision of staff; basic home care services.** (a) Staff who perform
468.21 basic home care services must be supervised periodically where the services are being
468.22 provided to verify that the work is being performed competently and to identify problems
468.23 and solutions to address issues relating to the staff's ability to provide the services. The
468.24 supervision of the unlicensed personnel must be done by staff of the home care provider
468.25 having the authority, skills, and ability to provide the supervision of unlicensed personnel
468.26 and who can implement changes as needed, and train staff.

468.27 (b) Supervision includes direct observation of unlicensed personnel while they
468.28 are providing the services and may also include indirect methods of gaining input such
468.29 as gathering feedback from the client. Supervisory review of staff must be provided at a
468.30 frequency based on the staff person's competency and performance.

468.31 (c) For an individual who is licensed as a home care provider, this section does
468.32 not apply.

468.33 Subd. 3. **Supervision of staff performing delegated nursing or therapy home**
468.34 **care tasks.** (a) Staff who perform delegated nursing or therapy home care tasks must
468.35 be supervised by an appropriately licensed health professional or a registered nurse

469.1 periodically where the services are being provided to verify that the work is being
 469.2 performed competently and to identify problems and solutions related to the staff person's
 469.3 ability to perform the tasks. Supervision of staff performing medication or treatment
 469.4 administration shall be provided by a registered nurse or appropriately licensed health
 469.5 professional and must include observation of the staff administering the medication or
 469.6 treatment and the interaction with the client.

469.7 (b) The direct supervision of staff performing delegated tasks must be provided
 469.8 within 30 days after the individual begins working for the home care provider and
 469.9 thereafter as needed based on performance. This requirement also applies to staff who
 469.10 have not performed delegated tasks for one year or longer.

469.11 Subd. 4. **Documentation.** A home care provider must retain documentation of
 469.12 supervision activities in the personnel records.

469.13 Subd. 5. **Exemption.** This section does not apply to an individual licensed under
 469.14 sections 144A.43 to 144A.4799.

469.15 **Sec. 26. [144A.4798] EMPLOYEE HEALTH STATUS.**

469.16 Subdivision 1. **Tuberculosis (TB) prevention and control.** A home care provider
 469.17 must establish and maintain a TB prevention and control program based on the most
 469.18 current guidelines issued by the Centers for Disease Control and Prevention (CDC).
 469.19 Components of a TB prevention and control program include screening all staff providing
 469.20 home care services, both paid and unpaid, at the time of hire for active TB disease and
 469.21 latent TB infection, and developing and implementing a written TB infection control plan.
 469.22 The commissioner shall make the most recent CDC standards available to home care
 469.23 providers on the department's Web site.

469.24 Subd. 2. **Communicable diseases.** A home care provider must follow
 469.25 current federal or state guidelines for prevention, control, and reporting of human
 469.26 immunodeficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus, or other
 469.27 communicable diseases as defined in Minnesota Rules, part 4605.7040.

469.28 **Sec. 27. [144A.4799] DEPARTMENT OF HEALTH LICENSED HOME CARE**
 469.29 **PROVIDER ADVISORY COUNCIL.**

469.30 Subdivision 1. **Membership.** The commissioner of health shall appoint eight
 469.31 persons to a home care provider advisory council consisting of the following:

469.32 (1) three public members as defined in section 214.02 who shall be either persons
 469.33 who are currently receiving home care services or have family members receiving home

470.1 care services, or persons who have family members who have received home care services
 470.2 within five years of the application date;

470.3 (2) three Minnesota home care licensees representing basic and comprehensive
 470.4 levels of licensure who may be a managerial official, an administrator, a supervising
 470.5 registered nurse, or an unlicensed personnel performing home care tasks;

470.6 (3) one member representing the Minnesota Board of Nursing; and

470.7 (4) one member representing the ombudsman for long-term care.

470.8 Subd. 2. **Organizations and meetings.** The advisory council shall be organized
 470.9 and administered under section 15.059 with per diems and costs paid within the limits of
 470.10 available appropriations. Meetings will be held quarterly and hosted by the department.
 470.11 Subcommittees may be developed as necessary by the commissioner. Advisory council
 470.12 meetings are subject to the Open Meeting Law under chapter 13D.

470.13 Subd. 3. **Duties.** At the commissioner's request, the advisory council shall provide
 470.14 advice regarding regulations of Department of Health licensed home care providers in
 470.15 this chapter such as:

470.16 (1) advice to the commissioner regarding community standards for home care
 470.17 practices;

470.18 (2) advice to the commissioner on enforcement of licensing standards and whether
 470.19 certain disciplinary actions are appropriate;

470.20 (3) advice to the commissioner about ways of distributing information to licensees
 470.21 and consumers of home care;

470.22 (4) advice to the commissioner about training standards;

470.23 (5) identify emerging issues and opportunities in the home care field, including the
 470.24 use of technology in home and telehealth capabilities; and

470.25 (6) perform other duties as directed by the commissioner.

470.26 Sec. 28. **[144A.481] HOME CARE LICENSING IMPLEMENTATION FOR**
 470.27 **NEW LICENSEES AND TRANSITION PERIOD FOR CURRENT LICENSEES.**

470.28 Subdivision 1. **Temporary home care licenses and changes of ownership.** (a)
 470.29 Beginning January 1, 2014, all temporary license applicants must apply for either a
 470.30 temporary basic or comprehensive home care license.

470.31 (b) Temporary home care licenses issued beginning January 1, 2014, will be
 470.32 issued according to the provisions in sections 144A.43 to 144A.4799 and fees in section
 470.33 144A.472 and will be required to comply with this chapter.

470.34 (c) No temporary licenses will be accepted or issued between December 1, 2013,
 470.35 and December 31, 2013.

471.1 (d) Beginning October 1, 2013, changes in ownership applications will require
471.2 payment of the new fees listed in section 144A.472. Providers who are providing
471.3 nursing, delegated nursing, or professional health care services, must submit the fee for
471.4 comprehensive home care providers, and all other providers must submit the fee for basic
471.5 home care providers as provided in section 144A.472. Change of ownership applicants will
471.6 be issued a new home care license based on the licensure law in effect on June 30, 2013.

471.7 Subd. 2. **Current home care licensees with licenses prior to July 1, 2013.** (a)
471.8 Beginning July 1, 2014, department licensed home care providers must apply for either
471.9 the basic or comprehensive home care license on their regularly scheduled renewal date.

471.10 (b) By June 30, 2015, all home care providers must either have a basic or
471.11 comprehensive home care license or temporary license.

471.12 Subd. 3. **Renewal and change of ownership application of home care licensure**
471.13 **during transition period.** Renewal and change of ownership applications of home care
471.14 licenses issued beginning July 1, 2014, will be issued according to sections 144A.43
471.15 to 144A.4799, and upon license renewal or issuance of a new license for a change of
471.16 ownership, providers must comply with sections 144A.43 to 144A.4799. Prior to renewal,
471.17 providers must comply with the home care licensure law in effect on June 30, 2013.

471.18 The fees charged for licenses renewed between July 1, 2014, and June 30, 2016,
471.19 shall be the lesser of 200 percent or \$1,000, except where the 200 percent or \$1,000
471.20 increase exceeds the actual renewal fee charged, with a maximum renewal fee of \$6,625.

471.21 For fiscal year 2014 only the fees for providers with revenues greater than \$25,000
471.22 and no more than \$100,000 will be \$313 and for providers with revenues no more than
471.23 \$25,000 the fee will be \$125.

471.24 The license renewal fee schedule in section 144A.472 will be effective July 1, 2016.

471.25 Sec. 29. **[144A.482] REGISTRATION OF HOME MANAGEMENT**

471.26 **PROVIDERS.**

471.27 (a) For purposes of this section, a home management provider is an individual or
471.28 organization that provides at least two of the following services: housekeeping, meal
471.29 preparation, and shopping, to a person who is unable to perform these activities due to
471.30 illness, disability, or physical condition.

471.31 (b) A person or organization that provides only home management services may not
471.32 operate in the state without a current certificate of registration issued by the commissioner
471.33 of health. To obtain a certificate of registration, the person or organization must annually
471.34 submit to the commissioner the name, mailing and physical address, e-mail address, and
471.35 telephone number of the individual or organization and a signed statement declaring that

472.1 the individual or organization is aware that the home care bill of rights applies to their
472.2 clients and that the person or organization will comply with the home care bill of rights
472.3 provisions contained in section 144A.44. An individual or organization applying for a
472.4 certificate must also provide the name, business address, and telephone number of each of
472.5 the individuals responsible for the management or direction of the organization.

472.6 (c) The commissioner shall charge an annual registration fee of \$20 for individuals
472.7 and \$50 for organizations. The registration fee shall be deposited in the state treasury and
472.8 credited to the state government special revenue fund.

472.9 (d) A home care provider that provides home management services and other home
472.10 care services must be licensed, but licensure requirements other than the home care bill of
472.11 rights do not apply to those employees or volunteers who provide only home management
472.12 services to clients who do not receive any other home care services from the provider.
472.13 A licensed home care provider need not be registered as a home management service
472.14 provider, but must provide an orientation on the home care bill of rights to its employees
472.15 or volunteers who provide home management services.

472.16 (e) An individual who provides home management services under this section must,
472.17 within 120 days after beginning to provide services, attend an orientation session approved
472.18 by the commissioner that provides training on the home care bill of rights and an orientation
472.19 on the aging process and the needs and concerns of elderly and disabled persons.

472.20 (f) The commissioner may suspend or revoke a provider's certificate of registration
472.21 or assess fines for violation of the home care bill of rights. Any fine assessed for a
472.22 violation of the home care bill of rights by a provider registered under this section shall be
472.23 in the amount established in the licensure rules for home care providers. As a condition
472.24 of registration, a provider must cooperate fully with any investigation conducted by the
472.25 commissioner, including providing specific information requested by the commissioner on
472.26 clients served and the employees and volunteers who provide services. Fines collected
472.27 under this paragraph shall be deposited in the state treasury and credited to the fund
472.28 specified in the statute or rule in which the penalty was established.

472.29 (g) The commissioner may use any of the powers granted in sections 144A.43 to
472.30 144A.4799 to administer the registration system and enforce the home care bill of rights
472.31 under this section.

472.32 **Sec. 30. AGENCY QUALITY IMPROVEMENT PROGRAM.**

472.33 **Subdivision 1. Annual legislative report on home care licensing.** The
472.34 commissioner shall establish a quality improvement program for the home care survey
472.35 and home care complaint investigation processes. The commissioner shall submit to the

473.1 legislature an annual report, beginning October 1, 2015, and each October 1 thereafter.

473.2 Each report will review the previous state fiscal year of home care licensing and regulatory
 473.3 activities. The report must include, but is not limited to, an analysis of:

473.4 (1) the number of FTE's in the Compliance Monitoring Division, including the
 473.5 Office of Health Facilities Complaint units assigned to home care licensing, survey,
 473.6 investigation, and enforcement process;

473.7 (2) numbers of and descriptive information about licenses issued, complaints
 473.8 received and investigated, including allegations made and correction orders issued,
 473.9 surveys completed and timelines, correction order reconsiderations, and results;

473.10 (3) descriptions of emerging trends in home care provision and areas of concern
 473.11 identified by the department in its regulation of home care providers;

473.12 (4) information and data regarding performance improvement projects underway
 473.13 and planned by the commissioner in the area of home care surveys; and

473.14 (5) work of the Department of Health Home Care Advisory Council.

473.15 Subd. 2. **Study of correction order appeal process.** Starting July 1, 2015, the
 473.16 commissioner shall study whether to add a correction order appeal process conducted by
 473.17 an independent reviewer, such as an administrative law judge or other office, and submit a
 473.18 report to the legislature by February 1, 2016. The commissioner shall review home care
 473.19 regulatory systems in other states as part of that study. The commissioner shall consult
 473.20 with the home care providers and representatives.

473.21 Sec. 31. **INTEGRATED LICENSING SYSTEM FOR HOME CARE AND HOME**
 473.22 **AND COMMUNITY-BASED SERVICES.**

473.23 (a) The Department of Health Compliance Monitoring Division and the Department
 473.24 of Human Services Licensing Division shall jointly develop an integrated licensing system
 473.25 for providers of both home care services subject to licensure under Minnesota Statutes,
 473.26 chapter 144A, and for home and community-based services subject to licensure under
 473.27 Minnesota Statutes, chapter 245D. The integrated licensing system shall:

473.28 (1) require only one license of any provider of services under Minnesota Statutes,
 473.29 sections 144A.43 to 144A.482, and 245D.03, subdivision 1;

473.30 (2) promote quality services that recognize a person's individual needs and protect
 473.31 the person's health, safety, rights, and well-being;

473.32 (3) promote provider accountability through application requirements, compliance
 473.33 inspections, investigations, and enforcement actions;

473.34 (4) reference other applicable requirements in existing state and federal laws,
 473.35 including the federal Affordable Care Act;

474.1 (5) establish internal procedures to facilitate ongoing communications between the
474.2 agencies, and with providers and services recipients about the regulatory activities;

474.3 (6) create a link between the agency Web sites so that providers and the public can
474.4 access the same information regardless of which Web site is accessed initially; and

474.5 (7) collect data on identified outcome measures as necessary for the agencies to
474.6 report to the Centers for Medicare and Medicaid Services.

474.7 (b) The joint recommendations for legislative changes to implement the integrated
474.8 licensing system are due to the legislature by February 15, 2014.

474.9 (c) Before implementation of the integrated licensing system, providers licensed as
474.10 home care providers under Minnesota Statutes, chapter 144A, may also provide home
474.11 and community-based services subject to licensure under Minnesota Statutes, chapter
474.12 245D, without obtaining a home and community-based services license under Minnesota
474.13 Statutes, chapter 245D. During this time, the conditions under clauses (1) to (3) shall
474.14 apply to these providers:

474.15 (1) the provider must comply with all requirements under Minnesota Statutes, chapter
474.16 245D, for services otherwise subject to licensure under Minnesota Statutes, chapter 245D;

474.17 (2) a violation of requirements under Minnesota Statutes, chapter 245D, may be
474.18 enforced by the Department of Health under the enforcement authority set forth in
474.19 Minnesota Statutes, section 144A.475; and

474.20 (3) the Department of Health will provide information to the Department of Human
474.21 Services about each provider licensed under this section, including the provider's license
474.22 application, licensing documents, inspections, information about complaints received, and
474.23 investigations conducted for possible violations of Minnesota Statutes, chapter 245D.

474.24 **Sec. 32. STUDY OF CORRECTION ORDER APPEAL PROCESS.**

474.25 Beginning July 1, 2015, the commissioner of health shall study whether to use
474.26 a correction order appeal process conducted by an independent reviewer, such as
474.27 an administrative law judge or other office. The commissioner shall review home
474.28 care regulatory systems in other states and consult with the home care providers and
474.29 representatives. By February 1, 2016, the commissioner shall submit a report to the chairs
474.30 and ranking minority members of the committees of the legislature with jurisdiction over
474.31 health and human services and judiciary issues with any recommendations regarding
474.32 an independent appeal process.

474.33 **Sec. 33. REPEALER.**

474.34 (a) Minnesota Statutes 2012, sections 144A.46; and 144A.461, are repealed.

475.1 (b) Minnesota Rules, parts 4668.0002; 4668.0003; 4668.0005; 4668.0008;
 475.2 4668.0012; 4668.0016; 4668.0017; 4668.0019; 4668.0030; 4668.0035; 4668.0040;
 475.3 4668.0050; 4668.0060; 4668.0065; 4668.0070; 4668.0075; 4668.0080; 4668.0100;
 475.4 4668.0110; 4668.0120; 4668.0130; 4668.0140; 4668.0150; 4668.0160; 4668.0170;
 475.5 4668.0180; 4668.0190; 4668.0200; 4668.0218; 4668.0220; 4668.0230; 4668.0240;
 475.6 4668.0800; 4668.0805; 4668.0810; 4668.0815; 4668.0820; 4668.0825; 4668.0830;
 475.7 4668.0835; 4668.0840; 4668.0845; 4668.0855; 4668.0860; 4668.0865; 4668.0870;
 475.8 4669.0001; 4669.0010; 4669.0020; 4669.0030; 4669.0040; and 4669.0050, are repealed.

475.9 Sec. 34. **EFFECTIVE DATE.**

475.10 Sections 1 to 30 are effective the day following final enactment.

475.11 **ARTICLE 12**

475.12 **HEALTH DEPARTMENT**

475.13 Section 1. Minnesota Statutes 2012, section 62J.692, subdivision 1, is amended to read:

475.14 Subdivision 1. **Definitions.** For purposes of this section, the following definitions
 475.15 apply:

475.16 (a) "Accredited clinical training" means the clinical training provided by a medical
 475.17 education program that is accredited through an organization recognized by the Department
 475.18 of Education, the Centers for Medicare and Medicaid Services, or another national body
 475.19 who reviews the accrediting organizations for multiple disciplines and whose standards
 475.20 for recognizing accrediting organizations are reviewed and approved by the commissioner
 475.21 of health in consultation with the Medical Education and Research Advisory Committee.

475.22 (b) "Commissioner" means the commissioner of health.

475.23 (c) "Clinical medical education program" means the accredited clinical training of
 475.24 physicians (medical students and residents), doctor of pharmacy practitioners, doctors
 475.25 of chiropractic, dentists, advanced practice nurses (clinical nurse specialists, certified
 475.26 registered nurse anesthetists, nurse practitioners, and certified nurse midwives), and
 475.27 physician assistants, dental therapists and advanced dental therapists, psychologists,
 475.28 clinical social workers, community paramedics, and community health workers.

475.29 (d) "Sponsoring institution" means a hospital, school, or consortium located in
 475.30 Minnesota that sponsors and maintains primary organizational and financial responsibility
 475.31 for a clinical medical education program in Minnesota and which is accountable to the
 475.32 accrediting body.

475.33 (e) "Teaching institution" means a hospital, medical center, clinic, or other
 475.34 organization that conducts a clinical medical education program in Minnesota.

476.1 (f) "Trainee" means a student or resident involved in a clinical medical education
476.2 program.

476.3 (g) "Eligible trainee FTE's" means the number of trainees, as measured by full-time
476.4 equivalent counts, that are at training sites located in Minnesota with currently active
476.5 medical assistance enrollment status and a National Provider Identification (NPI) number
476.6 where training occurs in either an inpatient or ambulatory patient care setting and where
476.7 the training is funded, in part, by patient care revenues. Training that occurs in nursing
476.8 facility settings is not eligible for funding under this section.

476.9 Sec. 2. Minnesota Statutes 2012, section 62J.692, subdivision 3, is amended to read:

476.10 Subd. 3. **Application process.** (a) A clinical medical education program conducted
476.11 in Minnesota by a teaching institution to train physicians, doctor of pharmacy practitioners,
476.12 dentists, chiropractors, ~~or~~ physician assistants is, dental therapists and advanced dental
476.13 therapists, psychologists, clinical social workers, community paramedics, or community
476.14 health workers are eligible for funds under subdivision 4 if the program:

476.15 (1) is funded, in part, by patient care revenues;

476.16 (2) occurs in patient care settings that face increased financial pressure as a result
476.17 of competition with nonteaching patient care entities; and

476.18 (3) emphasizes primary care or specialties that are in undersupply in Minnesota.

476.19 (b) A clinical medical education program for advanced practice nursing is eligible for
476.20 funds under subdivision 4 if the program meets the eligibility requirements in paragraph
476.21 (a), clauses (1) to (3), and is sponsored by the University of Minnesota Academic Health
476.22 Center, the Mayo Foundation, or institutions that are part of the Minnesota State Colleges
476.23 and Universities system or members of the Minnesota Private College Council.

476.24 (c) Applications must be submitted to the commissioner by a sponsoring institution
476.25 on behalf of an eligible clinical medical education program and must be received by
476.26 October 31 of each year for distribution in the following year. An application for funds
476.27 must contain the following information:

476.28 (1) the official name and address of the sponsoring institution and the official
476.29 name and site address of the clinical medical education programs on whose behalf the
476.30 sponsoring institution is applying;

476.31 (2) the name, title, and business address of those persons responsible for
476.32 administering the funds;

476.33 (3) for each clinical medical education program for which funds are being sought;
476.34 the type and specialty orientation of trainees in the program; the name, site address, and
476.35 medical assistance provider number and national provider identification number of each

477.1 training site used in the program; the federal tax identification number of each training site
 477.2 used in the program, where available; the total number of trainees at each training site; and
 477.3 the total number of eligible trainee FTEs at each site; and

477.4 (4) other supporting information the commissioner deems necessary to determine
 477.5 program eligibility based on the criteria in paragraphs (a) and (b) and to ensure the
 477.6 equitable distribution of funds.

477.7 (d) An application must include the information specified in clauses (1) to (3) for
 477.8 each clinical medical education program on an annual basis for three consecutive years.
 477.9 After that time, an application must include the information specified in clauses (1) to (3)
 477.10 when requested, at the discretion of the commissioner:

477.11 (1) audited clinical training costs per trainee for each clinical medical education
 477.12 program when available or estimates of clinical training costs based on audited financial
 477.13 data;

477.14 (2) a description of current sources of funding for clinical medical education costs,
 477.15 including a description and dollar amount of all state and federal financial support,
 477.16 including Medicare direct and indirect payments; and

477.17 (3) other revenue received for the purposes of clinical training.

477.18 (e) An applicant that does not provide information requested by the commissioner
 477.19 shall not be eligible for funds for the current funding cycle.

477.20 Sec. 3. Minnesota Statutes 2012, section 62J.692, subdivision 4, is amended to read:

477.21 Subd. 4. **Distribution of funds.** (a) The commissioner shall annually distribute the
 477.22 available medical education funds to all qualifying applicants based on ~~a distribution~~
 477.23 ~~formula that reflects a summation of two factors:~~

477.24 ~~(1) a public program volume factor, which is determined by the total volume of~~
 477.25 ~~public program revenue received by each training site as a percentage of all public~~
 477.26 ~~program revenue received by all training sites in the fund pool; and~~

477.27 ~~(2) a supplemental public program volume factor, which is determined by providing~~
 477.28 ~~a supplemental payment of 20 percent of each training site's grant to training sites whose~~
 477.29 ~~public program revenue accounted for at least 0.98 percent of the total public program~~
 477.30 ~~revenue received by all eligible training sites. Grants to training sites whose public~~
 477.31 ~~program revenue accounted for less than 0.98 percent of the total public program revenue~~
 477.32 ~~received by all eligible training sites shall be reduced by an amount equal to the total~~
 477.33 ~~value of the supplemental payment.~~

477.34 Public program revenue for the distribution formula includes revenue from medical
 477.35 assistance, prepaid medical assistance, general assistance medical care, and prepaid

478.1 general assistance medical care. Training sites that receive no public program revenue
478.2 are ineligible for funds available under this subdivision. For purposes of determining
478.3 training-site level grants to be distributed under paragraph (a), total statewide average
478.4 costs per trainee for medical residents is based on audited clinical training costs per trainee
478.5 in primary care clinical medical education programs for medical residents. Total statewide
478.6 average costs per trainee for dental residents is based on audited clinical training costs
478.7 per trainee in clinical medical education programs for dental students. Total statewide
478.8 average costs per trainee for pharmacy residents is based on audited clinical training costs
478.9 per trainee in clinical medical education programs for pharmacy students. Training sites
478.10 whose training site level grant is less than ~~\$1,000~~ \$5,000, based on the formula described
478.11 in this paragraph, or that train fewer than 0.1 FTE eligible trainees, are ineligible for
478.12 funds available under this subdivision. No training sites shall receive a grant per FTE
478.13 trainee that is in excess of the 95th percentile grant per FTE across all eligible training
478.14 sites; grants in excess of this amount will be redistributed to other eligible sites based on
478.15 the formula described in this paragraph.

478.16 (b) Funds distributed shall not be used to displace current funding appropriations
478.17 from federal or state sources.

478.18 (c) Funds shall be distributed to the sponsoring institutions indicating the amount
478.19 to be distributed to each of the sponsor's clinical medical education programs based on
478.20 the criteria in this subdivision and in accordance with the commissioner's approval letter.
478.21 Each clinical medical education program must distribute funds allocated under paragraph
478.22 (a) to the training sites as specified in the commissioner's approval letter. Sponsoring
478.23 institutions, which are accredited through an organization recognized by the Department
478.24 of Education or the Centers for Medicare and Medicaid Services, may contract directly
478.25 with training sites to provide clinical training. To ensure the quality of clinical training,
478.26 those accredited sponsoring institutions must:

478.27 (1) develop contracts specifying the terms, expectations, and outcomes of the clinical
478.28 training conducted at sites; and

478.29 (2) take necessary action if the contract requirements are not met. Action may include
478.30 the withholding of payments under this section or the removal of students from the site.

478.31 (d) Use of funds is limited to expenses related to clinical training program costs for
478.32 eligible programs.

478.33 (e) Any funds not distributed in accordance with the commissioner's approval letter
478.34 must be returned to the medical education and research fund within 30 days of receiving
478.35 notice from the commissioner. The commissioner shall distribute returned funds to the
478.36 appropriate training sites in accordance with the commissioner's approval letter.

479.1 ~~(e)~~ (f) A maximum of \$150,000 of the funds dedicated to the commissioner
479.2 under section 297F.10, subdivision 1, clause (2), may be used by the commissioner for
479.3 administrative expenses associated with implementing this section.

479.4 Sec. 4. Minnesota Statutes 2012, section 62J.692, subdivision 5, is amended to read:

479.5 Subd. 5. **Report.** (a) Sponsoring institutions receiving funds under this section
479.6 must sign and submit a medical education grant verification report (GVR) to verify that
479.7 the correct grant amount was forwarded to each eligible training site. If the sponsoring
479.8 institution fails to submit the GVR by the stated deadline, or to request and meet
479.9 the deadline for an extension, the sponsoring institution is required to return the full
479.10 amount of funds received to the commissioner within 30 days of receiving notice from
479.11 the commissioner. The commissioner shall distribute returned funds to the appropriate
479.12 training sites in accordance with the commissioner's approval letter.

479.13 (b) The reports must provide verification of the distribution of the funds and must
479.14 include:

479.15 (1) the total number of eligible trainee FTEs in each clinical medical education
479.16 program;

479.17 (2) the name of each funded program and, for each program, the dollar amount
479.18 distributed to each training site and a training site expenditure report;

479.19 (3) documentation of any discrepancies between the initial grant distribution notice
479.20 included in the commissioner's approval letter and the actual distribution;

479.21 (4) a statement by the sponsoring institution stating that the completed grant
479.22 verification report is valid and accurate; and

479.23 (5) other information the commissioner, ~~with advice from the advisory committee,~~
479.24 deems appropriate to evaluate the effectiveness of the use of funds for medical education.

479.25 (c) ~~By February 15 of~~ Each year, the commissioner, ~~with advice from the~~
479.26 ~~advisory committee,~~ shall provide an annual summary report to the legislature on the
479.27 implementation of this section.

479.28 Sec. 5. Minnesota Statutes 2012, section 62J.692, subdivision 7a, is amended to read:

479.29 Subd. 7a. **Clinical medical education innovations grants.** (a) The commissioner
479.30 shall award grants to teaching institutions and clinical training sites for projects that
479.31 increase dental access for underserved populations and promote innovative clinical
479.32 training of dental professionals.

479.33 (b) \$1,000,000 of the funds dedicated to the commissioner under section 297F.10,
479.34 subdivision 1, clause (2), plus any federal financial participation on these funds, shall

480.1 be distributed by the commissioner for primary care development grants pursuant to
 480.2 paragraph (c).

480.3 (c) The commissioner shall award grants to teaching institutions and clinical training
 480.4 sites for projects that increase the supply and availability of primary care providers for
 480.5 public program enrollees, improve access for underserved and rural populations, and
 480.6 promote interdisciplinary and team training of primary care providers and related personnel.

480.7 (d) In awarding the grants, the commissioner, in consultation with the commissioner
 480.8 of human services, shall consider the following:

480.9 (1) potential to successfully increase access to an underserved population;

480.10 (2) the long-term viability of the project to improve access beyond the period
 480.11 of initial funding;

480.12 (3) evidence of collaboration between the applicant and local communities;

480.13 (4) the efficiency in the use of the funding; and

480.14 (5) the priority level of the project in relation to state clinical education, access,
 480.15 and workforce goals.

480.16 ~~(b)~~ (e) The commissioner shall periodically evaluate the priorities in awarding the
 480.17 innovations grants in order to ensure that the priorities meet the changing workforce
 480.18 needs of the state.

480.19 Sec. 6. Minnesota Statutes 2012, section 62J.692, subdivision 9, is amended to read:

480.20 Subd. 9. **Review of eligible providers.** The commissioner ~~and the Medical~~
 480.21 ~~Education and Research Costs Advisory Committee~~ may review provider groups included
 480.22 in the definition of a clinical medical education program to assure that the distribution
 480.23 of the funds continue to be consistent with the purpose of this section. The results of
 480.24 any such reviews must be reported to the chairs and ranking minority members of the
 480.25 legislative committees with jurisdiction over health care policy and finance.

480.26 Sec. 7. Minnesota Statutes 2012, section 62J.692, is amended by adding a subdivision
 480.27 to read:

480.28 Subd. 11. **Distribution of funds.** If federal approval is not received for the formula
 480.29 described in subdivision 4, paragraph (a), 100 percent of available medical education
 480.30 and research funds shall be distributed based on a distribution formula that reflects as
 480.31 summation of two factors:

480.32 (1) a public program volume factor, that is determined by the total volume of public
 480.33 program revenue received by each training site as a percentage of all public program
 480.34 revenue received by all training sites in the fund pool; and

481.1 (2) a supplemental public program volume factor, that is determined by providing a
 481.2 supplemental payment of 20 percent of each training site's grant to training sites whose
 481.3 public program revenue accounted for a least 0.98 percent of the total public program
 481.4 revenue received by all eligible training sites. Grants to training sites whose public
 481.5 program revenue accounted for less than 0.98 percent of the total public program revenue
 481.6 received by all eligible training sites shall be reduced by an amount equal to the total
 481.7 value of the supplemental payment.

481.8 Sec. 8. Minnesota Statutes 2012, section 62Q.19, subdivision 1, is amended to read:

481.9 Subdivision 1. **Designation.** (a) The commissioner shall designate essential
 481.10 community providers. The criteria for essential community provider designation shall be
 481.11 the following:

481.12 (1) a demonstrated ability to integrate applicable supportive and stabilizing services
 481.13 with medical care for uninsured persons and high-risk and special needs populations,
 481.14 underserved, and other special needs populations; and

481.15 (2) a commitment to serve low-income and underserved populations by meeting the
 481.16 following requirements:

481.17 (i) has nonprofit status in accordance with chapter 317A;

481.18 (ii) has tax-exempt status in accordance with the Internal Revenue Service Code,
 481.19 section 501(c)(3);

481.20 (iii) charges for services on a sliding fee schedule based on current poverty income
 481.21 guidelines; and

481.22 (iv) does not restrict access or services because of a client's financial limitation;

481.23 (3) status as a local government unit as defined in section 62D.02, subdivision 11, a
 481.24 hospital district created or reorganized under sections 447.31 to 447.37, an Indian tribal
 481.25 government, an Indian health service unit, or a community health board as defined in
 481.26 chapter 145A;

481.27 (4) a former state hospital that specializes in the treatment of cerebral palsy, spina
 481.28 bifida, epilepsy, closed head injuries, specialized orthopedic problems, and other disabling
 481.29 conditions;

481.30 (5) a sole community hospital. For these rural hospitals, the essential community
 481.31 provider designation applies to all health services provided, including both inpatient and
 481.32 outpatient services. For purposes of this section, "sole community hospital" means a
 481.33 rural hospital that:

481.34 (i) is eligible to be classified as a sole community hospital according to Code
 481.35 of Federal Regulations, title 42, section 412.92, or is located in a community with a

482.1 population of less than 5,000 and located more than 25 miles from a like hospital currently
 482.2 providing acute short-term services;

482.3 (ii) has experienced net operating income losses in two of the previous three
 482.4 most recent consecutive hospital fiscal years for which audited financial information is
 482.5 available; and

482.6 (iii) consists of 40 or fewer licensed beds; ~~or~~

482.7 (6) a birth center licensed under section 144.615; or

482.8 (7) a hospital or affiliated specialty clinic that:

482.9 (i) serves patients who are predominately under the age of 21;

482.10 (ii) provides intensive specialty pediatric services that are only routinely provided
 482.11 in less than five hospitals in the state; and

482.12 (iii) serves children from at least half the counties in the state.

482.13 (b) Prior to designation, the commissioner shall publish the names of all applicants
 482.14 in the State Register. The public shall have 30 days from the date of publication to submit
 482.15 written comments to the commissioner on the application. No designation shall be made
 482.16 by the commissioner until the 30-day period has expired.

482.17 (c) The commissioner may designate an eligible provider as an essential community
 482.18 provider for all the services offered by that provider or for specific services designated by
 482.19 the commissioner.

482.20 (d) For the purpose of this subdivision, supportive and stabilizing services include at
 482.21 a minimum, transportation, child care, cultural, and linguistic services where appropriate.

482.22 Sec. 9. Minnesota Statutes 2012, section 103I.005, is amended by adding a subdivision
 482.23 to read:

482.24 Subd. 1a. **Bored geothermal heat exchanger.** "Bored geothermal heat exchanger"
 482.25 means an earth-coupled heating or cooling device consisting of a sealed closed-loop
 482.26 pipng system installed in a boring in the ground to transfer heat to or from the surrounding
 482.27 earth with no discharge.

482.28 Sec. 10. Minnesota Statutes 2012, section 103I.521, is amended to read:

482.29 **103I.521 FEES DEPOSITED WITH COMMISSIONER OF MANAGEMENT**
 482.30 **AND BUDGET.**

482.31 Unless otherwise specified, fees collected for licenses or registration by the
 482.32 commissioner under this chapter shall be deposited in the state treasury and credited to
 482.33 the state government special revenue fund.

483.1 Sec. 11. Minnesota Statutes 2012, section 144.123, subdivision 1, is amended to read:

483.2 Subdivision 1. **Who must pay.** Except for the limitation contained in this section,
483.3 the commissioner of health ~~shall charge a handling fee~~ may enter into a contractual
483.4 agreement to recover costs incurred for analysis for diagnostic purposes for each specimen
483.5 submitted to the Department of Health ~~for analysis for diagnostic purposes~~ by any hospital,
483.6 private laboratory, private clinic, or physician. ~~No fee shall be charged to any entity which~~
483.7 ~~receives direct or indirect financial assistance from state or federal funds administered by~~
483.8 ~~the Department of Health, including any public health department, nonprofit community~~
483.9 ~~clinic, sexually transmitted disease clinic, or similar entity. No fee will be charged~~ The
483.10 commissioner shall not charge for any biological materials submitted to the Department
483.11 of Health as a requirement of Minnesota Rules, part 4605.7040, or for those biological
483.12 materials requested by the department to gather information for disease prevention or
483.13 control purposes. The commissioner of health may establish other exceptions to the
483.14 handling fee as may be necessary to protect the public's health. ~~All fees collected pursuant~~
483.15 ~~to this section shall be deposited in the state treasury and credited to the state government~~
483.16 ~~special revenue fund.~~ Funds generated in a contractual agreement made pursuant to this
483.17 section shall be deposited in a special account and are appropriated to the commissioner
483.18 for purposes of providing the services specified in the contracts. All such contractual
483.19 agreements shall be processed in accordance with the provisions of chapter 16C.

483.20 **EFFECTIVE DATE.** This section is effective July 1, 2014.

483.21 Sec. 12. Minnesota Statutes 2012, section 144.125, subdivision 1, is amended to read:

483.22 Subdivision 1. **Duty to perform testing.** (a) It is the duty of (1) the administrative
483.23 officer or other person in charge of each institution caring for infants 28 days or less
483.24 of age, (2) the person required in pursuance of the provisions of section 144.215, to
483.25 register the birth of a child, or (3) the nurse midwife or midwife in attendance at the
483.26 birth, to arrange to have administered to every infant or child in its care tests for heritable
483.27 and congenital disorders according to subdivision 2 and rules prescribed by the state
483.28 commissioner of health.

483.29 (b) ~~Testing and the, recording and of test results, reporting of test results, and~~
483.30 follow-up of infants with heritable congenital disorders, including hearing loss detected
483.31 through the early hearing detection and intervention program in section 144.966, shall be
483.32 performed at the times and in the manner prescribed by the commissioner of health. The
483.33 ~~commissioner shall charge a fee so that the total of fees collected will approximate the~~
483.34 ~~costs of conducting the tests and implementing and maintaining a system to follow-up~~

484.1 ~~infants with heritable or congenital disorders, including hearing loss detected through the~~
 484.2 ~~early hearing detection and intervention program under section 144.966.~~

484.3 (c) The fee is \$101 per specimen. Effective July 1, 2010, the fee shall be increased
 484.4 to \$106 to support the newborn screening program, including tests administered under
 484.5 this section and section 144.966, shall be \$135 per specimen. The increased fee amount
 484.6 shall be deposited in the general fund. Costs associated with capital expenditures and
 484.7 the development of new procedures may be prorated over a three-year period when
 484.8 calculating the amount of the fees. This fee amount shall be deposited in the state treasury
 484.9 and credited to the state government special revenue fund.

484.10 (d) The fee to offset the cost of the support services provided under section 144.966,
 484.11 subdivision 3a, shall be \$15 per specimen. This fee shall be deposited in the state treasury
 484.12 and credited to the general fund.

484.13 **Sec. 13. [144.1251] NEWBORN SCREENING FOR CRITICAL CONGENITAL**
 484.14 **HEART DISEASE (CCHD).**

484.15 Subdivision 1. **Required testing and reporting.** (a) Each licensed hospital or
 484.16 state-licensed birthing center or facility that provides maternity and newborn care services
 484.17 shall provide screening for congenital heart disease to all newborns prior to discharge
 484.18 using pulse oximetry screening. The screening must occur after the infant is 24 hours old,
 484.19 before discharge from the nursery. If discharge occurs before the infant is 24 hours old,
 484.20 the screening must occur as close as possible to the time of discharge.

484.21 (b) For premature infants (less than 36 weeks of gestation) and infants admitted to a
 484.22 higher-level nursery (special care or intensive care), pulse oximetry must be performed
 484.23 when medically appropriate prior to discharge.

484.24 (c) Results of the screening must be reported to the Department of Health.

484.25 Subd. 2. **Implementation.** The Department of Health shall:

484.26 (1) communicate the screening protocol requirements;

484.27 (2) make information and forms available to the hospitals, birthing centers, and other
 484.28 facilities that are required to provide the screening, health care providers who provide
 484.29 prenatal care and care to newborns, and expectant parents and parents of newborns. The
 484.30 information and forms must include screening protocol and reporting requirements and
 484.31 parental options;

484.32 (3) provide training to ensure compliance with and appropriate implementation of
 484.33 the screening;

- 485.1 (4) establish the mechanism for the required data collection and reporting of
 485.2 screening and follow-up diagnostic results to the Department of Health according to the
 485.3 Department of Health's recommendations;
- 485.4 (5) coordinate the implementation of universal standardized screening;
- 485.5 (6) act as a resource for providers as the screening program is implemented, and in
 485.6 consultation with the Advisory Committee on Heritable and Congenital Disorders, develop
 485.7 and implement policies for early medical and developmental intervention services and
 485.8 long-term follow-up services for children and their families identified with a CCHD; and
 485.9 (7) comply with sections 144.125 to 144.128.

485.10 Sec. 14. Minnesota Statutes 2012, section 144.212, is amended to read:

485.11 **144.212 DEFINITIONS.**

485.12 Subdivision 1. **Scope.** As used in sections 144.211 to 144.227, the following terms
 485.13 have the meanings given.

485.14 Subd. 1a. **Amendment.** "Amendment" means completion or correction of made
 485.15 to certification items on a vital record: after a certification has been issued or more
 485.16 than one year after the event, whichever occurs first, that does not result in a sealed or
 485.17 replaced record.

485.18 Subd. 1b. **Authorized representative.** "Authorized representative" means an agent
 485.19 designated in a written and witnessed statement signed by the subject of the record or
 485.20 other qualified applicant.

485.21 Subd. 1c. **Certification item.** "Certification item" means all individual items
 485.22 appearing on a certificate of birth and the demographic and legal items on a certificate
 485.23 of death.

485.24 Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

485.25 Subd. 2a. **Correction.** "Correction" means a change made to a noncertification
 485.26 item, including information collected for medical and statistical purposes. A correction
 485.27 also means a change to a certification item within one year of the event provided that no
 485.28 certification, whether paper or electronic, has been issued.

485.29 Subd. 2b. **Court of competent jurisdiction.** "Court of competent jurisdiction"
 485.30 means a court within the United States with jurisdiction over the individual and such other
 485.31 individuals that the court deems necessary.

485.32 Subd. 2a 2c. **Delayed registration.** "Delayed registration" means registration of a
 485.33 record of birth or death filed one or more years after the date of birth or death.

486.1 Subd. 2d. **Disclosure.** "Disclosure" means to make available or make known
486.2 personally identifiable information contained in a vital record, by any means of
486.3 communication.

486.4 Subd. 3. **File.** "File" means to present a vital record or report for registration to the
486.5 Office of ~~the State Registrar~~ Vital Records and to have the vital record or report accepted
486.6 for registration by the Office of ~~the State Registrar~~ Vital Records.

486.7 Subd. 4. **Final disposition.** "Final disposition" means the burial, interment,
486.8 cremation, removal from the state, or other authorized disposition of a dead body or
486.9 dead fetus.

486.10 Subd. 4a. **Institution.** "Institution" means a public or private establishment that:
486.11 (1) provides inpatient or outpatient medical, surgical, or diagnostic care or treatment;
486.12 or
486.13 (2) provides nursing, custodial, or domiciliary care, or to which persons are
486.14 committed by law.

486.15 Subd. 4b. **Legal representative.** "Legal representative" means a licensed attorney
486.16 representing an individual.

486.17 Subd. 4c. **Local issuance office.** "Local issuance office" means a county
486.18 governmental office authorized by the state registrar to issue certified birth and death
486.19 records.

486.20 Subd. 4d. **Record.** "Record" means a report of a vital event that has been registered
486.21 by the state registrar.

486.22 Subd. 5. **Registration.** "Registration" means the process by which vital records
486.23 are completed, filed, and incorporated into the official records of the Office of the State
486.24 Registrar.

486.25 Subd. 6. **State registrar.** "State registrar" means the commissioner of health or a
486.26 designee.

486.27 Subd. 7. **System of vital statistics.** "System of vital statistics" includes the
486.28 registration, collection, preservation, amendment, verification, maintenance of the security
486.29 and integrity of, and certification of vital records, the collection of other reports required
486.30 by sections 144.211 to 144.227, and related activities including the tabulation, analysis,
486.31 publication, and dissemination of vital statistics.

486.32 Subd. 7a. **Verification.** "Verification" means a confirmation of the information on a
486.33 vital record based on the facts contained in a certification.

486.34 Subd. 8. **Vital record.** "Vital record" means a record or report of birth, stillbirth,
486.35 death, marriage, dissolution and annulment, and data related thereto. The birth record is
486.36 not a medical record of the mother or the child.

487.1 Subd. 9. **Vital statistics.** "Vital statistics" means the data derived from records and
 487.2 reports of birth, death, fetal death, induced abortion, marriage, dissolution and annulment,
 487.3 and related reports.

487.4 ~~Subd. 10. **Local registrar.** "Local registrar" means an individual designated under~~
 487.5 ~~section 144.214, subdivision 1, to perform the duties of a local registrar.~~

487.6 Subd. 11. **Consent to disclosure.** "Consent to disclosure" means an affidavit filed
 487.7 with the state registrar which sets forth the following information:

487.8 (1) the current name and address of the affiant;

487.9 (2) any previous name by which the affiant was known;

487.10 (3) the original and adopted names, if known, of the adopted child whose original
 487.11 birth record is to be disclosed;

487.12 (4) the place and date of birth of the adopted child;

487.13 (5) the biological relationship of the affiant to the adopted child; and

487.14 (6) the affiant's consent to disclosure of information from the original birth record of
 487.15 the adopted child.

487.16 Sec. 15. Minnesota Statutes 2012, section 144.213, is amended to read:

487.17 **144.213 OFFICE OF THE STATE REGISTRAR VITAL RECORDS.**

487.18 Subdivision 1. **Creation; state registrar; Office of Vital Records.** The
 487.19 commissioner shall establish an Office of the ~~State Registrar~~ Vital Records under the
 487.20 supervision of the state registrar. ~~The commissioner shall furnish to local registrars the~~
 487.21 ~~forms necessary for correct reporting of vital statistics, and shall instruct the local registrars~~
 487.22 ~~in the collection and compilation of the data.~~ The commissioner shall promulgate rules for
 487.23 the collection, filing, and registering of vital statistics information by the state and local
 487.24 ~~registrars~~ registrar, physicians, morticians, and others. Except as otherwise provided in
 487.25 sections 144.211 to 144.227, rules previously promulgated by the commissioner relating to
 487.26 the collection, filing and registering of vital statistics shall remain in effect until repealed,
 487.27 modified or superseded by a rule promulgated by the commissioner.

487.28 Subd. 2. **General duties.** (a) ~~The state registrar shall coordinate the work of~~
 487.29 ~~local registrars to maintain a statewide system of vital statistics. The state registrar is~~
 487.30 responsible for the administration and enforcement of sections 144.211 to 144.227; and
 487.31 shall supervise ~~local registrars in the enforcement of sections 144.211 to 144.227 and the~~
 487.32 rules promulgated thereunder. Local issuance offices that fail to comply with the statutes
 487.33 or rules or to properly train employees may have their issuance privileges and access to
 487.34 the vital records system revoked.

488.1 (b) To preserve vital records the state registrar is authorized to prepare typewritten,
 488.2 photographic, electronic or other reproductions of original records and files in the Office
 488.3 of Vital Records. The reproductions when certified by the state registrar shall be accepted
 488.4 as the original records.

488.5 (c) The state registrar shall also:

488.6 (1) establish, designate, and eliminate offices in the state to aid in the efficient
 488.7 issuance of vital records;

488.8 (2) direct the activities of all persons engaged in activities pertaining to the operation
 488.9 of the system of vital statistics;

488.10 (3) develop and conduct training programs to promote uniformity of policy and
 488.11 procedures throughout the state in matters pertaining to the system of vital statistics; and

488.12 (4) prescribe, furnish, and distribute all forms required by sections 144.211 to
 488.13 144.227 and any rules adopted under these sections, and prescribe other means for the
 488.14 transmission of data, including electronic submission, that will accomplish the purpose of
 488.15 complete, accurate, and timely reporting and registration.

488.16 ~~Subd. 3. **Record keeping.** To preserve vital records the state registrar is authorized~~
 488.17 ~~to prepare typewritten, photographic, electronic or other reproductions of original records~~
 488.18 ~~and files in the Office of the State Registrar. The reproductions when certified by the state~~
 488.19 ~~or local registrar shall be accepted as the original records.~~

488.20 Sec. 16. **[144.2131] SECURITY OF VITAL RECORDS SYSTEM.**

488.21 The state registrar shall:

488.22 (1) authenticate all users of the system of vital statistics and document that all users
 488.23 require access based on their official duties;

488.24 (2) authorize authenticated users of the system of vital statistics to access specific
 488.25 components of the vital statistics systems necessary for their official roles and duties;

488.26 (3) establish separation of duties between staff roles that may be susceptible to fraud
 488.27 or misuse and routinely perform audits of staff work for the purposes of identifying fraud
 488.28 or misuse within the vital statistics system;

488.29 (4) require that authenticated and authorized users of the system of vital
 488.30 statistics maintain a specified level of training related to security and provide written
 488.31 acknowledgment of security procedures and penalties;

488.32 (5) validate data submitted for registration through site visits or with independent
 488.33 sources outside the registration system at a frequency specified by the state registrar to
 488.34 maximize the integrity of the data collected;

- 489.1 (6) protect personally identifiable information and maintain systems pursuant to
 489.2 applicable state and federal laws;
- 489.3 (7) accept a report of death if the decedent was born in Minnesota or if the decedent
 489.4 was a resident of Minnesota from the United States Department of Defense or the United
 489.5 States Department of State when the death of a United States citizen occurs outside the
 489.6 United States;
- 489.7 (8) match death records registered in Minnesota and death records provided from
 489.8 other jurisdictions to live birth records in Minnesota;
- 489.9 (9) match death records received from the United States Department of Defense
 489.10 or the United States Department of State for deaths of United States citizens occurring
 489.11 outside the United States to live birth records in Minnesota;
- 489.12 (10) work with law enforcement to initiate and provide evidence for active fraud
 489.13 investigations;
- 489.14 (11) provide secure workplace, storage, and technology environments that have
 489.15 limited role-based access;
- 489.16 (12) maintain overt, covert, and forensic security measures for certifications,
 489.17 verifications, and automated systems that are part of the vital statistics system; and
- 489.18 (13) comply with applicable state and federal laws and rules associated with
 489.19 information technology systems and related information security requirements.

489.20 Sec. 17. Minnesota Statutes 2012, section 144.215, subdivision 3, is amended to read:

489.21 Subd. 3. **Father's name; child's name.** In any case in which paternity of a child is
 489.22 determined by a court of competent jurisdiction, ~~a declaration of parentage is executed~~
 489.23 ~~under section 257.34,~~ or a recognition of parentage is executed under section 257.75, the
 489.24 name of the father shall be entered on the birth record. If the order of the court declares
 489.25 the name of the child, it shall also be entered on the birth record. If the order of the court
 489.26 does not declare the name of the child, or there is no court order, then upon the request of
 489.27 both parents in writing, the surname of the child shall be defined by both parents.

489.28 Sec. 18. Minnesota Statutes 2012, section 144.215, subdivision 4, is amended to read:

489.29 Subd. 4. **Social Security number registration.** (a) Parents of a child born within
 489.30 this state shall give the parents' Social Security numbers to the Office of ~~the State Registrar~~
 489.31 Vital Records at the time of filing the birth record, but the numbers shall not appear on
 489.32 the certified record.

489.33 (b) The Social Security numbers are classified as private data, ~~as defined in section~~
 489.34 ~~13.02, subdivision 12, on individuals,~~ but the Office of ~~the State Registrar~~ Vital Records

490.1 shall provide a Social Security number to the public authority responsible for child support
490.2 services upon request by the public authority for use in the establishment of parentage and
490.3 the enforcement of child support obligations.

490.4 Sec. 19. Minnesota Statutes 2012, section 144.216, subdivision 1, is amended to read:

490.5 Subdivision 1. **Reporting a foundling.** Whoever finds a live born infant of unknown
490.6 parentage shall report within five days to the Office of ~~the State Registrar~~ Vital Records
490.7 such information as the commissioner may by rule require to identify the foundling.

490.8 Sec. 20. Minnesota Statutes 2012, section 144.217, subdivision 2, is amended to read:

490.9 Subd. 2. **Court petition.** If a delayed record of birth is rejected under subdivision
490.10 1, a person may petition the appropriate court in the county in which the birth allegedly
490.11 occurred for an order establishing a record of the date and place of the birth and the
490.12 parentage of the person whose birth is to be registered. The petition shall state:

490.13 (1) that the person for whom a delayed record of birth is sought was born in this state;

490.14 (2) that no record of birth can be found in the Office of ~~the State Registrar~~ Vital
490.15 Records;

490.16 (3) that diligent efforts by the petitioner have failed to obtain the evidence required
490.17 in subdivision 1;

490.18 (4) that the state registrar has refused to register a delayed record of birth; and

490.19 (5) other information as may be required by the court.

490.20 Sec. 21. Minnesota Statutes 2012, section 144.218, subdivision 5, is amended to read:

490.21 Subd. 5. **Replacement of vital records.** Upon the order of a court of this state, upon
490.22 the request of a court of another state, ~~upon the filing of a declaration of parentage under~~
490.23 ~~section 257.34~~, or upon the filing of a recognition of parentage with a the state registrar, a
490.24 replacement birth record must be registered consistent with the findings of the court, ~~the~~
490.25 ~~declaration of parentage~~, or the recognition of parentage.

490.26 Sec. 22. **[144.2181] AMENDMENT AND CORRECTION OF VITAL RECORDS.**

490.27 (a) A vital record registered under sections 144.212 to 144.227 may be amended
490.28 or corrected only according to sections 144.212 to 144.227 and rules adopted by the
490.29 commissioner of health to protect the integrity and accuracy of vital records.

490.30 (b)(1) A vital record that is amended under this section shall indicate that it has been
490.31 amended, except as otherwise provided in this section or by rule.

491.1 (2) Electronic documentation shall be maintained by the state registrar that
491.2 identifies the evidence upon which the amendment or correction was based, the date
491.3 of the amendment or correction, and the identity of the authorized person making the
491.4 amendment or correction.

491.5 (c) Upon receipt of a certified copy of an order of a court of competent jurisdiction
491.6 changing the name of a person whose birth is registered in Minnesota and upon request of
491.7 such person if 18 years of age or older or having the status of emancipated minor, the state
491.8 registrar shall amend the birth record to show the new name. If the person is a minor or
491.9 an incapacitated person then a parent, guardian, or legal representative of the minor or
491.10 incapacitated person may make the request.

491.11 (d) When an applicant does not submit the minimum documentation required for
491.12 amending a vital record or when the state registrar has cause to question the validity
491.13 or completeness of the applicant's statements or the documentary evidence, and the
491.14 deficiencies are not corrected, the state registrar shall not amend the vital record. The
491.15 state registrar shall advise the applicant of the reason for this action and shall further
491.16 advise the applicant of the right of appeal to a court with competent jurisdiction over
491.17 the Department of Health.

491.18 Sec. 23. Minnesota Statutes 2012, section 144.225, subdivision 1, is amended to read:

491.19 Subdivision 1. **Public information; access to vital records.** Except as otherwise
491.20 provided for in this section and section 144.2252, information contained in vital records
491.21 shall be public information. Physical access to vital records shall be subject to the
491.22 supervision and regulation of ~~the state and local registrars~~ registrar and their employees
491.23 pursuant to rules promulgated by the commissioner in order to protect vital records from
491.24 loss, mutilation or destruction and to prevent improper disclosure of vital records which
491.25 are confidential or private data on individuals, as defined in section 13.02, subdivisions
491.26 3 and 12.

491.27 Sec. 24. Minnesota Statutes 2012, section 144.225, subdivision 4, is amended to read:

491.28 Subd. 4. **Access to records for research purposes.** The state registrar may permit
491.29 persons performing medical research access to the information restricted in subdivision
491.30 2 or 2a if those persons agree in writing not to disclose private or confidential data on
491.31 individuals.

491.32 Sec. 25. Minnesota Statutes 2012, section 144.225, subdivision 7, is amended to read:

492.1 Subd. 7. **Certified birth or death record.** (a) The state ~~or local~~ registrar or local
 492.2 issuance office shall issue a certified birth or death record or a statement of no vital record
 492.3 found to an individual upon the individual's proper completion of an attestation provided
 492.4 by the commissioner and payment of the required fee:

492.5 (1) to a person who has a tangible interest in the requested vital record. A person
 492.6 who has a tangible interest is:

492.7 (i) the subject of the vital record;

492.8 (ii) a child of the subject;

492.9 (iii) the spouse of the subject;

492.10 (iv) a parent of the subject;

492.11 (v) the grandparent or grandchild of the subject;

492.12 (vi) if the requested record is a death record, a sibling of the subject;

492.13 (vii) the party responsible for filing the vital record;

492.14 (viii) the legal custodian, guardian or conservator, or health care agent of the subject;

492.15 (ix) a personal representative, by sworn affidavit of the fact that the certified copy is
 492.16 required for administration of the estate;

492.17 (x) a successor of the subject, as defined in section 524.1-201, if the subject is
 492.18 deceased, by sworn affidavit of the fact that the certified copy is required for administration
 492.19 of the estate;

492.20 (xi) if the requested record is a death record, a trustee of a trust by sworn affidavit of
 492.21 the fact that the certified copy is needed for the proper administration of the trust;

492.22 (xii) a person or entity who demonstrates that a certified vital record is necessary for
 492.23 the determination or protection of a personal or property right, pursuant to rules adopted
 492.24 by the commissioner; or

492.25 (xiii) adoption agencies in order to complete confidential postadoption searches as
 492.26 required by section 259.83;

492.27 (2) to any local, state, or federal governmental agency upon request if the certified
 492.28 vital record is necessary for the governmental agency to perform its authorized duties:

492.29 ~~An authorized governmental agency includes the Department of Human Services, the~~
 492.30 ~~Department of Revenue, and the United States Citizenship and Immigration Services;~~

492.31 (3) to an attorney upon evidence of the attorney's license;

492.32 (4) pursuant to a court order issued by a court of competent jurisdiction. For
 492.33 purposes of this section, a subpoena does not constitute a court order; or

492.34 (5) to a representative authorized by a person under clauses (1) to (4).

492.35 (b) The state ~~or local~~ registrar or local issuance office shall also issue a certified
 492.36 death record to an individual described in paragraph (a), clause (1), items (ii) to (viii), if,

493.1 on behalf of the individual, a licensed mortician furnishes the registrar with a properly
 493.2 completed attestation in the form provided by the commissioner within 180 days of the
 493.3 time of death of the subject of the death record. This paragraph is not subject to the
 493.4 requirements specified in Minnesota Rules, part 4601.2600, subpart 5, item B.

493.5 Sec. 26. Minnesota Statutes 2012, section 144.225, subdivision 8, is amended to read:

493.6 Subd. 8. **Standardized format for certified birth and death records.** ~~No later than~~
 493.7 ~~July 1, 2000,~~ The commissioner shall ~~develop~~ maintain a standardized format for certified
 493.8 birth records and death records issued by ~~the state and local registrars~~ registrar and local
 493.9 issuance offices. The format shall incorporate security features in accordance with this
 493.10 section. ~~The standardized format must be implemented on a statewide basis by July 1, 2001.~~

493.11 Sec. 27. Minnesota Statutes 2012, section 144.226, is amended to read:

493.12 **144.226 FEES.**

493.13 Subdivision 1. **Which services are for fee.** The fees for the following services shall
 493.14 be the following or an amount prescribed by rule of the commissioner:

493.15 (a) The fee for the issuance of a certified vital record, a search for a vital record that
 493.16 cannot be issued, or a certification that the vital record cannot be found is \$9. ~~No fee shall be~~
 493.17 ~~charged for a certified birth, stillbirth, or death record that is reissued within one year of the~~
 493.18 ~~original issue, if an amendment is made to the vital record and if the previously issued vital~~
 493.19 ~~record is surrendered.~~ The fee is payable at the time of application and is nonrefundable.

493.20 (b) The fee for processing a request for the replacement of a birth record for
 493.21 all events, except when filing a recognition of parentage pursuant to section 257.73,
 493.22 subdivision 1, is \$40. The fee is payable at the time of application and is nonrefundable.

493.23 (c) The fee for reviewing and processing a request for the filing of a delayed
 493.24 registration of birth, stillbirth, or death is \$40. The fee is payable at the time of application
 493.25 and is nonrefundable. ~~This fee includes one subsequent review of the request if the request~~
 493.26 ~~is not acceptable upon the initial receipt.~~

493.27 (d) The fee for reviewing and processing a request for the amendment of any vital
 493.28 record ~~when requested more than 45 days after the filing of the vital record~~ is \$40. ~~No fee~~
 493.29 ~~shall be charged for an amendment requested within 45 days after the filing of the vital~~
 493.30 ~~record.~~ The fee is payable at the time of application and is nonrefundable. ~~This fee includes~~
 493.31 ~~one subsequent review of the request if the request is not acceptable upon the initial receipt.~~

493.32 (e) The fee for reviewing and processing a request for the verification of information
 493.33 from vital records is \$9 when the applicant furnishes the specific information to locate
 493.34 the vital record. When the applicant does not furnish specific information, the fee is

494.1 \$20 per hour for staff time expended. Specific information includes the correct date of
494.2 the event and the correct name of the ~~registrant~~ subject of the record. Fees charged shall
494.3 approximate the costs incurred in searching and copying the vital records. The fee is
494.4 payable at the time of application and is nonrefundable.

494.5 (f) The fee for reviewing and processing a request for the issuance of a copy of any
494.6 document on file pertaining to a vital record or statement that a related document cannot
494.7 be found is \$9. The fee is payable at the time of application and is nonrefundable.

494.8 Subd. 2. **Fees to state government special revenue fund.** Fees collected under
494.9 this section by the state registrar shall be deposited in the state treasury and credited to
494.10 the state government special revenue fund.

494.11 Subd. 3. **Birth record surcharge.** (a) In addition to any fee prescribed under
494.12 subdivision 1, there shall be a nonrefundable surcharge of \$3 for each certified birth or
494.13 stillbirth record and for a certification that the vital record cannot be found. The ~~local~~
494.14 state registrar or local issuance office shall forward this amount to the commissioner of
494.15 management and budget for deposit into the account for the children's trust fund for the
494.16 prevention of child abuse established under section 256E.22. This surcharge shall not be
494.17 charged under those circumstances in which no fee for a certified birth or stillbirth record
494.18 is permitted under subdivision 1, paragraph (a). Upon certification by the commissioner of
494.19 management and budget that the assets in that fund exceed \$20,000,000, this surcharge
494.20 shall be discontinued.

494.21 (b) In addition to any fee prescribed under subdivision 1, there shall be a
494.22 nonrefundable surcharge of \$10 for each certified birth record. The ~~local~~
494.23 or local issuance office shall forward this amount to the commissioner of management and
494.24 budget for deposit in the general fund. ~~This surcharge shall not be charged under those~~
494.25 ~~circumstances in which no fee for a certified birth record is permitted under subdivision 1,~~
494.26 ~~paragraph (a).~~

494.27 Subd. 4. **Vital records surcharge.** (a) In addition to any fee prescribed under
494.28 subdivision 1, there is a nonrefundable surcharge of ~~\$2~~ \$4 for each certified and
494.29 noncertified birth, stillbirth, or death record, and for a certification that the record cannot
494.30 be found. The local issuance office or state registrar shall forward this amount to the
494.31 commissioner of management and budget to be deposited into the state government special
494.32 revenue fund. ~~This surcharge shall not be charged under those circumstances in which no~~
494.33 ~~fee for a birth, stillbirth, or death record is permitted under subdivision 1, paragraph (a).~~

494.34 (b) ~~Effective August 1, 2005, the surcharge in paragraph (a) is \$4.~~

494.35 Subd. 5. **Electronic verification.** A fee for the electronic verification or electronic
494.36 certification of a vital event, when the information being verified or certified is obtained

495.1 from a certified birth or death record, shall be established through contractual or
 495.2 interagency agreements ~~with interested local, state, or federal government agencies.~~

495.3 Subd. 6. **Alternative payment methods.** Notwithstanding subdivision 1, alternative
 495.4 payment methods may be approved and implemented by the state registrar or a local
 495.5 registrar issuance office.

495.6 Sec. 28. **[144.492] DEFINITIONS.**

495.7 Subdivision 1. **Applicability.** For the purposes of sections 144.492 to 144.494, the
 495.8 terms defined in this section have the meanings given them.

495.9 Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

495.10 Subd. 3. **Joint commission.** "Joint commission" means the independent,
 495.11 not-for-profit organization that accredits and certifies health care organizations and
 495.12 programs in the United States.

495.13 Subd. 4. **Stroke.** "Stroke" means the sudden death of brain cells in a localized
 495.14 area due to inadequate blood flow.

495.15 Sec. 29. **[144.493] CRITERIA.**

495.16 Subdivision 1. **Comprehensive stroke center.** A hospital meets the criteria for a
 495.17 comprehensive stroke center if the hospital has been certified as a comprehensive stroke
 495.18 center by the joint commission or another nationally recognized accreditation entity.

495.19 Subd. 2. **Primary stroke center.** A hospital meets the criteria for a primary stroke
 495.20 center if the hospital has been certified as a primary stroke center by the joint commission
 495.21 or another nationally recognized accreditation entity.

495.22 Subd. 3. **Acute stroke ready hospital.** A hospital meets the criteria for an acute
 495.23 stroke ready hospital if the hospital has the following elements of an acute stroke ready
 495.24 hospital:

495.25 (1) an acute stroke team available or on-call 24 hours a days, seven days a week;

495.26 (2) written stroke protocols, including triage, stabilization of vital functions, initial
 495.27 diagnostic tests, and use of medications;

495.28 (3) a written plan and letter of cooperation with emergency medical services regarding
 495.29 triage and communication that are consistent with regional patient care procedures;

495.30 (4) emergency department personnel who are trained in diagnosing and treating
 495.31 acute stroke;

495.32 (5) the capacity to complete basic laboratory tests, electrocardiograms, and chest
 495.33 x-rays 24 hours a day, seven days a week;

496.1 (6) the capacity to perform and interpret brain injury imaging studies 24 hours a
 496.2 days, seven days a week;

496.3 (7) written protocols that detail available emergent therapies and reflect current
 496.4 treatment guidelines, which include performance measures and are revised at least annually;

496.5 (8) a neurosurgery coverage plan, call schedule, and a triage and transportation plan;

496.6 (9) transfer protocols and agreements for stroke patients; and

496.7 (10) a designated medical director with experience and expertise in acute stroke care.

496.8 **Sec. 30. [144.494] DESIGNATING STROKE HOSPITALS.**

496.9 Subdivision 1. **Naming privileges.** Unless it has been designated a stroke hospital
 496.10 by the commissioner, the joint commission, or another nationally recognized accreditation
 496.11 entity, no hospital shall use the term "stroke center" or "stroke hospital" in its name or its
 496.12 advertising or shall otherwise indicate it has stroke treatment capabilities.

496.13 Subd. 2. **Designation.** A hospital that voluntarily meets the criteria for a
 496.14 comprehensive stroke center, primary stroke center, or acute stroke ready hospital may
 496.15 apply to the commissioner for designation, and upon the commissioner's review and
 496.16 approval of the application, shall be designated as a comprehensive stroke center, a
 496.17 primary stroke center, or an acute stroke ready hospital for a three-year period. If a hospital
 496.18 loses its certification as a comprehensive stroke center or primary stroke center from
 496.19 the joint commission or other nationally recognized accreditation entity, its Minnesota
 496.20 designation will be immediately withdrawn. Prior to the expiration of the three-year
 496.21 designation, a hospital seeking to remain part of the voluntary acute stroke system may
 496.22 reapply to the commissioner for designation.

496.23 **Sec. 31. [144.554] HEALTH FACILITIES CONSTRUCTION PLAN**
 496.24 **SUBMITTAL AND FEES.**

496.25 For hospitals, nursing homes, boarding care homes, residential hospices, supervised
 496.26 living facilities, freestanding outpatient surgical centers, and end-stage renal disease
 496.27 facilities, the commissioner shall collect a fee for the review and approval of architectural,
 496.28 mechanical, and electrical plans and specifications submitted before construction begins
 496.29 for each project relative to construction of new buildings, additions to existing buildings,
 496.30 or for remodeling or alterations of existing buildings. All fees collected in this section
 496.31 shall be deposited in the state treasury and credited to the state government special revenue
 496.32 fund. Fees must be paid at the time of submission of final plans for review and are not
 496.33 refundable. The fee is calculated as follows:

497.1	<u>Construction project total estimated cost</u>	<u>Fee</u>
497.2	<u>\$0 - \$10,000</u>	<u>\$30</u>
497.3	<u>\$10,001 - \$50,000</u>	<u>\$150</u>
497.4	<u>\$50,001 - \$100,000</u>	<u>\$300</u>
497.5	<u>\$100,001 - \$150,000</u>	<u>\$450</u>
497.6	<u>\$150,001 - \$200,000</u>	<u>\$600</u>
497.7	<u>\$200,001 - \$250,000</u>	<u>\$750</u>
497.8	<u>\$250,001 - \$300,000</u>	<u>\$900</u>
497.9	<u>\$300,001 - \$350,000</u>	<u>\$1,050</u>
497.10	<u>\$350,001 - \$400,000</u>	<u>\$1,200</u>
497.11	<u>\$400,001 - \$450,000</u>	<u>\$1,350</u>
497.12	<u>\$450,001 - \$500,000</u>	<u>\$1,500</u>
497.13	<u>\$500,001 - \$550,000</u>	<u>\$1,650</u>
497.14	<u>\$550,001 - \$600,000</u>	<u>\$1,800</u>
497.15	<u>\$600,001 - \$650,000</u>	<u>\$1,950</u>
497.16	<u>\$650,001 - \$700,000</u>	<u>\$2,100</u>
497.17	<u>\$700,001 - \$750,000</u>	<u>\$2,250</u>
497.18	<u>\$750,001 - \$800,000</u>	<u>\$2,400</u>
497.19	<u>\$800,001 - \$850,000</u>	<u>\$2,550</u>
497.20	<u>\$850,001 - \$900,000</u>	<u>\$2,700</u>
497.21	<u>\$900,001 - \$950,000</u>	<u>\$2,850</u>
497.22	<u>\$950,001 - \$1,000,000</u>	<u>\$3,000</u>
497.23	<u>\$1,000,001 - \$1,050,000</u>	<u>\$3,150</u>
497.24	<u>\$1,050,001 - \$1,100,000</u>	<u>\$3,300</u>
497.25	<u>\$1,100,001 - \$1,150,000</u>	<u>\$3,450</u>
497.26	<u>\$1,150,001 - \$1,200,000</u>	<u>\$3,600</u>
497.27	<u>\$1,200,001 - \$1,250,000</u>	<u>\$3,750</u>
497.28	<u>\$1,250,001 - \$1,300,000</u>	<u>\$3,900</u>
497.29	<u>\$1,300,001 - \$1,350,000</u>	<u>\$4,050</u>
497.30	<u>\$1,350,001 - \$1,400,000</u>	<u>\$4,200</u>
497.31	<u>\$1,400,001 - \$1,450,000</u>	<u>\$4,350</u>
497.32	<u>\$1,450,001 - \$1,500,000</u>	<u>\$4,500</u>
497.33	<u>\$1,500,001 and over</u>	<u>\$4,800</u>

497.34 Sec. 32. Minnesota Statutes 2012, section 144.966, subdivision 2, is amended to read:

497.35 Subd. 2. **Newborn Hearing Screening Advisory Committee.** (a) The
 497.36 commissioner of health shall establish a Newborn Hearing Screening Advisory Committee
 497.37 to advise and assist the Department of Health and the Department of Education in:

497.38 (1) developing protocols and timelines for screening, rescreening, and diagnostic
 497.39 audiological assessment and early medical, audiological, and educational intervention
 497.40 services for children who are deaf or hard-of-hearing;

498.1 (2) designing protocols for tracking children from birth through age three that may
498.2 have passed newborn screening but are at risk for delayed or late onset of permanent
498.3 hearing loss;

498.4 (3) designing a technical assistance program to support facilities implementing the
498.5 screening program and facilities conducting rescreening and diagnostic audiological
498.6 assessment;

498.7 (4) designing implementation and evaluation of a system of follow-up and tracking;
498.8 and

498.9 (5) evaluating program outcomes to increase effectiveness and efficiency and ensure
498.10 culturally appropriate services for children with a confirmed hearing loss and their families.

498.11 (b) The commissioner of health shall appoint at least one member from each of the
498.12 following groups with no less than two of the members being deaf or hard-of-hearing:

498.13 (1) a representative from a consumer organization representing culturally deaf
498.14 persons;

498.15 (2) a parent with a child with hearing loss representing a parent organization;

498.16 (3) a consumer from an organization representing oral communication options;

498.17 (4) a consumer from an organization representing cued speech communication
498.18 options;

498.19 (5) an audiologist who has experience in evaluation and intervention of infants
498.20 and young children;

498.21 (6) a speech-language pathologist who has experience in evaluation and intervention
498.22 of infants and young children;

498.23 (7) two primary care providers who have experience in the care of infants and young
498.24 children, one of which shall be a pediatrician;

498.25 (8) a representative from the early hearing detection intervention teams;

498.26 (9) a representative from the Department of Education resource center for the deaf
498.27 and hard-of-hearing or the representative's designee;

498.28 (10) a representative of the Commission of Deaf, DeafBlind and Hard-of-Hearing
498.29 Minnesotans;

498.30 (11) a representative from the Department of Human Services Deaf and
498.31 Hard-of-Hearing Services Division;

498.32 (12) one or more of the Part C coordinators from the Department of Education, the
498.33 Department of Health, or the Department of Human Services or the department's designees;

498.34 (13) the Department of Health early hearing detection and intervention coordinators;

498.35 (14) two birth hospital representatives from one rural and one urban hospital;

498.36 (15) a pediatric geneticist;

499.1 (16) an otolaryngologist;

499.2 (17) a representative from the Newborn Screening Advisory Committee under
499.3 this subdivision; and

499.4 (18) a representative of the Department of Education regional low-incidence
499.5 facilitators.

499.6 The commissioner must complete the appointments required under this subdivision by
499.7 September 1, 2007.

499.8 (c) The Department of Health member shall chair the first meeting of the committee.
499.9 At the first meeting, the committee shall elect a chair from its membership. The committee
499.10 shall meet at the call of the chair, at least four times a year. The committee shall adopt
499.11 written bylaws to govern its activities. The Department of Health shall provide technical
499.12 and administrative support services as required by the committee. These services shall
499.13 include technical support from individuals qualified to administer infant hearing screening,
499.14 rescreening, and diagnostic audiological assessments.

499.15 Members of the committee shall receive no compensation for their service, but
499.16 shall be reimbursed as provided in section 15.059 for expenses incurred as a result of
499.17 their duties as members of the committee.

499.18 (d) This subdivision expires June 30, ~~2013~~ 2019.

499.19 Sec. 33. Minnesota Statutes 2012, section 144.966, subdivision 3a, is amended to read:

499.20 Subd. 3a. **Support services to families.** (a) The commissioner shall contract with a
499.21 nonprofit organization to provide support and assistance to families with children who are
499.22 deaf or have a hearing loss. The family support provided must include:

499.23 (1) direct hearing loss specific parent-to-parent assistance and unbiased information
499.24 on communication, educational, and medical options; and

499.25 (2) individualized deaf or hard-of-hearing mentors who provide education, including
499.26 instruction in American Sign Language as an available option.

499.27 The commissioner shall give preference to a nonprofit organization that has the ability to
499.28 provide these services throughout the state.

499.29 (b) Family participation in the support and assistance services is voluntary.

499.30 Sec. 34. Minnesota Statutes 2012, section 144.98, subdivision 3, is amended to read:

499.31 Subd. 3. **Annual fees.** (a) An application for accreditation under subdivision 6 must
499.32 be accompanied by the annual fees specified in this subdivision. The annual fees include:

499.33 (1) base accreditation fee, ~~\$1,500~~ \$600;

499.34 (2) sample preparation techniques fee, \$200 per technique;

500.1 (3) an administrative fee for laboratories located outside this state, ~~\$3,750~~ \$2,000; and

500.2 (4) test category fees.

500.3 (b) For the programs in subdivision 3a, the commissioner may accredit laboratories
500.4 for fields of testing under the categories listed in clauses (1) to (10) upon completion of
500.5 the application requirements provided by subdivision 6 and receipt of the fees for each
500.6 category under each program that accreditation is requested. The categories offered and
500.7 related fees include:

500.8 (1) microbiology, ~~\$450~~ \$200;

500.9 (2) inorganics, ~~\$450~~ \$200;

500.10 (3) metals, ~~\$1,000~~ \$500;

500.11 (4) volatile organics, ~~\$1,300~~ \$1,000;

500.12 (5) other organics, ~~\$1,300~~ \$1,000;

500.13 (6) radiochemistry, ~~\$1,500~~ \$750;

500.14 (7) emerging contaminants, ~~\$1,500~~ \$1,000;

500.15 (8) agricultural contaminants, ~~\$1,250~~ \$1,000;

500.16 (9) toxicity (bioassay), ~~\$1,000~~ \$500; and

500.17 (10) physical characterization, \$250.

500.18 (c) The total annual fee includes the base fee, the sample preparation techniques
500.19 fees, the test category fees per program, and, when applicable, an administrative fee for
500.20 out-of-state laboratories.

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

500.22 Sec. 35. Minnesota Statutes 2012, section 144.98, subdivision 5, is amended to read:

500.23 Subd. 5. **State government special revenue fund.** Fees collected by the
500.24 commissioner under this section must be deposited in the state treasury and credited to
500.25 the state government special revenue fund.

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

500.27 Sec. 36. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision
500.28 to read:

500.29 Subd. 10. **Establishing a selection committee.** (a) The commissioner shall
500.30 establish a selection committee for the purpose of recommending approval of qualified
500.31 laboratory assessors and assessment bodies. Committee members shall demonstrate
500.32 competence in assessment practices. The committee shall initially consist of seven
500.33 members appointed by the commissioner as follows:

- 501.1 (1) one member from a municipal laboratory accredited by the commissioner;
 501.2 (2) one member from an industrial treatment laboratory accredited by the
 501.3 commissioner;
 501.4 (3) one member from a commercial laboratory located in this state and accredited by
 501.5 the commissioner;
 501.6 (4) one member from a commercial laboratory located outside the state and
 501.7 accredited by the commissioner;
 501.8 (5) one member from a nongovernmental client of environmental laboratories;
 501.9 (6) one member from a professional organization with a demonstrated interest in
 501.10 environmental laboratory data and accreditation; and
 501.11 (7) one employee of the laboratory accreditation program administered by the
 501.12 department.
 501.13 (b) Committee appointments begin on January 1 and end on December 31 of the
 501.14 same year.
 501.15 (c) The commissioner shall appoint persons to fill vacant committee positions,
 501.16 expand the total number of appointed positions, or change the designated positions upon
 501.17 the advice of the committee.
 501.18 (d) The commissioner shall rescind the appointment of a selection committee
 501.19 member for sufficient cause as the commissioner determines, such as:
 501.20 (1) neglect of duty;
 501.21 (2) failure to notify the commissioner of a real or perceived conflict of interest;
 501.22 (3) nonconformance with committee procedures;
 501.23 (4) failure to demonstrate competence in assessment practices; or
 501.24 (5) official misconduct.
 501.25 (e) Members of the selection committee shall be compensated according to the
 501.26 provisions in section 15.059, subdivision 3.

501.27 Sec. 37. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision
 501.28 to read:

- 501.29 Subd. 11. **Activities of the selection committee.** (a) The selection committee
 501.30 shall determine assessor and assessment body application requirements, the frequency
 501.31 of application submittal, and the application review schedule. The commissioner shall
 501.32 publish the application requirements and procedures on the accreditation program Web site.
 501.33 (b) In its selection process, the committee shall ensure its application requirements
 501.34 and review process:
 501.35 (1) meet the standards implemented in subdivision 2a;

502.1 (2) ensure assessors have demonstrated competence in technical disciplines offered
 502.2 for accreditation by the commissioner; and

502.3 (3) consider any history of repeated nonconformance or complaints regarding
 502.4 assessors or assessment bodies.

502.5 (c) The selection committee shall consider an application received from qualified
 502.6 applicants and shall supply a list of recommended assessors and assessment bodies to
 502.7 the commissioner of health no later than 90 days after the commissioner notifies the
 502.8 committee of the need for review of applications.

502.9 Sec. 38. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision
 502.10 to read:

502.11 Subd. 12. **Commissioner approval of assessors and scheduling of assessments.**

502.12 (a) The commissioner shall approve assessors who:

502.13 (1) are employed by the commissioner for the purpose of accrediting laboratories
 502.14 and demonstrate competence in assessment practices for environmental laboratories; or

502.15 (2) are employed by a state or federal agency with established agreements for
 502.16 mutual assistance or recognition with the commissioner and demonstrate competence in
 502.17 assessment practices for environmental laboratories.

502.18 (b) The commissioner may approve other assessors or assessment bodies who are
 502.19 recommended by the selection committee according to subdivision 11, paragraph (c). The
 502.20 commissioner shall publish the list of assessors and assessment bodies approved from the
 502.21 recommendations.

502.22 (c) The commissioner shall rescind approval for an assessor or assessment body for
 502.23 sufficient cause as the commissioner determines, such as:

502.24 (1) failure to meet the minimum qualifications for performing assessments;

502.25 (2) lack of availability;

502.26 (3) nonconformance with the applicable laws, rules, standards, policies, and
 502.27 procedures;

502.28 (4) misrepresentation of application information regarding qualifications and
 502.29 training; or

502.30 (5) excessive cost to perform the assessment activities.

502.31 Sec. 39. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision
 502.32 to read:

502.33 Subd. 13. **Laboratory requirements for assessor selection and scheduling**
 502.34 **assessments.** (a) A laboratory accredited or seeking accreditation that requires an

503.1 assessment by the commissioner must select an assessor, group of assessors, or an
503.2 assessment body from the published list specified in subdivision 12, paragraph (b). An
503.3 accredited laboratory must complete an assessment and make all corrective actions at least
503.4 once every 24 months. Unless the commissioner grants interim accreditation, a laboratory
503.5 seeking accreditation must complete an assessment and make all corrective actions
503.6 prior to, but no earlier than, 18 months prior to the date the application is submitted to
503.7 the commissioner.

503.8 (b) A laboratory shall not select the same assessor more than twice in succession
503.9 for assessments of the same facility unless the laboratory receives written approval
503.10 from the commissioner for the selection. The laboratory must supply a written request
503.11 to the commissioner for approval and must justify the reason for the request and provide
503.12 the alternate options considered.

503.13 (c) A laboratory must select assessors appropriate to the size and scope of the
503.14 laboratory's application or existing accreditation.

503.15 (d) A laboratory must enter into its own contract for direct payment of the assessors
503.16 or assessment body. The contract must authorize the assessor, assessment body, or
503.17 subcontractors to release all records to the commissioner regarding the assessment activity,
503.18 when the assessment is performed in compliance with this statute.

503.19 (e) A laboratory must agree to permit other assessors as selected by the commissioner
503.20 to participate in the assessment activities.

503.21 (f) If the laboratory determines no approved assessor is available to perform
503.22 the assessment, the laboratory must notify the commissioner in writing and provide a
503.23 justification for the determination. If the commissioner confirms no approved assessor
503.24 is available, the commissioner may designate an alternate assessor from those approved
503.25 in subdivision 12, paragraph (a), or the commissioner may delay the assessment until
503.26 an assessor is available. If an approved alternate assessor performs the assessment, the
503.27 commissioner may collect fees equivalent to the cost of performing the assessment
503.28 activities.

503.29 (g) Fees collected under this section are deposited in a special account and are
503.30 annually appropriated to the commissioner for the purpose of performing assessment
503.31 activities.

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

503.33 Sec. 40. Minnesota Statutes 2012, section 144.99, subdivision 4, is amended to read:

503.34 Subd. 4. **Administrative penalty orders.** (a) The commissioner may issue an
503.35 order requiring violations to be corrected and administratively assessing monetary

504.1 penalties for violations of the statutes, rules, and other actions listed in subdivision 1. The
504.2 procedures in section 144.991 must be followed when issuing administrative penalty
504.3 orders. Except in the case of repeated or serious violations, the penalty assessed in the
504.4 order must be forgiven if the person who is subject to the order demonstrates in writing
504.5 to the commissioner before the 31st day after receiving the order that the person has
504.6 corrected the violation or has developed a corrective plan acceptable to the commissioner.
504.7 The maximum amount of an administrative penalty order is \$10,000 for each violator for
504.8 all violations by that violator identified in an inspection or review of compliance.

504.9 (b) Notwithstanding paragraph (a), the commissioner may issue to a large public
504.10 water supply, serving a population of more than 10,000 persons, an administrative penalty
504.11 order imposing a penalty of at least \$1,000 per day per violation, not to exceed \$10,000
504.12 for each violation of sections 144.381 to 144.385 and rules adopted thereunder.

504.13 (c) Notwithstanding paragraph (a), the commissioner may issue to a certified lead
504.14 firm or person performing regulated lead work, an administrative penalty order imposing a
504.15 penalty of at least \$5,000 per violation per day, not to exceed \$10,000 for each violation of
504.16 sections 144.9501 to 144.9512 and rules adopted thereunder. All revenue collected from
504.17 monetary penalties in this section shall be deposited in the state treasury and credited to
504.18 the state government special revenue fund.

504.19 Sec. 41. Minnesota Statutes 2012, section 145.906, is amended to read:

504.20 **145.906 POSTPARTUM DEPRESSION EDUCATION AND INFORMATION.**

504.21 (a) The commissioner of health shall work with health care facilities, licensed health
504.22 and mental health care professionals, the women, infants, and children (WIC) program,
504.23 mental health advocates, consumers, and families in the state to develop materials and
504.24 information about postpartum depression, including treatment resources, and develop
504.25 policies and procedures to comply with this section.

504.26 (b) Physicians, traditional midwives, and other licensed health care professionals
504.27 providing prenatal care to women must have available to women and their families
504.28 information about postpartum depression.

504.29 (c) Hospitals and other health care facilities in the state must provide departing new
504.30 mothers and fathers and other family members, as appropriate, with written information
504.31 about postpartum depression, including its symptoms, methods of coping with the illness,
504.32 and treatment resources.

504.33 (d) Information about postpartum depression, including its symptoms, potential
504.34 impact on families, and treatment resources, must be available at WIC sites.

505.1 (e) The commissioner of health, in collaboration with the commissioner of human
 505.2 services and to the extent authorized by the federal Centers for Disease Control and
 505.3 Prevention, shall review the materials and information related to postpartum depression to
 505.4 determine their effectiveness in transmitting the information in a way that reduces racial
 505.5 health disparities as reported in surveys of maternal attitudes and experiences before,
 505.6 during, and after pregnancy, including those conducted by the commissioner of health. The
 505.7 commissioner shall implement changes to reduce racial health disparities in the information
 505.8 reviewed, as needed, and ensure that women of color are receiving the information.

505.9 Sec. 42. **[145.907] MATERNAL DEPRESSION; DEFINITION.**

505.10 "Maternal depression" means depression or other perinatal mood or anxiety disorder
 505.11 experienced by a woman during pregnancy or during the first year following the birth of
 505.12 her child.

505.13 Sec. 43. Minnesota Statutes 2012, section 145.986, is amended to read:

505.14 **145.986 STATEWIDE HEALTH IMPROVEMENT PROGRAM.**

505.15 Subdivision 1. **Grants to local communities Purpose.** The purpose of the statewide
 505.16 health improvement program is to:

505.17 (1) address the top three leading preventable causes of illness and death: tobacco use
 505.18 and exposure, poor diet, and lack of regular physical activity;

505.19 (2) promote the development, availability, and use of evidence-based, community
 505.20 level, comprehensive strategies to create healthy communities; and

505.21 (3) measure the impact of the evidence-based, community health improvement
 505.22 practices which over time work to contain health care costs and reduce chronic diseases.

505.23 **Subd. 1a. Grants to local communities.** (a) Beginning July 1, 2009, the
 505.24 commissioner of health shall award competitive grants to community health boards
 505.25 established pursuant to section 145A.09 and tribal governments to convene, coordinate,
 505.26 and implement evidence-based strategies targeted at reducing the percentage of
 505.27 Minnesotans who are obese or overweight and to reduce the use of tobacco.

505.28 (b) Grantee activities shall:

505.29 (1) be based on scientific evidence;

505.30 (2) be based on community input;

505.31 (3) address behavior change at the individual, community, and systems levels;

505.32 (4) occur in community, school, worksite, and health care settings; ~~and~~

505.33 (5) be focused on policy, systems, and environmental changes that support healthy
 505.34 behaviors; and

506.1 (6) address the health disparities and inequities that exist in the grantee's community.

506.2 (c) To receive a grant under this section, community health boards and tribal
506.3 governments must submit proposals to the commissioner. A local match of ten percent
506.4 of the total funding allocation is required. This local match may include funds donated
506.5 by community partners.

506.6 (d) In order to receive a grant, community health boards and tribal governments
506.7 must submit a health improvement plan to the commissioner of health for approval. The
506.8 commissioner may require the plan to identify a community leadership team, community
506.9 partners, and a community action plan that includes an assessment of area strengths and
506.10 needs, proposed action strategies, technical assistance needs, and a staffing plan.

506.11 (e) The grant recipient must implement the health improvement plan, evaluate the
506.12 effectiveness of the interventions strategies, and modify or discontinue interventions
506.13 strategies found to be ineffective.

506.14 ~~(f) By January 15, 2011, the commissioner of health shall recommend whether any~~
506.15 ~~funding should be distributed to community health boards and tribal governments based~~
506.16 ~~on health disparities demonstrated in the populations served.~~

506.17 ~~(g)~~ (f) Grant recipients shall report their activities and their progress toward the
506.18 outcomes established under subdivision 2 to the commissioner in a format and at a time
506.19 specified by the commissioner.

506.20 ~~(h)~~ (g) All grant recipients shall be held accountable for making progress toward
506.21 the measurable outcomes established in subdivision 2. The commissioner shall require a
506.22 corrective action plan and may reduce the funding level of grant recipients that do not
506.23 make adequate progress toward the measurable outcomes.

506.24 (h) Notwithstanding paragraph (a), the commissioner may award funding to
506.25 convene, coordinate, and implement evidence-based strategies targeted at reducing other
506.26 risk factors, aside from tobacco use and exposure, poor diet, and lack of regular physical
506.27 activity, that are associated with chronic disease and may impact public health. The
506.28 commissioner shall develop a criteria and procedures to allocate funding under this section.

506.29 Subd. 2. **Outcomes.** (a) The commissioner shall set measurable outcomes to meet
506.30 the goals specified in subdivision 1, and annually review the progress of grant recipients
506.31 in meeting the outcomes.

506.32 (b) The commissioner shall measure current public health status, using existing
506.33 measures and data collection systems when available, to determine baseline data against
506.34 which progress shall be monitored.

506.35 Subd. 3. **Technical assistance and oversight.** (a) The commissioner shall provide
506.36 content expertise, technical expertise, and training to grant recipients and advice on

507.1 evidence-based strategies, including those based on populations and types of communities
 507.2 served. The commissioner shall ensure that the statewide health improvement program
 507.3 meets the outcomes established under subdivision 2 by conducting a comprehensive
 507.4 statewide evaluation and assisting grant recipients to modify or discontinue interventions
 507.5 found to be ineffective.

507.6 (b) For the purposes of carrying out the grant program under this section, including
 507.7 for administrative purposes, the commissioner shall award contracts to appropriate entities
 507.8 to assist in training and provide technical assistance to grantees.

507.9 (c) Contracts awarded under paragraph (b) may be used to provide technical
 507.10 assistance and training in the areas of:

507.11 (1) community engagement and capacity building;

507.12 (2) tribal support;

507.13 (3) community asset building and risk behavior reduction;

507.14 (4) legal;

507.15 (5) communications;

507.16 (6) community, school, health care, work site, and other site-specific strategies; and

507.17 (7) health equity.

507.18 Subd. 4. **Evaluation.** (a) Using the outcome measures established in subdivision 3,
 507.19 the commissioner shall conduct a biennial evaluation of the statewide health improvement
 507.20 program funded under this section. Grant recipients shall cooperate with the commissioner
 507.21 in the evaluation and provide the commissioner with the information necessary to conduct
 507.22 the evaluation.

507.23 (b) Grant recipients will collect, monitor, and submit to the Department of Health
 507.24 baseline and annual data and provide information to improve the quality and impact of
 507.25 community health improvement strategies.

507.26 (c) For the purposes of carrying out the grant program under this section, including
 507.27 for administrative purposes, the commissioner shall award contracts to appropriate entities
 507.28 to assist in designing and implementing evaluation systems.

507.29 (d) Contracts awarded under paragraph (c) may be used to:

507.30 (1) develop grantee monitoring and reporting systems to track grantee progress,
 507.31 including aggregated and disaggregated data;

507.32 (2) manage, analyze, and report program evaluation data results; and

507.33 (3) utilize innovative support tools to analyze and predict the impact of prevention
 507.34 strategies on health outcomes and state health care costs over time.

507.35 Subd. 5. **Report.** The commissioner shall submit a biennial report to the legislature
 507.36 on the statewide health improvement program funded under this section. ~~These reports~~

508.1 The report must include information on each grant recipients recipient, including the
 508.2 activities that were conducted by the grantee using grant funds, evaluation data, and
 508.3 outcome measures, if available. the grantee's progress toward achieving the measurable
 508.4 outcomes established under subdivision 2, and the data provided to the commissioner by
 508.5 the grantee to measure these outcomes for grant activities. The commissioner shall provide
 508.6 information on grants in which a corrective action plan was required under subdivision
 508.7 1a, the types of plan action, and the progress that has been made toward meeting the
 508.8 measurable outcomes. In addition, the commissioner shall provide recommendations
 508.9 on future areas of focus for health improvement. These reports are due by January 15
 508.10 of every other year, beginning in 2010. In the report due on January 15, 2010, the
 508.11 commissioner shall include recommendations on a sustainable funding source for the
 508.12 statewide health improvement program other than the health care access fund In the report
 508.13 due on January 15, 2014, the commissioner shall include a description of the contracts
 508.14 awarded under subdivision 4, paragraph (c), and the monitoring and evaluation systems
 508.15 that were designed and implemented under these contracts.

508.16 **Subd. 6. Supplantation of existing funds.** Community health boards and tribal
 508.17 governments must use funds received under this section to develop new programs, expand
 508.18 current programs that work to reduce the percentage of Minnesotans who are obese or
 508.19 overweight or who use tobacco, or replace discontinued state or federal funds previously
 508.20 used to reduce the percentage of Minnesotans who are obese or overweight or who use
 508.21 tobacco. Funds must not be used to supplant current state or local funding to community
 508.22 health boards or tribal governments used to reduce the percentage of Minnesotans who are
 508.23 obese or overweight or to reduce tobacco use.

508.24 **Sec. 44. Minnesota Statutes 2012, section 145A.17, subdivision 1, is amended to read:**

508.25 **Subdivision 1. Establishment; goals.** The commissioner shall establish a program
 508.26 to fund family home visiting programs designed to foster healthy beginnings, improve
 508.27 pregnancy outcomes, promote school readiness, prevent child abuse and neglect, reduce
 508.28 juvenile delinquency, promote positive parenting and resiliency in children, and promote
 508.29 family health and economic self-sufficiency for children and families. The commissioner
 508.30 shall promote partnerships, collaboration, and multidisciplinary visiting done by teams of
 508.31 professionals and paraprofessionals from the fields of public health nursing, social work,
 508.32 and early childhood education. A program funded under this section must serve families
 508.33 at or below 200 percent of the federal poverty guidelines, and other families determined
 508.34 to be at risk, including but not limited to being at risk for child abuse, child neglect, or

- 509.1 juvenile delinquency. Programs must begin prenatally whenever possible and must be
 509.2 targeted to families with:
- 509.3 (1) adolescent parents;
 - 509.4 (2) a history of alcohol or other drug abuse;
 - 509.5 (3) a history of child abuse, domestic abuse, or other types of violence;
 - 509.6 (4) a history of domestic abuse, rape, or other forms of victimization;
 - 509.7 (5) reduced cognitive functioning;
 - 509.8 (6) a lack of knowledge of child growth and development stages;
 - 509.9 (7) low resiliency to adversities and environmental stresses;
 - 509.10 (8) insufficient financial resources to meet family needs;
 - 509.11 (9) a history of homelessness;
 - 509.12 (10) a risk of long-term welfare dependence or family instability due to employment
 509.13 barriers; ~~or~~
 - 509.14 (11) a serious mental health disorder, including maternal depression as defined in
 509.15 section 145.907; or
 - 509.16 ~~(11)~~ (12) other risk factors as determined by the commissioner.

509.17 Sec. 45. Minnesota Statutes 2012, section 149A.02, subdivision 1a, is amended to read:

509.18 Subd. 1a. **Alkaline hydrolysis.** "Alkaline hydrolysis" means the reduction of a dead
 509.19 human body to essential elements through exposure to a combination of heat and alkaline
 509.20 hydrolysis and the repositioning or movement of the body during the process to facilitate
 509.21 ~~reduction~~, a water-based dissolution process using alkaline chemicals, heat, agitation, and
 509.22 pressure to accelerate natural decomposition; the processing of the hydrolyzed remains
 509.23 after removal from the alkaline hydrolysis ~~chamber, vessel~~; placement of the processed
 509.24 remains in a hydrolyzed remains container; and release of the hydrolyzed remains to an
 509.25 appropriate party. Alkaline hydrolysis is a form of final disposition.

509.26 Sec. 46. Minnesota Statutes 2012, section 149A.02, is amended by adding a
 509.27 subdivision to read:

509.28 Subd. 1b. **Alkaline hydrolysis container.** "Alkaline hydrolysis container" means a
 509.29 hydrolyzable or biodegradable closed container or pouch resistant to leakage of bodily
 509.30 fluids that encases the body and into which a dead human body is placed prior to insertion
 509.31 into an alkaline hydrolysis vessel. Alkaline hydrolysis containers may be hydrolyzable or
 509.32 biodegradable alternative containers or caskets.

510.1 Sec. 47. Minnesota Statutes 2012, section 149A.02, is amended by adding a
510.2 subdivision to read:

510.3 Subd. 1c. **Alkaline hydrolysis facility.** "Alkaline hydrolysis facility" means a
510.4 building or structure containing one or more alkaline hydrolysis vessels for the alkaline
510.5 hydrolysis of dead human bodies.

510.6 Sec. 48. Minnesota Statutes 2012, section 149A.02, is amended by adding a
510.7 subdivision to read:

510.8 Subd. 1d. **Alkaline hydrolysis vessel.** "Alkaline hydrolysis vessel" means the
510.9 container in which the alkaline hydrolysis of a dead human body is performed.

510.10 Sec. 49. Minnesota Statutes 2012, section 149A.02, subdivision 2, is amended to read:

510.11 Subd. 2. **Alternative container.** "Alternative container" means a nonmetal
510.12 receptacle or enclosure, without ornamentation or a fixed interior lining, which is designed
510.13 for the encasement of dead human bodies and is made of hydrolyzable or biodegradable
510.14 materials, corrugated cardboard, fiberboard, pressed-wood, or other like materials.

510.15 Sec. 50. Minnesota Statutes 2012, section 149A.02, subdivision 3, is amended to read:

510.16 Subd. 3. **Arrangements for disposition.** "Arrangements for disposition" means
510.17 any action normally taken by a funeral provider in anticipation of or preparation for the
510.18 entombment, burial in a cemetery, alkaline hydrolysis, or cremation of a dead human body.

510.19 Sec. 51. Minnesota Statutes 2012, section 149A.02, subdivision 4, is amended to read:

510.20 Subd. 4. **Cash advance item.** "Cash advance item" means any item of service
510.21 or merchandise described to a purchaser as a "cash advance," "accommodation," "cash
510.22 disbursement," or similar term. A cash advance item is also any item obtained from a
510.23 third party and paid for by the funeral provider on the purchaser's behalf. Cash advance
510.24 items include, but are not limited to, cemetery, alkaline hydrolysis, or crematory services,
510.25 pallbearers, public transportation, clergy honoraria, flowers, musicians or singers, obituary
510.26 notices, gratuities, and death records.

510.27 Sec. 52. Minnesota Statutes 2012, section 149A.02, subdivision 5, is amended to read:

510.28 Subd. 5. **Casket.** "Casket" means a rigid container which is designed for the
510.29 encasement of a dead human body and is usually constructed of hydrolyzable or
510.30 biodegradable materials, wood, metal, fiberglass, plastic, or like material, and ornamented
510.31 and lined with fabric.

511.1 Sec. 53. Minnesota Statutes 2012, section 149A.02, is amended by adding a
511.2 subdivision to read:

511.3 Subd. 12a. **Crypt.** "Crypt" means a space in a mausoleum of sufficient size, used or
511.4 intended to be used, to entomb human remains, cremated remains, or hydrolyzed remains.

511.5 Sec. 54. Minnesota Statutes 2012, section 149A.02, is amended by adding a
511.6 subdivision to read:

511.7 Subd. 12b. **Direct alkaline hydrolysis.** "Direct alkaline hydrolysis" means a
511.8 final disposition of a dead human body by alkaline hydrolysis, without formal viewing,
511.9 visitation, or ceremony with the body present.

511.10 Sec. 55. Minnesota Statutes 2012, section 149A.02, subdivision 16, is amended to read:

511.11 Subd. 16. **Final disposition.** "Final disposition" means the acts leading to and the
511.12 entombment, burial in a cemetery, alkaline hydrolysis, or cremation of a dead human body.

511.13 Sec. 56. Minnesota Statutes 2012, section 149A.02, subdivision 23, is amended to read:

511.14 Subd. 23. **Funeral services.** "Funeral services" means any services which may
511.15 be used to: (1) care for and prepare dead human bodies for burial, alkaline hydrolysis,
511.16 cremation, or other final disposition; and (2) arrange, supervise, or conduct the funeral
511.17 ceremony or the final disposition of dead human bodies.

511.18 Sec. 57. Minnesota Statutes 2012, section 149A.02, is amended by adding a
511.19 subdivision to read:

511.20 Subd. 24a. **Holding facility.** "Holding facility" means a secure enclosed room or
511.21 confined area within a funeral establishment, crematory, or alkaline hydrolysis facility
511.22 used for temporary storage of human remains awaiting final disposition.

511.23 Sec. 58. Minnesota Statutes 2012, section 149A.02, is amended by adding a
511.24 subdivision to read:

511.25 Subd. 24b. **Hydrolyzed remains.** "Hydrolyzed remains" means the remains of a
511.26 dead human body following the alkaline hydrolysis process. Hydrolyzed remains does not
511.27 include pacemakers, prostheses, or similar foreign materials.

511.28 Sec. 59. Minnesota Statutes 2012, section 149A.02, is amended by adding a
511.29 subdivision to read:

512.1 Subd. 24c. **Hydrolyzed remains container.** "Hydrolyzed remains container" means
512.2 a receptacle in which hydrolyzed remains are placed. For purposes of this chapter, a
512.3 hydrolyzed remains container is interchangeable with "urn" or similar keepsake storage
512.4 jewelry.

512.5 Sec. 60. Minnesota Statutes 2012, section 149A.02, is amended by adding a
512.6 subdivision to read:

512.7 Subd. 26a. **Inurnment.** "Inurnment" means placing hydrolyzed or cremated remains
512.8 in a hydrolyzed or cremated remains container suitable for placement, burial, or shipment.

512.9 Sec. 61. Minnesota Statutes 2012, section 149A.02, subdivision 27, is amended to read:

512.10 Subd. 27. **Licensee.** "Licensee" means any person or entity that has been issued
512.11 a license to practice mortuary science, to operate a funeral establishment, to operate an
512.12 alkaline hydrolysis facility, or to operate a crematory by the Minnesota commissioner
512.13 of health.

512.14 Sec. 62. Minnesota Statutes 2012, section 149A.02, is amended by adding a
512.15 subdivision to read:

512.16 Subd. 30a. **Niche.** "Niche" means a space in a columbarium used, or intended to be
512.17 used, for the placement of hydrolyzed or cremated remains.

512.18 Sec. 63. Minnesota Statutes 2012, section 149A.02, is amended by adding a
512.19 subdivision to read:

512.20 Subd. 32a. **Placement.** "Placement" means the placing of a container holding
512.21 hydrolyzed or cremated remains in a crypt, vault, or niche.

512.22 Sec. 64. Minnesota Statutes 2012, section 149A.02, subdivision 34, is amended to read:

512.23 Subd. 34. **Preparation of the body.** "Preparation of the body" means placement of
512.24 the body into an appropriate cremation or alkaline hydrolysis container, embalming of
512.25 the body or such items of care as washing, disinfecting, shaving, positioning of features,
512.26 restorative procedures, application of cosmetics, dressing, and casketing.

512.27 Sec. 65. Minnesota Statutes 2012, section 149A.02, subdivision 35, is amended to read:

512.28 Subd. 35. **Processing.** "Processing" means the removal of foreign objects, drying or
512.29 cooling, and the reduction of the hydrolyzed or cremated remains by mechanical means

513.1 including, but not limited to, grinding, crushing, or pulverizing, to a granulated appearance
513.2 appropriate for final disposition.

513.3 Sec. 66. Minnesota Statutes 2012, section 149A.02, subdivision 37, is amended to read:

513.4 Subd. 37. **Public transportation.** "Public transportation" means all manner of
513.5 transportation via common carrier available to the general public including airlines, buses,
513.6 railroads, and ships. For purposes of this chapter, a livery service providing transportation
513.7 to private funeral establishments, alkaline hydrolysis facilities, or crematories is not public
513.8 transportation.

513.9 Sec. 67. Minnesota Statutes 2012, section 149A.02, is amended by adding a
513.10 subdivision to read:

513.11 Subd. 37c. **Scattering.** "Scattering" means the authorized dispersal of hydrolyzed
513.12 or cremated remains in a defined area of a dedicated cemetery or in areas where no local
513.13 prohibition exists provided that the hydrolyzed or cremated remains are not distinguishable
513.14 to the public, are not in a container, and that the person who has control over disposition
513.15 of the hydrolyzed or cremated remains has obtained written permission of the property
513.16 owner or governing agency to scatter on the property.

513.17 Sec. 68. Minnesota Statutes 2012, section 149A.02, is amended by adding a
513.18 subdivision to read:

513.19 Subd. 41. **Vault.** "Vault" means a space in a mausoleum of sufficient size, used or
513.20 intended to be used, to entomb human remains, cremated remains, or hydrolyzed remains.
513.21 Vault may also mean a sealed and lined casket enclosure.

513.22 Sec. 69. Minnesota Statutes 2012, section 149A.03, is amended to read:

513.23 **149A.03 DUTIES OF COMMISSIONER.**

513.24 The commissioner shall:

513.25 (1) enforce all laws and adopt and enforce rules relating to the:

513.26 (i) removal, preparation, transportation, arrangements for disposition, and final
513.27 disposition of dead human bodies;

513.28 (ii) licensure and professional conduct of funeral directors, morticians, interns,
513.29 practicum students, and clinical students;

513.30 (iii) licensing and operation of a funeral establishment; ~~and~~

513.31 (iv) licensing and operation of an alkaline hydrolysis facility; and

513.32 ~~(iv)~~ (v) licensing and operation of a crematory;

- 514.1 (2) provide copies of the requirements for licensure and permits to all applicants;
- 514.2 (3) administer examinations and issue licenses and permits to qualified persons
- 514.3 and other legal entities;
- 514.4 (4) maintain a record of the name and location of all current licensees and interns;
- 514.5 (5) perform periodic compliance reviews and premise inspections of licensees;
- 514.6 (6) accept and investigate complaints relating to conduct governed by this chapter;
- 514.7 (7) maintain a record of all current preneed arrangement trust accounts;
- 514.8 (8) maintain a schedule of application, examination, permit, and licensure fees,
- 514.9 initial and renewal, sufficient to cover all necessary operating expenses;
- 514.10 (9) educate the public about the existence and content of the laws and rules for
- 514.11 mortuary science licensing and the removal, preparation, transportation, arrangements
- 514.12 for disposition, and final disposition of dead human bodies to enable consumers to file
- 514.13 complaints against licensees and others who may have violated those laws or rules;
- 514.14 (10) evaluate the laws, rules, and procedures regulating the practice of mortuary
- 514.15 science in order to refine the standards for licensing and to improve the regulatory and
- 514.16 enforcement methods used; and
- 514.17 (11) initiate proceedings to address and remedy deficiencies and inconsistencies in
- 514.18 the laws, rules, or procedures governing the practice of mortuary science and the removal,
- 514.19 preparation, transportation, arrangements for disposition, and final disposition of dead
- 514.20 human bodies.

514.21 Sec. 70. **[149A.54] LICENSE TO OPERATE AN ALKALINE HYDROLYSIS**

514.22 **FACILITY.**

514.23 Subdivision 1. License requirement. Except as provided in section 149A.01,

514.24 subdivision 3, a place or premise shall not be maintained, managed, or operated which

514.25 is devoted to or used in the holding and alkaline hydrolysis of a dead human body

514.26 without possessing a valid license to operate an alkaline hydrolysis facility issued by the

514.27 commissioner of health.

514.28 Subd. 2. Requirements for an alkaline hydrolysis facility. (a) An alkaline

514.29 hydrolysis facility licensed under this section must consist of:

- 514.30 (1) a building or structure that complies with applicable local and state building
- 514.31 codes, zoning laws and ordinances, wastewater management and environmental standards,
- 514.32 containing one or more alkaline hydrolysis vessels for the alkaline hydrolysis of dead
- 514.33 human bodies;
- 514.34 (2) a method approved by the commissioner of health to dry the hydrolyzed remains
- 514.35 and which is located within the licensed facility;

515.1 (3) a means approved by the commissioner of health for refrigeration of dead human
515.2 bodies awaiting alkaline hydrolysis;

515.3 (4) an appropriate means of processing hydrolyzed remains to a granulated
515.4 appearance appropriate for final disposition; and

515.5 (5) an appropriate holding facility for dead human bodies awaiting alkaline
515.6 hydrolysis.

515.7 (b) An alkaline hydrolysis facility licensed under this section may also contain a
515.8 display room for funeral goods.

515.9 Subd. 3. **Application procedure; documentation; initial inspection.** An
515.10 application to license and operate an alkaline hydrolysis facility shall be submitted to the
515.11 commissioner of health. A completed application includes:

515.12 (1) a completed application form, as provided by the commissioner;

515.13 (2) proof of business form and ownership;

515.14 (3) proof of liability insurance coverage or other financial documentation, as
515.15 determined by the commissioner, that demonstrates the applicant's ability to respond in
515.16 damages for liability arising from the ownership, maintenance management, or operation
515.17 of an alkaline hydrolysis facility; and

515.18 (4) copies of wastewater and other environmental regulatory permits and
515.19 environmental regulatory licenses necessary to conduct operations.

515.20 Upon receipt of the application and appropriate fee, the commissioner shall review and
515.21 verify all information. Upon completion of the verification process and resolution of any
515.22 deficiencies in the application information, the commissioner shall conduct an initial
515.23 inspection of the premises to be licensed. After the inspection and resolution of any
515.24 deficiencies found and any reinspections as may be necessary, the commissioner shall
515.25 make a determination, based on all the information available, to grant or deny licensure. If
515.26 the commissioner's determination is to grant the license, the applicant shall be notified and
515.27 the license shall issue and remain valid for a period prescribed on the license, but not to
515.28 exceed one calendar year from the date of issuance of the license. If the commissioner's
515.29 determination is to deny the license, the commissioner must notify the applicant in writing
515.30 of the denial and provide the specific reason for denial.

515.31 Subd. 4. **Nontransferability of license.** A license to operate an alkaline hydrolysis
515.32 facility is not assignable or transferable and shall not be valid for any entity other than the
515.33 one named. Each license issued to operate an alkaline hydrolysis facility is valid only for the
515.34 location identified on the license. A 50 percent or more change in ownership or location of
515.35 the alkaline hydrolysis facility automatically terminates the license. Separate licenses shall
515.36 be required of two or more persons or other legal entities operating from the same location.

516.1 Subd. 5. **Display of license.** Each license to operate an alkaline hydrolysis
516.2 facility must be conspicuously displayed in the alkaline hydrolysis facility at all times.
516.3 Conspicuous display means in a location where a member of the general public within the
516.4 alkaline hydrolysis facility will be able to observe and read the license.

516.5 Subd. 6. **Period of licensure.** All licenses to operate an alkaline hydrolysis facility
516.6 issued by the commissioner are valid for a period of one calendar year beginning on July 1
516.7 and ending on June 30, regardless of the date of issuance.

516.8 Subd. 7. **Reporting changes in license information.** Any change of license
516.9 information must be reported to the commissioner, on forms provided by the
516.10 commissioner, no later than 30 calendar days after the change occurs. Failure to report
516.11 changes is grounds for disciplinary action.

516.12 Subd. 8. **Notification to the commissioner.** If the licensee is operating under a
516.13 wastewater or an environmental permit or license that is subsequently revoked, denied,
516.14 or terminated, the licensee shall notify the commissioner.

516.15 Subd. 9. **Application information.** All information submitted to the commissioner
516.16 for a license to operate an alkaline hydrolysis facility is classified as licensing data under
516.17 section 13.41, subdivision 5.

516.18 Sec. 71. **[149A.55] RENEWAL OF LICENSE TO OPERATE AN ALKALINE**
516.19 **HYDROLYSIS FACILITY.**

516.20 Subdivision 1. **Renewal required.** All licenses to operate an alkaline hydrolysis
516.21 facility issued by the commissioner expire on June 30 following the date of issuance of the
516.22 license and must be renewed to remain valid.

516.23 Subd. 2. **Renewal procedure and documentation.** Licensees who wish to renew
516.24 their licenses must submit to the commissioner a completed renewal application no later
516.25 than June 30 following the date the license was issued. A completed renewal application
516.26 includes:

516.27 (1) a completed renewal application form, as provided by the commissioner; and
516.28 (2) proof of liability insurance coverage or other financial documentation, as
516.29 determined by the commissioner, that demonstrates the applicant's ability to respond in
516.30 damages for liability arising from the ownership, maintenance, management, or operation
516.31 of an alkaline hydrolysis facility.

516.32 Upon receipt of the completed renewal application, the commissioner shall review and
516.33 verify the information. Upon completion of the verification process and resolution of
516.34 any deficiencies in the renewal application information, the commissioner shall make a
516.35 determination, based on all the information available, to reissue or refuse to reissue the

517.1 license. If the commissioner's determination is to reissue the license, the applicant shall
517.2 be notified and the license shall issue and remain valid for a period prescribed on the
517.3 license, but not to exceed one calendar year from the date of issuance of the license. If
517.4 the commissioner's determination is to refuse to reissue the license, section 149A.09,
517.5 subdivision 2, applies.

517.6 Subd. 3. **Penalty for late filing.** Renewal applications received after the expiration
517.7 date of a license will result in the assessment of a late filing penalty. The late filing penalty
517.8 must be paid before the reissuance of the license and received by the commissioner no
517.9 later than 31 calendar days after the expiration date of the license.

517.10 Subd. 4. **Lapse of license.** Licenses to operate alkaline hydrolysis facilities
517.11 shall automatically lapse when a completed renewal application is not received by the
517.12 commissioner within 31 calendar days after the expiration date of a license, or a late
517.13 filing penalty assessed under subdivision 3 is not received by the commissioner within 31
517.14 calendar days after the expiration of a license.

517.15 Subd. 5. **Effect of lapse of license.** Upon the lapse of a license, the person to whom
517.16 the license was issued is no longer licensed to operate an alkaline hydrolysis facility in
517.17 Minnesota. The commissioner shall issue a cease and desist order to prevent the lapsed
517.18 license holder from operating an alkaline hydrolysis facility in Minnesota and may pursue
517.19 any additional lawful remedies as justified by the case.

517.20 Subd. 6. **Restoration of lapsed license.** The commissioner may restore a lapsed
517.21 license upon receipt and review of a completed renewal application, receipt of the late
517.22 filing penalty, and reinspection of the premises, provided that the receipt is made within
517.23 one calendar year from the expiration date of the lapsed license and the cease and desist
517.24 order issued by the commissioner has not been violated. If a lapsed license is not restored
517.25 within one calendar year from the expiration date of the lapsed license, the holder of the
517.26 lapsed license cannot be relicensed until the requirements in section 149A.54 are met.

517.27 Subd. 7. **Reporting changes in license information.** Any change of license
517.28 information must be reported to the commissioner, on forms provided by the
517.29 commissioner, no later than 30 calendar days after the change occurs. Failure to report
517.30 changes is grounds for disciplinary action.

517.31 Subd. 8. **Application information.** All information submitted to the commissioner
517.32 by an applicant for renewal of licensure to operate an alkaline hydrolysis facility is
517.33 classified as licensing data under section 13.41, subdivision 5.

517.34 Sec. 72. Minnesota Statutes 2012, section 149A.65, is amended by adding a
517.35 subdivision to read:

518.1 Subd. 6. **Alkaline hydrolysis facilities.** The initial and renewal fee for an alkaline
518.2 hydrolysis facility is \$300. The late fee charge for a license renewal is \$25.

518.3 Sec. 73. Minnesota Statutes 2012, section 149A.65, is amended by adding a
518.4 subdivision to read:

518.5 Subd. 7. **State government special revenue fund.** Fees collected by the
518.6 commissioner under this section must be deposited in the state treasury and credited to
518.7 the state government special revenue fund.

518.8 Sec. 74. Minnesota Statutes 2012, section 149A.70, subdivision 1, is amended to read:

518.9 Subdivision 1. **Use of titles.** Only a person holding a valid license to practice
518.10 mortuary science issued by the commissioner may use the title of mortician, funeral
518.11 director, or any other title implying that the licensee is engaged in the business or practice
518.12 of mortuary science. Only the holder of a valid license to operate an alkaline hydrolysis
518.13 facility issued by the commissioner may use the title of alkaline hydrolysis facility, water
518.14 cremation, water-reduction, biocremation, green-cremation, resomation, dissolution, or
518.15 any other title, word, or term implying that the licensee operates an alkaline hydrolysis
518.16 facility. Only the holder of a valid license to operate a funeral establishment issued by the
518.17 commissioner may use the title of funeral home, funeral chapel, funeral service, or any
518.18 other title, word, or term implying that the licensee is engaged in the business or practice
518.19 of mortuary science. Only the holder of a valid license to operate a crematory issued by
518.20 the commissioner may use the title of crematory, crematorium, green-cremation, or any
518.21 other title, word, or term implying that the licensee operates a crematory or crematorium.

518.22 Sec. 75. Minnesota Statutes 2012, section 149A.70, subdivision 2, is amended to read:

518.23 Subd. 2. **Business location.** A funeral establishment, alkaline hydrolysis facility, or
518.24 crematory shall not do business in a location that is not licensed as a funeral establishment,
518.25 alkaline hydrolysis facility, or crematory and shall not advertise a service that is available
518.26 from an unlicensed location.

518.27 Sec. 76. Minnesota Statutes 2012, section 149A.70, subdivision 3, is amended to read:

518.28 Subd. 3. **Advertising.** No licensee, clinical student, practicum student, or intern
518.29 shall publish or disseminate false, misleading, or deceptive advertising. False, misleading,
518.30 or deceptive advertising includes, but is not limited to:

519.1 (1) identifying, by using the names or pictures of, persons who are not licensed to
519.2 practice mortuary science in a way that leads the public to believe that those persons will
519.3 provide mortuary science services;

519.4 (2) using any name other than the names under which the funeral establishment,
519.5 alkaline hydrolysis facility, or crematory is known to or licensed by the commissioner;

519.6 (3) using a surname not directly, actively, or presently associated with a licensed
519.7 funeral establishment, alkaline hydrolysis facility, or crematory, unless the surname had
519.8 been previously and continuously used by the licensed funeral establishment, alkaline
519.9 hydrolysis facility, or crematory; and

519.10 (4) using a founding or establishing date or total years of service not directly or
519.11 continuously related to a name under which the funeral establishment, alkaline hydrolysis
519.12 facility, or crematory is currently or was previously licensed.

519.13 Any advertising or other printed material that contains the names or pictures of
519.14 persons affiliated with a funeral establishment, alkaline hydrolysis facility, or crematory
519.15 shall state the position held by the persons and shall identify each person who is licensed
519.16 or unlicensed under this chapter.

519.17 Sec. 77. Minnesota Statutes 2012, section 149A.70, subdivision 5, is amended to read:

519.18 Subd. 5. **Reimbursement prohibited.** No licensee, clinical student, practicum
519.19 student, or intern shall offer, solicit, or accept a commission, fee, bonus, rebate, or other
519.20 reimbursement in consideration for recommending or causing a dead human body to
519.21 be disposed of by a specific body donation program, funeral establishment, alkaline
519.22 hydrolysis facility, crematory, mausoleum, or cemetery.

519.23 Sec. 78. Minnesota Statutes 2012, section 149A.71, subdivision 2, is amended to read:

519.24 Subd. 2. **Preventive requirements.** (a) To prevent unfair or deceptive acts or
519.25 practices, the requirements of this subdivision must be met.

519.26 (b) Funeral providers must tell persons who ask by telephone about the funeral
519.27 provider's offerings or prices any accurate information from the price lists described in
519.28 paragraphs (c) to (e) and any other readily available information that reasonably answers
519.29 the questions asked.

519.30 (c) Funeral providers must make available for viewing to people who inquire in
519.31 person about the offerings or prices of funeral goods or burial site goods, separate printed
519.32 or typewritten price lists using a ten-point font or larger. Each funeral provider must have a
519.33 separate price list for each of the following types of goods that are sold or offered for sale:

519.34 (1) caskets;

- 520.1 (2) alternative containers;
520.2 (3) outer burial containers;
520.3 (4) alkaline hydrolysis containers;
520.4 ~~(4)~~ (5) cremation containers;
520.5 (6) hydrolyzed remains containers;
520.6 ~~(5)~~ (7) cremated remains containers;
520.7 ~~(6)~~ (8) markers; and
520.8 ~~(7)~~ (9) headstones.

520.9 (d) Each separate price list must contain the name of the funeral provider's place
520.10 of business, address, and telephone number and a caption describing the list as a price
520.11 list for one of the types of funeral goods or burial site goods described in paragraph (c),
520.12 clauses (1) to ~~(7)~~ (9). The funeral provider must offer the list upon beginning discussion
520.13 of, but in any event before showing, the specific funeral goods or burial site goods and
520.14 must provide a photocopy of the price list, for retention, if so asked by the consumer. The
520.15 list must contain, at least, the retail prices of all the specific funeral goods and burial site
520.16 goods offered which do not require special ordering, enough information to identify each,
520.17 and the effective date for the price list. However, funeral providers are not required to
520.18 make a specific price list available if the funeral providers place the information required
520.19 by this paragraph on the general price list described in paragraph (e).

520.20 (e) Funeral providers must give a printed price list, for retention, to persons who
520.21 inquire in person about the funeral goods, funeral services, burial site goods, or burial site
520.22 services or prices offered by the funeral provider. The funeral provider must give the list
520.23 upon beginning discussion of either the prices of or the overall type of funeral service or
520.24 disposition or specific funeral goods, funeral services, burial site goods, or burial site
520.25 services offered by the provider. This requirement applies whether the discussion takes
520.26 place in the funeral establishment or elsewhere. However, when the deceased is removed
520.27 for transportation to the funeral establishment, an in-person request for authorization to
520.28 embalm does not, by itself, trigger the requirement to offer the general price list. If the
520.29 provider, in making an in-person request for authorization to embalm, discloses that
520.30 embalming is not required by law except in certain special cases, the provider is not
520.31 required to offer the general price list. Any other discussion during that time about prices
520.32 or the selection of funeral goods, funeral services, burial site goods, or burial site services
520.33 triggers the requirement to give the consumer a general price list. The general price list
520.34 must contain the following information:

- 520.35 (1) the name, address, and telephone number of the funeral provider's place of
520.36 business;

- 521.1 (2) a caption describing the list as a "general price list";
- 521.2 (3) the effective date for the price list;
- 521.3 (4) the retail prices, in any order, expressed either as a flat fee or as the prices per
- 521.4 hour, mile, or other unit of computation, and other information described as follows:
- 521.5 (i) forwarding of remains to another funeral establishment, together with a list of
- 521.6 the services provided for any quoted price;
- 521.7 (ii) receiving remains from another funeral establishment, together with a list of
- 521.8 the services provided for any quoted price;
- 521.9 (iii) separate prices for each alkaline hydrolysis or cremation offered by the funeral
- 521.10 provider, with the price including an alternative container or alkaline hydrolysis or
- 521.11 cremation container, any alkaline hydrolysis or crematory charges, and a description of the
- 521.12 services and container included in the price, where applicable, and the price of alkaline
- 521.13 hydrolysis or cremation where the purchaser provides the container;
- 521.14 (iv) separate prices for each immediate burial offered by the funeral provider,
- 521.15 including a casket or alternative container, and a description of the services and container
- 521.16 included in that price, and the price of immediate burial where the purchaser provides the
- 521.17 casket or alternative container;
- 521.18 (v) transfer of remains to the funeral establishment or other location;
- 521.19 (vi) embalming;
- 521.20 (vii) other preparation of the body;
- 521.21 (viii) use of facilities, equipment, or staff for viewing;
- 521.22 (ix) use of facilities, equipment, or staff for funeral ceremony;
- 521.23 (x) use of facilities, equipment, or staff for memorial service;
- 521.24 (xi) use of equipment or staff for graveside service;
- 521.25 (xii) hearse or funeral coach;
- 521.26 (xiii) limousine; and
- 521.27 (xiv) separate prices for all cemetery-specific goods and services, including all goods
- 521.28 and services associated with interment and burial site goods and services and excluding
- 521.29 markers and headstones;
- 521.30 (5) the price range for the caskets offered by the funeral provider, together with the
- 521.31 statement "A complete price list will be provided at the funeral establishment or casket
- 521.32 sale location." or the prices of individual caskets, as disclosed in the manner described
- 521.33 in paragraphs (c) and (d);
- 521.34 (6) the price range for the alternative containers offered by the funeral provider,
- 521.35 together with the statement "A complete price list will be provided at the funeral

522.1 establishment or alternative container sale location." or the prices of individual alternative
522.2 containers, as disclosed in the manner described in paragraphs (c) and (d);

522.3 (7) the price range for the outer burial containers offered by the funeral provider,
522.4 together with the statement "A complete price list will be provided at the funeral
522.5 establishment or outer burial container sale location." or the prices of individual outer
522.6 burial containers, as disclosed in the manner described in paragraphs (c) and (d);

522.7 (8) the price range for the alkaline hydrolysis container offered by the funeral
522.8 provider, together with the statement: "A complete price list will be provided at the funeral
522.9 establishment or alkaline hydrolysis container sale location.", or the prices of individual
522.10 alkaline hydrolysis containers, as disclosed in the manner described in paragraphs (c)
522.11 and (d);

522.12 (9) the price range for the hydrolyzed remains container offered by the funeral
522.13 provider, together with the statement: "A complete price list will be provided at the
522.14 funeral establishment or hydrolyzed remains container sale location.", or the prices
522.15 of individual hydrolyzed remains container, as disclosed in the manner described in
522.16 paragraphs (c) and (d);

522.17 ~~(8)~~ (10) the price range for the cremation containers offered by the funeral provider,
522.18 together with the statement "A complete price list will be provided at the funeral
522.19 establishment or cremation container sale location." or the prices of individual cremation
522.20 containers ~~and cremated remains containers~~, as disclosed in the manner described in
522.21 paragraphs (c) and (d);

522.22 ~~(9)~~ (11) the price range for the cremated remains containers offered by the funeral
522.23 provider, together with the statement, "A complete price list will be provided at the funeral
522.24 establishment or ~~cremation~~ cremated remains container sale location," or the prices of
522.25 individual cremation containers as disclosed in the manner described in paragraphs (c)
522.26 and (d);

522.27 ~~(10)~~ (12) the price for the basic services of funeral provider and staff, together with a
522.28 list of the principal basic services provided for any quoted price and, if the charge cannot
522.29 be declined by the purchaser, the statement "This fee for our basic services will be added
522.30 to the total cost of the funeral arrangements you select. (This fee is already included in
522.31 our charges for alkaline hydrolysis, direct cremations, immediate burials, and forwarding
522.32 or receiving remains.)" If the charge cannot be declined by the purchaser, the quoted
522.33 price shall include all charges for the recovery of unallocated funeral provider overhead,
522.34 and funeral providers may include in the required disclosure the phrase "and overhead"
522.35 after the word "services." This services fee is the only funeral provider fee for services,

523.1 facilities, or unallocated overhead permitted by this subdivision to be nondeclinable,
523.2 unless otherwise required by law;

523.3 ~~(11)~~ (13) the price range for the markers and headstones offered by the funeral
523.4 provider, together with the statement "A complete price list will be provided at the funeral
523.5 establishment or marker or headstone sale location." or the prices of individual markers
523.6 and headstones, as disclosed in the manner described in paragraphs (c) and (d); and

523.7 ~~(12)~~ (14) any package priced funerals offered must be listed in addition to and
523.8 following the information required in this paragraph ~~(e)~~ and must clearly state the funeral
523.9 goods and services being offered, the price being charged for those goods and services,
523.10 and the discounted savings.

523.11 (f) Funeral providers must give an itemized written statement, for retention, to each
523.12 consumer who arranges an at-need funeral or other disposition of human remains at the
523.13 conclusion of the discussion of the arrangements. The itemized written statement must be
523.14 signed by the consumer selecting the goods and services as required in section 149A.80.
523.15 If the statement is provided by a funeral establishment, the statement must be signed by
523.16 the licensed funeral director or mortician planning the arrangements. If the statement is
523.17 provided by any other funeral provider, the statement must be signed by an authorized
523.18 agent of the funeral provider. The statement must list the funeral goods, funeral services,
523.19 burial site goods, or burial site services selected by that consumer and the prices to be paid
523.20 for each item, specifically itemized cash advance items (these prices must be given to the
523.21 extent then known or reasonably ascertainable if the prices are not known or reasonably
523.22 ascertainable, a good faith estimate shall be given and a written statement of the actual
523.23 charges shall be provided before the final bill is paid), and the total cost of goods and
523.24 services selected. At the conclusion of an at-need arrangement, the funeral provider is
523.25 required to give the consumer a copy of the signed itemized written contract that must
523.26 contain the information required in this paragraph.

523.27 (g) Upon receiving actual notice of the death of an individual with whom a funeral
523.28 provider has entered a preneed funeral agreement, the funeral provider must provide
523.29 a copy of all preneed funeral agreement documents to the person who controls final
523.30 disposition of the human remains or to the designee of the person controlling disposition.
523.31 The person controlling final disposition shall be provided with these documents at the time
523.32 of the person's first in-person contact with the funeral provider, if the first contact occurs
523.33 in person at a funeral establishment, alkaline hydrolysis facility, crematory, or other place
523.34 of business of the funeral provider. If the contact occurs by other means or at another
523.35 location, the documents must be provided within 24 hours of the first contact.

524.1 Sec. 79. Minnesota Statutes 2012, section 149A.71, subdivision 4, is amended to read:

524.2 Subd. 4. **Casket, alternate container, alkaline hydrolysis containers, and**
524.3 **cremation container sales; records; required disclosures.** Any funeral provider who
524.4 sells or offers to sell a casket, alternate container, alkaline hydrolysis container, hydrolyzed
524.5 remains container, or cremation container, or cremated remains container to the public
524.6 must maintain a record of each sale that includes the name of the purchaser, the purchaser's
524.7 mailing address, the name of the decedent, the date of the decedent's death, and the place
524.8 of death. These records shall be open to inspection by the regulatory agency. Any funeral
524.9 provider selling a casket, alternate container, or cremation container to the public, and not
524.10 having charge of the final disposition of the dead human body, shall provide a copy of the
524.11 statutes and rules controlling the removal, preparation, transportation, arrangements for
524.12 disposition, and final disposition of a dead human body. This subdivision does not apply to
524.13 morticians, funeral directors, funeral establishments, crematories, or wholesale distributors
524.14 of caskets, alternate containers, alkaline hydrolysis containers, or cremation containers.

524.15 Sec. 80. Minnesota Statutes 2012, section 149A.72, subdivision 3, is amended to read:

524.16 Subd. 3. **Casket for alkaline hydrolysis or cremation provisions; deceptive acts**
524.17 **or practices.** In selling or offering to sell funeral goods or funeral services to the public, it
524.18 is a deceptive act or practice for a funeral provider to represent that a casket is required for
524.19 alkaline hydrolysis or cremations by state or local law or otherwise.

524.20 Sec. 81. Minnesota Statutes 2012, section 149A.72, is amended by adding a
524.21 subdivision to read:

524.22 Subd. 3a. **Casket for alkaline hydrolysis provision; preventive measures.** To
524.23 prevent deceptive acts or practices, funeral providers must place the following disclosure
524.24 in immediate conjunction with the prices shown for alkaline hydrolysis: "Minnesota
524.25 law does not require you to purchase a casket for alkaline hydrolysis. If you want to
524.26 arrange for alkaline hydrolysis, you can use an alkaline hydrolysis container. An alkaline
524.27 hydrolysis container is a hydrolyzable or biodegradable closed container or pouch resistant
524.28 to leakage of bodily fluids that encases the body and into which a dead human body is
524.29 placed prior to insertion into an alkaline hydrolysis vessel. The containers we provide
524.30 are (specify containers provided)." This disclosure is required only if the funeral provider
524.31 arranges alkaline hydrolysis.

524.32 Sec. 82. Minnesota Statutes 2012, section 149A.72, subdivision 9, is amended to read:

525.1 Subd. 9. **Deceptive acts or practices.** In selling or offering to sell funeral goods,
525.2 funeral services, burial site goods, or burial site services to the public, it is a deceptive act
525.3 or practice for a funeral provider to represent that federal, state, or local laws, or particular
525.4 cemeteries, alkaline hydrolysis facilities, or crematories, require the purchase of any funeral
525.5 goods, funeral services, burial site goods, or burial site services when that is not the case.

525.6 Sec. 83. Minnesota Statutes 2012, section 149A.73, subdivision 1, is amended to read:

525.7 Subdivision 1. **Casket for alkaline hydrolysis or cremation provisions; deceptive**
525.8 **acts or practices.** In selling or offering to sell funeral goods, funeral services, burial site
525.9 goods, or burial site services to the public, it is a deceptive act or practice for a funeral
525.10 provider to require that a casket be purchased for alkaline hydrolysis or cremation.

525.11 Sec. 84. Minnesota Statutes 2012, section 149A.73, subdivision 2, is amended to read:

525.12 Subd. 2. **Casket for alkaline hydrolysis or cremation; preventive requirements.**
525.13 To prevent unfair or deceptive acts or practices, if funeral providers arrange for alkaline
525.14 hydrolysis or cremations, they must make a an alkaline hydrolysis container or cremation
525.15 container available for alkaline hydrolysis or cremations.

525.16 Sec. 85. Minnesota Statutes 2012, section 149A.73, subdivision 4, is amended to read:

525.17 Subd. 4. **Required purchases of funeral goods or services; preventive**
525.18 **requirements.** To prevent unfair or deceptive acts or practices, funeral providers must
525.19 place the following disclosure in the general price list, immediately above the prices
525.20 required by section 149A.71, subdivision 2, paragraph (e), clauses (4) to (10): "The goods
525.21 and services shown below are those we can provide to our customers. You may choose
525.22 only the items you desire. If legal or other requirements mean that you must buy any items
525.23 you did not specifically ask for, we will explain the reason in writing on the statement we
525.24 provide describing the funeral goods, funeral services, burial site goods, and burial site
525.25 services you selected." However, if the charge for "services of funeral director and staff"
525.26 cannot be declined by the purchaser, the statement shall include the sentence "However,
525.27 any funeral arrangements you select will include a charge for our basic services." between
525.28 the second and third sentences of the sentences specified in this subdivision. The statement
525.29 may include the phrase "and overhead" after the word "services" if the fee includes a
525.30 charge for the recovery of unallocated funeral overhead. If the funeral provider does
525.31 not include this disclosure statement, then the following disclosure statement must be
525.32 placed in the statement of funeral goods, funeral services, burial site goods, and burial site
525.33 services selected, as described in section 149A.71, subdivision 2, paragraph (f): "Charges

526.1 are only for those items that you selected or that are required. If we are required by law or
526.2 by a cemetery, alkaline hydrolysis facility, or crematory to use any items, we will explain
526.3 the reasons in writing below." A funeral provider is not in violation of this subdivision by
526.4 failing to comply with a request for a combination of goods or services which would be
526.5 impossible, impractical, or excessively burdensome to provide.

526.6 Sec. 86. Minnesota Statutes 2012, section 149A.74, is amended to read:

526.7 **149A.74 FUNERAL SERVICES PROVIDED WITHOUT PRIOR APPROVAL.**

526.8 Subdivision 1. **Services provided without prior approval; deceptive acts or**
526.9 **practices.** In selling or offering to sell funeral goods or funeral services to the public, it
526.10 is a deceptive act or practice for any funeral provider to embalm a dead human body
526.11 unless state or local law or regulation requires embalming in the particular circumstances
526.12 regardless of any funeral choice which might be made, or prior approval for embalming
526.13 has been obtained from an individual legally authorized to make such a decision. In
526.14 seeking approval to embalm, the funeral provider must disclose that embalming is not
526.15 required by law except in certain circumstances; that a fee will be charged if a funeral
526.16 is selected which requires embalming, such as a funeral with viewing; and that no
526.17 embalming fee will be charged if the family selects a service which does not require
526.18 embalming, such as direct alkaline hydrolysis, direct cremation, or immediate burial.

526.19 Subd. 2. **Services provided without prior approval; preventive requirement.**

526.20 To prevent unfair or deceptive acts or practices, funeral providers must include on
526.21 the itemized statement of funeral goods or services, as described in section 149A.71,
526.22 subdivision 2, paragraph (f), the statement "If you selected a funeral that may require
526.23 embalming, such as a funeral with viewing, you may have to pay for embalming. You do
526.24 not have to pay for embalming you did not approve if you selected arrangements such
526.25 as direct alkaline hydrolysis, direct cremation, or immediate burial. If we charged for
526.26 embalming, we will explain why below."

526.27 Sec. 87. Minnesota Statutes 2012, section 149A.91, subdivision 9, is amended to read:

526.28 Subd. 9. **Embalmed Bodies awaiting final disposition.** All ~~embalmed~~ bodies
526.29 awaiting final disposition shall be kept in an appropriate holding facility or preparation
526.30 and embalming room. The holding facility must be secure from access by anyone except
526.31 the authorized personnel of the funeral establishment, preserve the dignity and integrity of
526.32 the body, and protect the health and safety of the personnel of the funeral establishment.

526.33 Sec. 88. Minnesota Statutes 2012, section 149A.93, subdivision 3, is amended to read:

527.1 Subd. 3. **Disposition permit.** A disposition permit is required before a body can
527.2 be buried, entombed, alkaline hydrolyzed, or cremated. No disposition permit shall be
527.3 issued until a fact of death record has been completed and filed with the local or state
527.4 registrar of vital statistics.

527.5 Sec. 89. Minnesota Statutes 2012, section 149A.93, subdivision 6, is amended to read:

527.6 Subd. 6. **Conveyances permitted for transportation.** A dead human body may be
527.7 transported by means of private vehicle or private aircraft, provided that the body must be
527.8 encased in an appropriate container, that meets the following standards:

527.9 (1) promotes respect for and preserves the dignity of the dead human body;

527.10 (2) shields the body from being viewed from outside of the conveyance;

527.11 (3) has ample enclosed area to accommodate a cot, stretcher, rigid tray, casket,
527.12 alternative container, alkaline hydrolysis container, or cremation container in a horizontal
527.13 position;

527.14 (4) is designed to permit loading and unloading of the body without excessive tilting
527.15 of the cot, stretcher, rigid tray, casket, alternative container, alkaline hydrolysis container,
527.16 or cremation container; and

527.17 (5) if used for the transportation of more than one dead human body at one time,
527.18 the vehicle must be designed so that a body or container does not rest directly on top of
527.19 another body or container and that each body or container is secured to prevent the body
527.20 or container from excessive movement within the conveyance.

527.21 A vehicle that is a dignified conveyance and was specified for use by the deceased
527.22 or by the family of the deceased may be used to transport the body to the place of final
527.23 disposition.

527.24 Sec. 90. Minnesota Statutes 2012, section 149A.94, is amended to read:

527.25 **149A.94 FINAL DISPOSITION.**

527.26 Subdivision 1. **Generally.** Every dead human body lying within the state, except
527.27 unclaimed bodies delivered for dissection by the medical examiner, those delivered for
527.28 anatomical study pursuant to section 149A.81, subdivision 2, or lawfully carried through
527.29 the state for the purpose of disposition elsewhere; and the remains of any dead human
527.30 body after dissection or anatomical study, shall be decently buried; or entombed in a
527.31 public or private cemetery, alkaline hydrolyzed or cremated; within a reasonable time
527.32 after death. Where final disposition of a body will not be accomplished within 72 hours
527.33 following death or release of the body by a competent authority with jurisdiction over the
527.34 body, the body must be properly embalmed, refrigerated, or packed with dry ice. A body

528.1 may not be kept in refrigeration for a period exceeding six calendar days, or packed in dry
528.2 ice for a period that exceeds four calendar days, from the time of death or release of the
528.3 body from the coroner or medical examiner.

528.4 Subd. 3. **Permit required.** No dead human body shall be buried, entombed, or
528.5 cremated without a disposition permit. The disposition permit must be filed with the person
528.6 in charge of the place of final disposition. Where a dead human body will be transported out
528.7 of this state for final disposition, the body must be accompanied by a certificate of removal.

528.8 Subd. 4. **Alkaline hydrolysis or cremation.** Inurnment of alkaline hydrolyzed or
528.9 cremated remains and release to an appropriate party is considered final disposition and no
528.10 further permits or authorizations are required for transportation, interment, entombment, or
528.11 placement of the cremated remains, except as provided in section 149A.95, subdivision 16.

528.12 Sec. 91. [149A.941] ALKALINE HYDROLYSIS FACILITIES AND ALKALINE
528.13 HYDROLYSIS.

528.14 Subdivision 1. **License required.** A dead human body may only be hydrolyzed in
528.15 this state at an alkaline hydrolysis facility licensed by the commissioner of health.

528.16 Subd. 2. **General requirements.** Any building to be used as an alkaline hydrolysis
528.17 facility must comply with all applicable local and state building codes, zoning laws and
528.18 ordinances, wastewater management regulations, and environmental statutes, rules, and
528.19 standards. An alkaline hydrolysis facility must have, on site, a purpose built human
528.20 alkaline hydrolysis system approved by the commissioner of health, a system approved by
528.21 the commissioner of health for drying the hydrolyzed remains, a motorized mechanical
528.22 device approved by the commissioner of health for processing hydrolyzed remains and
528.23 must have in the building a holding facility approved by the commissioner of health for
528.24 the retention of dead human bodies awaiting alkaline hydrolysis. The holding facility
528.25 must be secure from access by anyone except the authorized personnel of the alkaline
528.26 hydrolysis facility, preserve the dignity of the remains, and protect the health and safety of
528.27 the alkaline hydrolysis facility personnel.

528.28 Subd. 3. **Lighting and ventilation.** The room where the alkaline hydrolysis vessel
528.29 is located and the room where the chemical storage takes place shall be properly lit and
528.30 ventilated with an exhaust fan that provides at least 12 air changes per hour.

528.31 Subd. 4. **Plumbing connections.** All plumbing fixtures, water supply lines,
528.32 plumbing vents, and waste drains shall be properly vented and connected pursuant to the
528.33 Minnesota Plumbing Code. The alkaline hydrolysis facility shall be equipped with a
528.34 functional sink with hot and cold running water.

529.1 Subd. 5. **Flooring, walls, ceiling, doors, and windows.** The room where the
529.2 alkaline hydrolysis vessel is located and the room where the chemical storage takes place
529.3 shall have nonporous flooring, so that a sanitary condition is provided. The walls and
529.4 ceiling of the room where the alkaline hydrolysis vessel is located and the room where
529.5 the chemical storage takes place shall run from floor to ceiling and be covered with tile,
529.6 or by plaster or sheetrock painted with washable paint or other appropriate material so
529.7 that a sanitary condition is provided. The doors, walls, ceiling, and windows shall be
529.8 constructed to prevent odors from entering any other part of the building. All windows
529.9 or other openings to the outside must be screened and all windows must be treated in a
529.10 manner that prevents viewing into the room where the alkaline hydrolysis vessel is located
529.11 and the room where the chemical storage takes place. A viewing window for authorized
529.12 family members or their designees is not a violation of this subdivision.

529.13 Subd. 6. **Equipment and supplies.** The alkaline hydrolysis facility must have a
529.14 functional emergency eye wash and quick drench shower.

529.15 Subd. 7. **Access and privacy.** (a) The room where the alkaline hydrolysis vessel is
529.16 located and the room where the chemical storage takes place must be private and have no
529.17 general passageway through it. The room shall, at all times, be secure from the entrance of
529.18 unauthorized persons. Authorized persons are:

529.19 (1) licensed morticians;

529.20 (2) registered interns or students as described in section 149A.91, subdivision 6;

529.21 (3) public officials or representatives in the discharge of their official duties;

529.22 (4) trained alkaline hydrolysis facility operators; and

529.23 (5) the persons with the right to control the dead human body as defined in section
529.24 149A.80, subdivision 2, and their designees.

529.25 (b) Each door allowing ingress or egress shall carry a sign that indicates that the
529.26 room is private and access is limited. All authorized persons who are present in or enter
529.27 the room where the alkaline hydrolysis vessel is located while a body is being prepared for
529.28 final disposition must be attired according to all applicable state and federal regulations
529.29 regarding the control of infectious disease and occupational and workplace health and
529.30 safety.

529.31 Subd. 8. **Sanitary conditions and permitted use.** The room where the alkaline
529.32 hydrolysis vessel is located and the room where the chemical storage takes place and all
529.33 fixtures, equipment, instruments, receptacles, clothing, and other appliances or supplies
529.34 stored or used in the room must be maintained in a clean and sanitary condition at all times.

530.1 Subd. 9. **Boiler use.** When a boiler is required by the manufacturer of the alkaline
530.2 hydrolysis vessel for its operation, all state and local regulations for that boiler must be
530.3 followed.

530.4 Subd. 10. **Occupational and workplace safety.** All applicable provisions of state
530.5 and federal regulations regarding exposure to workplace hazards and accidents shall be
530.6 followed in order to protect the health and safety of all authorized persons at the alkaline
530.7 hydrolysis facility.

530.8 Subd. 11. **Licensed personnel.** A licensed alkaline hydrolysis facility must employ
530.9 a licensed mortician to carry out the process of alkaline hydrolysis of a dead human body.
530.10 It is the duty of the licensed alkaline hydrolysis facility to provide proper procedures for
530.11 all personnel, and the licensed alkaline hydrolysis facility shall be strictly accountable for
530.12 compliance with this chapter and other applicable state and federal regulations regarding
530.13 occupational and workplace health and safety.

530.14 Subd. 12. **Authorization to hydrolyze required.** No alkaline hydrolysis facility
530.15 shall hydrolyze or cause to be hydrolyzed any dead human body or identifiable body part
530.16 without receiving written authorization to do so from the person or persons who have the
530.17 legal right to control disposition as described in section 149A.80 or the person's legal
530.18 designee. The written authorization must include:

530.19 (1) the name of the deceased and the date of death of the deceased;

530.20 (2) a statement authorizing the alkaline hydrolysis facility to hydrolyze the body;

530.21 (3) the name, address, telephone number, relationship to the deceased, and signature
530.22 of the person or persons with legal right to control final disposition or a legal designee;

530.23 (4) directions for the disposition of any nonhydrolyzed materials or items recovered
530.24 from the alkaline hydrolysis vessel;

530.25 (5) acknowledgment that the hydrolyzed remains will be dried and mechanically
530.26 reduced to a granulated appearance and placed in an appropriate container and
530.27 authorization to place any hydrolyzed remains that a selected urn or container will not
530.28 accommodate into a temporary container;

530.29 (6) acknowledgment that, even with the exercise of reasonable care, it is not possible
530.30 to recover all particles of the hydrolyzed remains and that some particles may inadvertently
530.31 become commingled with particles of other hydrolyzed remains that remain in the alkaline
530.32 hydrolysis vessel or other mechanical devices used to process the hydrolyzed remains;

530.33 (7) directions for the ultimate disposition of the hydrolyzed remains; and

530.34 (8) a statement that includes, but is not limited to, the following information:

530.35 "During the alkaline hydrolysis process, chemical dissolution using heat, water, and an
530.36 alkaline solution is used to chemically break down the human tissue and the hydrolyzable

531.1 alkaline hydrolysis container. After the process is complete, the liquid effluent solution
531.2 contains the chemical by-products of the alkaline hydrolysis process except for the
531.3 deceased's bone fragments. The solution is cooled and released according to local
531.4 environmental regulations. A water rinse is applied to the hydrolyzed remains which are
531.5 then dried and processed to facilitate inurnment or scattering."

531.6 Subd. 13. **Limitation of liability.** A licensed alkaline hydrolysis facility acting in
531.7 good faith, with reasonable reliance upon an authorization to hydrolyze, pursuant to an
531.8 authorization to hydrolyze and in an otherwise lawful manner, shall be held harmless from
531.9 civil liability and criminal prosecution for any actions taken by the alkaline hydrolysis
531.10 facility.

531.11 Subd. 14. **Acceptance of delivery of body.** (a) No dead human body shall be
531.12 accepted for final disposition by alkaline hydrolysis unless:

531.13 (1) encased in an appropriate alkaline hydrolysis container;

531.14 (2) accompanied by a disposition permit issued pursuant to section 149A.93,
531.15 subdivision 3, including a photocopy of the completed death record or a signed release
531.16 authorizing alkaline hydrolysis of the body received from the coroner or medical
531.17 examiner; and

531.18 (3) accompanied by an alkaline hydrolysis authorization that complies with
531.19 subdivision 12.

531.20 (b) An alkaline hydrolysis facility shall refuse to accept delivery of an alkaline
531.21 hydrolysis container where there is:

531.22 (1) evidence of leakage of fluids from the alkaline hydrolysis container;

531.23 (2) a known dispute concerning hydrolysis of the body delivered;

531.24 (3) a reasonable basis for questioning any of the representations made on the written
531.25 authorization to hydrolyze; or

531.26 (4) any other lawful reason.

531.27 Subd. 15. **Bodies awaiting hydrolysis.** A dead human body must be hydrolyzed
531.28 within 24 hours of the alkaline hydrolysis facility accepting legal and physical custody of
531.29 the body.

531.30 Subd. 16. **Handling of alkaline hydrolysis containers for dead human bodies.**

531.31 All alkaline hydrolysis facility employees handling alkaline hydrolysis containers for
531.32 dead human bodies shall use universal precautions and otherwise exercise all reasonable
531.33 precautions to minimize the risk of transmitting any communicable disease from the body.

531.34 No dead human body shall be removed from the container in which it is delivered.

531.35 Subd. 17. **Identification of body.** All licensed alkaline hydrolysis facilities shall
531.36 develop, implement, and maintain an identification procedure whereby dead human

532.1 bodes can be identified from the time the alkaline hydrolysis facility accepts delivery
532.2 of the remains until the hydrolyzed remains are released to an authorized party. After
532.3 hydrolyzation, an identifying disk, tab, or other permanent label shall be placed within the
532.4 hydrolyzed remains container before the hydrolyzed remains are released from the alkaline
532.5 hydrolysis facility. Each identification disk, tab, or label shall have a number that shall
532.6 be recorded on all paperwork regarding the decedent. This procedure shall be designed
532.7 to reasonably ensure that the proper body is hydrolyzed and that the hydrolyzed remains
532.8 are returned to the appropriate party. Loss of all or part of the hydrolyzed remains or the
532.9 inability to individually identify the hydrolyzed remains is a violation of this subdivision.

532.10 Subd. 18. **Alkaline hydrolysis vessel for human remains.** A licensed alkaline
532.11 hydrolysis facility shall knowingly hydrolyze only dead human bodies or human remains
532.12 in an alkaline hydrolysis vessel, along with the alkaline hydrolysis container used for
532.13 infectious disease control.

532.14 Subd. 19. **Alkaline hydrolysis procedures; privacy.** The final disposition of
532.15 dead human bodies by alkaline hydrolysis shall be done in privacy. Unless there is
532.16 written authorization from the person with the legal right to control the disposition,
532.17 only authorized alkaline hydrolysis facility personnel shall be permitted in the alkaline
532.18 hydrolysis area while any dead human body is in the alkaline hydrolysis area awaiting
532.19 alkaline hydrolysis, in the alkaline hydrolysis vessel, being removed from the alkaline
532.20 hydrolysis vessel, or being processed and placed in a hydrolyzed remains container.

532.21 Subd. 20. **Alkaline hydrolysis procedures; commingling of hydrolyzed remains**
532.22 **prohibited.** Except with the express written permission of the person with the legal right
532.23 to control the disposition, no alkaline hydrolysis facility shall hydrolyze more than one
532.24 dead human body at the same time and in the same alkaline hydrolysis vessel, or introduce
532.25 a second dead human body into an alkaline hydrolysis vessel until reasonable efforts have
532.26 been employed to remove all fragments of the preceding hydrolyzed remains, or hydrolyze
532.27 a dead human body and other human remains at the same time and in the same alkaline
532.28 hydrolysis vessel. This section does not apply where commingling of human remains
532.29 during alkaline hydrolysis is otherwise provided by law. The fact that there is incidental
532.30 and unavoidable residue in the alkaline hydrolysis vessel used in a prior hydrolyzation is
532.31 not a violation of this subdivision.

532.32 Subd. 21. **Alkaline hydrolysis procedures; removal from alkaline hydrolysis**
532.33 **vessel.** Upon completion of the alkaline hydrolysis process, reasonable efforts shall be
532.34 made to remove from the alkaline hydrolysis vessel all of the recoverable hydrolyzed
532.35 remains and nonhydrolyzed materials or items. Further, all reasonable efforts shall be
532.36 made to separate and recover the nonhydrolyzed materials or items from the hydrolyzed

533.1 human remains and dispose of these materials in a lawful manner, by the alkaline
533.2 hydrolysis facility. The hydrolyzed human remains shall be placed in an appropriate
533.3 container to be transported to the processing area.

533.4 **Subd. 22. Drying device or mechanical processor procedures; commingling of**
533.5 **hydrolyzed remains prohibited.** Except with the express written permission of the
533.6 person with the legal right to control the final disposition or otherwise provided by
533.7 law, no alkaline hydrolysis facility shall dry or mechanically process the hydrolyzed
533.8 human remains of more than one body at a time in the same drying device or mechanical
533.9 processor, or introduce the hydrolyzed human remains of a second body into a drying
533.10 device or mechanical processor until processing of any preceding hydrolyzed human
533.11 remains has been terminated and reasonable efforts have been employed to remove all
533.12 fragments of the preceding hydrolyzed remains. The fact that there is incidental and
533.13 unavoidable residue in the drying device, the mechanical processor, or any container used
533.14 in a prior alkaline hydrolysis process, is not a violation of this provision.

533.15 **Subd. 23. Alkaline hydrolysis procedures; processing hydrolyzed remains.** The
533.16 hydrolyzed human remains shall be dried and then reduced by a motorized mechanical
533.17 device to a granulated appearance appropriate for final disposition and placed in an
533.18 alkaline hydrolysis remains container along with the appropriate identifying disk, tab,
533.19 or permanent label. Processing must take place within the licensed alkaline hydrolysis
533.20 facility. Dental gold, silver or amalgam, jewelry, or mementos, to the extent that they
533.21 can be identified, may be removed prior to processing the hydrolyzed remains, only by
533.22 staff licensed or registered by the commissioner of health; however, any dental gold and
533.23 silver, jewelry, or mementos that are removed shall be returned to the hydrolyzed remains
533.24 container unless otherwise directed by the person or persons having the right to control the
533.25 final disposition. Every person who removes or possesses dental gold or silver, jewelry,
533.26 or mementos from any hydrolyzed remains without specific written permission of the
533.27 person or persons having the right to control those remains is guilty of a misdemeanor.
533.28 The fact that residue and any unavoidable dental gold or dental silver, or other precious
533.29 metals remain in the alkaline hydrolysis vessel or other equipment or any container used
533.30 in a prior hydrolysis is not a violation of this section.

533.31 **Subd. 24. Alkaline hydrolysis procedures; container of insufficient capacity.**
533.32 If a hydrolyzed remains container is of insufficient capacity to accommodate all
533.33 hydrolyzed remains of a given dead human body, subject to directives provided in the
533.34 written authorization to hydrolyze, the alkaline hydrolysis facility shall place the excess
533.35 hydrolyzed remains in a secondary alkaline hydrolysis remains container and attach the
533.36 second container, in a manner so as not to be easily detached through incidental contact, to

534.1 the primary alkaline hydrolysis remains container. The secondary container shall contain a
534.2 duplicate of the identification disk, tab, or permanent label that was placed in the primary
534.3 container and all paperwork regarding the given body shall include a notation that the
534.4 hydrolyzed remains were placed in two containers. Keepsake jewelry or similar miniature
534.5 hydrolyzed remains containers are not subject to the requirements of this subdivision.

534.6 **Subd. 25. Disposition procedures; commingling of hydrolyzed remains**
534.7 **prohibited.** No hydrolyzed remains shall be disposed of or scattered in a manner or in
534.8 a location where the hydrolyzed remains are commingled with those of another person
534.9 without the express written permission of the person with the legal right to control
534.10 disposition or as otherwise provided by law. This subdivision does not apply to the
534.11 scattering or burial of hydrolyzed remains at sea or in a body of water from individual
534.12 containers, to the scattering or burial of hydrolyzed remains in a dedicated cemetery, to
534.13 the disposal in a dedicated cemetery of accumulated residue removed from an alkaline
534.14 hydrolysis vessel or other alkaline hydrolysis equipment, to the inurnment of members
534.15 of the same family in a common container designed for the hydrolyzed remains of more
534.16 than one body, or to the inurnment in a container or interment in a space that has been
534.17 previously designated, at the time of sale or purchase, as being intended for the inurnment
534.18 or interment of the hydrolyzed remains of more than one person.

534.19 **Subd. 26. Alkaline hydrolysis procedures; disposition of accumulated residue.**
534.20 Every alkaline hydrolysis facility shall provide for the removal and disposition in a
534.21 dedicated cemetery of any accumulated residue from any alkaline hydrolysis vessel,
534.22 drying device, mechanical processor, container, or other equipment used in alkaline
534.23 hydrolysis. Disposition of accumulated residue shall be according to the regulations of the
534.24 dedicated cemetery and any applicable local ordinances.

534.25 **Subd. 27. Alkaline hydrolysis procedures; release of hydrolyzed remains.**
534.26 Following completion of the hydrolyzation, the inurned hydrolyzed remains shall be
534.27 released according to the instructions given on the written authorization to hydrolyze. If
534.28 the hydrolyzed remains are to be shipped, they must be securely packaged and transported
534.29 by a method which has an internal tracing system available and which provides for a
534.30 receipt signed by the person accepting delivery. Where there is a dispute over release
534.31 or disposition of the hydrolyzed remains, an alkaline hydrolysis facility may deposit
534.32 the hydrolyzed remains with a court of competent jurisdiction pending resolution of the
534.33 dispute or retain the hydrolyzed remains until the person with the legal right to control
534.34 disposition presents satisfactory indication that the dispute is resolved.

534.35 **Subd. 28. Unclaimed hydrolyzed remains.** If, after 30 calendar days following
534.36 the inurnment, the hydrolyzed remains are not claimed or disposed of according to the

535.1 written authorization to hydrolyze, the alkaline hydrolysis facility or funeral establishment
535.2 may give written notice, by certified mail, to the person with the legal right to control
535.3 the final disposition or a legal designee, that the hydrolyzed remains are unclaimed and
535.4 requesting further release directions. Should the hydrolyzed remains be unclaimed 120
535.5 calendar days following the mailing of the written notification, the alkaline hydrolysis
535.6 facility or funeral establishment may dispose of the hydrolyzed remains in any lawful
535.7 manner deemed appropriate.

535.8 Subd. 29. **Required records.** Every alkaline hydrolysis facility shall create and
535.9 maintain on its premises or other business location in Minnesota an accurate record of
535.10 every hydrolyzation provided. The record shall include all of the following information
535.11 for each hydrolyzation:

535.12 (1) the name of the person or funeral establishment delivering the body for alkaline
535.13 hydrolysis;

535.14 (2) the name of the deceased and the identification number assigned to the body;

535.15 (3) the date of acceptance of delivery;

535.16 (4) the names of the alkaline hydrolysis vessel, drying device, and mechanical
535.17 processor operator;

535.18 (5) the time and date that the body was placed in and removed from the alkaline
535.19 hydrolysis vessel;

535.20 (6) the time and date that processing and inurnment of the hydrolyzed remains
535.21 was completed;

535.22 (7) the time, date, and manner of release of the hydrolyzed remains;

535.23 (8) the name and address of the person who signed the authorization to hydrolyze;

535.24 (9) all supporting documentation, including any transit or disposition permits, a
535.25 photocopy of the death record, and the authorization to hydrolyze; and

535.26 (10) the type of alkaline hydrolysis container.

535.27 Subd. 30. **Retention of records.** Records required under subdivision 29 shall be
535.28 maintained for a period of three calendar years after the release of the hydrolyzed remains.
535.29 Following this period and subject to any other laws requiring retention of records, the
535.30 alkaline hydrolysis facility may then place the records in storage or reduce them to
535.31 microfilm, microfiche, laser disc, or any other method that can produce an accurate
535.32 reproduction of the original record, for retention for a period of ten calendar years from
535.33 the date of release of the hydrolyzed remains. At the end of this period and subject to any
535.34 other laws requiring retention of records, the alkaline hydrolysis facility may destroy
535.35 the records by shredding, incineration, or any other manner that protects the privacy of
535.36 the individuals identified.

536.1 Sec. 92. Minnesota Statutes 2012, section 149A.96, subdivision 9, is amended to read:

536.2 Subd. 9. **Hydrolyzed and cremated remains.** Subject to section 149A.95,
536.3 subdivision 16, inurnment of the hydrolyzed or cremated remains and release to an
536.4 appropriate party is considered final disposition and no further permits or authorizations
536.5 are required for disinterment, transportation, or placement of the hydrolyzed or cremated
536.6 remains.

536.7 Sec. 93. Minnesota Statutes 2012, section 257.75, subdivision 7, is amended to read:

536.8 Subd. 7. **Hospital and Department of Health; recognition form.** Hospitals that
536.9 provide obstetric services and the state registrar of vital statistics shall distribute the
536.10 educational materials and recognition of parentage forms prepared by the commissioner of
536.11 human services to new parents, shall assist parents in understanding the recognition of
536.12 parentage form, including following the provisions for notice under subdivision 5, shall
536.13 provide notary services for parents who complete the recognition of parentage form, and
536.14 shall timely file the completed recognition of parentage form with the Office of the State
536.15 Registrar of Vital Statistics Records unless otherwise instructed by the Office of the State
536.16 Registrar of Vital Statistics Records. ~~On and after January 1, 1994, hospitals may not~~
536.17 ~~distribute the declaration of parentage forms.~~

536.18 Sec. 94. Minnesota Statutes 2012, section 260C.635, subdivision 1, is amended to read:

536.19 Subdivision 1. **Legal effect.** (a) Upon adoption, the adopted child becomes the legal
536.20 child of the adopting parent and the adopting parent becomes the legal parent of the child
536.21 with all the rights and duties between them of a birth parent and child.

536.22 (b) The child shall inherit from the adoptive parent and the adoptive parent's
536.23 relatives the same as though the child were the birth child of the parent, and in case of the
536.24 child's death intestate, the adoptive parent and the adoptive parent's relatives shall inherit
536.25 the child's estate as if the child had been the adoptive parent's birth child.

536.26 (c) After a decree of adoption is entered, the birth parents or previous legal parents
536.27 of the child shall be relieved of all parental responsibilities for the child except child
536.28 support that has accrued to the date of the order for guardianship to the commissioner
536.29 which continues to be due and owing. The child's birth or previous legal parent shall not
536.30 exercise or have any rights over the adopted child or the adopted child's property, person,
536.31 privacy, or reputation.

536.32 (d) The adopted child shall not owe the birth parents or the birth parent's relatives
536.33 any legal duty nor shall the adopted child inherit from the birth parents or kindred unless
536.34 otherwise provided for in a will of the birth parent or kindred.

537.1 (e) Upon adoption, the court shall complete a certificate of adoption form and mail
537.2 the form to the Office of the State Registrar Vital Records at the Minnesota Department
537.3 of Health. Upon receiving the certificate of adoption, the state registrar shall register a
537.4 replacement vital record in the new name of the adopted child as required under section
537.5 144.218.

537.6 Sec. 95. Minnesota Statutes 2012, section 517.001, is amended to read:

537.7 **517.001 DEFINITION.**

537.8 As used in this chapter, "local registrar" ~~has the meaning given in section 144.212,~~
537.9 ~~subdivision 10~~ means an individual designated by the county board of commissioners to
537.10 register marriages.

537.11 Sec. 96. **FUNERAL ESTABLISHMENTS; BRANCH LOCATIONS.**

537.12 The commissioner of health shall review the statutory requirements for preparation
537.13 and embalming rooms and develop legislation with input from stakeholders that provides
537.14 appropriate health and safety protection for funeral home locations where deceased bodies
537.15 are present, but are branch locations associated through a majority ownership of a licensed
537.16 funeral establishment that meets the requirements of Minnesota Statutes, sections 149A.50
537.17 and 149A.92, subdivisions 2 to 10. The review shall include consideration of distance
537.18 between the main location and branch, and other health and safety issues.

537.19 Sec. 97. **REVISOR'S INSTRUCTION.**

537.20 The revisor shall substitute the term "vertical heat exchangers" or "vertical
537.21 heat exchanger" with "bored geothermal heat exchangers" or "bored geothermal heat
537.22 exchanger" wherever it appears in Minnesota Statutes, sections 103I.005, subdivisions
537.23 2 and 12; 103I.101, subdivisions 2 and 5; 103I.105; 103I.205, subdivision 4; 103I.208,
537.24 subdivision 2; 103I.501; 103I.531, subdivision 5; and 103I.641, subdivisions 1, 2, and 3.

537.25 Sec. 98. **REPEALER.**

537.26 (a) Minnesota Statutes 2012, sections 62J.693; 103I.005, subdivision 20; 149A.025;
537.27 149A.20, subdivision 8; 149A.30, subdivision 2; 149A.40, subdivision 8; 149A.45,
537.28 subdivision 6; 149A.50, subdivision 6; 149A.51, subdivision 7; 149A.52, subdivision 5a;
537.29 149A.53, subdivision 9; and 485.14, are repealed.

537.30 (b) Minnesota Statutes 2012, section 144.123, subdivision 2, is repealed effective
537.31 July 1, 2014.

538.1

ARTICLE 13

538.2

**PAYMENT METHODOLOGIES FOR HOME AND
COMMUNITY-BASED SERVICES**

538.3

538.4 Section 1. Minnesota Statutes 2012, section 256B.4912, subdivision 2, is amended to
538.5 read:

538.6 Subd. 2. **Payment methodologies.** (a) The commissioner shall establish, as defined
538.7 under section 256B.4914, statewide payment methodologies that meet federal waiver
538.8 requirements for home and community-based waiver services for individuals with
538.9 disabilities. The payment methodologies must abide by the principles of transparency
538.10 and equitability across the state. The methodologies must involve a uniform process of
538.11 structuring rates for each service and must promote quality and participant choice.

538.12 (b) As of January 1, 2012, counties shall not implement changes to established
538.13 processes for rate-setting methodologies for individuals using components of or data
538.14 from research rates.

538.15 Sec. 2. Minnesota Statutes 2012, section 256B.4912, subdivision 3, is amended to read:

538.16 Subd. 3. **Payment requirements.** The payment methodologies established under
538.17 this section shall accommodate:

- 538.18 (1) supervision costs;
- 538.19 (2) ~~staffing patterns~~ staff compensation;
- 538.20 (3) staffing and supervisory patterns;
- 538.21 ~~(3)~~ (4) program-related expenses;
- 538.22 ~~(4)~~ (5) general and administrative expenses; and
- 538.23 ~~(5)~~ (6) consideration of recipient intensity.

538.24 Sec. 3. Minnesota Statutes 2012, section 256B.4913, is amended by adding a
538.25 subdivision to read:

538.26 Subd. 4a. **Rate stabilization adjustment.** (a) The commissioner of human services
538.27 shall adjust individual reimbursement rates by no more than 1.0 percent per year effective
538.28 January 1, 2016. Rates determined under section 256B.4914 must be adjusted so that
538.29 the unit rate varies no more than 1.0 percent per year from the rate effective December
538.30 1 of the prior calendar year. This adjustment is made annually for three calendar years
538.31 from the date of implementation.

538.32 (b) Rate stabilization adjustment applies to services that are authorized in a
538.33 recipient's service plan prior to January 1, 2016.

539.1 (c) Exemptions shall be made only when there is a significant change in the
 539.2 recipient's assessed needs that results in a service authorization change. Exemption
 539.3 adjustments shall be limited to the difference in the authorized framework rate specific to
 539.4 change in assessed need. Exemptions shall be managed within lead agencies' budgets per
 539.5 existing allocation procedures.

539.6 (d) This subdivision expires January 1, 2019.

539.7 Sec. 4. Minnesota Statutes 2012, section 256B.4913, subdivision 5, is amended to read:

539.8 Subd. 5. **Stakeholder consultation.** The commissioner shall continue consultation
 539.9 on regular intervals with the existing stakeholder group established as part of the
 539.10 rate-setting methodology process and others, to gather input, concerns, and data, and
 539.11 exchange ideas for the legislative proposals for to assist in the full implementation of
 539.12 the new rate payment system and to make pertinent information available to the public
 539.13 through the department's Web site.

539.14 Sec. 5. Minnesota Statutes 2012, section 256B.4913, subdivision 6, is amended to read:

539.15 Subd. 6. **Implementation.** (a) The commissioner ~~may~~ shall implement changes
 539.16 no sooner than on January 1, 2014, to payment rates for individuals receiving home and
 539.17 community-based waived services after the enactment of legislation that establishes
 539.18 specific payment methodology frameworks, processes for rate calculations, and specific
 539.19 values to populate the ~~payment methodology frameworks~~ disability waiver rates system.

539.20 (b) On January 1, 2014, all new service authorizations must use the disability waiver
 539.21 rates system. Beginning January 1, 2014, all renewing individual service plans must use the
 539.22 disability waiver rates system as reassessment and reauthorization occurs. By December
 539.23 31, 2014, data for all recipients must be entered into the disability waiver rates system.

539.24 Sec. 6. **[256B.4914] HOME AND COMMUNITY-BASED SERVICES WAIVERS;**
 539.25 **RATE SETTING.**

539.26 Subdivision 1. **Application.** The payment methodologies in this section apply to
 539.27 home and community-based services waivers under sections 256B.092 and 256B.49. This
 539.28 section does not change existing waiver policies and procedures.

539.29 Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the
 539.30 meanings given them, unless the context clearly indicates otherwise.

539.31 (b) "Commissioner" means the commissioner of human services.

539.32 (c) "Component value" means underlying factors that are part of the cost of providing
 539.33 services that are built into the waiver rates methodology to calculate service rates.

540.1 (d) "Customized living tool" means a methodology for setting service rates that
540.2 delineates and documents the amount of each component service included in a recipient's
540.3 customized living service plan.

540.4 (e) "Disability waiver rates system" means a statewide system that establishes rates
540.5 that are based on uniform processes and captures the individualized nature of waiver
540.6 services and recipient needs.

540.7 (f) "Lead agency" means a county, partnership of counties, or tribal agency charged
540.8 with administering waived services under sections 256B.092 and 256B.49.

540.9 (g) "Median" means the amount that divides distribution into two equal groups,
540.10 one-half above the median and one-half below the median.

540.11 (h) "Payment or rate" means reimbursement to an eligible provider for services
540.12 provided to a qualified individual based on an approved service authorization.

540.13 (i) "Rates management system" means a Web-based software application that uses
540.14 a framework and component values, as determined by the commissioner, to establish
540.15 service rates.

540.16 (j) "Recipient" means a person receiving home and community-based services
540.17 funded under any of the disability waivers.

540.18 Subd. 3. **Applicable services.** Applicable services are those authorized under
540.19 the state's home and community-based services waivers under sections 256B.092 and
540.20 256B.49, including the following, as defined in the federally approved home and
540.21 community-based services plan:

540.22 (1) 24 hour customized living;

540.23 (2) adult day care;

540.24 (3) adult day care bath;

540.25 (4) behavioral programming;

540.26 (5) companion services;

540.27 (6) customized living;

540.28 (7) day training and habilitation;

540.29 (8) housing access coordination;

540.30 (9) independent living skills;

540.31 (10) in-home family support;

540.32 (11) night supervision;

540.33 (12) personal support;

540.34 (13) prevocational services;

540.35 (14) residential care services;

540.36 (15) residential support services;

- 541.1 (16) respite services;
 541.2 (17) structured day services;
 541.3 (18) supported employment services;
 541.4 (19) supported living services;
 541.5 (20) transportation services; and
 541.6 (21) other services as approved by the federal government in the state home and
 541.7 community-based services plan.

541.8 Subd. 4. **Data collection for rate determination.** (a) Rates for all applicable home
 541.9 and community-based waived services, including rate exceptions under subdivision 12,
 541.10 are set via the rates management system.

541.11 (b) Only data and information in the rates management system may be used to
 541.12 calculate an individual's rate.

541.13 (c) Service providers, with information from the community support plan, shall enter
 541.14 values and information needed to calculate an individual's rate into the rates management
 541.15 system. These values and information include:

541.16 (1) shared staffing hours;

541.17 (2) individual staffing hours;

541.18 (3) staffing ratios;

541.19 (4) information to document variable levels of service qualification for variable
 541.20 levels of reimbursement in each framework;

541.21 (5) shared or individualized arrangements for unit-based services, including the
 541.22 staffing ratio; and

541.23 (6) number of trips and miles for transportation services.

541.24 (d) Updates to individual data shall include:

541.25 (1) data for each individual that is updated annually when renewing service plans; and

541.26 (2) requests by individuals or lead agencies to update a rate whenever there is a
 541.27 change in an individual's service needs, with accompanying documentation.

541.28 (e) Lead agencies shall review and approve values to calculate the final payment rate
 541.29 for each individual. Lead agencies must notify the individual and the service provider
 541.30 of the final agreed-upon values and rate. If a value used was mistakenly or erroneously
 541.31 entered and used to calculate a rate, a provider may petition lead agencies to correct it.
 541.32 Lead agencies must respond to these requests.

541.33 Subd. 5. **Base wage index and standard component values.** (a) The base wage
 541.34 index is established to determine staffing costs associated with providing services to
 541.35 individuals receiving home and community-based services. For purposes of developing
 541.36 and calculating the proposed base wage, Minnesota-specific wages taken from job

542.1 descriptions and standard occupational classification (SOC) codes from the Bureau of
542.2 Labor Statistics as defined in the most recent edition of the Occupational Handbook shall
542.3 be used. The base wage index shall be calculated as follows:

542.4 (1) for residential direct-care basic staff, 50 percent of the median wage for personal
542.5 and home health aide (SOC code 39-9021); 30 percent of the median wage for nursing
542.6 aide (SOC code 31-1012); and 20 percent of the median wage for social and human
542.7 services aide (SOC code 21-1093);

542.8 (2) for residential direct-care intensive staff, 20 percent of the median wage for home
542.9 health aide (SOC code 31-1011); 20 percent of the median wage for personal and home
542.10 health aide (SOC code 39-9021); 20 percent of the median wage for nursing aide (SOC code
542.11 21-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
542.12 and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

542.13 (3) for day services, 20 percent of the median wage for nursing aide (SOC code
542.14 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053);
542.15 and 60 percent of the median wage for social and human services code (SOC code 21-1093);

542.16 (4) for residential asleep-overnight staff, the wage will be \$7.66 per hour, except in
542.17 a family foster care setting, the wage is \$2.80 per hour;

542.18 (5) for behavior program analyst staff, 100 percent of the median wage for mental
542.19 health counselors (SOC code 21-1014);

542.20 (6) for behavior program professional staff, 100 percent of the median wage for
542.21 clinical counseling and school psychologist (SOC code 19-3031);

542.22 (7) for behavior program specialist staff, 100 percent of the median wage for
542.23 psychiatric technicians (SOC code 29-2053);

542.24 (8) for supportive living services staff, 20 percent of the median wage for nursing
542.25 aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC
542.26 code 29-2053); and 60 percent of the median wage for social and human services aide
542.27 (SOC code 21-1093);

542.28 (9) for housing access coordination staff, 50 percent of the median wage for
542.29 community and social services specialist (SOC code 21-1099); and 50 percent of the
542.30 median wage for social and human services aide (SOC code 21-1093);

542.31 (10) for in-home family support staff, 20 percent of the median wage for nursing
542.32 aide (SOC code 31-1012); 30 percent of community social service specialist (SOC code
542.33 21-1099); 40 percent of the median wage for social and human services aide (SOC code
542.34 21-1093); and ten percent of the median wage for psychiatric technician (SOC code
542.35 29-2053);

543.1 (11) for independent living skills staff, 40 percent of the median wage for community
543.2 social service specialist (SOC code 21-1099); 50 percent of the median wage for social
543.3 and human services aide (SOC code 21-1093); and ten percent of the median wage for
543.4 psychiatric technician (SOC code 29-2053);

543.5 (12) for supported employment staff, 20 percent of the median wage for nursing aide
543.6 (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC
543.7 code 29-2053); and 60 percent of the median wage for social and human services aide
543.8 (SOC code 21-1093);

543.9 (13) for adult companion staff, 50 percent of the median wage for personal and home
543.10 care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides,
543.11 orderlies, and attendants (SOC code 31-1012);

543.12 (14) for night supervision staff, 20 percent of the median wage for home health aide
543.13 (SOC code 31-1011); 20 percent of the median wage for personal and home health aide
543.14 (SOC code 39-9021); 20 percent of the median wage for nursing aide (SOC code 31-1012);
543.15 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20
543.16 percent of the median wage for social and human services aide (SOC code 21-1093);

543.17 (15) for respite staff, 50 percent of the median wage for personal and home care aide
543.18 (SOC code 39-9021); and 50 percent of the median wage for nursing aides, orderlies, and
543.19 attendants (SOC code 31-1012);

543.20 (16) for personal support staff, 50 percent of the median wage for personal and home
543.21 care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides,
543.22 orderlies, and attendants (SOC code 31-1012); and

543.23 (17) for supervisory staff, the basic wage is \$17.43 per hour with exception of the
543.24 supervisor of behavior analyst and behavior specialists, which shall be \$30.75 per hour.

543.25 (b) Component values for residential support services, excluding family foster
543.26 care, are:

543.27 (1) supervisory span of control ratio: 11 percent;

543.28 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;

543.29 (3) employee-related cost ratio: 23.6 percent;

543.30 (4) general administrative support ratio: 13.25 percent;

543.31 (5) program-related expense ratio: 1.3 percent; and

543.32 (6) absence and utilization factor ratio: 3.9 percent.

543.33 (c) Component values for family foster care are:

543.34 (1) supervisory span of control ratio: 11 percent;

543.35 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;

543.36 (3) employee-related cost ratio: 23.6 percent;

- 544.1 (4) general administrative support ratio: 3.3 percent; and
- 544.2 (5) program-related expense ratio: 1.3 percent.
- 544.3 (d) Component values for day services for all services are:
- 544.4 (1) supervisory span of control ratio: 11 percent;
- 544.5 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 544.6 (3) employee-related cost ratio: 23.6 percent;
- 544.7 (4) program plan support ratio: 5.6 percent;
- 544.8 (5) client programming and support ratio: ten percent;
- 544.9 (6) general administrative support ratio: 13.25 percent;
- 544.10 (7) program-related expense ratio: 1.8 percent; and
- 544.11 (8) absence and utilization factor ratio: 3.9 percent.
- 544.12 (e) Component values for unit-based with program services are:
- 544.13 (1) supervisory span of control ratio: 11 percent;
- 544.14 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 544.15 (3) employee-related cost ratio: 23.6 percent;
- 544.16 (4) program plan supports ratio: 3.1 percent;
- 544.17 (5) client programming and supports ratio: 8.6 percent;
- 544.18 (6) general administrative support ratio: 13.25 percent;
- 544.19 (7) program-related expense ratio: 6.1 percent; and
- 544.20 (8) absence and utilization factor ratio: 3.9 percent.
- 544.21 (f) Component values for unit-based services without programming except respite
- 544.22 are:
- 544.23 (1) supervisory span of control ratio: 11 percent;
- 544.24 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 544.25 (3) employee-related cost ratio: 23.6 percent;
- 544.26 (4) program plan support ratio: 3.1 percent;
- 544.27 (5) client programming and support ratio: 8.6 percent;
- 544.28 (6) general administrative support ratio: 13.25 percent;
- 544.29 (7) program-related expense ratio: 6.1 percent; and
- 544.30 (8) absence and utilization factor ratio: 3.9 percent.
- 544.31 (g) Component values for unit-based services without programming for respite are:
- 544.32 (1) supervisory span of control ratio: 11 percent;
- 544.33 (2) employee vacation, sick, and training allowance ratio: 8.71 percent;
- 544.34 (3) employee-related cost ratio: 23.6 percent;
- 544.35 (4) general administrative support ratio: 13.25 percent;
- 544.36 (5) program-related expense ratio: 6.1 percent; and

545.1 (6) absence and utilization factor ratio: 3.9 percent.

545.2 (h) On July 1, 2017, the commissioner shall update the base wage index in paragraph
545.3 (b) based on the wage data by standard occupational code (SOC) from the Bureau of
545.4 Labor Statistics available on December 31, 2016. The commissioner shall publish these
545.5 updated values and load them into the rate management system. This adjustment occurs
545.6 every five years. For adjustments in 2021 and beyond, the commissioner shall use the data
545.7 available on December 31 of the calendar year five years prior.

545.8 (i) On July 1, 2017, the commissioner shall update the framework components in
545.9 paragraph (c) for changes in the Consumer Price Index. The commissioner will adjust
545.10 these values higher or lower by the percentage change in the Consumer Price Index-All
545.11 Items, United States city average (CPI-U) from January 1, 2014, to January 1, 2017. The
545.12 commissioner shall publish these updated values and load them into the rate management
545.13 system. This adjustment occurs every five years. For adjustments in 2021 and beyond, the
545.14 commissioner shall use the data available on January 1 of the calendar year four years
545.15 prior and January 1 of the current calendar year.

545.16 Subd. 6. **Payments for residential support services.** (a) Payments for residential
545.17 support services, as defined in sections 256B.092, subdivision 11, and 256B.49,
545.18 subdivision 22, must be calculated as follows:

545.19 (1) determine the number of units of service to meet a recipient's needs;

545.20 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
545.21 national and Minnesota-specific rates or rates derived by the commissioner as provided
545.22 in subdivision 5. This is defined as the direct-care rate;

545.23 (3) for a recipient requiring customization for deaf and hard-of-hearing language
545.24 accessibility under subdivision 12, add the customization rate provided in subdivision 12
545.25 to the result of clause (2). This is defined as the customized direct-care rate;

545.26 (4) multiply the number of residential services direct staff hours by the appropriate
545.27 staff wage in subdivision 5, paragraph (a), or the customized direct-care rate;

545.28 (5) multiply the number of direct staff hours by the product of the supervision span
545.29 of control ratio in subdivision 5, paragraph (b), clause (1), and the appropriate supervision
545.30 wage in subdivision 5, paragraph (a), clause (17);

545.31 (6) combine the results of clauses (4) and (5), and multiply the result by one plus
545.32 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b),
545.33 clause (2). This is defined as the direct staffing cost;

545.34 (7) for employee-related expenses, multiply the direct staffing cost by one plus the
545.35 employee-related cost ratio in subdivision 5, paragraph (b), clause (3);

545.36 (8) for client programming and supports, the commissioner shall add \$2,179; and

546.1 (9) for transportation, if provided, the commissioner shall add \$1,680, or \$3,000 if
546.2 customized for adapted transport, per year.

546.3 (b) The total rate shall be calculated using the following steps:

546.4 (1) subtotal paragraph (a), clauses (7) to (9);

546.5 (2) sum the standard general and administrative rate, the program-related expense
546.6 ratio, and the absence and utilization ratio; and

546.7 (3) divide the result of clause (1) by one minus the result of clause (2). This is
546.8 the total payment amount.

546.9 Subd. 7. **Payments for day programs.** Payments for services with day programs
546.10 including adult day care, day treatment and habilitation, prevocational services, and
546.11 structured day services must be calculated as follows:

546.12 (1) determine the number of units of service to meet a recipient's needs;

546.13 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
546.14 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

546.15 (3) for a recipient requiring customization for deaf and hard-of-hearing language
546.16 accessibility under subdivision 12, add the customization rate provided in subdivision 12
546.17 to the result of clause (2). This is defined as the customized direct-care rate;

546.18 (4) multiply the number of day program direct staff hours by the appropriate staff
546.19 wage in subdivision 5, paragraph (a), or the customized direct-care rate;

546.20 (5) multiply the number of day direct staff hours by the product of the supervision
546.21 span of control ratio in subdivision 5, paragraph (d), clause (1), and the appropriate
546.22 supervision wage in subdivision 5, paragraph (a), clause (17);

546.23 (6) combine the results of clauses (4) and (5), and multiply the result by one plus
546.24 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (d),
546.25 clause (2). This is defined as the direct staffing rate;

546.26 (7) for program plan support, multiply the result of clause (6) by one plus the
546.27 program plan support ratio in subdivision 5, paragraph (d), clause (4);

546.28 (8) for employee-related expenses, multiply the result of clause (7) by one plus the
546.29 employee-related cost ratio in subdivision 5, paragraph (d), clause (3);

546.30 (9) for client programming and supports, multiply the result of clause (8) by one plus
546.31 the client programming and support ratio in subdivision 5, paragraph (d), clause (5);

546.32 (10) for program facility costs, add \$8.30 per week with consideration of staffing
546.33 ratios to meet individual needs;

546.34 (11) for adult day bath services, add \$7.01 per 15 minute unit;

546.35 (12) this is the subtotal rate;

547.1 (13) sum the standard general and administrative rate, the program-related expense
547.2 ratio, and the absence and utilization factor ratio;

547.3 (14) divide the result of clause (12) by one minus the result of clause (13). This is
547.4 the total payment amount;

547.5 (15) for transportation provided as part of day training and habilitation for an
547.6 individual who does not require a lift, add:

547.7 (i) \$10.50 for a trip between zero and ten miles for a nonshared ride in a vehicle
547.8 without a lift, \$8.83 for a shared ride in a vehicle without a lift, and \$9.25 for a shared
547.9 ride in a vehicle with a lift;

547.10 (ii) \$15.75 for a trip between 11 and 20 miles for a nonshared ride in a vehicle
547.11 without a lift, \$10.58 for a shared ride in a vehicle without a lift, and \$11.88 for a shared
547.12 ride in a vehicle with a lift;

547.13 (iii) \$25.75 for a trip between 21 and 50 miles for a nonshared ride in a vehicle
547.14 without a lift, \$13.92 for a shared ride in a vehicle without a lift, and \$16.88 for a shared
547.15 ride in a vehicle with a lift; or

547.16 (iv) \$33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a
547.17 lift, \$16.50 for a shared ride in a vehicle without a lift. and \$20.75 for a shared ride in a
547.18 vehicle with a lift;

547.19 (16) for transportation provide as part of day training and habilitation for an
547.20 individual who does require a lift, add:

547.21 (i) \$19.05 for a trip between zero and ten miles for a nonshared ride in a vehicle with
547.22 a lift, and \$15.05 for a shared ride in a vehicle with a lift;

547.23 (ii) \$32.16 for a trip between 11 and 20 miles for a nonshared ride in a vehicle with a
547.24 lift, and \$28.16 for a shared ride in a vehicle with a lift;

547.25 (iii) \$58.76 for a trip between 21 and 50 miles for a nonshared ride in a vehicle with
547.26 a lift, and \$58.76 for a shared ride in a vehicle with a lift; or

547.27 (iv) \$80.93 for a trip of 51 miles or more for a nonshared ride in a vehicle with a
547.28 lift, and \$80.93 for a shared ride in a vehicle with a lift.

547.29 **Subd. 8. Payments for unit-based services with programming.** Payments for
547.30 unit-based with program services, including behavior programming, housing access
547.31 coordination, in-home family support, independent living skills training, hourly supported
547.32 living services, and supported employment provided to an individual outside of any day or
547.33 residential service plan must be calculated as follows, unless the services are authorized
547.34 separately under subdivision 6 or 7:

547.35 (1) determine the number of units of service to meet a recipient's needs;

- 548.1 (2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics
548.2 Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;
548.3 (3) for a recipient requiring customization for deaf and hard-of-hearing language
548.4 accessibility under subdivision 12, add the customization rate provided in subdivision 12
548.5 to the result of clause (2). This is defined as the customized direct-care rate;
548.6 (4) multiply the number of direct staff hours by the appropriate staff wage in
548.7 subdivision 5, paragraph (a), or the customized direct care rate;
548.8 (5) multiply the number of direct staff hours by the product of the supervision span
548.9 of control ratio in subdivision 5, paragraph (e), clause (1), and the appropriate supervision
548.10 wage in subdivision 5, paragraph (a), clause (17);
548.11 (6) combine the results of clauses (4) and (5), and multiply the result by one plus
548.12 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (e),
548.13 clause (2). This is defined as the direct staffing rate;
548.14 (7) for program plan support, multiply the result of clause (6) by one plus the
548.15 program plan supports ratio in subdivision 5, paragraph (e), clause (4);
548.16 (8) for employee-related expenses, multiply the result of clause (7) by one plus the
548.17 employee-related cost ratio in subdivision 5, paragraph (e), clause (3);
548.18 (9) for client programming and supports, multiply the result of clause (8) by one plus
548.19 the client programming and supports ratio in subdivision 5, paragraph (e), clause (5);
548.20 (10) this is the subtotal rate;
548.21 (11) sum the standard general and administrative rate, the program-related expense
548.22 ratio, and the absence and utilization factor ratio; and
548.23 (12) divide the result of clause (10) by one minus the result of clause (11). This is
548.24 the total payment amount.
- 548.25 **Subd. 9. Payments for unit-based services without programming.** Payments
548.26 for unit-based without program services, including night supervision, personal support,
548.27 respite, and companion care provided to an individual outside of any day or residential
548.28 service plan must be calculated as follows unless the services are authorized separately
548.29 under subdivision 6 or 7:
- 548.30 (1) for all services except respite, determine the number of units of service to meet
548.31 a recipient's needs;
548.32 (2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
548.33 Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;
548.34 (3) for a recipient requiring customization for deaf and hard-of-hearing language
548.35 accessibility under subdivision 12, add the customization rate provided in subdivision 12
548.36 to the result of clause (2). This is defined as the customized direct care rate;

- 549.1 (4) multiply the number of direct staff hours by the appropriate staff wage in
549.2 subdivision 5 or the customized direct care rate;
- 549.3 (5) multiply the number of direct staff hours by the product of the supervision span
549.4 of control ratio in subdivision 5, paragraph (f), clause (1), and the appropriate supervision
549.5 wage in subdivision 5, paragraph (a), clause (17);
- 549.6 (6) combine the results of clauses (4) and (5), and multiply the result by one plus
549.7 the employee vacation, sick, and training allowance ratio in, subdivision 5, paragraph (f),
549.8 clause (2). This is defined as the direct staffing rate;
- 549.9 (7) for program plan support, multiply the result of clause (6) by one plus the
549.10 program plan support ratio in subdivision 5, paragraph (f), clause (4);
- 549.11 (8) for employee-related expenses, multiply the result of clause (7) by one plus the
549.12 employee-related cost ratio in subdivision 5, paragraph (f), clause (3);
- 549.13 (9) for client programming and supports, multiply the result of clause (8) by one plus
549.14 the client programming and support ratio in subdivision 5, paragraph (f), clause (5);
- 549.15 (10) this is the subtotal rate;
- 549.16 (11) sum the standard general and administrative rate, the program-related expense
549.17 ratio, and the absence and utilization factor ratio;
- 549.18 (12) divide the result of clause (10) by one minus the result of clause (11). This is
549.19 the total payment amount;
- 549.20 (13) for respite services, determine the number of daily units of service to meet an
549.21 individual's needs;
- 549.22 (14) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics
549.23 Minnesota-specific rate or rates derived by the commissioner as provided in subdivision 5;
- 549.24 (15) for a recipient requiring deaf and hard-of-hearing customization under
549.25 subdivision 12, add the customization rate provided in subdivision 12 to the result of
549.26 clause (14). This is defined as the customized direct care rate;
- 549.27 (16) multiply the number of direct staff hours by the appropriate staff wage in
549.28 subdivision 5, paragraph (a);
- 549.29 (17) multiply the number of direct staff hours by the product of the supervisory span
549.30 of control ratio in subdivision 5, paragraph (g), clause (1), and the appropriate supervision
549.31 wage in subdivision 5, paragraph (a), clause (17);
- 549.32 (18) combine the results of clauses (16) and (17), and multiply the result by one plus
549.33 the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (g),
549.34 clause (2). This is defined as the direct staffing rate;
- 549.35 (19) for employee-related expenses, multiply the result of clause (18) by one plus
549.36 the employee-related cost ratio in subdivision 5, paragraph (g), clause (3).

550.1 (20) this is the subtotal rate;

550.2 (21) sum the standard general and administrative rate, the program-related expense
550.3 ratio, and the absence and utilization factor ratio; and

550.4 (22) divide the result of clause (20) by one minus the result of clause (21). This is
550.5 the total payment amount.

550.6 Subd. 10. **Updating payment values and additional information.** (a) The
550.7 commissioner shall develop and implement uniform procedures to refine terms and update
550.8 or adjust values used to calculate payment rates in this section. For calendar year 2014,
550.9 the commissioner shall use the values, terms, and procedures provided in this section.

550.10 (b) The commissioner shall work with stakeholders to assess efficacy of values
550.11 and payment rates. The commissioner shall report back to the legislature with proposed
550.12 changes for component values and recommendations for revisions on the schedule
550.13 provided in paragraphs (c) and (d).

550.14 (c) The commissioner shall work with stakeholders to continue refining a
550.15 subset of component values, which are to be referred to as interim values, and report
550.16 recommendations to the legislature by February 15, 2014. Interim component values are:
550.17 transportation rates for day training and habilitation; transportation for adult day, structured
550.18 day, and prevocational services; geographic difference factor; day program facility rate;
550.19 services where monitoring technology replaces staff time; shared services for independent
550.20 living skills training; and supported employment and billing for indirect services.

550.21 (d) The commissioner shall report and make recommendations to the legislature on:
550.22 February 15, 2015; February 15, 2017; February 15, 2019; and February 15, 2021. After
550.23 2021 reports shall be provided on a four-year cycle.

550.24 (e) The commissioner shall provide a public notice via LISTSERV in October of
550.25 each year beginning October 1, 2014. The notice shall contain information detailing
550.26 legislatively approved changes in: calculation values, including derived wage rates
550.27 and related employee and administrative factors; services utilization; county and tribal
550.28 allocation changes; and information on adjustments to be made to calculation values
550.29 and timing of those adjustments. Information in this notice shall be effective January
550.30 1 of the following year.

550.31 Subd. 11. **Payment implementation.** Upon implementation of the payment
550.32 methodologies under this section, those payment rates supersede rates established in county
550.33 contracts for recipients receiving waiver services under section 256B.092 or 256B.49.

550.34 Subd. 12. **Customization of rates for individuals.** (a) For persons determined to
550.35 have higher needs based on being deaf or hard-of-hearing, the direct-care costs must be
550.36 increased by an adjustment factor prior to calculating the rate under subdivisions 6, 7, 8,

551.1 and 9. The customization rate with respect to deaf or hard-of-hearing persons shall be
 551.2 \$2.50 per hour for waiver recipients who meet the respective criteria as determined by
 551.3 the commissioner.

551.4 (b) For the purposes of this section, "deaf or hard-of-hearing" means:

551.5 (1) the person has a developmental disability and an assessment score which
 551.6 indicates a hearing impairment that is severe or that the person has no useful hearing;

551.7 (2) the person has a developmental disability and an expressive communications
 551.8 score that indicates the person uses single signs or gestures, uses an augmentative
 551.9 communication aid, or does not have functional communication, or the person's expressive
 551.10 communications is unknown; and

551.11 (3) the person has a developmental disability and a communication score which
 551.12 indicates the person comprehends signs, gestures and modeling prompts or does not
 551.13 comprehend verbal, visual or gestural communication or that the person's receptive
 551.14 communication score is unknown; or

551.15 (4) the person receives long-term care services and has an assessment score that
 551.16 indicates they hear only very loud sounds, have no useful hearing, or a determination
 551.17 cannot be made; and the person receives long-term care services and has an assessment
 551.18 that indicates the person communicates needs with sign language, symbol board, written
 551.19 messages, gestures or an interpreter; communicates with inappropriate content, makes
 551.20 garbled sounds or displays echolalia, or does not communicate needs.

551.21 Subd. 13. **Transportation.** The commissioner shall require that the purchase
 551.22 of transportation services be cost-effective and be limited to market rates where the
 551.23 transportation mode is generally available and accessible.

551.24 Subd. 14. **Exceptions.** (a) In a format prescribed by the commissioner, lead
 551.25 agencies must identify individuals with exceptional needs that cannot be met under the
 551.26 disability waiver rate system. The commissioner shall use that information to evaluate
 551.27 and, if necessary, approve an alternative payment rate for those individuals.

551.28 (b) Lead agencies must submit exceptions requests to the state.

551.29 (c) An application for a rate exception may be submitted for the following criteria:

551.30 (1) an individual has service needs that cannot be met through additional units
 551.31 of service; or

551.32 (2) an individual's rate determined under subdivisions 6, 7, 8, and 9 results in an
 551.33 individual being discharged.

551.34 (d) Exception requests will include the following information:

551.35 (1) the service needs required by each individual that are not accounted for in
 551.36 subdivisions 6, 7, 8, and 9;

552.1 (2) the service rate requested and the difference from the rate determined in
552.2 subdivisions 6, 7, 8, and 9;

552.3 (3) a basis for the underlying costs used for the rate exception and any accompanying
552.4 documentation;

552.5 (4) the duration of the rate exception; and

552.6 (5) any contingencies for approval.

552.7 (e) Approved rate exceptions shall be managed within lead agency allocations under
552.8 sections 256B.092 and 256B.49.

552.9 (f) Individual disability waiver recipients may request that a lead agency submit an
552.10 exceptions request. A lead agency that denies such a request shall notify the individual
552.11 waiver recipient of its decision and the reasons for denying the request in writing no later
552.12 than 30 days after the individual's request has been made.

552.13 (g) The commissioner shall determine whether to approve or deny an exception
552.14 request no more than 30 days after receiving the request. If the commissioner denies the
552.15 request, the commissioner shall notify the lead agency and the individual disability waiver
552.16 recipient in writing of the reasons for the denial.

552.17 (h) The individual disability waiver recipient may appeal any denial of an exception
552.18 request by either the lead agency or the commissioner, pursuant to sections 256.045 and
552.19 256.0451. When the denial of an exception request results in the proposed demission of a
552.20 waiver recipient from a residential or day habilitation program, the commissioner shall
552.21 issue a temporary stay of demission, when requested by the disability waiver recipient,
552.22 consistent with the provisions of section 256.045, subdivisions 4a and 6, paragraph (c).
552.23 The temporary stay shall remain in effect until the lead agency can provide an informed
552.24 choice of appropriate, alternative services to the disability waiver.

552.25 (i) Providers may petition lead agencies to update values that were entered
552.26 incorrectly or erroneously into the rate management system, based on past service level
552.27 discussions and determination in subdivision 4, without applying for a rate exception.

552.28 Subd. 15. **County or tribal allocations.** (a) Upon implementation of the disability
552.29 waiver rates management system on January 1, 2014, the commissioner shall establish
552.30 a method of tracking and reporting the fiscal impact of the disability waiver rates
552.31 management system on individual lead agencies.

552.32 (b) Beginning January 1, 2014, and continuing through full implementation on
552.33 December 31, 2017, the commissioner shall make annual adjustments to lead agencies'
552.34 home and community-based waived service budget allocations to adjust for rate
552.35 differences and the resulting impact on county allocations upon implementation of the
552.36 disability waiver rates system.

553.1 Subd. 16. **Budget neutrality adjustment.** The commissioner shall calculate the
553.2 total spending for all home and community-based waiver services under the payments as
553.3 defined in subdivisions 6, 7, 8, and 9 for all recipients as of July 1, 2013, and compare it to
553.4 spending for services defined for subdivisions 6, 7, 8, and 9 under current law. If spending
553.5 for services in one particular subdivision differs, there will be a percentage adjustment
553.6 to increase or decrease individual rates for the services defined in each subdivision so
553.7 aggregate spending matches projections under current law.

553.8 Subd. 17. **Implementation.** (a) On January 1, 2014, the commissioner shall fully
553.9 implement the calculation of rates for waived services under sections 256B.092 and
553.10 256B.49 without additional legislative approval.

553.11 (b) The commissioner shall phase in the application of rates determined in
553.12 subdivisions 6 to 9 for two years.

553.13 (c) The commissioner shall preserve rates in effect on December 31, 2013, for
553.14 the two-year period.

553.15 (d) The commissioner shall calculate and measure the difference in cost per
553.16 individual using the historical rate and the rates under subdivisions 6 to 9 for all existing
553.17 individuals. This measurement shall occur statewide, and for individuals in every county.
553.18 The commissioner shall provide the results of this analysis by county for calendar year
553.19 2014 to the legislative committees and divisions with jurisdiction over health and human
553.20 services finance by February 15, 2015.

553.21 (e) The commissioner shall calculate the average rate per unit for each service by
553.22 county. For individuals enrolled after January 1, 2014, individuals will receive the higher
553.23 of the rate produced under subdivisions 6 to 9, or the by-county average rate.

553.24 (f) On January 1, 2016, the rates determined in subdivisions 6 to 9 shall be applied.

553.25 Sec. 7. **REPEALER.**

553.26 Minnesota Statutes 2012, section 256B.4913, subdivisions 1, 2, 3, and 4, is repealed.

553.27 **ARTICLE 14**

553.28 **HEALTH AND HUMAN SERVICES APPROPRIATIONS**

553.29 Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

553.30 The sums shown in the columns marked "Appropriations" are appropriated to the
553.31 agencies and for the purposes specified in this article. The appropriations are from the
553.32 general fund, or another named fund, and are available for the fiscal years indicated
553.33 for each purpose. The figures "2014" and "2015" used in this article mean that the
553.34 appropriations listed under them are available for the fiscal year ending June 30, 2014, or

555.1 federal administrative reimbursement is
555.2 appropriated to the commissioner may be
555.3 transferred to the special revenue fund.

555.4 **ARRA Supplemental Nutrition Assistance**

555.5 **Benefit Increases.** The funds provided for
555.6 food support benefit increases under the
555.7 Supplemental Nutrition Assistance Program
555.8 provisions of the American Recovery and
555.9 Reinvestment Act (ARRA) of 2009 must be
555.10 used for benefit increases beginning July 1,
555.11 2009.

555.12 **Supplemental Nutrition Assistance**

555.13 **Program Employment and Training.**

555.14 (1) Notwithstanding Minnesota Statutes,
555.15 sections 256D.051, subdivisions 1a, 6b,
555.16 and 6c, and 256J.626, federal Supplemental
555.17 Nutrition Assistance employment and
555.18 training funds received as reimbursement of
555.19 MFIP consolidated fund grant expenditures
555.20 for diversionary work program participants
555.21 and child care assistance program
555.22 expenditures must be deposited in the general
555.23 fund. The amount of funds must be limited to
555.24 \$4,900,000 per year in fiscal years 2014 and
555.25 2015, and to \$4,400,000 per year in fiscal
555.26 years 2016 and 2017, contingent on approval
555.27 by the federal Food and Nutrition Service.

555.28 (2) Consistent with the receipt of the federal
555.29 funds, the commissioner may adjust the
555.30 level of working family credit expenditures
555.31 claimed as TANF maintenance of effort.
555.32 Notwithstanding any contrary provision in
555.33 this article, this rider expires June 30, 2017.

555.34 **TANF Maintenance of Effort.** (a) In order
555.35 to meet the basic maintenance of effort

556.1 (MOE) requirements of the TANF block grant
556.2 specified under Code of Federal Regulations,
556.3 title 45, section 263.1, the commissioner may
556.4 only report nonfederal money expended for
556.5 allowable activities listed in the following
556.6 clauses as TANF/MOE expenditures:

556.7 (1) MFIP cash, diversionary work program,
556.8 and food assistance benefits under Minnesota
556.9 Statutes, chapter 256J;

556.10 (2) the child care assistance programs
556.11 under Minnesota Statutes, sections 119B.03
556.12 and 119B.05, and county child care
556.13 administrative costs under Minnesota
556.14 Statutes, section 119B.15;

556.15 (3) state and county MFIP administrative
556.16 costs under Minnesota Statutes, chapters
556.17 256J and 256K;

556.18 (4) state, county, and tribal MFIP
556.19 employment services under Minnesota
556.20 Statutes, chapters 256J and 256K;

556.21 (5) expenditures made on behalf of legal
556.22 noncitizen MFIP recipients who qualify for
556.23 the MinnesotaCare program under Minnesota
556.24 Statutes, chapter 256L;

556.25 (6) qualifying working family credit
556.26 expenditures under Minnesota Statutes,
556.27 section 290.0671;

556.28 (7) qualifying Minnesota education credit
556.29 expenditures under Minnesota Statutes,
556.30 section 290.0674; and

556.31 (8) qualifying Head Start expenditures under
556.32 Minnesota Statutes, section 119A.50.

556.33 (b) The commissioner shall ensure that
556.34 sufficient qualified nonfederal expenditures

557.1 are made each year to meet the state's
557.2 TANF/MOE requirements. For the activities
557.3 listed in paragraph (a), clauses (2) to
557.4 (8), the commissioner may only report
557.5 expenditures that are excluded from the
557.6 definition of assistance under Code of
557.7 Federal Regulations, title 45, section 260.31.

557.8 (c) For fiscal years beginning with state fiscal
557.9 year 2003, the commissioner shall ensure
557.10 that the maintenance of effort used by the
557.11 commissioner of management and budget
557.12 for the February and November forecasts
557.13 required under Minnesota Statutes, section
557.14 16A.103, contains expenditures under
557.15 paragraph (a), clause (1), equal to at least 16
557.16 percent of the total required under Code of
557.17 Federal Regulations, title 45, section 263.1.

557.18 (d) The requirement in Minnesota Statutes,
557.19 section 256.011, subdivision 3, that federal
557.20 grants or aids secured or obtained under that
557.21 subdivision be used to reduce any direct
557.22 appropriations provided by law, do not apply
557.23 if the grants or aids are federal TANF funds.

557.24 (e) For the federal fiscal years beginning on
557.25 or after October 1, 2007, the commissioner
557.26 may not claim an amount of TANF/MOE in
557.27 excess of the 75 percent standard in Code
557.28 of Federal Regulations, title 45, section
557.29 263.1(a)(2), except:

557.30 (1) to the extent necessary to meet the 80
557.31 percent standard under Code of Federal
557.32 Regulations, title 45, section 263.1(a)(1),
557.33 if it is determined by the commissioner
557.34 that the state will not meet the TANF work
557.35 participation target rate for the current year;

558.1 (2) to provide any additional amounts
 558.2 under Code of Federal Regulations, title 45,
 558.3 section 264.5, that relate to replacement of
 558.4 TANF funds due to the operation of TANF
 558.5 penalties; and

558.6 (3) to provide any additional amounts that
 558.7 may contribute to avoiding or reducing
 558.8 TANF work participation penalties through
 558.9 the operation of the excess MOE provisions
 558.10 of Code of Federal Regulations, title 45,
 558.11 section 261.43(a)(2).

558.12 For the purposes of clauses (1) to (3),
 558.13 the commissioner may supplement the
 558.14 MOE claim with working family credit
 558.15 expenditures or other qualified expenditures
 558.16 to the extent such expenditures are otherwise
 558.17 available after considering the expenditures
 558.18 allowed in this subdivision and subdivisions
 558.19 2 and 3.

558.20 (f) Notwithstanding any contrary provision
 558.21 in this article, paragraphs (a) to (e) expire
 558.22 June 30, 2017.

558.23 **Working Family Credit Expenditures**
 558.24 **as TANF/MOE.** The commissioner may
 558.25 claim as TANF maintenance of effort up to
 558.26 \$6,707,000 per year of working family credit
 558.27 expenditures in each fiscal year.

558.28 **Subd. 2. Working Family Credit to be Claimed**
 558.29 **for TANF/MOE**

558.30 The commissioner may count the following
 558.31 amounts of working family credit
 558.32 expenditures as TANF/MOE:

558.33 (1) fiscal year 2014, \$45,196,000;

558.34 (2) fiscal year 2015, \$41,885,000;

559.1 (3) fiscal year 2016, \$8,869,000; and

559.2 (4) fiscal year 2017, \$11,181,000.

559.3 **Subd. 3. TANF Transfer to Federal Child Care**
 559.4 **and Development Fund**

559.5 (a) The following TANF fund amounts

559.6 are appropriated to the commissioner for

559.7 purposes of MFIP/transition year child care

559.8 assistance under Minnesota Statutes, section

559.9 119B.05:

559.10 (1) fiscal year 2014; \$14,020,000; and

559.11 (2) fiscal year 2015, \$14,020,000.

559.12 (b) The commissioner shall authorize the

559.13 transfer of sufficient TANF funds to the

559.14 federal child care and development fund to

559.15 meet this appropriation and shall ensure that

559.16 all transferred funds are expended according

559.17 to federal child care and development fund

559.18 regulations.

559.19 **Subd. 4. Central Office**

559.20 The amounts that may be spent from this

559.21 appropriation for each purpose are as follows:

559.22 **(a) Operations**

559.23 Appropriations by Fund

559.24 <u>General</u>	<u>88,876,000</u>	<u>91,189,000</u>
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559.25 <u>State Government</u>		
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559.26 <u>Special Revenue</u>	<u>3,690,000</u>	<u>4,790,000</u>
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559.27 <u>Health Care Access</u>	<u>12,453,000</u>	<u>13,004,000</u>
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559.28 <u>Federal TANF</u>	<u>100,000</u>	<u>100,000</u>
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559.29 **DHS Receipt Center Accounting.** The

559.30 commissioner is authorized to transfer

559.31 appropriations to, and account for DHS

559.32 receipt center operations in, the special

559.33 revenue fund.

560.1 **Administrative Recovery; Set-Aside.** The
560.2 commissioner may invoice local entities
560.3 through the SWIFT accounting system as an
560.4 alternative means to recover the actual cost
560.5 of administering the following provisions:
560.6 (1) Minnesota Statutes, section 125A.744,
560.7 subdivision 3;
560.8 (2) Minnesota Statutes, section 245.495,
560.9 paragraph (b);
560.10 (3) Minnesota Statutes, section 256B.0625,
560.11 subdivision 20, paragraph (k);
560.12 (4) Minnesota Statutes, section 256B.0924,
560.13 subdivision 6, paragraph (g);
560.14 (5) Minnesota Statutes, section 256B.0945,
560.15 subdivision 4, paragraph (d); and
560.16 (6) Minnesota Statutes, section 256F.10,
560.17 subdivision 6, paragraph (b).
560.18 **Systems Modernization.** The following
560.19 amounts are appropriated for transfer to
560.20 the state systems account authorized in
560.21 Minnesota Statutes, section 256.014:
560.22 (1) \$1,825,000 in fiscal year 2014 and
560.23 \$2,502,000 in fiscal year 2015 is for the
560.24 state share of Medicaid-allocated costs of
560.25 the health insurance exchange information
560.26 technology and operational structure. The
560.27 funding base is \$3,222,000 in fiscal year 2016
560.28 and \$3,037,000 in fiscal year 2017 but shall
560.29 not be included in the base thereafter; and
560.30 (2) \$1,000,000 in fiscal year 2014 and
560.31 \$2,000,000 in fiscal year 2015 are for the
560.32 modernization and streamlining of agency
560.33 eligibility and child support systems. The
560.34 funding base is \$2,000,000 in fiscal year

561.1 2016 and \$2,000,000 in fiscal year 2017 but
 561.2 shall not be included in the base thereafter.

561.3 The unexpended balance of the \$1,000,000
 561.4 appropriation in fiscal year 2014 and the
 561.5 \$2,000,000 appropriation in fiscal year 2015
 561.6 must be transferred from the Department of
 561.7 Human Services state systems account to
 561.8 the Office of Enterprise Technology when
 561.9 the Office of Enterprise Technology has
 561.10 negotiated a federally approved internal
 561.11 service fund rates and billing process with
 561.12 sufficient internal accounting controls to
 561.13 properly maximize federal reimbursement
 561.14 to Minnesota for human services system
 561.15 modernization projects, but not later than
 561.16 June 30, 2015.

561.17 If contingent funding is fully or partially
 561.18 disbursed under **article.., section ..**, and
 561.19 transferred to the state systems account, the
 561.20 unexpended balance of that appropriation
 561.21 must be transferred to the Office of Enterprise
 561.22 Technology in accordance with this clause.
 561.23 Contingent funding must not exceed
 561.24 \$14,297,000 for the biennium.

561.25 **Base Adjustment.** The general fund base
 561.26 is increased by \$646,000 in fiscal year 2016
 561.27 and \$461,000 in fiscal year 2017. The health
 561.28 access fund base is decreased by \$551,000 in
 561.29 fiscal years 2016 and 2017.

561.30 **(b) Children and Families**

	<u>Appropriations by Fund</u>	
561.32 <u>General</u>	<u>7,569,000</u>	<u>7,519,000</u>
561.33 <u>Federal TANF</u>	<u>2,282,000</u>	<u>2,282,000</u>

561.34 **Financial Institution Data Match and**
 561.35 **Payment of Fees.** The commissioner is

562.1 authorized to allocate up to \$310,000 each
 562.2 year in fiscal years 2014 and 2015 from the
 562.3 PRISM special revenue account to make
 562.4 payments to financial institutions in exchange
 562.5 for performing data matches between account
 562.6 information held by financial institutions
 562.7 and the public authority's database of child
 562.8 support obligors as authorized by Minnesota
 562.9 Statutes, section 13B.06, subdivision 7.

562.10 **(c) Health Care**

562.11		<u>Appropriations by Fund</u>	
562.12	<u>General</u>	<u>13,643,000</u>	<u>13,227,000</u>
562.13	<u>Health Care Access</u>	<u>24,602,000</u>	<u>26,728,000</u>

562.14 **Base Adjustment.** The general fund base
 562.15 is decreased by \$86,000 in fiscal year 2016
 562.16 and by \$86,000 in fiscal year 2017. The
 562.17 health care access fund base is increased
 562.18 by \$7,956,000 in fiscal year 2016 and by
 562.19 \$6,354,000 in fiscal year 2017.

562.20 **(d) Continuing Care**

562.21		<u>Appropriations by Fund</u>	
562.22	<u>General</u>	<u>17,361,000</u>	<u>17,426,000</u>
562.23	<u>State Government</u>		
562.24	<u>Special Revenue</u>	<u>125,000</u>	<u>125,000</u>

562.25 **Base Adjustment.** The general fund base is
 562.26 decreased by \$1,000 in fiscal year 2016 and
 562.27 by \$1,000 in fiscal year 2017.

562.28 **(e) Chemical and Mental Health**

562.29		<u>Appropriations by Fund</u>	
562.30	<u>General</u>	<u>4,313,000</u>	<u>4,179,000</u>
562.31	<u>Lottery Prize Fund</u>	<u>157,000</u>	<u>157,000</u>

562.32 **Subd. 5. Forecasted Programs**

562.33 The amounts that may be spent from this
 562.34 appropriation for each purpose are as follows:

563.1 **(a) MFIP/DWP**563.2 Appropriations by Fund563.3 General 73,742,000 79,302,000563.4 Federal TANF 80,342,000 76,851,000563.5 **(b) MFIP Child Care Assistance** 62,030,000 64,731,000563.6 **(c) General Assistance** 54,787,000 56,068,000563.7 **General Assistance Standard.** The563.8 commissioner shall set the monthly standard563.9 of assistance for general assistance units563.10 consisting of an adult recipient who is563.11 childless and unmarried or living apart563.12 from parents or a legal guardian at \$203.563.13 The commissioner may reduce this amount563.14 according to Laws 1997, chapter 85, article563.15 3, section 54.563.16 **Emergency General Assistance.** The563.17 amount appropriated for emergency general563.18 assistance funds is limited to no more563.19 than \$6,729,812 in fiscal year 2014 and563.20 \$6,729,812 in fiscal year 2015. Funds563.21 to counties shall be allocated by the563.22 commissioner using the allocation method in563.23 Minnesota Statutes, section 256D.06.563.24 **(d) MN Supplemental Assistance** 38,646,000 39,821,000563.25 **(e) Group Residential Housing** 140,447,000 149,984,000563.26 **(f) MinnesotaCare** 299,290,000 261,930,000563.27 This appropriation is from the health care563.28 access fund.563.29 **(g) Medical Assistance** 4,616,756,000 4,621,963,000563.30 **Medical Eligibility for Inmates in Medical**563.31 **Institutions.** The commissioner of human563.32 services shall execute an interagency563.33 agreement with the commissioner of

564.1 corrections to recover the medical assistance
 564.2 cost attributable to medical assistance
 564.3 eligibility for inmates of public institutions
 564.4 admitted to hospitals on an inpatient basis.
 564.5 The amount that must be recovered from
 564.6 the Department of Corrections shall include
 564.7 all state medical assistance costs, including
 564.8 administrative costs, attributable to inmates
 564.9 under state and county jurisdiction admitted
 564.10 to hospitals on an inpatient basis.

564.11 **Support Services for Deaf and**

564.12 **Hard-of-Hearing.** \$121,000 in fiscal
 564.13 year 2014 and \$141,000 in fiscal year 2015;
 564.14 and \$10,000 in fiscal year 2014 and \$13,000
 564.15 in fiscal year 2015 are from the health care
 564.16 access fund for the hospital reimbursement
 564.17 increase in Minnesota Statutes, section
 564.18 256.969, subdivision 29, paragraph (b).

564.19 **(h) Alternative Care**

47,058,000

47,078,000

564.20 **Alternative Care Transfer.** Any money
 564.21 allocated to the alternative care program that
 564.22 is not spent for the purposes indicated does
 564.23 not cancel but shall be transferred to the
 564.24 medical assistance account.

564.25 **(i) CD Treatment Fund**

81,440,000

74,875,000

564.26 **Balance Transfer.** The commissioner must
 564.27 transfer \$18,188,000 from the consolidated
 564.28 chemical dependency treatment fund to the
 564.29 general fund by September 30, 2013.

564.30 **Subd. 6. Grant Programs**

564.31 The amounts that may be spent from this
 564.32 appropriation for each purpose are as follows:

564.33 **(a) Support Services Grants**

565.1	<u>Appropriations by Fund</u>		
565.2	<u>General</u>	<u>11,333,000</u>	<u>11,133,000</u>
565.3	<u>Federal TANF</u>	<u>94,611,000</u>	<u>94,611,000</u>
565.4	<u>Paid Work Experience.</u> \$1,159,000 in fiscal		
565.5	year 2014, and \$1,009,000 in fiscal year		
565.6	<u>2015 is from the general fund for paid work</u>		
565.7	<u>experience for long-term MFIP recipients.</u>		
565.8	<u>Paid work includes full and partial wage</u>		
565.9	<u>subsidies and other related services such as</u>		
565.10	<u>job development, marketing, preworksite</u>		
565.11	<u>training, job coaching, and postplacement</u>		
565.12	<u>services. Unexpended funds for fiscal year</u>		
565.13	<u>2014 do not cancel but are available for this</u>		
565.14	<u>purpose in fiscal year 2015.</u>		
565.15	<u>Work Study Funding for MFIP</u>		
565.16	<u>Participants.</u> \$250,000 each year is from		
565.17	<u>the general fund to pilot work study jobs for</u>		
565.18	<u>MFIP recipients in approved postsecondary</u>		
565.19	<u>education programs. This is a onetime</u>		
565.20	<u>appropriation. Unexpended funds for fiscal</u>		
565.21	<u>year 2014 do not cancel but are available for</u>		
565.22	<u>this purpose in fiscal year 2015.</u>		
565.23	<u>Base Adjustment.</u> The general fund base is		
565.24	<u>decreased by \$2,418,000 in fiscal years 2016</u>		
565.25	<u>and 2017.</u>		
565.26	<u>(b) Basic Sliding Fee Child Care Assistance</u>		
565.27	<u>Grants</u>	<u>39,039,000</u>	<u>40,391,000</u>
565.28	<u>(c) Child Care Development Grants</u>	<u>1,487,000</u>	<u>1,487,000</u>
565.29	<u>(d) Child Support Enforcement Grants</u>	<u>50,000</u>	<u>50,000</u>
565.30	<u>Federal Child Support Demonstration</u>		
565.31	<u>Grants.</u> Federal administrative		
565.32	<u>reimbursement resulting from the federal</u>		
565.33	<u>child support grant expenditures authorized</u>		
565.34	<u>under United States Code, title 42, section</u>		

567.1	<u>(g) Child and Economic Support Grants</u>	<u>20,972,000</u>	<u>20,973,000</u>
567.2	<u>Minnesota Food Assistance Program.</u>		
567.3	<u>Unexpended funds for the Minnesota food</u>		
567.4	<u>assistance program for fiscal year 2014 do</u>		
567.5	<u>not cancel but are available for this purpose</u>		
567.6	<u>in fiscal year 2015.</u>		
567.7	<u>Family Assets for Independence. \$250,000</u>		
567.8	<u>each year is for the Family Assets for</u>		
567.9	<u>Independence Minnesota program. This</u>		
567.10	<u>appropriation is available in either year of the</u>		
567.11	<u>biennium and may be transferred between</u>		
567.12	<u>fiscal years.</u>		
567.13	<u>Food Shelf Programs. \$500,000 in fiscal</u>		
567.14	<u>year 2014 and \$500,000 in fiscal year</u>		
567.15	<u>2015 are for food shelf programs under</u>		
567.16	<u>Minnesota Statutes, section 256E.34. If the</u>		
567.17	<u>appropriation for either year is insufficient,</u>		
567.18	<u>the appropriation for the other year is</u>		
567.19	<u>available for it.</u>		
567.20	<u>Homeless Youth Act. \$4,000,000 is for</u>		
567.21	<u>purposes of Minnesota Statutes, section</u>		
567.22	<u>256K.45.</u>		
567.23	<u>Safe Harbor Shelter and Housing.</u>		
567.24	<u>\$2,000,000 in fiscal year 2014 and</u>		
567.25	<u>\$2,000,000 in fiscal year 2015 is for a safe</u>		
567.26	<u>harbor shelter and housing fund for housing</u>		
567.27	<u>and supportive services for youth who are</u>		
567.28	<u>sexually exploited.</u>		
567.29	<u>(h) Health Care Grants</u>		
567.30	<u>Appropriations by Fund</u>		
567.31	<u>General</u>	<u>190,000</u>	<u>190,000</u>
567.32	<u>Health Care Access</u>	<u>190,000</u>	<u>1,413,000</u>
567.33	<u>Emergency Medical Assistance Referral</u>		
567.34	<u>and Assistance Grants. (a) The</u>		

568.1 commissioner of human services shall
568.2 award grants to nonprofit programs that
568.3 provide immigration legal services based
568.4 on indigency to provide legal services for
568.5 immigration assistance to individuals with
568.6 emergency medical conditions or complex
568.7 and chronic health conditions who are not
568.8 currently eligible for medical assistance
568.9 or other public health care programs, but
568.10 who may meet eligibility requirements with
568.11 immigration assistance.

568.12 (b) The grantees, in collaboration with
568.13 hospitals and safety net providers, shall
568.14 provide referral assistance to connect
568.15 individuals identified in paragraph (a) with
568.16 alternative resources and services to assist in
568.17 meeting their health care needs. \$100,000
568.18 is appropriated in fiscal year 2014 and
568.19 \$100,000 in fiscal year 2015. This is a
568.20 onetime appropriation.

568.21 (c) The programs receiving grants under
568.22 paragraph (a) must report to the commissioner
568.23 of human services the number of individuals
568.24 who were provided immigration assistance
568.25 under the grants and who were eventually
568.26 determined to be eligible for medical
568.27 assistance or another public health care
568.28 program due to this assistance. The
568.29 commissioner shall report this information to
568.30 the chairs and ranking minority members of
568.31 the legislative committees with jurisdiction
568.32 over human services policy and finance by
568.33 January 1, 2015.

568.34 **Base Adjustment.** The general fund is
568.35 decreased by \$100,000 in fiscal year 2016

569.1 and \$100,000 in fiscal year 2017. The health
 569.2 care access fund is decreased by \$1,223,000
 569.3 in fiscal years 2016 and 2017.

569.4 **(i) Aging and Adult Services Grants** 22,043,000 22,910,000

569.5 **Base Adjustment.** The general fund is
 569.6 increased by \$5,000 in fiscal year 2016 and
 569.7 \$5,000 in fiscal year 2017.

569.8 **(j) Deaf and Hard-of-Hearing Grants** 1,767,000 1,767,000

569.9 **(k) Disabilities Grants** 17,844,000 17,426,000

569.10 **Advocating Change Together.** \$310,000 in
 569.11 fiscal year 2014 is for a grant to Advocating
 569.12 Change Together (ACT) to maintain and
 569.13 promote services for persons with intellectual
 569.14 and developmental disabilities throughout
 569.15 the state. Of this appropriation:

569.16 (1) \$120,000 is for direct costs associated
 569.17 with the delivery and evaluation of
 569.18 peer-to-peer training programs administered
 569.19 throughout the state, focusing on education,
 569.20 employment, housing, transportation, and
 569.21 voting;

569.22 (2) \$100,000 is for delivery of statewide
 569.23 conferences focusing on leadership and
 569.24 skill development within the disability
 569.25 community; and

569.26 (3) \$90,000 is for administrative and general
 569.27 operating costs associated with managing
 569.28 or maintaining facilities, program delivery,
 569.29 staff, and technology. This is a onetime
 569.30 appropriation.

569.31 **Base Adjustment.** The general fund base
 569.32 is increased by \$448,000 in fiscal year 2016
 569.33 and by \$470,000 in fiscal year 2017.

570.1 **(l) Adult Mental Health Grants**570.2 Appropriations by Fund

570.3	<u>General</u>	<u>70,777,000</u>	<u>69,108,000</u>
570.4	<u>Health Care Access</u>	<u>750,000</u>	<u>750,000</u>
570.5	<u>Lottery Prize</u>	<u>1,733,000</u>	<u>1,733,000</u>

570.6 **Problem Gambling.** \$225,000 in fiscal year
570.7 2014 and \$225,000 in fiscal year 2015 is
570.8 appropriated from the lottery prize fund for a
570.9 grant to the state affiliate recognized by the
570.10 National Council on Problem Gambling. The
570.11 affiliate must provide services to increase
570.12 public awareness of problem gambling,
570.13 education and training for individuals and
570.14 organizations providing effective treatment
570.15 services to problem gamblers and their
570.16 families, and research relating to problem
570.17 gambling.

570.18 **Funding Usage.** Up to 75 percent of a fiscal
570.19 year's appropriations for adult mental health
570.20 grants may be used to fund allocations in that
570.21 portion of the fiscal year ending December
570.22 31.

570.23 **Base Adjustment.** The general fund base is
570.24 decreased by \$4,197,000 in fiscal year 2016
570.25 and by \$4,197,000 in fiscal year 2017.

570.26 **(m) Child Mental Health Grants** 15,233,000 15,234,000

570.27 **Mental Health First Aid Training.** \$45,000
570.28 for the biennium ending June 30, 2015, isto
570.29 train teachers, social service personnel, law
570.30 enforcement, and others who come into
570.31 contact with children with mental illnesses,
570.32 in children and adolescents mental health
570.33 first aid training.

571.1 **Funding Usage.** Up to 75 percent of a fiscal
 571.2 year's appropriation for child mental health
 571.3 grants may be used to fund allocations in that
 571.4 portion of the fiscal year ending December
 571.5 31.

571.6 <u>(n) CD Treatment Support Grants</u>	<u>1,996,000</u>	<u>1,636,000</u>
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571.7 **SBIRT Training.** \$300,000 each year is
 571.8 for grants to train primary care clinicians to
 571.9 provide substance abuse brief intervention
 571.10 and referral to treatment (SBIRT). This is a
 571.11 onetime appropriation.

571.12 **Fetal Alcohol Syndrome Grant. (a)**
 571.13 \$360,000 is appropriated in fiscal year 2014
 571.14 to the commissioner of human services for
 571.15 a grant to the Minnesota Organization on
 571.16 Fetal Alcohol Syndrome (MOFAS). This is a
 571.17 onetime appropriation.

571.18 **(b) Grant money must be used to reduce the**
 571.19 incidence of FASD and other prenatal drug
 571.20 related effects in children in Minnesota by
 571.21 identifying and serving pregnant women
 571.22 suspected of or known to use or abuse
 571.23 alcohol or other drugs. The grant recipient
 571.24 must provide intensive services to chemically
 571.25 dependent women in order to increase
 571.26 positive birth outcomes and report to the
 571.27 commissioner necessary data to prepare
 571.28 the required report to the legislature. The
 571.29 organization may retain two percent of the
 571.30 grant money for administrative costs.

571.31 **(c) A grant recipient must report to the**
 571.32 commissioner of human services annually
 571.33 by January 15 on the services and programs
 571.34 funded by the appropriation. The report must
 571.35 include measurable outcomes, including

572.1 the number of pregnant women served and
 572.2 toxic-free babies born in the previous year.

572.3 **Base Adjustment.** The general fund base is
 572.4 decreased by \$300,000 in fiscal year 2016
 572.5 and \$300,000 in fiscal year 2017.

572.6 **Subd. 7. State-Operated Services**

572.7 **Transfer Authority Related to**
 572.8 **State-Operated Services.** Money
 572.9 appropriated for state-operated services
 572.10 may be transferred between fiscal years
 572.11 of the biennium with the approval of the
 572.12 commissioner of management and budget.

572.13 The amounts that may be spent from the
 572.14 appropriation for each purpose are as follows:

572.15	<u>(a) SOS Mental Health</u>	<u>115,738,000</u>	<u>115,738,000</u>
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572.16 **Dedicated Receipts Available.** Of the
 572.17 revenue received under Minnesota Statutes,
 572.18 section 246.18, subdivision 8, paragraph
 572.19 (a), \$1,000,000 each year is available for
 572.20 the purposes of paragraph (b), clause (1),
 572.21 of that subdivision, \$1,000,000 each year
 572.22 is available to transfer to the adult mental
 572.23 health budget activity for the purposes of
 572.24 paragraph (b), clause (2), of that subdivision,
 572.25 and up to \$2,713,000 each year is available
 572.26 for the purposes of paragraph (b), clause (3),
 572.27 of that subdivision.

572.28	<u>(b) SOS MN Security Hospital</u>	<u>69,582,000</u>	<u>69,582,000</u>
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572.29	<u>Subd. 8. Sex Offender Program</u>	<u>76,769,000</u>	<u>79,745,000</u>
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572.30 **Transfer Authority Related to Minnesota**
 572.31 **Sex Offender Program.** Money
 572.32 appropriated for the Minnesota sex offender
 572.33 program may be transferred between fiscal

573.1 years of the biennium with the approval of the
 573.2 commissioner of management and budget.

573.3 Subd. 9. Technical Activities 80,440,000 80,829,000

573.4 This appropriation is from the federal TANF
 573.5 fund.

573.6 Base Adjustment. The federal TANF fund
 573.7 base is increased by \$278,000 in fiscal year
 573.8 2016 and increased by \$651,000 in fiscal
 573.9 year 2017.

573.10 Subd. 10. Transfer.

573.11 Sec. 3. COMMISSIONER OF HEALTH

573.12 Subdivision 1. Total Appropriation \$ 158,912,000 \$ 155,115,000

573.13 Appropriations by Fund

	<u>2014</u>	<u>2015</u>
573.14		
573.15 <u>General</u>	<u>79,476,000</u>	<u>74,256,000</u>
573.16 <u>State Government</u>		
573.17 <u>Special Revenue</u>	<u>48,680,000</u>	<u>50,703,000</u>
573.18 <u>Health Care Access</u>	<u>18,743,000</u>	<u>18,143,000</u>
573.19 <u>Federal TANF</u>	<u>11,713,000</u>	<u>11,713,000</u>
573.20 <u>Special Revenue</u>	<u>300,000</u>	<u>300,000</u>

573.21 The amounts that may be spent for each
 573.22 purpose are specified in the following
 573.23 subdivisions.

573.24 Subd 2. Health Improvement

573.25 Appropriations by Fund

573.26 <u>General</u>	<u>52,864,000</u>	<u>47,644,000</u>
573.27 <u>State Government</u>		
573.28 <u>Special Revenue</u>	<u>1,033,000</u>	<u>1,033,000</u>
573.29 <u>Health Care Access</u>	<u>9,219,000</u>	<u>9,219,000</u>
573.30 <u>Federal TANF</u>	<u>11,713,000</u>	<u>11,713,000</u>

573.31 Statewide Health Improvement Program.

573.32 \$7,500,000 in fiscal year 2014 and
 573.33 \$7,500,000 in fiscal year 2015 is from the
 573.34 health care access fund for the statewide

574.1 health improvement program under
574.2 Minnesota Statutes, section 145.986.

574.3 Of the appropriation in fiscal year 2014,
574.4 \$10,000 is for the commissioner of
574.5 management and budget to develop and
574.6 implement a return on taxpayer investment
574.7 (ROTI) methodology and practice related
574.8 to the state health improvement program.

574.9 In developing the methodology, the
574.10 commissioner shall assess ROTI initiatives
574.11 in other states, design implications for
574.12 Minnesota, and identify one or more
574.13 Minnesota institutions of higher education
574.14 capable of providing rigorous and consistent
574.15 nonpartisan institutional support for ROTI.

574.16 The commissioner shall consult with
574.17 representatives of other state agencies,
574.18 counties, legislative staff, Minnesota
574.19 institutions of higher education, and other
574.20 stakeholders in developing the methodology.

574.21 The commissioner shall report the results to
574.22 the chairs and ranking minority members of
574.23 the legislative committees and divisions with
574.24 jurisdiction over health and human services,
574.25 taxes, and finance by March 15, 2015.

574.26 **Statewide Cancer Surveillance System. Of**
574.27 **the general fund appropriation, \$350,000 in**
574.28 **fiscal year 2014 and \$350,000 in fiscal year**
574.29 **2015 is to develop and implement a new**
574.30 **cancer reporting system under Minnesota**
574.31 **Statutes, sections 144.671 to 144.69. Any**
574.32 **information technology development or**
574.33 **support costs necessary for the cancer**
574.34 **surveillance system must be incorporated**
574.35 **into the agency's service level agreement and**
574.36 **paid to the Office of Enterprise Technology.**

- 575.1 **Minnesota Poison Information Center.**
- 575.2 \$250,000 in fiscal year 2014 and \$250,000
- 575.3 in fiscal year 2015 from the general fund
- 575.4 is for regional poison information centers
- 575.5 according to Minnesota Statutes, section
- 575.6 145.93.
- 575.7 **Text Message Suicide Prevention Program.**
- 575.8 \$1,500,000 for the biennium ending June 30,
- 575.9 2015, is for a grant to a nonprofit organization
- 575.10 to establish and implement a statewide text
- 575.11 message suicide prevention program. The
- 575.12 program shall implement a suicide prevention
- 575.13 counseling text line designed to use text
- 575.14 messaging to connect with crisis counselors
- 575.15 and to obtain emergency information and
- 575.16 referrals to local resources in the local
- 575.17 community. The program shall include
- 575.18 training within schools and communities to
- 575.19 encourage the use of the program.
- 575.20 **Support Services for Deaf and**
- 575.21 **Hard-of-Hearing.** (a) \$365,000 in fiscal
- 575.22 year 2014 and \$349,000 in fiscal year 2015
- 575.23 are for providing support services to families
- 575.24 as required under Minnesota Statutes, section
- 575.25 144.966, subdivision 3a.
- 575.26 (b) \$164,000 in fiscal year 2014 and \$156,000
- 575.27 in fiscal year 2015 are for home-based
- 575.28 education in American Sign Language for
- 575.29 families with children who are deaf or have
- 575.30 hearing loss, as required under Minnesota
- 575.31 Statutes, section 144.966, subdivision 3a.
- 575.32 **Reproductive Health Strategic Plan to**
- 575.33 **Reduce Health Disparities for Somali**
- 575.34 **Women.** To the extent funds are available
- 575.35 for fiscal years 2014 and 2015 for grants

576.1 provided pursuant to Minnesota Statutes,
576.2 section 145.928, the commissioner
576.3 shall provide a grant to a Somali-based
576.4 organization located in the metropolitan area
576.5 to develop a reproductive health strategic
576.6 plan to eliminate reproductive health
576.7 disparities for Somali women. The plan shall
576.8 develop initiatives to provide educational
576.9 and information resources to health care
576.10 providers, community organizations, and
576.11 Somali women to ensure effective interaction
576.12 with Somali culture and western medicine
576.13 and the delivery of appropriate health care
576.14 services, and the achievement of better health
576.15 outcomes for Somali women. The plan must
576.16 engage health care providers, the Somali
576.17 community, and Somali health-centered
576.18 organizations. The commissioner shall
576.19 submit a report to the chairs and ranking
576.20 minority members of the senate and house
576.21 committees with jurisdiction over health
576.22 policy on the strategic plan developed under
576.23 this grant for eliminating reproductive health
576.24 disparities for Somali women. The report
576.25 must be submitted by February 15, 2014.

576.26 **TANF Appropriations.** (1) \$1,156,000 of
576.27 the TANF funds is appropriated each year of
576.28 the biennium to the commissioner for family
576.29 planning grants under Minnesota Statutes,
576.30 section 145.925.

576.31 (2) \$3,579,000 of the TANF funds is
576.32 appropriated each year of the biennium to
576.33 the commissioner for home visiting and
576.34 nutritional services listed under Minnesota
576.35 Statutes, section 145.882, subdivision 7,
576.36 clauses (6) and (7). Funds must be distributed

577.1 to community health boards according to
 577.2 Minnesota Statutes, section 145A.131,
 577.3 subdivision 1.

577.4 (3) \$2,000,000 of the TANF funds is
 577.5 appropriated each year of the biennium to
 577.6 the commissioner for decreasing racial and
 577.7 ethnic disparities in infant mortality rates
 577.8 under Minnesota Statutes, section 145.928,
 577.9 subdivision 7.

577.10 (4) \$4,978,000 of the TANF funds is
 577.11 appropriated each year of the biennium to the
 577.12 commissioner for the family home visiting
 577.13 grant program according to Minnesota
 577.14 Statutes, section 145A.17. \$4,000,000 of the
 577.15 funding must be distributed to community
 577.16 health boards according to Minnesota
 577.17 Statutes, section 145A.131, subdivision 1.

577.18 \$978,000 of the funding must be distributed
 577.19 to tribal governments based on Minnesota
 577.20 Statutes, section 145A.14, subdivision 2a.

577.21 (5) The commissioner may use up to 6.23
 577.22 percent of the funds appropriated each fiscal
 577.23 year to conduct the ongoing evaluations
 577.24 required under Minnesota Statutes, section
 577.25 145A.17, subdivision 7, and training and
 577.26 technical assistance as required under
 577.27 Minnesota Statutes, section 145A.17,
 577.28 subdivisions 4 and 5.

577.29 **TANF Carryforward.** Any unexpended
 577.30 balance of the TANF appropriation in the
 577.31 first year of the biennium does not cancel but
 577.32 is available for the second year.

577.33 **Subd. 3. Policy Quality and Compliance**

577.34	<u>Appropriations by Fund</u>		
577.35	<u>General</u>	<u>9,391,000</u>	<u>9,391,000</u>

578.1	<u>State Government</u>		
578.2	<u>Special Revenue</u>	<u>14,434,000</u>	<u>16,454,000</u>
578.3	<u>Health Care Access</u>	<u>9,524,000</u>	<u>8,924,000</u>

578.4 **Base Level Adjustment.** The state
 578.5 government special revenue fund base shall
 578.6 be reduced by \$2,000 in fiscal year 2017. The
 578.7 health care access base shall be increased by
 578.8 \$600,000 in fiscal year 2016 and decreased
 578.9 by \$600,000 in fiscal year 2017.

578.10 **Subd. 4. Health Protection**

578.11	<u>Appropriations by Fund</u>		
578.12	<u>General</u>	<u>9,449,000</u>	<u>9,449,000</u>
578.13	<u>State Government</u>		
578.14	<u>Special Revenue</u>	<u>33,213,000</u>	<u>33,216,000</u>
578.15	<u>Special Revenue</u>	<u>300,000</u>	<u>300,000</u>

578.16 **Infectious Disease Laboratory.** Of the
 578.17 general fund appropriation, \$200,000 in
 578.18 fiscal year 2014 and \$200,000 in fiscal year
 578.19 2015 are to monitor infectious disease trends
 578.20 and investigate infectious disease outbreaks.

578.21 **Surveillance for Elevated Blood Lead**
 578.22 **Levels.** Of the general fund appropriation,
 578.23 \$100,000 in fiscal year 2014 and \$100,000
 578.24 in fiscal year 2015 are for the blood lead
 578.25 surveillance system under Minnesota
 578.26 Statutes, section 144.9502.

578.27 **Base Level Adjustment.** The state
 578.28 government special revenue base is increased
 578.29 by \$6,000 in fiscal year 2016 and by \$13,000
 578.30 in fiscal year 2017.

578.31	<u>Subd. 5. Administrative Support Services</u>	<u>7,772,000</u>	<u>7,772,000</u>
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578.32 **Regional Support for Local Public Health**

578.33 **Departments.** \$350,000 in fiscal year
 578.34 2014 and \$350,000 in fiscal year 2015 is

580.1 of the administrative services unit. The
 580.2 administrative services unit may receive
 580.3 and expend reimbursements for services
 580.4 performed by other agencies.

580.5 **Administrative Services Unit - Volunteer**
 580.6 **Health Care Provider Program.** Of this
 580.7 appropriation, \$150,000 in fiscal year 2014
 580.8 and \$150,000 in fiscal year 2015 are to pay
 580.9 for medical professional liability coverage
 580.10 required under Minnesota Statutes, section
 580.11 214.40.

580.12 **Administrative Services Unit - Contested**
 580.13 **Cases and Other Legal Proceedings.** Of
 580.14 this appropriation, \$200,000 in fiscal year
 580.15 2014 and \$200,000 in fiscal year 2015 are
 580.16 for costs of contested case hearings and other
 580.17 unanticipated costs of legal proceedings
 580.18 involving health-related boards funded
 580.19 under this section. Upon certification of a
 580.20 health-related board to the administrative
 580.21 services unit that the costs will be incurred
 580.22 and that there is insufficient money available
 580.23 to pay for the costs out of money currently
 580.24 available to that board, the administrative
 580.25 services unit is authorized to transfer money
 580.26 from this appropriation to the board for
 580.27 payment of those costs with the approval
 580.28 of the commissioner of management and
 580.29 budget.

580.30 Subd. 9. **Board of Optometry** 107,000 107,000

580.31 Subd. 10. **Board of Pharmacy** 2,555,000 2,555,000

580.32 **Prescription Electronic Reporting.** Of
 580.33 this appropriation, \$356,000 in fiscal year
 580.34 2014 and \$356,000 in fiscal year 2015 from
 580.35 the state government special revenue fund

581.1	<u>are to the board to operate the prescription</u>		
581.2	<u>monitoring program in Minnesota Statutes,</u>		
581.3	<u>section 152.126.</u>		
581.4	<u>Subd. 11. Board of Physical Therapy</u>	<u>346,000</u>	<u>346,000</u>
581.5	<u>Subd. 12. Board of Podiatry</u>	<u>76,000</u>	<u>76,000</u>
581.6	<u>Subd. 13. Board of Psychology</u>	<u>847,000</u>	<u>847,000</u>
581.7	<u>Subd. 14. Board of Social Work</u>	<u>1,054,000</u>	<u>1,054,000</u>
581.8	<u>Subd. 15. Board of Veterinary Medicine</u>	<u>230,000</u>	<u>230,000</u>
581.9	<u>Subd. 16. Board of Behavioral Health and</u>		
581.10	<u>Therapy</u>	<u>415,000</u>	<u>415,000</u>
581.11	<u>Sec. 5. EMERGENCY MEDICAL SERVICES</u>		
581.12	<u>REGULATORY BOARD</u>	<u>\$ 2,741,000</u>	<u>\$ 2,741,000</u>
581.13	<u>Regional Grants. \$585,000 in fiscal year</u>		
581.14	<u>2014 and \$585,000 in fiscal year 2015 are</u>		
581.15	<u>for regional emergency medical services</u>		
581.16	<u>programs, to be distributed equally to the</u>		
581.17	<u>eight emergency medical service regions.</u>		
581.18	<u>Cooper/Sams Volunteer Ambulance</u>		
581.19	<u>Program. \$700,000 in fiscal year 2014 and</u>		
581.20	<u>\$700,000 in fiscal year 2015 are for the</u>		
581.21	<u>Cooper/Sams volunteer ambulance program</u>		
581.22	<u>under Minnesota Statutes, section 144E.40.</u>		
581.23	<u>(a) Of this amount, \$611,000 in fiscal year</u>		
581.24	<u>2014 and \$611,000 in fiscal year 2015</u>		
581.25	<u>are for the ambulance service personnel</u>		
581.26	<u>longevity award and incentive program under</u>		
581.27	<u>Minnesota Statutes, section 144E.40.</u>		
581.28	<u>(b) Of this amount, \$89,000 in fiscal year</u>		
581.29	<u>2014 and \$89,000 in fiscal year 2015 are</u>		
581.30	<u>for the operations of the ambulance service</u>		
581.31	<u>personnel longevity award and incentive</u>		
581.32	<u>program under Minnesota Statutes, section</u>		
581.33	<u>144E.40.</u>		

582.1 **Ambulance Training Grant.** \$361,000 in
 582.2 fiscal year 2014 and \$361,000 in fiscal year
 582.3 2015 are for training grants.

582.4 **EMSRB Board Operations.** \$1,095,000 in
 582.5 fiscal year 2014 and \$1,095,000 in fiscal year
 582.6 2015 are for operations.

582.7 Sec. 6. **COUNCIL ON DISABILITY** \$ 614,000 \$ 614,000

582.8 Sec. 7. **OMBUDSMAN FOR MENTAL**
 582.9 **HEALTH AND DEVELOPMENTAL**
 582.10 **DISABILITIES** \$ 1,654,000 \$ 1,654,000

582.11 Sec. 8. **OMBUDSPERSON FOR FAMILIES** \$ 333,000 \$ 334,000

582.12 Sec. 9. Minnesota Statutes 2012, section 256.01, subdivision 34, is amended to read:

582.13 Subd. 34. **Federal administrative reimbursement dedicated.** Federal
 582.14 administrative reimbursement resulting from the following activities is appropriated to the
 582.15 commissioner for the designated purposes:

- 582.16 (1) reimbursement for the Minnesota senior health options project; ~~and~~
 582.17 (2) reimbursement related to prior authorization and inpatient admission certification
 582.18 by a professional review organization. A portion of these funds must be used for activities
 582.19 to decrease unnecessary pharmaceutical costs in medical assistance; and
 582.20 (3) reimbursement resulting from the federal child support grant expenditures
 582.21 authorized under United States Code, title 42, section 1315.

582.22 Sec. 10. Minnesota Statutes 2012, section 256.01, is amended by adding a subdivision
 582.23 to read:

582.24 Subd. 35. **Federal reimbursement for privatized adoption grants.** Federal
 582.25 reimbursement for privatized adoption grant and foster care recruitment grant expenditures
 582.26 is appropriated to the commissioner for adoption grants and foster care and adoption
 582.27 administrative purposes.

582.28 Sec. 11. Minnesota Statutes 2012, section 256.01, is amended by adding a subdivision
 582.29 to read:

583.1 Subd. 36. DHS receipt center accounting. The commissioner may transfer
583.2 appropriations to, and account for DHS receipt center operations in, the special revenue
583.3 fund.

583.4 Sec. 12. TRANSFERS AND ADJUSTMENTS.

583.5 (a) The appropriation in subdivision 5, paragraph (g), includes up to \$53,391,000
583.6 in fiscal year 2014; \$216,637,000 in fiscal year 2015; \$261,660,000 in fiscal year 2016;
583.7 and \$279,984,000 in fiscal year 2017, for medical assistance eligibility and administration
583.8 changes related to:

583.9 (1) eligibility for children age two to 18 with income up to 275 percent of the federal
583.10 poverty guidelines;

583.11 (2) eligibility for pregnant women with income up to 275 percent of the federal
583.12 poverty guidelines;

583.13 (3) Affordable Care Act enrollment and renewal processes, including elimination
583.14 of six-month renewals, ex parte eligibility reviews, preprinted renewal forms, changes
583.15 in verification requirements, and other changes in the eligibility determination and
583.16 enrollment and renewal process;

583.17 (4) automatic eligibility for children who turn 18 in foster care until they reach age 26;

583.18 (5) eligibility related to spousal impoverishment provisions for waiver recipients; and

583.19 (6) presumptive eligibility determinations by hospitals.

583.20 (b) The commissioner of the Department of Human Services shall determine the
583.21 difference between the actual costs to the medical assistance program attributable to
583.22 the program changes in paragraph (a), clauses (1) to (6), and the costs of paragraph (a),
583.23 clauses (1) to (6), that were estimated during the 2013 legislative session based on data
583.24 from the 2013 February forecast. The costs in this paragraph must be calculated between
583.25 beginning January 1, 2014, and June 30, 2017.

583.26 (c) For each fiscal year from 2014 to 2017, the commissioner of human services
583.27 shall certify the actual cost differences to the medical assistance program determined
583.28 under paragraph (b), and report the costs to the commissioner of management and budget
583.29 by June 30 of each fiscal year. In each fiscal year, the commissioner of management
583.30 and budget shall reduce the transfer from the health care access fund under section 3
583.31 by the amounts determined in paragraph (b). If for any fiscal year the amount of the
583.32 cost difference determined under paragraph (b) exceeds the amount of the transfer under
583.33 section 3, the transfer for that year must be zero.

583.34 (d) This section expires on January 1, 2018.

584.1 Sec. 13. **HEALTH CARE ACCESS FUND TRANSFER TO GENERAL FUND**
584.2 **FOR MINNESOTACARE POPULATIONS.**

584.3 (a) The commissioner of Minnesota management and budget shall transfer from the
584.4 health care access fund to the general fund \$53,391,000 in fiscal year 2014; \$216,637,000
584.5 in fiscal year 2015; \$261,660,000 in fiscal year 2016; and \$279,984,000 in fiscal year
584.6 2017, for medical assistance changes in section 1.

584.7 (b) This section expires on January 1, 2018.

584.8 Sec. 14. **HEALTH CARE ACCESS FUND TRANSFER TO GENERAL FUND.**

584.9 (a) The commissioner of Minnesota management and budget shall transfer from the
584.10 health care access fund to the general fund \$122,543,000 in fiscal year 2014; \$14,631,000
584.11 in fiscal year 2015; \$25,141,000 in fiscal year 2016; and \$32,325,000 in fiscal year 2017.
584.12 For each fiscal year, the commissioner must reduce the amount of the transfer under this
584.13 section according to section 1, paragraph (c).

584.14 (b) This section expires on January 1, 2018.

584.15 Sec. 15. **TRANSFERS.**

584.16 Subdivision 1. **Grants.** The commissioner of human services, with the approval of
584.17 the commissioner of management and budget, may transfer unencumbered appropriation
584.18 balances for the biennium ending June 30, 2015, within fiscal years among the MFIP,
584.19 general assistance, general assistance medical care under Minnesota Statutes 2009
584.20 Supplement, section 256D.03, subdivision 3, medical assistance, MinnesotaCare, MFIP
584.21 child care assistance under Minnesota Statutes, section 119B.05, Minnesota supplemental
584.22 aid, group residential housing programs, the entitlement portion of the chemical
584.23 dependency consolidated treatment fund, and between fiscal years of the biennium. The
584.24 commissioner shall inform the chairs and ranking minority members of the senate Health
584.25 and Human Services Finance Division and the house of representatives Health and Human
584.26 Services Finance Committee quarterly about transfers made under this provision.

584.27 Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative
584.28 money may be transferred within the Departments of Human Services and Health as the
584.29 commissioners consider necessary, with the advance approval of the commissioner of
584.30 management and budget. The commissioner shall inform the chairs and ranking minority
584.31 members of the senate Health and Human Services Finance Division and the house of
584.32 representatives Health and Human Services Finance Committee quarterly about transfers
584.33 made under this provision.

585.1 Sec. 16. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

585.2 The commissioners of health and human services shall not use indirect cost
 585.3 allocations to pay for the operational costs of any program for which they are responsible.

585.4 Sec. 17. **EXPIRATION OF UNCODIFIED LANGUAGE.**

585.5 All uncodified language contained in this article expires on June 30, 2015, unless a
 585.6 different expiration date is explicit.

585.7 Sec. 18. **EFFECTIVE DATE.**

585.8 This article is effective July 1, 2013, unless a different effective date is specified.

585.9 **ARTICLE 15**585.10 **REFORM 2020 CONTINGENT APPROPRIATIONS**585.11 Section 1. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

585.12 The sums shown in the columns marked "Appropriations" are appropriated to the
 585.13 agencies and for the purposes specified in this article. The appropriations are from the
 585.14 general fund, or another named fund, and are available for the fiscal years indicated
 585.15 for each purpose. The figures "2014" and "2015" used in this article mean that the
 585.16 appropriations listed under them are available for the fiscal year ending June 30, 2014, or
 585.17 June 30, 2015, respectively. "The first year" is fiscal year 2014. "The second year" is fiscal
 585.18 year 2015. "The biennium" is fiscal years 2014 and 2015.

585.19
 585.20
 585.21
 585.22

APPROPRIATIONS
Available for the Year
Ending June 30
2014 **2015**

585.23 Sec. 2. **COMMISSIONER OF HUMAN**
585.24 **SERVICES**

585.25 Subdivision 1. **Total Appropriation** 817,000 895,000

585.26 Subd. 2. **Central Office**

585.27 The amounts that may be spent from this
 585.28 appropriation for each purpose are as follows:

585.29 **(a) Operations** 4,688,000 11,643,000

585.30 **Base Adjustment.** The general fund base is
 585.31 decreased by \$11,056,000 in fiscal year 2016
 585.32 and \$11,056,000 in fiscal year 2017.

586.1	<u>(b) Continuing Care</u>	<u>2,334,000</u>	<u>2,556,000</u>
586.2	<u>Base Adjustment.</u> The general fund base is		
586.3	<u>decreased by \$2,000 in fiscal year 2016 and</u>		
586.4	<u>by \$27,000,000 in fiscal year 2017.</u>		
586.5	<u>(c) Group Residential Housing</u>	<u>(1,166,000)</u>	<u>(8,602,000)</u>
586.6	<u>(d) Medical Assistance</u>	<u>(2,647,000)</u>	<u>(2,627,000)</u>
586.7	<u>(e) Alternative Care</u>	<u>(7,386,000)</u>	<u>(6,851,000)</u>
586.8	<u>(f) Child and Community Service Grants</u>	<u>3,000,000</u>	<u>3,000,000</u>
586.9	<u>(g) Aging and Adult Services Grants</u>	<u>1,430,000</u>	<u>1,237,000</u>
586.10	<u>Gaps Analysis.</u> In fiscal year 2014, and		
586.11	<u>in each even-numbered year thereafter,</u>		
586.12	<u>\$435,000 is appropriated to conduct an</u>		
586.13	<u>analysis of gaps in long-term care services</u>		
586.14	<u>under Minnesota Statutes, section 144A.351.</u>		
586.15	<u>This is a biennial appropriation. The base is</u>		
586.16	<u>increased by \$435,000 in fiscal year 2016.</u>		
586.17	<u>Notwithstanding any contrary provisions in</u>		
586.18	<u>this article, this provision does not expire.</u>		
586.19	<u>Base Adjustment.</u> The general fund base is		
586.20	<u>increased by \$597,000 in fiscal year 2016,</u>		
586.21	<u>and by \$100,000 in fiscal year 2017.</u>		
586.22	<u>(h) Disabilities Grants</u>	<u>(564,000)</u>	<u>(539,000)</u>
586.23	<u>Base Adjustment.</u> The general fund base is		
586.24	<u>increased by \$25,000 in fiscal year 2016 and</u>		
586.25	<u>by \$25,000 in fiscal year 2017.</u>		
586.26	Sec. 3. <u>FEDERAL APPROVAL.</u>		
586.27	<u>(a) The implementation of this article is contingent on federal approval.</u>		
586.28	<u>(b) Upon full or partial approval of the waiver application, the commissioner shall</u>		
586.29	<u>develop a plan for implementing the provisions in this article that received federal</u>		
586.30	<u>approval as well as any that do not require federal approval. The plan must:</u>		
586.31	<u>(1) include fiscal estimates for the 2014-2015 and 2016-2017 biennia;</u>		

588.1	<u>This appropriation is from the health care</u>	
588.2	<u>access fund.</u>	
588.3	<u>(g) Medical Assistance Grants</u>	<u>(159,733,000)</u>
588.4	<u>(h) Alternative Care Grants</u>	<u>-0-</u>
588.5	<u>(i) CD Entitlement Grants</u>	<u>2,364,000</u>
588.6	<u>Subd. 3. Technical Activities</u>	<u>417,000</u>
588.7	<u>This appropriation is from the TANF fund.</u>	
588.8	<u>EFFECTIVE DATE.</u> This section is effective the day following final enactment.	

APPENDIX
Article locations in S1034-1

ARTICLE 1	AFFORDABLE CARE ACT IMPLEMENTATION; BETTER HEALTH CARE FOR MORE MINNESOTANS	Page.Ln 3.19
ARTICLE 2	CONTINGENT REFORM 2020; REDESIGNING HOME AND COMMUNITY-BASED SERVICES	Page.Ln 42.10
ARTICLE 3	SAFE AND HEALTHY DEVELOPMENT OF CHILDREN, YOUTH, AND FAMILIES	Page.Ln 111.21
ARTICLE 4	STRENGTHENING CHEMICAL AND MENTAL HEALTH SERVICES	Page.Ln 149.5
ARTICLE 5	DEPARTMENT OF HUMAN SERVICES PROGRAM INTEGRITY AND OFFICE OF INSPECTOR GENERAL	Page.Ln 179.13
ARTICLE 6	HEALTH CARE	Page.Ln 208.24
ARTICLE 7	CONTINUING CARE	Page.Ln 236.1
ARTICLE 8	WAIVER PROVIDER STANDARDS	Page.Ln 274.9
ARTICLE 9	WAIVER PROVIDER STANDARDS TECHNICAL CHANGES	Page.Ln 371.15
ARTICLE 10	HEALTH-RELATED LICENSING BOARDS	Page.Ln 389.7
ARTICLE 11	HOME CARE PROVIDERS	Page.Ln 409.17
ARTICLE 12	HEALTH DEPARTMENT	Page.Ln 475.11
ARTICLE 13	PAYMENT METHODOLOGIES FOR HOME AND COMMUNITY-BASED SERVICES	Page.Ln 538.1
ARTICLE 14	HEALTH AND HUMAN SERVICES APPROPRIATIONS	Page.Ln 553.27
ARTICLE 15	REFORM 2020 CONTINGENT APPROPRIATIONS	Page.Ln 585.9
ARTICLE 16	HUMAN SERVICES FORECAST ADJUSTMENTS	Page.Ln 587.13

62J.693 MEDICAL RESEARCH.

Subdivision 1. **Definitions.** For purposes of this section, health care research means approved clinical, outcomes, and health services investigations.

Subd. 2. **Grant application process.** (a) The commissioner of health shall make recommendations for a process for the submission, review, and approval of research grant applications. The process shall give priority for grants to applications that are intended to gather preliminary data for submission for a subsequent proposal for funding from a federal agency or foundation, which awards research money on a competitive, peer-reviewed basis. Grant recipients must be able to demonstrate the ability to comply with federal regulations on human subjects research in accordance with Code of Federal Regulations, title 45, section 46, and shall conduct the proposed research. Grants may be awarded to the University of Minnesota, the Mayo Clinic, or any other public or private organization in the state involved in medical research. The commissioner shall report to the legislature by January 15, 2000, with recommendations.

(b) The commissioner may appoint a research advisory committee to provide advice and oversight on the grant application process. If the commissioner appoints a research advisory committee, the committee shall be governed by section 15.059 for membership terms and removal of members.

103I.005 DEFINITIONS.

Subd. 20. **Vertical heat exchanger.** "Vertical heat exchanger" means an earth-coupled heating or cooling device consisting of a sealed closed-loop piping system installed vertically in the ground to transfer heat to or from the surrounding earth with no discharge.

144.123 FEES FOR DIAGNOSTIC LABORATORY SERVICES; EXCEPTIONS.

Subd. 2. **Fee amounts.** The commissioner of health shall charge a handling fee prescribed in subdivision 1. The fee shall approximate the costs to the department of handling specimens including reporting, postage, specimen kit preparation, and overhead costs. The fee prescribed in subdivision 1 shall be \$25 per specimen.

144A.46 LICENSURE.

Subdivision 1. **License required.** (a) A home care provider may not operate in the state without a current license issued by the commissioner of health. A home care provider may hold a separate license for each class of home care licensure.

(b) Within ten days after receiving an application for a license, the commissioner shall acknowledge receipt of the application in writing. The acknowledgment must indicate whether the application appears to be complete or whether additional information is required before the application will be considered complete. Within 90 days after receiving a complete application, the commissioner shall either grant or deny the license. If an applicant is not granted or denied a license within 90 days after submitting a complete application, the license must be deemed granted. An applicant whose license has been deemed granted must provide written notice to the commissioner before providing a home care service.

(c) Each application for a home care provider license, or for a renewal of a license, shall be accompanied by a fee to be set by the commissioner under section 144.122 and information sufficient to show that the applicant meets the requirements of licensure.

Subd. 2. **Exemptions.** The following individuals or organizations are exempt from the requirement to obtain a home care provider license:

(1) a person who is licensed as a registered nurse under sections 148.171 to 148.285 and who independently provides nursing services in the home without any contractual or employment relationship to a home care provider or other organization;

(2) a personal care assistant who provides services to only one individual under the medical assistance program as authorized under sections 256B.0625, subdivision 19a, and 256B.04, subdivision 16;

(3) a person or organization that offers, provides, or arranges for personal care assistance services under the medical assistance program as authorized under sections 256B.0625, subdivision 19a, 256B.04, subdivision 16, and 256B.0659;

(4) a person who is licensed under sections 148.65 to 148.78 and who independently provides physical therapy services in the home without any contractual or employment relationship to a home care provider or other organization;

APPENDIX

Repealed Minnesota Statutes: S1034-1

(5) a provider that is licensed by the commissioner of human services to provide semi-independent living services under Minnesota Rules, parts 9525.0500 to 9525.0660 when providing home care services to a person with a developmental disability;

(6) a provider that is licensed by the commissioner of human services to provide home and community-based services under Minnesota Rules, parts 9525.2000 to 9525.2140 when providing home care services to a person with a developmental disability;

(7) a person or organization that provides only home management services, if the person or organization is registered under section 144A.461; or

(8) a person who is licensed as a social worker under chapter 148D and who provides social work services in the home independently and not through any contractual or employment relationship with a home care provider or other organization.

An exemption under this subdivision does not excuse the individual from complying with applicable provisions of the home care bill of rights.

Subd. 3. **Enforcement.** (a) The commissioner may refuse to grant or renew a license, may suspend or revoke a license, or may impose a conditional license for violation of statutes or rules relating to home care services or for conduct detrimental to the welfare of the consumer. A suspension may include terms that must be completed before a suspension is lifted. Terms for a suspension or conditional license may include one or more of the following and the scope of each will be determined by the commissioner:

(1) requiring a consultant to review, evaluate, and make recommended changes to the provider's practices and submit reports to the commissioner at the cost of the provider;

(2) requiring supervision of the provider's practices at the cost of the provider by an unrelated person who has sufficient knowledge and qualifications to oversee the practices and who will submit reports to the commissioner;

(3) requiring the provider or the provider's employees to obtain training at the cost of the provider;

(4) requiring the provider to submit reports to the commissioner;

(5) prohibiting the provider from taking any new clients for a period of time; or

(6) any other action reasonably required to accomplish the purpose of section 144A.45, subdivision 2, and this subdivision.

(b) Prior to any suspension, revocation, or refusal to renew a license, the home care provider shall be entitled to notice and a hearing as provided by sections 14.57 to 14.69. In addition to any other remedy provided by law, the commissioner may, without a prior contested case hearing, temporarily suspend a license or prohibit delivery of services by a provider for not more than 60 days if the commissioner determines that the health or safety of a consumer is in imminent danger, provided: (1) advance notice is given to the provider; (2) after notice, the provider fails to correct the problem; (3) the commissioner has reason to believe that other administrative remedies are not likely to be effective; and (4) there is an opportunity for a contested case hearing within the 60 days.

(c) The process of suspending or revoking a license must include a plan for transferring affected clients to other providers by the provider, which will be monitored by the commissioner. Within three business days of being notified of the final revocation or suspension action, the provider shall provide the commissioner, the lead agencies as defined in section 256B.0911, and the ombudsman for long-term care with the following information: (1) a list of all clients, including full names and all contact information on file; (2) a list of each client's contact person, including full names and all contact information on file; (3) the location of each client; (4) the payor sources for each client, including payor source identification numbers; and (5) for each client, a copy of the client's service agreement, and a list of the types of services being provided. The revocation or suspension notification requirement is satisfied by mailing the notice to the address in the license record. The provider shall cooperate with the commissioner and the lead agencies during the process of transferring care of clients to qualified providers. Within three business days of being notified of the final revocation or suspension action, the provider must notify and disclose to each of the provider's clients, or the client's contact persons, that the commissioner is taking action against the provider's license by providing a copy of the revocation or suspension notice issued by the commissioner. When the home care provider voluntarily discontinues services, the provider will notify the commissioner, lead agencies, and the ombudsman for long-term care about its clients as required in this section.

(d) The owner and managerial officials, as defined in the home care licensure rules, Minnesota Rules, chapter 4668, of a home care provider whose Minnesota license has not been renewed or has been revoked because of noncompliance with applicable law or rule shall not be eligible to apply for nor will be granted a home care license, including other licenses in this chapter, or be given status as an enrolled personal care assistance provider agency or personal

APPENDIX

Repealed Minnesota Statutes: S1034-1

care assistant by the Department of Human Services pursuant to section 256B.0659 for five years following the effective date of the nonrenewal or revocation. If the owner and managerial officials already have enrollment status, their enrollment will be terminated by the Department of Human Services.

(e) The commissioner shall not issue a license to a home care provider if an owner or managerial official includes any individual who was an owner or managerial official of a home care provider whose Minnesota license was not renewed or was revoked as described in paragraph (d) for five years following the effective date of nonrenewal or revocation.

(f) Notwithstanding the provisions of paragraph (a), the commissioner shall not renew, or shall suspend or revoke the license of any home care provider which includes any individual as an owner or managerial official who was an owner or managerial official of a home care provider whose Minnesota license was not renewed or was revoked as described in paragraph (d) for five years following the effective date of the nonrenewal or revocation. The commissioner shall notify the home care provider 30 days in advance of the date of nonrenewal, suspension, or revocation of the license. Within ten days after the receipt of this notification, the home care provider may request, in writing, that the commissioner stay the nonrenewal, revocation, or suspension of the license. The home care provider shall specify the reasons for requesting the stay; the steps that will be taken to attain or maintain compliance with the licensure laws and regulations; any limits on the authority or responsibility of the owners or managerial officials whose actions resulted in the notice of nonrenewal, revocation, or suspension; and any other information to establish that the continuing affiliation with these individuals will not jeopardize client health, safety, or well being. The commissioner shall determine whether the stay will be granted within 30 days of receiving the provider's request. The commissioner may propose additional restrictions or limitations on the provider's license and require that the granting of the stay be contingent upon compliance with those provisions. The commissioner shall take into consideration the following factors when determining whether the stay should be granted:

(1) the threat that continued involvement of the owners and managerial officials in the home care provider poses to client health, safety, and well being;

(2) the compliance history of the home care provider; and

(3) the appropriateness of any limits suggested by the home care provider.

If the commissioner grants the stay, the order shall include any restrictions or limitation on the provider's license. The failure of the provider to comply with any restrictions or limitations shall result in the immediate removal of the stay and the commissioner shall take immediate action to suspend, revoke, or not renew the license.

(g) The provisions contained in paragraphs (d) and (e) shall apply to any nonrenewal or revocation of a home care license occurring after June 1, 1993, the effective date of the home care licensure rules.

(h) For the purposes of this subdivision, owners of a home care provider are those individuals whose ownership interest provides sufficient authority or control to affect or change decisions related to the operation of the home care provider. An owner includes a sole proprietor, a general partner, or any other individual whose individual ownership interest can affect the management and direction of the policies of the home care provider. For the purposes of this subdivision, managerial officials are those individuals who had the responsibility for the ongoing management or direction of the policies, services, or employees of the home care provider relating to the areas of noncompliance which led to the license revocation or nonrenewal.

Subd. 3a. **Injunctive relief.** In addition to any other remedy provided by law, the commissioner may bring an action in district court to enjoin a person who is involved in the management, operation, or control of a home care provider, or an employee of the home care provider from illegally engaging in activities regulated by sections 144A.43 to 144A.47. The commissioner may bring an action under this subdivision in the district court in Ramsey County or in the district in which a home care provider is providing services. The court may grant a temporary restraining order in the proceeding if continued activity by the person who is involved in the management, operation, or control of a home care provider, or by an employee of the home care provider, would create an imminent risk of harm to a recipient of home care services.

Subd. 3b. **Subpoena.** In matters pending before the commissioner under sections 144A.43 to 144A.47, the commissioner may issue subpoenas and compel the attendance of witnesses and the production of all necessary papers, books, records, documents, and other evidentiary material. If a person fails or refuses to comply with a subpoena or order of the commissioner to appear or testify regarding any matter about which the person may be lawfully questioned or to produce any papers, books, records, documents, or evidentiary materials in the matter to be heard, the commissioner may apply to the district court in any district, and the court shall order the person to comply with the commissioner's order or subpoena. The commissioner of health may administer oaths to

APPENDIX

Repealed Minnesota Statutes: S1034-1

witnesses, or take their affirmation. Depositions may be taken in or outside the state in the manner provided by law for the taking of depositions in civil actions. A subpoena or other process or paper may be served upon a named person anywhere within the state by an officer authorized to serve subpoenas in civil actions, with the same fees and mileage and in the same manner as prescribed by law for process issued out of a district court. A person subpoenaed under this subdivision shall receive the same fees, mileage, and other costs that are paid in proceedings in district court.

Subd. 3c. **Time limits for appeals.** To appeal the assessment of civil penalties under section 144A.45, subdivision 2, clause (4), a denial of a waiver or variance, and an action against a license under subdivision 3, a provider must request a hearing no later than 15 days after the provider receives notice of the action.

Subd. 4. **Relation to other regulatory programs.** In the exercise of the authority granted under sections 144A.43 to 144A.47, the commissioner shall not duplicate or replace standards and requirements imposed under another state regulatory program. The commissioner shall not impose additional training or education requirements upon members of a licensed or registered occupation or profession, except as necessary to address or prevent problems that are unique to the delivery of services in the home or to enforce and protect the rights of consumers listed in section 144A.44. The commissioner of health shall not require a home care provider certified under the Medicare program to comply with a rule adopted under section 144A.45 if the home care provider is required to comply with any equivalent federal law or regulation relating to the same subject matter. The commissioner of health shall specify in the rules those provisions that are not applicable to certified home care providers. To the extent possible, the commissioner shall coordinate the inspections required under sections 144A.45 to 144A.47 with the health facility licensure inspections required under sections 144.50 to 144.58 or 144A.10 when the health care facility is also licensed under the provisions of Laws 1987, chapter 378.

Subd. 5. **Prior criminal convictions.** (a) Before the commissioner issues an initial or renewal license, an owner or managerial official shall be required to complete a background study under section 144.057. No person may be involved in the management, operation, or control of a provider, if the person has been disqualified under the provisions of chapter 245C. Individuals disqualified under these provisions can request a reconsideration, and if the disqualification is set aside are then eligible to be involved in the management, operation or control of the provider. For purposes of this section, owners of a home care provider subject to the background check requirement are those individuals whose ownership interest provides sufficient authority or control to affect or change decisions related to the operation of the home care provider. An owner includes a sole proprietor, a general partner, or any other individual whose individual ownership interest can affect the management and direction of the policies of the home care provider. For the purposes of this section, managerial officials subject to the background check requirement are those individuals who provide "direct contact" as defined in section 245C.02, subdivision 11, or those individuals who have the responsibility for the ongoing management or direction of the policies, services, or employees of the home care provider. Data collected under this subdivision shall be classified as private data under section 13.02, subdivision 12.

(b) Employees, contractors, and volunteers of a home care provider or hospice are subject to the background study required by section 144.057. These individuals shall be disqualified under the provisions of chapter 245C. Nothing in this section shall be construed to prohibit a home care provider from requiring self-disclosure of criminal conviction information.

(c) Termination of an employee in good faith reliance on information or records obtained under paragraph (a) or (b) regarding a confirmed conviction does not subject the home care provider to civil liability or liability for unemployment benefits.

144A.461 REGISTRATION.

A person or organization that provides only home management services defined as home care services under section 144A.43, subdivision 3, clause (8), may not operate in the state without a current certificate of registration issued by the commissioner of health. To obtain a certificate of registration, the person or organization must annually submit to the commissioner the name, address, and telephone number of the person or organization and a signed statement declaring that the person or organization is aware that the home care bill of rights applies to their clients and that the person or organization will comply with the bill of rights provisions contained in section 144A.44. A person who provides home management services under this section must, within 120 days after beginning to provide services, attend an orientation session approved by the commissioner that provides training on the bill of rights and an orientation on the aging process and the needs and concerns of elderly and disabled persons. An organization applying for a certificate must also provide the name, business address, and telephone number of each of the

APPENDIX

Repealed Minnesota Statutes: S1034-1

individuals responsible for the management or direction of the organization. The commissioner shall charge an annual registration fee of \$20 for individuals and \$50 for organizations. A home care provider that provides home management services and other home care services must be licensed, but licensure requirements other than the home care bill of rights do not apply to those employees or volunteers who provide only home management services to clients who do not receive any other home care services from the provider. A licensed home care provider need not be registered as a home management service provider, but must provide an orientation on the home care bill of rights to its employees or volunteers who provide home management services. The commissioner may suspend or revoke a provider's certificate of registration or assess fines for violation of the home care bill of rights. Any fine assessed for a violation of the bill of rights by a provider registered under this section shall be in the amount established in the licensure rules for home care providers. As a condition of registration, a provider must cooperate fully with any investigation conducted by the commissioner, including providing specific information requested by the commissioner on clients served and the employees and volunteers who provide services. The commissioner may use any of the powers granted in sections 144A.43 to 144A.47 to administer the registration system and enforce the home care bill of rights under this section.

149A.025 ALKALINE HYDROLYSIS.

For purposes of this chapter, the disposal of a dead human body through the process of alkaline hydrolysis shall be subject to the same licensing requirements and regulations that apply to cremation, crematories, and cremated remains as described in this chapter. The licensing requirements and regulations of this chapter shall also apply to the entities where the process of alkaline hydrolysis occurs and to the remains that result from the alkaline hydrolysis process.

149A.20 LICENSE TO PRACTICE MORTUARY SCIENCE.

Subd. 8. **Fees.** Fees shall be paid to the commissioner of management and budget, state of Minnesota, and shall be credited to the state government special revenue fund in the state treasury.

149A.30 RECIPROCAL LICENSING.

Subd. 2. **Fees.** Fees shall be paid to the commissioner of management and budget, state of Minnesota, and shall be credited to the state government special revenue fund in the state treasury.

149A.40 RENEWAL OF LICENSE TO PRACTICE MORTUARY SCIENCE.

Subd. 8. **Renewal fees.** The renewal fees shall be paid to the commissioner of management and budget, state of Minnesota, and shall be credited to the state government special revenue fund in the state treasury.

149A.45 EMERITUS REGISTRATION FOR MORTUARY SCIENCE PRACTITIONERS.

Subd. 6. **Fees.** The renewal fees shall be paid to the commissioner of management and budget and shall be credited to the state government special revenue fund in the state treasury.

149A.50 LICENSE TO OPERATE A FUNERAL ESTABLISHMENT.

Subd. 6. **Initial licensure and inspection fees.** The licensure and inspection fees shall be paid to the commissioner of management and budget, state of Minnesota, to the credit of the state government special revenue fund in the state treasury.

149A.51 RENEWAL OF LICENSE TO OPERATE A FUNERAL ESTABLISHMENT.

Subd. 7. **Renewal and reinspection fees.** The renewal and reinspection fees shall be paid to the commissioner of management and budget, state of Minnesota, and shall be credited to the state government special revenue fund in the state treasury.

149A.52 LICENSE TO OPERATE A CREMATORY.

APPENDIX

Repealed Minnesota Statutes: S1034-1

Subd. 5a. **Initial licensure and inspection fees.** The licensure and inspection fees shall be paid to the commissioner of management and budget and shall be credited to the state government special revenue fund in the state treasury.

149A.53 RENEWAL OF LICENSE TO OPERATE CREMATORY.

Subd. 9. **Renewal and reinspection fees.** The renewal and reinspection fees shall be paid to the commissioner of management and budget and shall be credited to the state government special revenue fund in the state treasury.

151.19 REGISTRATION; FEES.

Subd. 2. **Nonresident pharmacies.** The board shall require and provide for an annual nonresident special pharmacy registration for all pharmacies located outside of this state that regularly dispense medications for Minnesota residents and mail, ship, or deliver prescription medications into this state. Nonresident special pharmacy registration shall be granted by the board upon payment of any applicable fee specified in section 151.065 and the disclosure and certification by a pharmacy:

(1) that it is licensed in the state in which the dispensing facility is located and from which the drugs are dispensed;

(2) the location, names, and titles of all principal corporate officers and all pharmacists who are dispensing drugs to residents of this state;

(3) that it complies with all lawful directions and requests for information from the Board of Pharmacy of all states in which it is licensed or registered, except that it shall respond directly to all communications from the board concerning emergency circumstances arising from the dispensing of drugs to residents of this state;

(4) that it maintains its records of drugs dispensed to residents of this state so that the records are readily retrievable from the records of other drugs dispensed;

(5) that it cooperates with the board in providing information to the Board of Pharmacy of the state in which it is licensed concerning matters related to the dispensing of drugs to residents of this state;

(6) that during its regular hours of operation, but not less than six days per week, for a minimum of 40 hours per week, a toll-free telephone service is provided to facilitate communication between patients in this state and a pharmacist at the pharmacy who has access to the patients' records; the toll-free number must be disclosed on the label affixed to each container of drugs dispensed to residents of this state; and

(7) that, upon request of a resident of a long-term care facility located within the state of Minnesota, the resident's authorized representative, or a contract pharmacy or licensed health care facility acting on behalf of the resident, the pharmacy will dispense medications prescribed for the resident in unit-dose packaging or, alternatively, comply with the provisions of section 151.415, subdivision 5.

151.25 REGISTRATION OF MANUFACTURERS; FEE; PROHIBITIONS.

The board shall require and provide for the annual registration of every person engaged in manufacturing drugs, medicines, chemicals, or poisons for medicinal purposes, now or hereafter doing business with accounts in this state. Upon a payment of any applicable fee specified in section 151.065, the board shall issue a registration certificate in such form as it may prescribe to such manufacturer. Such registration certificate shall be displayed in a conspicuous place in such manufacturer's or wholesaler's place of business for which it is issued and expire on the date set by the board. It shall be unlawful for any person to manufacture drugs, medicines, chemicals, or poisons for medicinal purposes unless such a certificate has been issued to the person by the board. It shall be unlawful for any person engaged in the manufacture of drugs, medicines, chemicals, or poisons for medicinal purposes, or the person's agent, to sell legend drugs to other than a pharmacy, except as provided in this chapter.

151.45 WHOLESALE DRUG DISTRIBUTOR ADVISORY TASK FORCE.

The board shall appoint a Wholesale Drug Distributor Advisory Task Force composed of five members, to be selected and to perform duties and responsibilities as follows:

(a) One member shall be a pharmacist who is neither a member of the board nor a board employee.

APPENDIX

Repealed Minnesota Statutes: S1034-1

(b) Two members shall be representatives of wholesale drug distributors as defined in section 151.44, paragraph (b).

(c) One member shall be a representative of drug manufacturers.

(d) One member shall be a public member as defined by section 214.02.

(e) The advisory task force shall review and make recommendations to the board on the merit of all rules dealing with wholesale drug distributors and drug manufacturers that are proposed by the board; and no rule affecting wholesale drug distributors proposed by the board shall be adopted without first being submitted to the task force for review and comment.

(f) In making advisory task force appointments, the board shall consider recommendations received from each of the wholesale drug distributor, pharmacist, and drug manufacturer classes cited in paragraphs (a) to (c), and shall adopt rules that provide for solicitation of the recommendations.

151.47 WHOLESALE DRUG DISTRIBUTOR LICENSING REQUIREMENTS.

Subd. 2. **Requirements must conform with federal law.** All requirements set forth in this section shall conform to wholesale drug distributor licensing guidelines formally adopted by the United States Food and Drug Administration; and in case of conflict between a wholesale drug distributor licensing requirement imposed by the board and a Food and Drug Administration wholesale drug distributor guideline, the latter shall control.

151.48 OUT-OF-STATE WHOLESALE DRUG DISTRIBUTOR LICENSING.

(a) It is unlawful for an out-of-state wholesale drug distributor to conduct business in the state without first obtaining a license from the board and paying any applicable fee specified in section 151.065.

(b) Application for an out-of-state wholesale drug distributor license under this section shall be made on a form furnished by the board.

(c) No person acting as principal or agent for any out-of-state wholesale drug distributor may sell or distribute drugs in the state unless the distributor has obtained a license.

(d) The board may adopt regulations that permit out-of-state wholesale drug distributors to obtain a license on the basis of reciprocity to the extent that an out-of-state wholesale drug distributor:

(1) possesses a valid license granted by another state under legal standards comparable to those that must be met by a wholesale drug distributor of this state as prerequisites for obtaining a license under the laws of this state; and

(2) can show that the other state would extend reciprocal treatment under its own laws to a wholesale drug distributor of this state.

245A.655 FEDERAL GRANTS TO ESTABLISH AND MAINTAIN A SINGLE COMMON ENTRY POINT FOR REPORTING MALTREATMENT OF A VULNERABLE ADULT.

(a) The commissioner of human services shall seek federal funding to design, implement, maintain, and evaluate the common entry point for reports of suspected maltreatment made under Minnesota Statutes, section 626.557. The purpose of the federal grant funds is to establish a common entry point with a statewide toll-free telephone number and Web site-based system to report known or suspected abuse, neglect, or exploitation of a vulnerable adult.

(b) A common entry point must be operated in a manner that enables the common entry point staff to:

(1) operate under Minnesota Statutes, section 626.557, subdivision 9, paragraph (b); and subdivision 9a;

(2) when appropriate, refer calls that do not allege the abuse, neglect, or exploitation of a vulnerable adult to other organizations that might better resolve the reporter's concerns; and

(3) immediately identify and locate prior reports of abuse, neglect, or exploitation.

(c) A common entry point must be operated in a manner that enables the commissioner of human services to:

(1) track critical steps in the investigative process to ensure compliance with all requirements for all reports;

(2) maintain data to facilitate the production of aggregate statistical reports for monitoring patterns of abuse, neglect, or exploitation;

(3) serve as a resource for the evaluation, management, and planning of preventative and remedial services for vulnerable adults who have been subject to abuse, neglect, or exploitation;

APPENDIX

Repealed Minnesota Statutes: S1034-1

(4) set standards, priorities, and policies to maximize the efficiency and effectiveness of the common entry point; and

(5) develop a system to manage consumer complaints related to the common entry point.

(d) The commissioner of human services may take the actions necessary to design and implement the common entry point in paragraph (a). Funds awarded by the federal government for the purposes of this section are appropriated to the commissioner of human services.

245B.01 RULE CONSOLIDATION.

This chapter establishes new methods to ensure the quality of services to persons with developmental disabilities, and streamlines and simplifies regulation of services and supports for persons with developmental disabilities. Sections 245B.02 to 245B.07 establish new standards that eliminate duplication and overlap of regulatory requirements by consolidating and replacing rule parts from four program rules. Section 245B.08 authorizes the commissioner of human services to develop and use new regulatory strategies to maintain compliance with the streamlined requirements.

245B.02 DEFINITIONS.

Subdivision 1. **Scope.** The terms used in this chapter have the meanings given them.

Subd. 2. **Applicant.** "Applicant" has the meaning given in section 245A.02, subdivision 3.

Subd. 3. **Case manager.** "Case manager" means the individual designated by the county board under rules of the commissioner to provide case management services as delineated in section 256B.092 or successor provisions.

Subd. 4. **Consumer.** "Consumer" means a person who has been determined eligible to receive and is receiving services or support for persons with developmental disabilities.

Subd. 5. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or the commissioner's designated representative.

Subd. 6. **Day training and habilitation services; developmental disabilities.** "Day training and habilitation services for adults with developmental disabilities" has the meaning given in sections 252.40 to 252.46.

Subd. 7. **Department.** "Department" means the Department of Human Services.

Subd. 8. **Direct service.** "Direct service" means, for a consumer receiving residential-based services, day training and habilitation services, or respite care services, one or more of the following: supervision, assistance, or training.

Subd. 8a. **Emergency.** "Emergency" means any fires, severe weather, natural disasters, power failures, or any event that affects the ordinary daily operation of the program, including, but not limited to, events that threaten the immediate health and safety of a person receiving services and that require calling 911, emergency evacuation, moving to an emergency shelter, or temporary closure or relocation of the program to another facility or service site.

Subd. 9. **Health services.** "Health services" means any service or treatment consistent with the health needs of the consumer, such as medication administration and monitoring, medical, dental, nutritional, health monitoring, wellness education, and exercise.

Subd. 10. **Incident.** "Incident" means an occurrence that affects the ordinary provision of services to a person and includes any of the following:

(1) serious injury as determined by section 245.91, subdivision 6;

(2) a consumer's death;

(3) any medical emergency, unexpected serious illness, or significant unexpected changes in an illness or medical condition, or the mental health status of a person that requires calling 911 or a mental health mobile crisis intervention team, physician treatment, or hospitalization;

(4) a consumer's unauthorized or unexplained absence;

(5) physical aggression by a consumer against another consumer that causes physical pain, injury, or persistent emotional distress, including, but not limited to, hitting, slapping, kicking, scratching, pinching, biting, pushing, and spitting;

(6) any sexual activity between consumers involving force or coercion as defined under section 609.341, subdivisions 3 and 14; or

(7) a report of child or vulnerable adult maltreatment under section 626.556 or 626.557.

Subd. 11. **Individual service plan.** "Individual service plan" has the meaning given in section 256B.092 or successor provisions.

Subd. 12. **Individual who is related.** "Individual who is related" has the meaning given in section 245A.02, subdivision 13.

APPENDIX

Repealed Minnesota Statutes: S1034-1

Subd. 12a. **Interdisciplinary team.** "Interdisciplinary team" means a team composed of the case manager, the person, the person's legal representative and advocate, if any, and representatives of providers of the service areas relevant to the needs of the person as described in the individual service plan.

Subd. 13. **Intermediate care facility for persons with developmental disabilities.** "Intermediate care facility for persons with developmental disabilities" or "ICF/MR" means a residential program licensed to provide services to persons with developmental disabilities under section 252.28 and chapter 245A and a physical facility licensed as a supervised living facility under chapter 144, which together are certified by the Department of Health as an intermediate care facility for persons with developmental disabilities.

Subd. 14. **Least restrictive environment.** "Least restrictive environment" means an environment where services:

(1) are delivered with minimum limitation, intrusion, disruption, or departure from typical patterns of living available to persons without disabilities;

(2) do not subject the consumer or others to unnecessary risks to health or safety; and

(3) maximize the consumer's level of independence, productivity, and inclusion in the community.

Subd. 15. **Legal representative.** "Legal representative" means the parent or parents of a consumer who is under 18 years of age or a guardian, conservator, or guardian ad litem authorized by the court, or other legally authorized representative to make decisions about services for a consumer.

Subd. 16. **License.** "License" has the meaning given in section 245A.02, subdivision 8.

Subd. 17. **License holder.** "License holder" has the meaning given in section 245A.02, subdivision 9.

Subd. 18. **Person with developmental disability.** "Person with developmental disability" means a person who has been diagnosed under section 256B.092 as having substantial limitations in present functioning, manifested as significantly subaverage intellectual functioning, existing concurrently with demonstrated deficits in adaptive behavior, and who manifests these conditions before the person's 22nd birthday. A person with a related condition means a person who meets the diagnostic definition under section 252.27, subdivision 1a.

Subd. 19. **Psychotropic medication use checklist.** "Psychotropic medication use checklist" means the psychotropic medication monitoring checklist and manual used to govern the administration of psychotropic medications. The commissioner may revise or update the psychotropic medication use checklist to comply with legal requirements or to meet professional standards or guidelines in the area of developmental disabilities. For purposes of this chapter, psychotropic medication means any medication prescribed to treat mental illness and associated behaviors or to control or alter behavior. The major classes of psychotropic medication are antipsychotic (neuroleptic), antidepressant, antianxiety, antimania, stimulant, and sedative or hypnotic. Other miscellaneous medications are considered to be a psychotropic medication when they are specifically prescribed to treat a mental illness or to control or alter behavior.

Subd. 20. **Residential-based habilitation.** "Residential-based habilitation" means care, supervision, and training provided primarily in the consumer's own home or place of residence but also including community-integrated activities following the individual service plan. Residential habilitation services are provided in coordination with the provision of day training and habilitation services for those persons receiving day training and habilitation services under sections 252.40 to 252.46.

Subd. 21. **Respite care.** "Respite care" has the meaning given in section 245A.02, subdivision 15.

Subd. 22. **Service.** "Service" means care, supervision, activities, or training designed to achieve the outcomes assigned to the license holder.

Subd. 23. **Semi-independent living services or SILS** "Semi-independent living services" or "SILS" has the meaning given in section 252.275.

Subd. 23a. **Supported employment.** "Supported employment" services include individualized counseling, individualized job development and placement that produce an appropriate job match for the individual and the employer, on-the-job training in work and related work skills required for job performance, ongoing supervision and monitoring of the person's performance, long-term support services to assure job retention, training in related skills essential to obtaining and retaining employment such as the effective use of community resources, use of break and lunch areas, transportation and mobility training, and transportation between the individual's place of residence and the work place when other forms of transportation are unavailable or inaccessible.

APPENDIX

Repealed Minnesota Statutes: S1034-1

Subd. 24. **Volunteer.** "Volunteer" means an individual who, under the direction of the license holder, provides direct services without pay to consumers served by the license holder.

245B.03 APPLICABILITY AND EFFECT.

Subdivision 1. **Applicability.** The standards in this chapter govern services to persons with developmental disabilities receiving services from license holders providing residential-based habilitation; day training and habilitation services for adults; supported employment; semi-independent living services; residential programs that serve more than four consumers, including intermediate care facilities for persons with developmental disabilities; and respite care provided outside the consumer's home for more than four consumers at the same time at a single site.

Subd. 2. **Relationship to other standards governing services at ICF's/MR.** (a) ICF's/MR are exempt from:

- (1) section 245B.04;
- (2) section 245B.06, subdivisions 4 and 6; and
- (3) section 245B.07, subdivisions 4, paragraphs (b) and (c); 7; and 8, paragraph (a), clause (4), and paragraph (b).

(b) License holders also licensed under chapter 144 as a supervised living facility are exempt from section 245B.04.

(c) Residential service sites controlled by license holders licensed under this chapter for home and community-based waived services for four or fewer adults are exempt from compliance with Minnesota Rules, parts 9543.0040, subpart 2, item C; 9555.5505; 9555.5515, items B and G; 9555.5605; 9555.5705; 9555.6125, subparts 3, item C, subitem (2), and 4 to 6; 9555.6185; 9555.6225, subpart 8; 9555.6245; 9555.6255; and 9555.6265; and as provided under section 245B.06, subdivision 2, the license holder is exempt from the program abuse prevention plans and individual abuse prevention plans otherwise required under sections 245A.65, subdivision 2, and 626.557, subdivision 14. The commissioner may approve alternative methods of providing overnight supervision using the process and criteria for granting a variance in section 245A.04, subdivision 9. This chapter does not apply to foster care homes that do not provide residential habilitation services funded under the home and community-based waiver programs defined in section 256B.092.

(d) Residential service sites controlled by license holders licensed under this chapter for home and community-based waived services for four or fewer children are exempt from compliance with Minnesota Rules, parts 2960.3060, subpart 3, items B and C; 2960.3070; 2960.3100, subpart 1, items C, F, and I; and 2960.3210.

(e) The commissioner may exempt license holders from applicable standards of this chapter when the license holder meets the standards under section 245A.09, subdivision 7. License holders that are accredited by an independent accreditation body shall continue to be licensed under this chapter.

(f) License holders governed by sections 245B.02 to 245B.07 must also meet the licensure requirements in chapter 245A.

(g) Nothing in this chapter prohibits license holders from concurrently serving consumers with and without developmental disabilities provided this chapter's standards are met as well as other relevant standards.

(h) The documentation that sections 245B.02 to 245B.07 require of the license holder meets the individual program plan required in section 256B.092 or successor provisions.

Subd. 3. **Continuity of care.** (a) When a consumer changes service to the same type of service provided under a different license held by the same license holder and the policies and procedures under section 245B.07, subdivision 8, are substantially similar, the license holder is exempt from the requirements in sections 245B.06, subdivisions 2, paragraphs (e) and (f), and 4; and 245B.07, subdivision 9, clause (2).

(b) When a direct service staff person begins providing direct service under one or more licenses other than the license for which the staff person initially received the staff orientation requirements under section 245B.07, subdivision 5, the license holder is exempt from all staff orientation requirements under section 245B.07, subdivision 5, except that:

(1) if the service provision location changes, the staff person must receive orientation regarding any policies or procedures under section 245B.07, subdivision 8, that are specific to the service provision location; and

(2) if the staff person provides direct service to one or more consumers for whom the staff person has not previously provided direct service, the staff person must review each consumer's:

- (i) service plans and risk management plan in accordance with section 245B.07, subdivision 5,

APPENDIX

Repealed Minnesota Statutes: S1034-1

paragraph (b), clause (1); and (ii) medication administration in accordance with section 245B.07, subdivision 5, paragraph (b), clause (6).

245B.031 ACCREDITATION, ALTERNATIVE INSPECTION, AND DEEMED COMPLIANCE.

Subdivision 1. **Day training and habilitation or supported employment services programs; alternative inspection status.** (a) A license holder providing day training and habilitation services or supported employment services according to this chapter, with a three-year accreditation from the Commission on Rehabilitation Facilities, that has had at least one on-site inspection by the commissioner following issuance of the initial license, may request alternative inspection status under this section.

(b) The request for alternative inspection status must be made in the manner prescribed by the commissioner, and must include:

(1) a copy of the license holder's application to the Commission on Rehabilitation Facilities for accreditation;

(2) the most recent Commission on Rehabilitation Facilities accreditation survey report; and

(3) the most recent letter confirming the three-year accreditation and approval of the license holder's quality improvement plan.

Based on the request and the accompanying materials, the commissioner may approve alternative inspection status.

(c) Following approval of alternative inspection status, the commissioner may terminate the alternative inspection status or deny a subsequent alternative inspection status if the commissioner determines that any of the following conditions have occurred after approval of the alternative inspection process:

(1) the license holder has not maintained full three-year accreditation;

(2) the commissioner has substantiated maltreatment for which the license holder or facility is determined to be responsible during the three-year accreditation period; and

(3) during the three-year accreditation period, the license holder has been issued an order for conditional license, a fine, suspension, or license revocation that has not been reversed upon appeal.

(d) The commissioner's decision that the conditions for approval for the alternative licensing inspection status have not been met is final and not subject to appeal under the provisions of chapter 14.

Subd. 2. **Programs with three-year accreditation, exempt from certain statutes.** (a) A license holder approved for alternative inspection status under this section is exempt from the requirements under:

(1) section 245B.04;

(2) section 245B.05, subdivisions 5 and 6;

(3) section 245B.06, subdivisions 1, 3, 4, 5, and 6; and

(4) section 245B.07, subdivisions 1, 4, and 6.

(b) Upon receipt of a complaint regarding a requirement under paragraph (a), the commissioner shall refer the complaint to the Commission on Rehabilitation Facilities for possible follow-up.

Subd. 3. **Programs with three-year accreditation, deemed to be in compliance with nonexempt licensing requirements.** (a) License holders approved for alternative inspection status under this section are required to maintain compliance with all licensing standards from which they are not exempt under subdivision 2, paragraph (a).

(b) License holders approved for alternative inspection status under this section shall be deemed to be in compliance with all nonexempt statutes, and the commissioner shall not perform routine licensing inspections.

(c) Upon receipt of a complaint regarding the services of a license holder approved for alternative inspection under this section that is not related to a licensing requirement from which the license holder is exempt under subdivision 2, the commissioner shall investigate the complaint and may take any action as provided under section 245A.06 or 245A.07.

Subd. 4. **Investigations of alleged maltreatment of minors or vulnerable adults.** Nothing in this section changes the commissioner's responsibilities to investigate alleged or suspected maltreatment of a minor under section 626.556 or vulnerable adult under section 626.557.

Subd. 5. **Request to Commission on Rehabilitation Facilities to expand accreditation survey.** The commissioner shall submit a request to the Commission on Rehabilitation Facilities

APPENDIX

Repealed Minnesota Statutes: S1034-1

to routinely inspect for compliance with standards that are similar to the following nonexempt licensing requirements:

- (1) section 245A.65;
- (2) section 245A.66;
- (3) section 245B.05, subdivisions 1, 2, and 7;
- (4) section 245B.055;
- (5) section 245B.06, subdivisions 2, 7, 9, and 10;
- (6) section 245B.07, subdivisions 2, 5, and 8, paragraph (a), clause (7);
- (7) section 245C.04, subdivision 1, paragraph (f);
- (8) section 245C.07;
- (9) section 245C.13, subdivision 2;
- (10) section 245C.20; and
- (11) Minnesota Rules, parts 9525.2700 to 9525.2810.

245B.04 CONSUMER RIGHTS.

Subdivision 1. **License holder's responsibility for consumers' rights.** The license holder must:

(1) provide the consumer or the consumer's legal representative a copy of the consumer's rights on the day that services are initiated and an explanation of the rights in subdivisions 2 and 3 within five working days of service initiation and annually thereafter. Reasonable accommodations shall be made by the license holder to provide this information in other formats as needed to facilitate understanding of the rights by the consumer and the consumer's legal representative, if any;

(2) document the consumer's or the consumer's legal representative's receipt of a copy of the rights and an explanation of the rights; and

(3) ensure the exercise and protection of the consumer's rights in the services provided by the license holder and authorized in the individual service plan.

Subd. 2. **Service-related rights.** A consumer's service-related rights include the right to:

(1) refuse or terminate services and be informed of the consequences of refusing or terminating services;

(2) know, in advance, limits to the services available from the license holder;

(3) know conditions and terms governing the provision of services, including the license holder's policies and procedures related to initiation and termination;

(4) know what the charges are for services, regardless of who will be paying for the services, and be notified upon request of changes in those charges;

(5) know, in advance, whether services are covered by insurance, government funding, or other sources, and be told of any charges the consumer or other private party may have to pay; and

(6) receive licensed services from individuals who are competent and trained, who have professional certification or licensure, as required, and who meet additional qualifications identified in the individual service plan.

Subd. 3. **Protection-related rights.** (a) The consumer's protection-related rights include the right to:

(1) have personal, financial, services, and medical information kept private, and be advised of the license holder's policies and procedures regarding disclosure of such information;

(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 treated with courtesy and respect for the consumer's individuality, mode of communication, and culture, and receive respectful treatment of the consumer's property;

(5) reasonable observance of cultural and ethnic practice and religion;

(6) be free from bias and harassment regarding race, gender, age, disability, spirituality, and sexual orientation;

(7) 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;

(8) 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;

(9) voice grievances, know the contact persons responsible for addressing problems and how to contact those persons;

APPENDIX

Repealed Minnesota Statutes: S1034-1

(10) any procedures for grievance or complaint resolution and the right to appeal under section 256.045;

(11) know the name and address of the state, county, or advocacy agency to contact for additional information or assistance;

(12) assert these rights personally, or have them asserted by the consumer's family or legal representative, without retaliation;

(13) give or withhold written informed consent to participate in any research or experimental treatment;

(14) 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 resident;

(15) receive and send, without interference, uncensored, unopened mail or electronic correspondence or communication;

(16) marital privacy for visits with the consumer's spouse and, if both are residents of the site, the right to share a bedroom and bed;

(17) associate with other persons of the consumer's choice;

(18) personal privacy; and

(19) engage in chosen activities.

(b) Restriction of a person's rights under paragraph (a), clauses (13) to (15), or this paragraph is allowed only if determined necessary to ensure the health, safety, and well-being of the person. Any restriction of these rights must be documented in the service plan for the person and 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, at a minimum, every three months for persons who do not have a legal representative and annually for persons who do have a legal representative from the date of initial approval; 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.

245B.05 CONSUMER PROTECTION STANDARDS.

Subdivision 1. **Environment.** The license holder must:

(1) ensure that services are provided in a safe and hazard-free environment when the license holder is the owner, lessor, or tenant of the service site. All other license holders shall inform the consumer or the consumer's legal representative and case manager about any environmental safety concerns in writing;

(2) ensure that doors are locked or toxic substances or dangerous items normally accessible to persons served by the program are stored in locked cabinets, drawers, or containers only to protect the safety of consumers and not as a substitute for staff supervision or interactions with consumers. If doors are locked or toxic substances or dangerous items normally accessible to persons served by the program are stored in locked cabinets, drawers, or containers, the license holder must justify and document how this determination was made in consultation with the person or the person's legal representative and how access will otherwise be provided to the person and all other affected persons receiving services;

(3) follow procedures that minimize the consumer's health risk from communicable diseases; and

(4) maintain equipment, vehicles, supplies, and materials owned or leased by the license holder in good condition.

Subd. 2. **Licensed capacity for facility-based day training and habilitation services.** The licensed capacity of each day training and habilitation service site must be determined by the amount of primary space available, the scheduling of activities at other service sites, and the space requirements of consumers receiving services at the site. Primary space does not include hallways, stairways, closets, utility areas, bathrooms, kitchens, and floor areas beneath stationary equipment. A facility-based day training and habilitation site must have a minimum of 40 square feet of primary space available for each consumer who is present at the site at any one time. Licensed capacity under this subdivision does not apply to: (1) consumers receiving community-based day training and habilitation services; and (2) the temporary use of a facility-based training and habilitation service site for the limited purpose of providing transportation to consumers receiving

APPENDIX

Repealed Minnesota Statutes: S1034-1

community-based day training and habilitation services from the license holder. The license holder must comply at all times with all applicable fire and safety codes under section 245A.04, subdivision 2a, and adequate supervision requirements under section 245B.055 for all persons receiving day training and habilitation services.

Subd. 3. **Residential service sites for more than four consumers; four-bed ICF's/MR.** Residential service sites licensed to serve more than four consumers and four-bed ICF's/MR must meet the fire protection provisions of either the Residential Board and Care Occupancies Chapter or the Health Care Occupancies Chapter of the Life Safety Code (LSC), National Fire Protection Association, 1985 edition, or its successors. Sites meeting the definition of a residential board and care occupancy for 16 or less beds must have the emergency evacuation capability of residents evaluated in accordance with Appendix F of the LSC or its successors, except for those sites that meet the LSC Health Care Occupancies Chapter or its successors.

Subd. 5. **Consumer health.** The license holder is responsible for meeting the health service needs assigned to the license holder in the individual service plan and for bringing health needs as discovered by the license holder promptly to the attention of the consumer, the consumer's legal representative, and the case manager. The license holder is required to maintain documentation on how the consumer's health needs will be met, including a description of procedures the license holder will follow for the consumer regarding medication monitoring and administration and seizure monitoring, if needed. The medication administration procedures are those procedures necessary to implement medication and treatment orders issued by appropriately licensed professionals, and must be established in consultation with a registered nurse, nurse practitioner, physician's assistant, or medical doctor.

Subd. 6. **First aid.** When the license holder is providing direct service and supervision to a consumer who requires a 24-hour plan of care and receives services at a site licensed under this chapter, the license holder must have available a staff person trained in first aid, and, if needed under section 245B.07, subdivision 6, paragraph (d), cardiopulmonary resuscitation from a qualified source, as determined by the commissioner.

Subd. 7. **Reporting incidents.** (a) The license holder must maintain information about and report incidents under section 245B.02, subdivision 10, clauses (1) to (7), to the consumer's legal representative, other licensed caregiver, if any, and case manager within 24 hours of the occurrence, or within 24 hours of receipt of the information unless the incident has been reported by another license holder. An incident under section 245B.02, subdivision 10, clause (8), must be reported as required under paragraph (c) unless the incident has been reported by another license holder.

(b) When the incident involves more than one consumer, the license holder must not disclose personally identifiable information about any other consumer when making the report to each consumer's legal representative, other licensed caregiver, if any, and case manager unless the license holder has the consent of a consumer or a consumer's legal representative.

(c) Within 24 hours of reporting maltreatment as required under section 626.556 or 626.557, the license holder must inform the consumer's legal representative and case manager of the report unless there is reason to believe that the legal representative or case manager is involved in the suspected maltreatment. The information the license holder must disclose is the nature of the activity or occurrence reported, the agency that receives the report, and the telephone number of the Department of Human Services Licensing Division.

(d) Except as provided in paragraph (e), death or serious injury of the consumer must also be reported to the Department of Human Services Licensing Division and the ombudsman, as required under sections 245.91 and 245.94, subdivision 2a.

(e) 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 ombudsman, as required under sections 245.91 and 245.94, subdivision 2a.

245B.055 STAFFING FOR DAY TRAINING AND HABILITATION SERVICES.

Subdivision 1. **Scope.** This section applies only to license holders that provide day training and habilitation services.

Subd. 2. **Factors.** (a) The number of direct service staff members that a license holder must have on duty at a given time to meet the minimum staffing requirements established in this section varies according to:

- (1) the number of persons who are enrolled and receiving direct services at that given time;
- (2) the staff ratio requirement established under subdivision 3 for each of the persons who is present; and

APPENDIX

Repealed Minnesota Statutes: S1034-1

(3) whether the conditions described in subdivision 8 exist and warrant additional staffing beyond the number determined to be needed under subdivision 7.

(b) The commissioner shall consider the factors in paragraph (a) in determining a license holder's compliance with the staffing requirements and shall further consider whether the staff ratio requirement established under subdivision 3 for each person receiving services accurately reflects the person's need for staff time.

Subd. 3. Staff ratio requirement for each person receiving services. The case manager, in consultation with the interdisciplinary team shall determine at least once each year which of the ratios in subdivisions 4, 5, and 6 is appropriate for each person receiving services on the basis of the characteristics described in subdivisions 4, 5, and 6. The ratio assigned each person and the documentation of how the ratio was arrived at must be kept in each person's individual service plan. Documentation must include an assessment of the person with respect to the characteristics in subdivisions 4, 5, and 6 recorded on a standard assessment form required by the commissioner.

Subd. 4. Person requiring staff ratio of one to four. A person who has one or more of the following characteristics must be assigned a staff ratio requirement of one to four:

(1) on a daily basis the person requires total care and monitoring or constant hand-over-hand physical guidance to successfully complete at least three of the following activities: toileting, communicating basic needs, eating, or ambulating; or

(2) the person assaults others, is self-injurious, or manifests severe dysfunctional behaviors at a documented level of frequency, intensity, or duration requiring frequent daily ongoing intervention and monitoring as established in an approved behavior management program.

Subd. 5. Person requiring staff ratio of one to eight. A person who has all of the following characteristics must be assigned a staff ratio requirement of one to eight:

(1) the person does not meet the requirements in subdivision 4; and

(2) on a daily basis the person requires verbal prompts or spot checks and minimal or no physical assistance to successfully complete at least three of the following activities: toileting, communicating basic needs, eating, or ambulating.

Subd. 6. Person requiring staff ratio of one to six. A person who does not have any of the characteristics described in subdivision 4 or 5 must be assigned a staff ratio requirement of one to six.

Subd. 7. Determining number of direct service staff required. The minimum number of direct service staff members required at any one time to meet the combined staff ratio requirements of the persons present at that time can be determined by following the steps in clauses (1) through (4):

(1) assign each person in attendance the three-digit decimal below that corresponds to the staff ratio requirement assigned to that person. A staff ratio requirement of one to four equals 0.250. A staff ratio requirement of one to eight equals 0.125. A staff ratio requirement of one to six equals 0.166. A staff ratio requirement of one to ten equals 0.100;

(2) add all of the three-digit decimals (one three-digit decimal for every person in attendance) assigned in clause (1);

(3) when the sum in clause (2) falls between two whole numbers, round off the sum to the larger of the two whole numbers; and

(4) the larger of the two whole numbers in clause (3) equals the number of direct service staff members needed to meet the staff ratio requirements of the persons in attendance.

Subd. 8. Conditions requiring additional direct service staff. The license holder shall increase the number of direct service staff members present at any one time beyond the number arrived at in subdivision 4 if necessary when any one or combination of the following circumstances can be documented by the commissioner as existing:

(1) the health and safety needs of the persons receiving services cannot be met by the number of staff members available under the staffing pattern in effect even though the number has been accurately calculated under subdivision 7; or

(2) the behavior of a person presents an immediate danger and the person is not eligible for a special needs rate exception under Minnesota Rules, parts 9510.1020 to 9510.1140.

Subd. 9. Supervision requirements. At no time shall one direct service staff member be assigned responsibility for supervision and training of more than ten persons receiving supervision and training, except as otherwise stated in each person's risk management plan.

245B.06 SERVICE STANDARDS.

Subdivision 1. Outcome-based services. (a) The license holder must provide outcome-based services in response to the consumer's identified needs as specified in the individual service plan.

APPENDIX

Repealed Minnesota Statutes: S1034-1

(b) Services must be based on the needs and preferences of the consumer and the consumer's personal goals and be consistent with the principles of least restrictive environment, self-determination, and consistent with:

- (1) the recognition of each consumer's history, dignity, and cultural background;
- (2) the affirmation and protection of each consumer's civil and legal rights;
- (3) the provision of services and supports for each consumer which:
 - (i) promote community inclusion and self-sufficiency;
 - (ii) provide services in the least restrictive environment;
 - (iii) promote social relationships, natural supports, and participation in community life;
 - (iv) allow for a balance between safety and opportunities; and
 - (v) provide opportunities for the development and exercise of age-appropriate skills, decision making and choice, personal advocacy, and communication; and
- (4) the provision of services and supports for families which address the needs of the consumer in the context of the family and support family self-sufficiency.

(c) The license holder must make available to the consumer opportunities to participate in the community, functional skill development, reduced dependency on care providers, and opportunities for development of decision-making skills. "Outcome" means the behavior, action, or status attained by the consumer that can be observed, measured, and can be determined reliable and valid. Outcomes are the equivalent of the long-range goals and short-term goals referenced in section 256B.092, and any rules promulgated under that section.

Subd. 2. Risk management plan. (a) The license holder must develop, document in writing, and implement a risk management plan that meets the requirements of this subdivision. License holders licensed under this chapter are exempt from sections 245A.65, subdivision 2, and 626.557, subdivision 14, if the requirements of this subdivision are met.

(b) The risk management plan must identify areas in which the consumer is vulnerable, based on an assessment, at a minimum, of the following areas:

- (1) an adult consumer's susceptibility to physical, emotional, and sexual abuse as defined in section 626.5572, subdivision 2, and financial exploitation as defined in section 626.5572, subdivision 9; a minor consumer's susceptibility to sexual and physical abuse as defined in section 626.556, subdivision 2; and a consumer's susceptibility to self-abuse, regardless of age;
- (2) the consumer's health needs, considering the consumer's physical disabilities; allergies; sensory impairments; seizures; diet; need for medications; and ability to obtain medical treatment;
- (3) the consumer's safety needs, considering the consumer's ability to take reasonable safety precautions; community survival skills; water survival skills; ability to seek assistance or provide medical care; and access to toxic substances or dangerous items;
- (4) environmental issues, considering the program's location in a particular neighborhood or community; the type of grounds and terrain surrounding the building; and the consumer's ability to respond to weather-related conditions, open locked doors, and remain alone in any environment; and
- (5) the consumer's behavior, including behaviors that may increase the likelihood of physical aggression between consumers or sexual activity between consumers involving force or coercion, as defined under section 245B.02, subdivision 10, clauses (6) and (7).

(c) When assessing a consumer's vulnerability, the license holder must consider only the consumer's skills and abilities, independent of staffing patterns, supervision plans, the environment, or other situational elements.

(d) License holders jointly providing services to a consumer shall coordinate and use the resulting assessment of risk areas for the development of each license holder's risk management or the shared risk management plan. The license holder's plan must include the specific actions a staff person will take to protect the consumer and minimize risks for the identified vulnerability areas. The specific actions must include the proactive measures being taken, training being provided, or a detailed description of actions a staff person will take when intervention is needed.

(e) Prior to or upon initiating services, a license holder must develop an initial risk management plan that is, at a minimum, verbally approved by the consumer or consumer's legal representative and case manager. The license holder must document the date the license holder receives the consumer's or consumer's legal representative's and case manager's verbal approval of the initial plan.

(f) As part of the meeting held within 45 days of initiating service, as required under section 245B.06, subdivision 4, the license holder must review the initial risk management plan for accuracy and revise the plan if necessary. The license holder must give the consumer or consumer's legal representative and case manager an opportunity to participate in this plan review. If the license holder revises the plan, or if the consumer or consumer's legal representative and

APPENDIX

Repealed Minnesota Statutes: S1034-1

case manager have not previously signed and dated the plan, the license holder must obtain dated signatures to document the plan's approval.

(g) After plan approval, the license holder must review the plan at least annually and update the plan based on the individual consumer's needs and changes to the environment. The license holder must give the consumer or consumer's legal representative and case manager an opportunity to participate in the ongoing plan development. The license holder shall obtain dated signatures from the consumer or consumer's legal representative and case manager to document completion of the annual review and approval of plan changes.

Subd. 3. **Assessments.** (a) The license holder shall assess and reassess the consumer within stated time lines and assessment areas specified in the individual service plan or as requested in writing by the case manager.

(b) For each area of assessment requested, the license holder must provide a written summary, analysis, and recommendations for use in the development of the individual service plan.

(c) All assessments must include information about the consumer that is descriptive of:

(1) the consumer's strengths and functional skills; and

(2) the level of support and supervision the consumer needs to achieve the outcomes in subdivision 1.

Subd. 4. **Supports and methods.** The license holder, in coordination with other service providers, shall meet with the consumer, the consumer's legal representative, case manager, and other members of the interdisciplinary team within 45 days of service initiation. Within ten working days after the meeting, the license holder shall develop and document in writing:

(1) the methods that will be used to support the individual or accomplish the outcomes in subdivision 1, including information about physical and social environments, the equipment and materials required, and techniques that are consistent with the consumer's communication mode and learning style specified as the license holder's responsibility in the individual service plan;

(2) the projected starting date for service supports and the criteria for identifying when the desired outcome has been achieved and when the service supports need to be reviewed; and

(3) the names of the staff, staff position, or contractors responsible for implementing each outcome.

Subd. 5. **Progress reviews.** The license holder must participate in progress review meetings following stated time lines established in the consumer's individual service plan or as requested in writing by the consumer, the consumer's legal representative, or the case manager, at a minimum of once a year. The license holder must summarize the progress toward achieving the desired outcomes and make recommendations in a written report sent to the consumer or the consumer's legal representative and case manager prior to the review meeting.

Subd. 6. **Reports.** The license holder shall provide written reports regarding the consumer's status as requested by the consumer, or the consumer's legal representative and case manager.

Subd. 7. **Staffing requirements.** The license holder must provide supervision to ensure the health, safety, and protection of rights of each consumer and to be able to implement each consumer's individual service plan. Day training and habilitation programs must meet the minimum staffing requirements as specified in sections 252.40 to 252.46 and rules promulgated under those sections.

Subd. 8. **Leaving the residence.** Each consumer requiring a 24-hour plan of care shall receive services during the day outside the residence unless otherwise specified in the individual's service plan. License holders, providing services to consumers living in a licensed site, shall ensure that they are prepared to care for consumers whenever they are at the residence during the day because of illness, work schedules, or other reasons.

Subd. 9. **Day training and habilitation service days.** Day training and habilitation services must meet a minimum of 195 available service days.

Subd. 10. **Prohibition.** Psychotropic medication and the use of aversive and deprivation procedures, as referenced in section 245.825 and rules promulgated under that section, cannot be used as a substitute for adequate staffing, as punishment, or for staff convenience.

245B.07 MANAGEMENT STANDARDS.

Subdivision 1. **Consumer data file.** The license holder must maintain the following information for each consumer:

(1) identifying information that includes date of birth, medications, legal representative, history, medical, and other individual-specific information, and names and telephone numbers of contacts;

APPENDIX

Repealed Minnesota Statutes: S1034-1

(2) consumer health information, including individual medication administration and monitoring information;

(3) the consumer's individual service plan. When a consumer's case manager does not provide a current individual service plan, the license holder shall make a written request to the case manager to provide a copy of the individual service plan and inform the consumer or the consumer's legal representative of the right to an individual service plan and the right to appeal under section 256.045. In the event the case manager fails to provide an individual service plan after a written request from the license holder, the license holder shall not be sanctioned or penalized financially for not having a current individual service plan in the consumer's data file;

(4) copies of assessments, analyses, summaries, and recommendations;

(5) progress review reports;

(6) incidents involving the consumer;

(7) reports required under section 245B.05, subdivision 7;

(8) discharge summary, when applicable;

(9) record of other license holders serving the consumer that includes a contact person and telephone numbers, services being provided, services that require coordination between two license holders, and name of staff responsible for coordination;

(10) information about verbal aggression directed at the consumer by another consumer; and

(11) information about self-abuse.

Subd. 2. **Access to records.** The license holder must ensure that the following people have access to the information in subdivision 1:

(1) the consumer, the consumer's legal representative, and anyone properly authorized by the consumer or legal representative;

(2) the consumer's case manager;

(3) staff providing direct services to the consumer unless the information is not relevant to carrying out the individual service plan; and

(4) the county adult foster care licensor, when services are also licensed as an adult foster home. Adult foster home means a licensed residence operated by an operator who, for financial gain or otherwise, provides 24-hour foster care to no more than four functionally impaired residents.

Subd. 3. **Retention of consumer's records.** The license holder must retain the records required for consumers for at least three years following termination of services.

Subd. 4. **Staff qualifications.** (a) The license holder must ensure that staff is competent through training, experience, and education to meet the consumer's needs and additional requirements as written in the individual service plan. Staff qualifications must be documented. Staff under 18 years of age may not perform overnight duties or administer medication.

(b) Delivery and evaluation of services provided by the license holder to a consumer must be coordinated by a designated person. The designated person or coordinator must minimally have a four-year degree in a field related to service provision, and one year work experience with consumers with developmental disabilities, a two-year degree in a field related to service provision, and two years of work experience with consumers with developmental disabilities, or a diploma in community-based developmental disability services from an accredited postsecondary institution and two years of work experience with consumers with developmental disabilities. The coordinator must provide supervision, support, and evaluation of activities that include:

(1) oversight of the license holder's responsibilities designated in the individual service plan;

(2) instruction and assistance to staff implementing the individual service plan areas;

(3) evaluation of the effectiveness of service delivery, methodologies, and progress on consumer outcomes based on the condition set for objective change; and

(4) review of incident and emergency reports, identification of incident patterns, and implementation of corrective action as necessary to reduce occurrences.

(c) The coordinator is responsible for taking the action necessary to facilitate the accomplishment of the outcomes for each consumer as specified in the consumer's individual service plan.

(d) The license holder must provide for adequate supervision of direct care staff to ensure implementation of the individual service plan.

Subd. 5. **Staff orientation.** (a) Within 60 days of hiring staff who provide direct service, the license holder must provide 30 hours of staff orientation. Direct care staff must complete 15 of the 30 hours orientation before providing any unsupervised direct service to a consumer. If the staff person has received orientation training from a license holder licensed under this chapter, or provides semi-independent living services only, the 15-hour requirement may be reduced to

APPENDIX

Repealed Minnesota Statutes: S1034-1

eight hours. The total orientation of 30 hours may be reduced to 15 hours if the staff person has previously received orientation training from a license holder licensed under this chapter.

(b) The 30 hours of orientation must combine supervised on-the-job training with review of and instruction on the following material:

(1) review of the consumer's service plans and risk management plan to achieve an understanding of the consumer as a unique individual and staff responsibilities related to implementation of those plans;

(2) review and instruction on implementation of the license holder's policies and procedures, including their location and access;

(3) staff responsibilities related to emergency procedures;

(4) explanation of specific job functions, including implementing objectives from the consumer's individual service plan;

(5) explanation of responsibilities related to section 245A.65; sections 626.556 and 626.557, governing maltreatment reporting and service planning for children and vulnerable adults; and section 245.825, governing use of aversive and deprivation procedures;

(6) medication administration as it applies to the individual consumer, from a training curriculum developed by a health services professional described in section 245B.05, subdivision 5, and when the consumer meets the criteria of having overriding health care needs, then medication administration taught by a health services professional. Staff may administer medications only after they demonstrate the ability, as defined in the license holder's medication administration policy and procedures. Once a consumer with overriding health care needs is admitted, staff will be provided with remedial training as deemed necessary by the license holder and the health professional to meet the needs of that consumer.

For purposes of this section, overriding health care needs means a health care condition that affects the service options available to the consumer because the condition requires:

(i) specialized or intensive medical or nursing supervision; and

(ii) nonmedical service providers to adapt their services to accommodate the health and safety needs of the consumer;

(7) consumer rights and staff responsibilities related to protecting and ensuring the exercise of the consumer rights; and

(8) other topics necessary as determined by the consumer's individual service plan or other areas identified by the license holder.

(c) The license holder must document each employee's orientation received.

Subd. 6. Staff training. (a) A license holder providing semi-independent living services shall ensure that direct service staff annually complete hours of training equal to one percent of the number of hours the staff person worked. All other license holders shall ensure that direct service staff annually complete hours of training as follows:

(1) if the direct services staff have been employed for one to 24 months and:

(i) the average number of work hours scheduled per week is 30 to 40 hours, the staff must annually complete 40 training hours;

(ii) the average number of work hours scheduled per week is 20 to 29 hours, the staff must annually complete 30 training hours; and

(iii) the average number of work hours scheduled per week is one to 19 hours, the staff must annually complete 20 training hours; or

(2) if the direct services staff have been employed for more than 24 months and:

(i) the average number of work hours scheduled per week is 30 to 40 hours, the staff must annually complete 20 training hours;

(ii) the average number of work hours scheduled per week is 20 to 29 hours, the staff must annually complete 15 training hours; and

(iii) the average number of work hours scheduled per week is one to 19 hours, the staff must annually complete 12 training hours.

If direct service staff has received training from a license holder licensed under a program rule identified in this chapter or completed course work regarding disability-related issues from a postsecondary educational institute, that training may also count toward training requirements for other services and for other license holders.

(b) The license holder must document the training completed by each employee.

(c) Training shall address staff competencies necessary to address the consumer needs as identified in the consumer's individual service plan and ensure consumer health, safety, and protection of rights. Training may also include other areas identified by the license holder.

(d) For consumers requiring a 24-hour plan of care, the license holder shall provide training in cardiopulmonary resuscitation, from a qualified source determined by the commissioner, if

APPENDIX

Repealed Minnesota Statutes: S1034-1

the consumer's health needs as determined by the consumer's physician indicate trained staff would be necessary to the consumer.

Subd. 7. **Volunteers.** The license holder must ensure that volunteers who provide direct services to consumers receive the training and orientation necessary to fulfill their responsibilities.

Subd. 7a. **Subcontractors.** If the license holder uses a subcontractor to perform services licensed under this chapter on the license holder's behalf, the license holder must ensure that the subcontractor meets and maintains compliance with all requirements under this chapter that apply to the services to be provided.

Subd. 8. **Policies and procedures.** The license holder must develop and implement the policies and procedures in paragraphs (a) to (c).

(a) Policies and procedures that promote consumer health and safety by ensuring:

(1) consumer safety in emergency situations;

(2) consumer health through sanitary practices;

(3) safe transportation, when the license holder is responsible for transportation of consumers, with provisions for handling emergency situations;

(4) a system of record keeping for both individuals and the organization, for review of incidents and emergencies, and corrective action if needed;

(5) a plan for responding to all incidents, as defined in section 245B.02, subdivision 10, and reporting all incidents required to be reported under section 245B.05, subdivision 7;

(6) safe medication administration as identified in section 245B.05, subdivision 5, incorporating an observed skill assessment to ensure that staff demonstrate the ability to administer medications consistent with the license holder's policy and procedures;

(7) psychotropic medication monitoring when the consumer is prescribed a psychotropic medication, including the use of the psychotropic medication use checklist. If the responsibility for implementing the psychotropic medication use checklist has not been assigned in the individual service plan and the consumer lives in a licensed site, the residential license holder shall be designated; and

(8) criteria for admission or service initiation developed by the license holder.

(b) Policies and procedures that protect consumer rights and privacy by ensuring:

(1) consumer data privacy, in compliance with the Minnesota Data Practices Act, chapter 13; and

(2) that complaint procedures provide consumers with a simple process to bring grievances and consumers receive a response to the grievance within a reasonable time period. The license holder must provide a copy of the program's grievance procedure and time lines for addressing grievances. The program's grievance procedure must permit consumers served by the program and the authorized representatives to bring a grievance to the highest level of authority in the program.

(c) Policies and procedures that promote continuity and quality of consumer supports by ensuring:

(1) continuity of care and service coordination, including provisions for service termination, temporary service suspension, and efforts made by the license holder to coordinate services with other vendors who also provide support to the consumer. The policy must include the following requirements:

(i) the license holder must notify the consumer or consumer's legal representative and the consumer's case manager in writing of the intended termination or temporary service suspension and the consumer's right to seek a temporary order staying the termination or suspension of service according to the procedures in section 256.045, subdivision 4a or subdivision 6, paragraph (c);

(ii) 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;

(iii) the license holder must provide information requested by the consumer or consumer's legal representative or case manager when services are temporarily suspended or upon notice of termination;

(iv) use of temporary service suspension procedures are restricted to situations in which the consumer's behavior causes immediate and serious danger to the health and safety of the individual or others;

(v) 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 termination or temporary service suspension; and

(vi) during the period of temporary service suspension, the license holder will work with the appropriate county agency to develop reasonable alternatives to protect the individual and others; and

APPENDIX

Repealed Minnesota Statutes: S1034-1

(2) quality services measured through a program evaluation process including regular evaluations of consumer satisfaction and sharing the results of the evaluations with the consumers and legal representatives.

Subd. 9. **Availability of current written policies and procedures.** The license holder shall:

(1) review and update, as needed, the written policies and procedures in this chapter;

(2) inform consumers or the consumer's legal representatives of the written policies and procedures in this chapter upon service initiation. Copies of policies and procedures affecting a consumer's rights under section 245D.04 must be provided upon service initiation. Copies of all other policies and procedures must be available to consumers or the consumer's legal representatives, case managers, the county where services are located, and the commissioner upon request;

(3) provide all consumers or the consumers' legal representatives and case managers a copy of the revised policies and procedures and explanation of the revisions that affect consumers' service-related or protection-related rights under section 245B.04 and maltreatment reporting policies and procedures. Unless there is reasonable cause, the license holder must provide this notice at least 30 days before implementing the revised policy and procedure. The license holder must document the reason for not providing the notice at least 30 days before implementing the revisions;

(4) annually notify all consumers or the consumers' legal representatives and case managers of any revised policies and procedures under this chapter, other than those in clause (3). Upon request, the license holder must provide the consumer or consumer's legal representative and case manager copies of the revised policies and procedures;

(5) before implementing revisions to policies and procedures under this chapter, inform all employees of the revisions and provide training on implementation of the revised policies and procedures; and

(6) document and maintain relevant information related to the policies and procedures in this chapter.

Subd. 10. **Consumer funds.** (a) The license holder must ensure that consumers retain the use and availability of personal funds or property unless restrictions are justified in the consumer's individual service plan.

(b) The license holder must ensure separation of consumer funds from funds of the license holder, the program, or program staff.

(c) Whenever the license holder assists a consumer with the safekeeping of funds or other property, the license holder must have written authorization to do so by the consumer or the consumer's legal representative, and the case manager. In addition, the license holder must:

(1) document receipt and disbursement of the consumer's funds or the property;

(2) annually survey, document, and implement the preferences of the consumer, consumer's legal representative, and the case manager for frequency of receiving a statement that itemizes receipts and disbursements of consumer funds or other property; and

(3) return to the consumer upon the consumer's request, funds and property in the license holder's possession subject to restrictions in the consumer's individual service plan, as soon as possible, but no later than three working days after the date of the request.

(d) License holders and program staff must not:

(1) borrow money from a consumer;

(2) purchase personal items from a consumer;

(3) sell merchandise or personal services to a consumer;

(4) require a consumer to purchase items for which the license holder is eligible for reimbursement;

(5) use consumer funds in a manner that would violate section 256B.04, or any rules promulgated under that section; or

(6) accept powers-of-attorney from a person receiving services from the license holder for any purpose, and may not accept an appointment as guardian or conservator of a person receiving services from the license holder. This does not apply to license holders that are Minnesota counties or other units of government.

Subd. 11. **Travel time to and from a day training and habilitation site.** Except in unusual circumstances, the license holder must not transport a consumer receiving services for longer than 90 minutes per one-way trip. Nothing in this subdivision relieves the provider of the obligation to provide the number of program hours as identified in the individualized service plan.

Subd. 12. **Separate license required for separate sites.** The license holder shall apply for separate licenses for each day training and habilitation service site owned or leased by the license holder at which persons receiving services and the provider's employees who provide training and habilitation services are present for a cumulative total of more than 30 days within

APPENDIX

Repealed Minnesota Statutes: S1034-1

any 12-month period, and for each residential service site. Notwithstanding this subdivision, a separate license is not required for:

(1) a day training and habilitation service site used only for the limited purpose of providing transportation to consumers receiving community-based day training and habilitation services from a license holder;

(2) a day training and habilitation program that is in a separate building that is adjacent to the central operation of the day training and habilitation program; or

(3) a satellite day training and habilitation program. For purposes of this clause, a satellite day training and habilitation program is a program that is affiliated with the central operations of an existing day training and habilitation program and is in a separate nonadjacent building in the same county as the central operation day training and habilitation program.

Subd. 13. **Variance.** The commissioner may grant a variance to any of the requirements in sections 245B.02 to 245B.07 except section 245B.07, subdivision 8(1)(vii), or provisions governing data practices and information rights of consumers if the conditions in section 245A.04, subdivision 9 are met. Upon the request of the license holder, the commissioner shall continue variances from the standards in this chapter previously granted under Minnesota Rules that are repealed as a result of this chapter. The commissioner may approve variances for a license holder on a program, geographic, or organizational basis.

245B.08 COMPLIANCE STRATEGIES.

Subdivision 1. **Alternative methods of determining compliance.** (a) In addition to methods specified in chapters 245A and 245C, the commissioner may use alternative methods and new regulatory strategies to determine compliance with this section. The commissioner may use sampling techniques to ensure compliance with this section. Notwithstanding section 245A.09, subdivision 7, paragraph (e), the commissioner may also extend periods of licensure, not to exceed five years, for license holders who have demonstrated substantial and consistent compliance with sections 245B.02 to 245B.07 and have consistently maintained the health and safety of consumers and have demonstrated by alternative methods in paragraph (b) that they meet or exceed the requirements of this section. For purposes of this section, "substantial and consistent compliance" means that during the current licensing period:

(1) the license holder's license has not been made conditional, suspended, or revoked;

(2) there have been no substantiated allegations of maltreatment against the license holder;

(3) there have been no program deficiencies that have been identified that would jeopardize the health or safety of consumers being served; and

(4) the license holder is in substantial compliance with the other requirements of chapters 245A and 245C and other applicable laws and rules.

(b) To determine the length of a license, the commissioner shall consider:

(1) information from affected consumers, and the license holder's responsiveness to consumers' concerns and recommendations;

(2) self assessments and peer reviews of the standards of this section, corrective actions taken by the license holder, and sharing the results of the inspections with consumers, the consumers' families, and others, as requested;

(3) length of accreditation by an independent accreditation body, if applicable;

(4) information from the county where the license holder is located; and

(5) information from the license holder demonstrating performance that meets or exceeds the minimum standards of this chapter.

(c) The commissioner may reduce the length of the license if the license holder fails to meet the criteria in paragraph (a) and the conditions specified in paragraph (b).

Subd. 2. **Additional measures.** The commissioner may require the license holder to implement additional measures on a time-limited basis to ensure the health and safety of consumers when the health and safety of consumers has been determined to be at risk as determined by substantiated incidents of maltreatment under sections 626.556 and 626.557. The license holder may request reconsideration of the actions taken by the commissioner under this subdivision according to section 245A.06.

Subd. 3. **Sanctions available.** 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; make correction orders and make a license conditional for failure to comply with applicable laws or rules under section 245A.06; or deny an application for license under section 245A.05.

Subd. 4. **Efficient application.** The commissioner shall establish application procedures for license holders licensed under this chapter to reduce the need to submit duplicative material.

APPENDIX

Repealed Minnesota Statutes: S1034-1

Subd. 5. **Information.** The commissioner shall make information available to consumers and interested others regarding the licensing status of a license holder.

Subd. 6. **Implementation.** The commissioner shall seek advice from parties affected by the implementation of this chapter.

Subd. 7. **Deem status.** The commissioner may exempt a license holder from duplicative standards if the license holder is already licensed under chapter 245A.

245D.08 RECORD REQUIREMENTS.

Subdivision 1. **Record-keeping systems.** The license holder must ensure that the content and format of service recipient, personnel, and program records are uniform, legible, and in compliance with the requirements of this chapter.

Subd. 2. **Service recipient record.** (a) The license holder must:

(1) maintain a record of current services provided to each person on the premises where the services are provided or coordinated; and

(2) protect service recipient records against loss, tampering, or unauthorized disclosure in compliance with sections 13.01 to 13.10 and 13.46.

(b) The license holder must maintain the following information for each person:

(1) identifying information, including the person's name, date of birth, address, and telephone number;

(2) the name, address, and telephone number of the person's legal representative, if any, an emergency contact, the case manager, and family members or others as identified by the person or case manager;

(3) service information, including service initiation information, verification of the person's eligibility for services, and documentation verifying that services have been provided as identified in the service plan according to paragraph (a);

(4) health information, including medical history and allergies, and when the license holder is assigned responsibility for meeting the person's health needs according to section 245D.05:

(i) current orders for medication, treatments, or medical equipment;

(ii) medication administration procedures;

(iii) a medication administration record documenting the implementation of the medication administration procedures, including any agreements for administration of injectable medications by the license holder; and

(iv) a medical appointment schedule;

(5) the person's current service plan or that portion of the plan assigned to the license holder. When a person's case manager does not provide a current service plan, the license holder must make a written request to the case manager to provide a copy of the service plan and inform the person of the right to a current service plan and the right to appeal under section 256.045;

(6) a record of other service providers serving the person when the person's service plan identifies the need for coordination between the service providers that includes a contact person and telephone numbers, services being provided, and names of staff responsible for coordination;

(7) documentation of orientation to the service recipient rights according to section 245D.04, subdivision 1, and maltreatment reporting policies and procedures according to section 245A.65, subdivision 1, paragraph (c);

(8) copies of authorizations to handle a person's funds according to section 245D.06, subdivision 4, paragraph (a);

(9) documentation of complaints received and grievance resolution;

(10) incident reports required under section 245D.06, subdivision 1;

(11) copies of written reports regarding the person's status when requested according to section 245D.07, subdivision 3; and

(12) discharge summary, including service termination notice and related documentation, when applicable.

Subd. 3. **Access to service recipient records.** The license holder must ensure that the following people have access to the information in subdivision 1 in accordance with applicable state and federal law, regulation, or rule:

(1) the person, the person's legal representative, and anyone properly authorized by the person;

(2) the person's case manager;

(3) staff providing services to the person unless the information is not relevant to carrying out the service plan; and

(4) the county adult foster care licenser, when services are also licensed as adult foster care.

APPENDIX

Repealed Minnesota Statutes: S1034-1

Subd. 4. **Personnel records.** The license holder must maintain a personnel record of each employee, direct service volunteer, and subcontractor to document and verify staff qualifications, orientation, and training. For the purposes of this subdivision, the terms "staff" and "staff person" mean paid employee, direct service volunteer, or subcontractor. The personnel record must include:

(1) the staff person's date of hire, completed application, a position description signed by the staff person, documentation that the staff person meets the position requirements as determined by the license holder, the date of first supervised direct contact with a person served by the program, and the date of first unsupervised direct contact with a person served by the program;

(2) documentation of staff qualifications, orientation, training, and performance evaluations as required under section 245D.09, subdivisions 3, 4, and 5, including the date the training was completed, the number of hours per subject area, and the name and qualifications of the trainer or instructor; and

(3) a completed background study as required under chapter 245C.

256B.055 ELIGIBILITY CATEGORIES.

Subd. 3. **AFDC families.** Until March 31, 1998, medical assistance may be paid for a person who is eligible for or receiving, or who would be eligible for, except for excess income or assets, public assistance under the aid to families with dependent children program in effect as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193.

Subd. 5. **Pregnant women; dependent unborn child.** Medical assistance may be paid for a pregnant woman who has written verification of a positive pregnancy test from a physician or licensed registered nurse, who meets the other eligibility criteria of this section and who would be categorically eligible for assistance under the state's AFDC plan in effect as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193, if the child had been born and was living with the woman. For purposes of this subdivision, a woman is considered pregnant for 60 days postpartum.

Subd. 10b. **Children.** This subdivision supersedes subdivision 10 as long as the Minnesota health care reform waiver remains in effect. When the waiver expires, the commissioner of human services shall publish a notice in the State Register and notify the revisor of statutes. Medical assistance may be paid for a child less than two years of age with countable family income as established for infants under section 256B.057, subdivision 1.

256B.056 ELIGIBILITY REQUIREMENTS FOR MEDICAL ASSISTANCE.

Subd. 5b. **Individuals with low income.** Recipients of medical assistance not residing in a long-term care facility who have slightly fluctuating income which is below the medical assistance income limit shall report and verify their income on a semiannual basis.

256B.057 ELIGIBILITY REQUIREMENTS FOR SPECIAL CATEGORIES.

Subd. 1c. **No asset test for pregnant women.** Beginning September 30, 1998, eligibility for medical assistance for a pregnant woman must be determined without regard to asset standards established in section 256B.056, subdivision 3.

Subd. 2. **Children.** (a) Except as specified in subdivision 1b, effective October 1, 2003, a child one through 18 years of age in a family whose countable income is no greater than 150 percent of the federal poverty guidelines for the same family size, is eligible for medical assistance.

(b) For applications processed within one calendar month prior to the effective date, eligibility shall be determined by applying the income standards and methodologies in effect prior to the effective date for any months in the six-month budget period before that date and the income standards and methodologies in effect on the effective date for any months in the six-month budget period on or after that date. The income standards for each month shall be added together and compared to the applicant's total countable income for the six-month budget period to determine eligibility.

256B.0911 LONG-TERM CARE CONSULTATION SERVICES.

Subd. 4a. **Preadmission screening activities related to nursing facility admissions.** (a) All applicants to Medicaid certified nursing facilities, including certified boarding care facilities, must be screened prior to admission regardless of income, assets, or funding sources for nursing facility care, except as described in subdivision 4b. The purpose of the screening is to determine

APPENDIX

Repealed Minnesota Statutes: S1034-1

the need for nursing facility level of care as described in paragraph (d) and to complete activities required under federal law related to mental illness and developmental disability as outlined in paragraph (b).

(b) A person who has a diagnosis or possible diagnosis of mental illness or developmental disability must receive a preadmission screening before admission regardless of the exemptions outlined in subdivision 4b, paragraph (b), to identify the need for further evaluation and specialized services, unless the admission prior to screening is authorized by the local mental health authority or the local developmental disabilities case manager, or unless authorized by the county agency according to Public Law 101-508.

The following criteria apply to the preadmission screening:

(1) the lead agency must use forms and criteria developed by the commissioner to identify persons who require referral for further evaluation and determination of the need for specialized services; and

(2) the evaluation and determination of the need for specialized services must be done by:

(i) a qualified independent mental health professional, for persons with a primary or secondary diagnosis of a serious mental illness; or

(ii) a qualified developmental disability professional, for persons with a primary or secondary diagnosis of developmental disability. For purposes of this requirement, a qualified developmental disability professional must meet the standards for a qualified developmental disability professional under Code of Federal Regulations, title 42, section 483.430.

(c) The local county mental health authority or the state developmental disability authority under Public Laws 100-203 and 101-508 may prohibit admission to a nursing facility if the individual does not meet the nursing facility level of care criteria or needs specialized services as defined in Public Laws 100-203 and 101-508. For purposes of this section, "specialized services" for a person with developmental disability means active treatment as that term is defined under Code of Federal Regulations, title 42, section 483.440 (a)(1).

(d) The determination of the need for nursing facility level of care must be made according to criteria developed by the commissioner, and in section 256B.092, using forms developed by the commissioner. Effective no sooner than on or after July 1, 2012, for individuals age 21 and older, and on or after October 1, 2019, for individuals under age 21, the determination of need for nursing facility level of care shall be based on criteria in section 144.0724, subdivision 11. In assessing a person's needs, consultation team members shall have a physician available for consultation and shall consider the assessment of the individual's attending physician, if any. The individual's physician must be included if the physician chooses to participate. Other personnel may be included on the team as deemed appropriate by the lead agency.

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

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

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

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

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

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

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

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

(1) persons described in paragraph (a);

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

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

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

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

APPENDIX

Repealed Minnesota Statutes: S1034-1

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

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

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

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

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

(5) the county is contacted on the first working day following the emergency admission. Transfer of a patient from an acute care hospital to a nursing facility is not considered an emergency except for a person who has received hospital services in the following situations: hospital admission for observation, care in an emergency room without hospital admission, or following hospital 24-hour bed care.

(e) A nursing facility must provide written information to all persons admitted regarding the person's right to request and receive long-term care consultation services as defined in subdivision 1a. The information must be provided prior to the person's discharge from the facility and in a format specified by the commissioner.

Subd. 4c. **Screening requirements.** (a) A person may be screened for nursing facility admission by telephone or in a face-to-face screening interview. Certified assessors shall identify each individual's needs using the following categories:

(1) the person needs no face-to-face screening interview to determine the need for nursing facility level of care based on information obtained from other health care professionals;

(2) the person needs an immediate face-to-face screening interview to determine the need for nursing facility level of care and complete activities required under subdivision 4a; or

(3) the person may be exempt from screening requirements as outlined in subdivision 4b, but will need transitional assistance after admission or in-person follow-along after a return home.

(b) Persons admitted on a nonemergency basis to a Medicaid-certified nursing facility must be screened prior to admission.

(c) The lead agency screening or intake activity must include processes to identify persons who may require transition assistance as described in subdivision 3b.

256B.0917 SENIORS' AGENDA FOR INDEPENDENT LIVING (SAIL) PROJECTS.

Subdivision 1. **Purpose, mission, goals, and objectives.** (a) The purpose of implementing seniors' agenda for independent living (SAIL) projects under this section is to demonstrate a new cooperative strategy for the long-term care system in the state of Minnesota.

The projects are part of the initial plan for a 20-year strategy. The mission of the 20-year strategy is to create a new community-based care paradigm for long-term care in Minnesota in order to maximize independence of the older adult population, and to ensure cost-effective use of financial and human resources. The goals for the 20-year strategy are to:

(1) achieve a broad awareness and use of low-cost home care and other residential alternatives to nursing homes;

(2) develop a statewide system of information and assistance to enable easy access to long-term care services;

(3) develop sufficient alternatives to nursing homes to serve the increased number of people needing long-term care;

(4) maintain the moratorium on new construction of nursing home beds and to lower the percentage of elderly persons served in institutional settings; and

(5) build a community-based approach and community commitment to delivering long-term care services for elderly persons in their homes.

(b) The objective for the fiscal years 1994 and 1995 biennial plan is to continue at least four but not more than six projects in anticipation of a statewide program. These projects will continue the process of implementing:

(1) a coordinated planning and administrative process;

(2) a refocused function of the preadmission screening program;

(3) the development of additional home, community, and residential alternatives to nursing homes;

(4) a program to support the informal caregivers for elderly persons;

APPENDIX

Repealed Minnesota Statutes: S1034-1

- (5) programs to strengthen the use of volunteers; and
- (6) programs to support the building of community commitment to provide long-term care for elderly persons.

The services offered through these projects are available to those who have their own funds to pay for services, as well as to persons who are eligible for medical assistance and to persons who are 180-day eligible clients to the extent authorized in this section.

Subd. 2. Design of SAIL projects; local long-term care coordinating team. (a) The commissioner of human services shall contract with SAIL projects in four to six counties or groups of counties to demonstrate the feasibility and cost-effectiveness of a local long-term care strategy that is consistent with the state's long-term care goals identified in subdivision 1. The commissioner shall publish a notice in the State Register announcing the availability of project funding and giving instructions for making an application. The instructions for the application shall identify the amount of funding available for project components.

(b) To be selected for the project, a county board or boards must establish a long-term care coordinating team consisting of county social service agencies, public health nursing service agencies, local boards of health, a representative of local nursing home providers, a representative of local home care providers, and the area agencies on aging in a geographic area which is responsible for:

- (1) developing a local long-term care strategy consistent with state goals and objectives;
- (2) submitting an application to be selected as a project;
- (3) coordinating planning for funds to provide services to elderly persons, including funds received under title III of the Older Americans Act, title XX of the Social Security Act and the Local Public Health Act; and

(4) ensuring efficient services provision and nonduplication of funding.

(c) The board or boards shall designate a public agency to serve as the lead agency. The lead agency receives and manages the project funds from the state and is responsible for the implementation of the local strategy. If selected as a project, the local long-term care coordinating team must semiannually evaluate the progress of the local long-term care strategy in meeting state measures of performance and results as established in the contract.

(d) Each member of the local coordinating team must indicate its endorsement of the local strategy. The local long-term care coordinating team may include in its membership other units of government which provide funding for services to the frail elderly. The team must cooperate with consumers and other public and private agencies, including nursing homes, in the geographic area in order to develop and offer a variety of cost-effective services to the elderly and their caregivers.

(e) The board or boards shall apply to be selected as a project. If the project is selected, the commissioner of human services shall contract with the lead agency for the project and shall provide additional administrative funds for implementing the provisions of the contract, within the appropriation available for this purpose.

(f) Projects shall be selected according to the following conditions.

No project may be selected unless it demonstrates that:

(i) the objectives of the local project will help to achieve the state's long-term care goals as defined in subdivision 1;

(ii) in the case of a project submitted jointly by several counties, all of the participating counties are contiguous;

(iii) there is a designated local lead agency that is empowered to make contracts with the state and local vendors on behalf of all participants;

(iv) the project proposal demonstrates that the local cooperating agencies have the ability to perform the project as described and that the implementation of the project has a reasonable chance of achieving its objectives;

(v) the project will serve an area that covers at least four counties or contains at least 2,500 persons who are 85 years of age or older, according to the projections of the state demographer or the census if the data is more recent; and

(vi) the local coordinating team documents efforts of cooperation with consumers and other agencies and organizations, both public and private, in planning for service delivery.

Subd. 3. Local long-term care strategy. The local long-term care strategy must list performance outcomes and indicators which meet the state's objectives. The local strategy must provide for:

(1) accessible information, assessment, and preadmission screening activities as described in subdivision 4;

(2) an increase in numbers of alternative care clients served under section 256B.0913, including those who are relocated from nursing homes, which results in a reduction of the medical assistance nursing home caseload; and

APPENDIX

Repealed Minnesota Statutes: S1034-1

(3) the development of additional services such as adult family foster care homes; family adult day care; assisted living projects and congregate housing service projects in apartment buildings; expanded home care services for evenings and weekends; expanded volunteer services; and caregiver support and respite care projects.

The county or groups of counties selected for the projects shall be required to comply with federal regulations, alternative care funding policies in section 256B.0913, and the federal waiver programs' policies in section 256B.0915. The requirements for preadmission screening are defined in section 256B.0911, subdivisions 1 to 6. Requirements for an access, screening, and assessment function are defined in subdivision 4. Requirements for the service development and service provision are defined in subdivision 5.

Subd. 4. Information, screening, and assessment function. (a) The projects selected by and under contract with the commissioner shall establish an accessible information, screening, and assessment function for persons who need assistance and information regarding long-term care. This accessible information, screening, and assessment activity shall include information and referral, early intervention, follow-up contacts, telephone screening, home visits, assessments, preadmission screening, and relocation case management for the frail elderly and their caregivers in the area served by the county or counties. The purpose is to ensure that information and help is provided to elderly persons and their families in a timely fashion, when they are making decisions about long-term care. These functions may be split among various agencies, but must be coordinated by the local long-term care coordinating team.

(b) Accessible information, screening, and assessment functions shall be reimbursed as follows:

(1) The screenings of all persons entering nursing homes shall be reimbursed as defined in section 256B.0911, subdivision 6; and

(2) Additional state administrative funds shall be available for the access, screening, and assessment activities that are not reimbursed under clause (1). This amount shall not exceed the amount authorized in the guidelines and in instructions for the application and must be within the amount appropriated for this activity.

(c) Any information and referral functions funded by other sources, such as title III of the Older Americans Act and title XX of the Social Security Act, shall be considered by the local long-term care coordinating team in establishing this function to avoid duplication and to ensure access to information for persons needing help and information regarding long-term care.

(d) The lead agency or the agencies under contract with the lead agency which are responsible for the accessible information, screening, and assessment function must complete the forms and reports required by the commissioner as specified in the contract.

Subd. 5. Service development and delivery. (a) In addition to the access, screening, and assessment activity, each local strategy may include provisions for the following:

(1) the addition of a full-time staff person who is responsible to develop the following services and recruit providers as established in the contract:

(i) additional adult family foster care homes;

(ii) family adult day care providers as defined in section 256B.0919, subdivision 2;

(iii) an assisted living program in an apartment;

(iv) a congregate housing service project in a subsidized housing project; and

(v) the expansion of evening and weekend coverage of home care services as deemed necessary by the local strategic plan;

(2) small incentive grants to new adult family care providers for renovations needed to meet licensure requirements;

(3) a plan to divert new applicants to nursing homes and to relocate a targeted population from nursing homes, using the individual's own resources or the funding available for services;

(4) one or more caregiver support and respite care projects, as described in subdivision 6; and

(5) one or more living-at-home/block nurse projects, as described in subdivisions 7 to 10.

(b) The expansion of alternative care clients under paragraph (a) shall be accomplished with the funds provided under section 256B.0913, and includes the allocation of targeted funds. The funding for all participating counties must be coordinated by the local long-term care coordinating team and must be part of the local long-term care strategy. Alternative care funds may be transferred from one SAIL county to another within a designated SAIL project area during a fiscal year as authorized by the local long-term care coordinating team and approved by the commissioner. The base allocation used for a future year shall reflect the final transfer. Each county retains responsibility for reimbursement as defined in section 256B.0913, subdivision 12. All other requirements for the alternative care program must be met unless an exception is provided in this section. The commissioner may establish by contract a reimbursement

APPENDIX

Repealed Minnesota Statutes: S1034-1

mechanism for alternative care that does not require invoice processing through the Medical Assistance Management Information System (MMIS). The commissioner and local agencies must assure that the same client and reimbursement data is obtained as is available under MMIS.

(c) The administration of these components is the responsibility of the agencies selected by the local coordinating team and under contract with the local lead agency. However, administrative funds for paragraph (a), clauses (2) to (4), and grant funds for paragraph (a), clause (5), shall be granted to the local lead agency. The funding available for each component is based on the plan submitted and the amount negotiated in the contract.

Subd. 7. **Contract.** (a) The commissioner of human services shall execute a contract with Living at Home/Block Nurse Program, Inc. (LAH/BN, Inc.). The contract shall require LAH/BN, Inc. to:

(1) develop criteria for and award grants to establish community-based organizations that will implement living-at-home/block nurse programs throughout the state;

(2) award grants to enable living-at-home/block nurse programs to continue to implement the combined living-at-home/block nurse program model;

(3) serve as a state technical assistance center to assist and coordinate the living-at-home/block nurse programs established; and

(4) manage contracts with individual living-at-home/block nurse programs.

(b) The contract shall be effective July 1, 1997, and section 16B.17 shall not apply.

Subd. 8. **Living-at-home/block nurse program grant.** (a) The organization awarded the contract under subdivision 7, shall develop and administer a grant program to establish or expand up to 33 community-based organizations that will implement living-at-home/block nurse programs that are designed to enable senior citizens to live as independently as possible in their homes and in their communities. At least one-half of the programs must be in counties outside the seven-county metropolitan area. Nonprofit organizations and units of local government are eligible to apply for grants to establish the community organizations that will implement living-at-home/block nurse programs. In awarding grants, the organization awarded the contract under subdivision 7 shall give preference to nonprofit organizations and units of local government from communities that:

(1) have high nursing home occupancy rates;

(2) have a shortage of health care professionals;

(3) are located in counties adjacent to, or are located in, counties with existing living-at-home/block nurse programs; and

(4) meet other criteria established by LAH/BN, Inc., in consultation with the commissioner.

(b) Grant applicants must also meet the following criteria:

(1) the local community demonstrates a readiness to establish a community model of care, including the formation of a board of directors, advisory committee, or similar group, of which at least two-thirds is comprised of community citizens interested in community-based care for older persons;

(2) the program has sponsorship by a credible, representative organization within the community;

(3) the program has defined specific geographic boundaries and defined its organization, staffing and coordination/delivery of services;

(4) the program demonstrates a team approach to coordination and care, ensuring that the older adult participants, their families, the formal and informal providers are all part of the effort to plan and provide services; and

(5) the program provides assurances that all community resources and funding will be coordinated and that other funding sources will be maximized, including a person's own resources.

(c) Grant applicants must provide a minimum of five percent of total estimated development costs from local community funding. Grants shall be awarded for four-year periods, and the base amount shall not exceed \$80,000 per applicant for the grant period. The organization under contract may increase the grant amount for applicants from communities that have socioeconomic characteristics that indicate a higher level of need for assistance. Subject to the availability of funding, grants and grant renewals awarded or entered into on or after July 1, 1997, shall be renewed by LAH/BN, Inc. every four years, unless LAH/BN, Inc. determines that the grant recipient has not satisfactorily operated the living-at-home/block nurse program in compliance with the requirements of paragraphs (b) and (d). Grants provided to living-at-home/block nurse programs under this paragraph may be used for both program development and the delivery of services.

(d) Each living-at-home/block nurse program shall be designed by representatives of the communities being served to ensure that the program addresses the specific needs of the community residents. The programs must be designed to:

APPENDIX

Repealed Minnesota Statutes: S1034-1

(1) incorporate the basic community, organizational, and service delivery principles of the living-at-home/block nurse program model;

(2) provide senior citizens with registered nurse directed assessment, provision and coordination of health and personal care services on a sliding fee basis as an alternative to expensive nursing home care;

(3) provide information, support services, homemaking services, counseling, and training for the client and family caregivers;

(4) encourage the development and use of respite care, caregiver support, and in-home support programs, such as adult foster care and in-home adult day care;

(5) encourage neighborhood residents and local organizations to collaborate in meeting the needs of senior citizens in their communities;

(6) recruit, train, and direct the use of volunteers to provide informal services and other appropriate support to senior citizens and their caregivers; and

(7) provide coordination and management of formal and informal services to senior citizens and their families using less expensive alternatives.

Subd. 9. State technical assistance center. The organization under contract shall be the state technical assistance center to provide orientation and technical assistance, and to coordinate the living-at-home/block nurse programs established. The state resource center shall:

(1) provide communities with criteria in planning and designing their living-at-home/block nurse programs;

(2) provide general orientation and technical assistance to communities who desire to establish living-at-home/block nurse programs;

(3) provide ongoing analysis and data collection of existing and newly established living-at-home/block nurse programs and provide data to the organization performing the independent assessment; and

(4) serve as the living-at-home/block nurse programs' liaison to the legislature and other state agencies.

Subd. 10. Implementation plan. The organization under contract shall develop a plan that specifies a strategy for implementing living-at-home/block nurse programs statewide. The plan must also analyze the data collected by the state technical assistance center and describe the effectiveness of services provided by living-at-home/block nurse programs, including the program's impact on acute care costs. The organization shall report to the commissioner of human services and to the legislature by January 1, 1993.

Subd. 11. SAIL evaluation and expansion. The commissioner shall evaluate the success of the SAIL projects against the objective stated in subdivision 1, paragraph (b), and recommend to the legislature the continuation or expansion of the long-term care strategy by February 15, 1995.

Subd. 12. Public awareness campaign. The commissioner, with assistance from the commissioner of health and with the advice of the long-term care planning committee, shall contract for a public awareness campaign to educate the general public, seniors, consumers, caregivers, and professionals about the aging process, the long-term care system, and alternatives available including alternative care and residential alternatives. Particular emphasis will be given to informing consumers on how to access the alternatives and obtain information on the long-term care system. The commissioner shall pursue the development of new names for preadmission screening, alternative care, foster care, and other services as deemed necessary for the public awareness campaign.

Subd. 14. Essential community supports grants. (a) The purpose of the essential community supports grant program is to provide targeted services to persons 65 years and older who need essential community support, but whose needs do not meet the level of care required for nursing facility placement under section 144.0724, subdivision 11.

(b) Within the limits of the appropriation and not to exceed \$400 per person per month, funding must be available to a person who:

(1) is age 65 or older;

(2) is not eligible for medical assistance;

(3) would otherwise be financially eligible for the alternative care program under section 256B.0913, subdivision 4;

(4) has received a community assessment under section 256B.0911, subdivision 3a or 3b, and does not require the level of care provided in a nursing facility;

(5) has a community support plan; and

(6) has been determined by a community assessment under section 256B.0911, subdivision 3a or 3b, to be a person who would require provision of at least one of the following services, as defined in the approved elderly waiver plan, in order to maintain their community residence:

(i) caregiver support;

APPENDIX

Repealed Minnesota Statutes: S1034-1

- (ii) homemaker;
- (iii) chore; or
- (iv) a personal emergency response device or system.

(c) The person receiving any of the essential community supports in this subdivision must also receive service coordination as part of their community support plan.

(d) A person who has been determined to be eligible for an essential community support grant must be reassessed at least annually and continue to meet the criteria in paragraph (b) to remain eligible for an essential community support grant.

(e) The commissioner shall allocate grants to counties and tribes under contract with the department based upon the historic use of the medical assistance elderly waiver and alternative care grant programs and other criteria as determined by the commissioner.

256B.096 QUALITY MANAGEMENT, ASSURANCE, AND IMPROVEMENT SYSTEM FOR MINNESOTANS RECEIVING DISABILITY SERVICES.

Subdivision 1. **Scope.** In order to improve the quality of services provided to Minnesotans with disabilities and to meet the requirements of the federally approved home and community-based waivers under section 1915c of the Social Security Act, a statewide quality assurance and improvement system for Minnesotans receiving disability services shall be developed. The disability services included are the home and community-based services waiver programs for persons with developmental disabilities under section 256B.092, subdivision 4, and for persons with disabilities under section 256B.49.

Subd. 2. **Stakeholder advisory group.** The commissioner shall consult with a stakeholder advisory group on the development and implementation of the state quality management, assurance, and improvement system, including representatives of disability service recipients, disability service providers, disability advocacy groups, county human service agencies, and state agency staff from the Departments of Human Services and Health, and the ombudsman for mental health and developmental disabilities on the development of a statewide quality assurance and improvement system.

Subd. 3. **Annual survey of service recipients.** The commissioner, in consultation with the stakeholder advisory group, shall develop an annual independent random statewide survey of between five and ten percent of service recipients to determine the effectiveness and quality of disability services. The survey shall be consistent with the system performance expectations of the Centers for Medicare and Medicaid Services quality management requirements and framework. The survey shall analyze whether desired outcomes have been achieved for persons with different demographic, diagnostic, health, and functional needs receiving different types of services, in different settings, with different costs. The survey shall be field tested during 2008. The biennial report established in subdivision 5 shall include recommendations on statewide and regional reports of the survey results that, if published, would be useful to regions, counties, and providers to plan and measure the impact of quality improvement activities.

Subd. 4. **Improvements for incident reporting, investigation, analysis, and follow-up.** In consultation with the stakeholder advisory group, the commissioner shall identify the information, data sources, and technology needed to improve the system of incident reporting, including:

- (1) reports made under the Maltreatment of Minors and Vulnerable Adults Acts; and
- (2) investigation, analysis, and follow-up for disability services.

The commissioner must ensure that the federal home and community-based waiver requirements are met and that incidents that may have jeopardized safety and health or violated service-related assurances, civil and human rights, and other protections designed to prevent abuse, neglect, and exploitation, are reviewed, investigated, and acted upon in a timely manner.

256B.49 HOME AND COMMUNITY-BASED SERVICE WAIVERS FOR DISABLED.

Subd. 16a. **Medical assistance reimbursement.** (a) The commissioner shall seek federal approval for medical assistance reimbursement of independent living skills services, foster care waiver service, supported employment, prevocational service, and structured day service under the home and community-based waiver for persons with a brain injury, the community alternatives for disabled individuals waivers, and the community alternative care waivers.

(b) Medical reimbursement shall be made only when the provider demonstrates evidence of its capacity to meet basic health, safety, and protection standards through the following methods:

- (1) for independent living skills services, supported employment, prevocational service, and structured day service through one of the methods in paragraphs (c) and (d); and

APPENDIX

Repealed Minnesota Statutes: S1034-1

(2) for foster care waiver services through the method in paragraph (e).

(c) The provider is licensed to provide services under chapter 245B and agrees to apply these standards to services funded through the brain injury, community alternatives for disabled persons, or community alternative care home and community-based waivers.

(d) The commissioner shall certify that the provider has policies and procedures governing the following:

(1) protection of the consumer's rights and privacy;

(2) risk assessment and planning;

(3) record keeping and reporting of incidents and emergencies with documentation of corrective action if needed;

(4) service outcomes, regular reviews of progress, and periodic reports;

(5) complaint and grievance procedures;

(6) service termination or suspension;

(7) necessary training and supervision of direct care staff that includes:

(i) documentation in personnel files of 20 hours of orientation training in providing training related to service provision;

(ii) training in recognizing the symptoms and effects of certain disabilities, health conditions, and positive behavioral supports and interventions;

(iii) a minimum of five hours of related training annually; and

(iv) when applicable:

(A) safe medication administration;

(B) proper handling of consumer funds; and

(C) compliance with prohibitions and standards developed by the commissioner to satisfy federal requirements regarding the use of restraints and restrictive interventions. The commissioner shall review at least biennially that each service provider's policies and procedures governing basic health, safety, and protection of rights continue to meet minimum standards.

(e) The commissioner shall seek federal approval for Medicaid reimbursement of foster care services under the home and community-based waiver for persons with a brain injury, the community alternatives for disabled individuals waiver, and community alternative care waiver when the provider demonstrates evidence of its capacity to meet basic health, safety, and protection standards. The commissioner shall verify that the adult foster care provider is licensed under Minnesota Rules, parts 9555.5105 to 9555.6265; that the child foster care provider is licensed as a family foster care or a foster care residence under Minnesota Rules, parts 2960.3000 to 2960.3340, and certify that the provider has policies and procedures that govern:

(1) compliance with prohibitions and standards developed by the commissioner to meet federal requirements regarding the use of restraints and restrictive interventions;

(2) documentation of service needs and outcomes, regular reviews of progress, and periodic reports; and

(3) safe medication management and administration.

The commissioner shall review at least biennially that each service provider's policies and procedures governing basic health, safety, and protection of rights standards continue to meet minimum standards.

(f) The commissioner shall seek federal waiver approval for Medicaid reimbursement of family adult day services under all disability waivers. After the waiver is granted, the commissioner shall include family adult day services in the common services menu that is currently under development.

256B.4913 PAYMENT METHODOLOGY DEVELOPMENT.

Subdivision 1. **Research period and rates.** (a) For the purposes of this section, "research rate" means a proposed payment rate for the provision of home and community-based waived services to meet federal requirements and assess the implications of changing resources on the provision of services and "research period" means the time period during which the research rate is being assessed by the commissioner.

(b) The commissioner shall determine and publish initial frameworks and values to generate research rates for individuals receiving home and community-based services.

(c) The initial values issued by the commissioner shall ensure projected spending for home and community-based services for each service area is equivalent to projected spending under current law in the most recent expenditure forecast.

(d) The initial values issued shall be based on the most updated information and cost data available on supervision, employee-related costs, client programming and supports, programming

APPENDIX

Repealed Minnesota Statutes: S1034-1

planning supports, transportation, administrative overhead, and utilization costs. These service areas are:

- (1) residential services, defined as corporate foster care, family foster care, residential care, supported living services, customized living, and 24-hour customized living;
- (2) day program services, defined as adult day care, day training and habilitation, prevocational services, structured day services, and transportation;
- (3) unit-based services with programming, defined as in-home family support, independent living services, supported living services, supported employment, behavior programming, and housing access coordination; and
- (4) unit-based services without programming, defined as respite, personal support, and night supervision.

(e) The commissioner shall make available the underlying assessment information, without any identifying information, and the statistical modeling used to generate the initial research rate and calculate budget neutrality.

Subd. 2. **Framework values.** (a) The commissioner shall propose legislation with the specific payment methodology frameworks, process for calculation, and specific values to populate the frameworks by February 15, 2013.

(b) The commissioner shall provide underlying data and information used to formulate the final frameworks and values to the existing stakeholder workgroup by January 15, 2013.

(c) The commissioner shall provide recommendations for the final frameworks and values, and the basis for the recommendations, to the legislative committees with jurisdiction over health and human services finance by February 15, 2013.

(d) The commissioner shall review the following topics during the research period and propose, as necessary, recommendations to address the following research questions:

- (1) underlying differences in the cost to provide services throughout the state;
- (2) a data-driven process for determining labor costs and customizations for staffing classifications included in each rate framework based on the services performed;
- (3) the allocation of resources previously established under section 256B.501, subdivision 4b;
- (4) further definition and development of unit-based services;
- (5) the impact of splitting the allocation of resources for unit-based services for those with programming aspects and those without;
- (6) linking assessment criteria to future assessment processes for determination of customizations;
- (7) recognition of cost differences in the use of monitoring technology where it is appropriate to substitute for supervision;
- (8) implications for day services of reimbursement based on a unit rate and a daily rate;
- (9) a definition of shared and individual staffing for unit-based services;
- (10) the underlying costs of providing transportation associated with day services; and
- (11) an exception process for individuals with exceptional needs that cannot be met under the initial research rate, and an alternative payment structure for those individuals.

(e) The commissioner shall develop a comprehensive plan based on information gathered during the research period that uses statistically reliable and valid assessment data to refine payment methodologies.

(f) The commissioner shall make recommendations and provide underlying data and information used to formulate these research recommendations to the existing stakeholder workgroup by January 15, 2013.

Subd. 3. **Data collection.** (a) The commissioner shall conduct any necessary research and gather additional data for the further development and refinement of payment methodology components. These include but are not limited to:

- (1) levels of service utilization and patterns of use;
- (2) staffing patterns for each service;
- (3) profiles of individual service needs; and
- (4) cost factors involved in providing transportation services.

(b) The commissioner shall provide this information to the existing stakeholder workgroup by January 15, 2013.

Subd. 4. **Rate stabilization adjustment.** Beginning January 1, 2014, the commissioner shall adjust individual rates determined by the new payment methodology so that the new rate varies no more than one percent per year from the rate effective on December 31 of the prior calendar

APPENDIX

Repealed Minnesota Statutes: S1034-1

year. This adjustment is made annually and is effective for three calendar years from the date of implementation. This subdivision expires January 1, 2017.

256B.5012 ICF/MR PAYMENT SYSTEM IMPLEMENTATION.

Subd. 13. **ICF/DD rate decrease effective July 1, 2013.** Notwithstanding subdivision 12, and if the commissioner has not received federal approval before July 1, 2013, of the Long-Term Care Realignment Waiver application submitted under Laws 2011, First Special Session chapter 9, article 7, section 52, or only receives approval to implement portions of the waiver request, for each facility reimbursed under this section for services provided from July 1, 2013, through December 31, 2013, the commissioner shall decrease operating payments up to 1.67 percent of the operating payment rates in effect on June 30, 2013. The commissioner shall prorate the reduction in the event that only portions of the waiver request are approved and after application of the continuing care provider payment delay provision in Laws 2012, chapter 247, article 6, section 2, subdivision 4, paragraph (f). For each facility, the commissioner shall apply the rate reduction 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. The total rate reduction shall include the adjustment provided in section 256B.501, subdivision 12.

256J.24 FAMILY COMPOSITION; ASSISTANCE STANDARDS; EXIT LEVEL.

Subd. 6. **Family cap.** (a) MFIP assistance units shall not receive an increase in the cash portion of the transitional standard as a result of the birth of a child, unless one of the conditions under paragraph (b) is met. The child shall be considered a member of the assistance unit according to subdivisions 1 to 3, but shall be excluded in determining family size for purposes of determining the amount of the cash portion of the transitional standard under subdivision 5. The child shall be included in determining family size for purposes of determining the food portion of the transitional standard. The transitional standard under this subdivision shall be the total of the cash and food portions as specified in this paragraph. The family wage level under this subdivision shall be based on the family size used to determine the food portion of the transitional standard.

(b) A child shall be included in determining family size for purposes of determining the amount of the cash portion of the MFIP transitional standard when at least one of the following conditions is met:

(1) for families receiving MFIP assistance on July 1, 2003, the child is born to the adult parent before May 1, 2004;

(2) for families who apply for the diversionary work program under section 256J.95 or MFIP assistance on or after July 1, 2003, the child is born to the adult parent within ten months of the date the family is eligible for assistance;

(3) the child was conceived as a result of a sexual assault or incest, provided that the incident has been reported to a law enforcement agency;

(4) the child's mother is a minor caregiver as defined in section 256J.08, subdivision 59, and the child, or multiple children, are the mother's first birth;

(5) the child is the mother's first child subsequent to a pregnancy that did not result in a live birth; or

(6) any child previously excluded in determining family size under paragraph (a) shall be included if the adult parent or parents have not received benefits from the diversionary work program under section 256J.95 or MFIP assistance in the previous ten months. An adult parent or parents who reapply and have received benefits from the diversionary work program or MFIP assistance in the past ten months shall be under the ten-month grace period of their previous application under clause (2).

(c) Income and resources of a child excluded under this subdivision, except child support received or distributed on behalf of this child, must be considered using the same policies as for other children when determining the grant amount of the assistance unit.

(d) The caregiver must assign support and cooperate with the child support enforcement agency to establish paternity and collect child support on behalf of the excluded child. Failure to cooperate results in the sanction specified in section 256J.46, subdivisions 2 and 2a. Current support paid on behalf of the excluded child shall be distributed according to section 256.741, subdivision 15.

(e) County agencies must inform applicants of the provisions under this subdivision at the time of each application and at recertification.

APPENDIX

Repealed Minnesota Statutes: S1034-1

(f) Children excluded under this provision shall be deemed MFIP recipients for purposes of child care under chapter 119B.

256L.01 DEFINITIONS.

Subd. 3. **Eligible providers.** "Eligible providers" means those health care providers who provide covered health services to medical assistance recipients under rules established by the commissioner for that program.

Subd. 4a. **Gross individual or gross family income.** (a) "Gross individual or gross family income" for nonfarm self-employed means income calculated for the 12-month period of eligibility using as a baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year and adding back in depreciation, and carryover net operating loss amounts that apply to the business in which the family is currently engaged.

(b) "Gross individual or gross family income" for farm self-employed means income calculated for the 12-month period of eligibility using as the baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year.

(c) "Gross individual or gross family income" means the total income for all family members, calculated for the 12-month period of eligibility.

256L.02 PROGRAM ADMINISTRATION.

Subd. 3. **Financial management.** (a) The commissioner shall manage spending for the MinnesotaCare program in a manner that maintains a minimum reserve. As part of each state revenue and expenditure forecast, the commissioner must make an assessment of the expected expenditures for the covered services for the remainder of the current biennium and for the following biennium. The estimated expenditure, including the reserve, shall be compared to an estimate of the revenues that will be available in the health care access fund. Based on this comparison, and after consulting with the chairs of the house of representatives Ways and Means Committee and the senate Finance Committee, the commissioner shall, as necessary, make the adjustments specified in paragraph (b) to ensure that expenditures remain within the limits of available revenues for the remainder of the current biennium and for the following biennium. The commissioner shall not hire additional staff using appropriations from the health care access fund until the commissioner of management and budget makes a determination that the adjustments implemented under paragraph (b) are sufficient to allow MinnesotaCare expenditures to remain within the limits of available revenues for the remainder of the current biennium and for the following biennium.

(b) The adjustments the commissioner shall use must be implemented in this order: first, stop enrollment of single adults and households without children; second, upon 45 days' notice, stop coverage of single adults and households without children already enrolled in the MinnesotaCare program; third, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income above 200 percent of the federal poverty guidelines; fourth, upon 90 days' notice, decrease the premium subsidy amounts by ten percent for families with gross annual income at or below 200 percent; and fifth, require applicants to be uninsured for at least six months prior to eligibility in the MinnesotaCare program. If these measures are insufficient to limit the expenditures to the estimated amount of revenue, the commissioner shall further limit enrollment or decrease premium subsidies.

256L.03 COVERED HEALTH SERVICES.

Subd. 4. **Coordination with medical assistance.** The commissioner shall coordinate the provision of hospital inpatient services under the MinnesotaCare program with enrollee eligibility under the medical assistance spenddown.

256L.031 HEALTHY MINNESOTA CONTRIBUTION PROGRAM.

Subdivision 1. **Defined contributions to enrollees.** (a) Beginning July 1, 2012, the commissioner shall provide each MinnesotaCare enrollee eligible under section 256L.04, subdivision 7, with family income equal to or greater than 200 percent of the federal poverty guidelines with a monthly defined contribution to purchase health coverage under a health plan as defined in section 62A.011, subdivision 3.

(b) Enrollees eligible under this section shall not be charged premiums under section 256L.15 and are exempt from the managed care enrollment requirement of section 256L.12.

APPENDIX

Repealed Minnesota Statutes: S1034-1

(c) Sections 256L.03; 256L.05, subdivision 3; and 256L.11 do not apply to enrollees eligible under this section unless otherwise provided in this section. Covered services, cost sharing, disenrollment for nonpayment of premium, enrollee appeal rights and complaint procedures, and the effective date of coverage for enrollees eligible under this section shall be as provided under the terms of the health plan purchased by the enrollee.

(d) Unless otherwise provided in this section, all MinnesotaCare requirements related to eligibility, income and asset methodology, income reporting, and program administration, continue to apply to enrollees obtaining coverage under this section.

Subd. 2. Use of defined contribution; health plan requirements. (a) An enrollee may use up to the monthly defined contribution to pay premiums for coverage under a health plan as defined in section 62A.011, subdivision 3, or as provided in section 256L.031, subdivision 6.

(b) An enrollee must select a health plan within four calendar months of approval of MinnesotaCare eligibility. If a health plan is not selected and purchased within this time period, the enrollee must reapply and must meet all eligibility criteria. The commissioner may determine criteria under which an enrollee has more than four calendar months to select a health plan.

(c) Coverage purchased under this section must:

(1) include mental health and chemical dependency treatment services; and

(2) comply with the coverage limitations specified in section 256L.03, subdivision 1, paragraph (b).

Subd. 3. Determination of defined contribution amount. (a) The commissioner shall determine the defined contribution sliding scale using the base contribution specified in this paragraph for the specified age ranges. The commissioner shall use a sliding scale for defined contributions that provides:

(1) persons with household incomes equal to 200 percent of the federal poverty guidelines with a defined contribution of 93 percent of the base contribution;

(2) persons with household incomes equal to 250 percent of the federal poverty guidelines with a defined contribution of 80 percent of the base contribution; and

(3) persons with household incomes in evenly spaced increments between the percentages of the federal poverty guideline or income level specified in clauses (1) and (2) with a base contribution that is a percentage interpolated from the defined contribution percentages specified in clauses (1) and (2).

19-29	\$125
30-34	\$135
35-39	\$140
40-44	\$175
45-49	\$215
50-54	\$295
55-59	\$345
60+	\$360

(b) The commissioner shall multiply the defined contribution amounts developed under paragraph (a) by 1.20 for enrollees who purchase coverage through the Minnesota Comprehensive Health Association.

Subd. 4. Administration by commissioner. (a) The commissioner shall administer the defined contributions. The commissioner shall:

(1) calculate and process defined contributions for enrollees; and

(2) pay the defined contribution amount to health plan companies or the Minnesota Comprehensive Health Association, as applicable, for enrollee health plan coverage.

(b) Nonpayment of a health plan premium shall result in disenrollment from MinnesotaCare effective the first day of the calendar month following the calendar month for which the premium was due. Persons disenrolled for nonpayment or who voluntarily terminate coverage may not reenroll until four calendar months have elapsed.

Subd. 5. Assistance to enrollees. The commissioner of human services, in consultation with the commissioner of commerce, shall develop an efficient and cost-effective method of referring eligible applicants to professional insurance agent associations.

Subd. 6. Minnesota Comprehensive Health Association (MCHA). Beginning July 1, 2012, MinnesotaCare enrollees eligible for coverage through a health plan offered by the Minnesota Comprehensive Health Association may enroll in MCHA in accordance with section 62E.14. Any difference between the revenue and actual covered losses to MCHA related to the

APPENDIX

Repealed Minnesota Statutes: S1034-1

implementation of this section are appropriated annually to the commissioner of human services from the health care access fund and shall be paid to MCHA.

Subd. 7. **Federal approval.** The commissioner shall seek federal financial participation for the adult enrollees eligible under this section.

256L.04 ELIGIBLE PERSONS.

Subd. 1b. **Children with family income greater than 275 percent of federal poverty guidelines.** Children with family income greater than 275 percent of federal poverty guidelines for the applicable family size shall be eligible for MinnesotaCare. All other provisions of sections 256L.01 to 256L.18, including the insurance-related barriers to enrollment under section 256L.07, shall apply unless otherwise specified.

Subd. 2a. **Applications for other benefits.** To be eligible for MinnesotaCare, individuals and families must take all necessary steps to obtain other benefits as described in Code of Federal Regulations, title 42, section 435.608. Applicants and enrollees must apply for other benefits within 30 days of notification.

Subd. 7a. **Ineligibility.** Adults whose income is greater than the limits established under this section may not enroll in the MinnesotaCare program.

Subd. 9. **General assistance medical care.** A person cannot have coverage under both MinnesotaCare and general assistance medical care in the same month. Eligibility for MinnesotaCare cannot be replaced by eligibility for general assistance medical care, and eligibility for general assistance medical care cannot be replaced by eligibility for MinnesotaCare.

256L.07 ELIGIBILITY FOR MINNESOTACARE.

Subdivision 1. **General requirements.** (a) Children enrolled in the original children's health plan as of September 30, 1992, children who enrolled in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, and children who have family gross incomes that are equal to or less than 200 percent of the federal poverty guidelines are eligible without meeting the requirements of subdivision 2 and the four-month requirement in subdivision 3, as long as they maintain continuous coverage in the MinnesotaCare program or medical assistance.

Parents enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above 275 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. Beginning January 1, 2008, individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 200 percent of the federal poverty guidelines or 250 percent of the federal poverty guidelines on or after July 1, 2009, are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or individual exceeds program income limits.

(b) Children may remain enrolled in MinnesotaCare if their gross family income as defined in section 256L.01, subdivision 4, is greater than 275 percent of federal poverty guidelines. The premium for children remaining eligible under this paragraph shall be the maximum premium determined under section 256L.15, subdivision 2, paragraph (b).

(c) Notwithstanding paragraph (a), parents are not eligible for MinnesotaCare if gross household income exceeds \$57,500 for the 12-month period of eligibility.

Subd. 4. **Families with children in need of chemical dependency treatment.** Premiums for families with children when a parent has been determined to be in need of chemical dependency treatment pursuant to an assessment conducted by the county under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision 6, or 260C.212, who are eligible for MinnesotaCare under section 256L.04, subdivision 1, may be paid by the county of residence of the person in need of treatment for one year from the date the family is determined to be eligible or if the family is currently enrolled in MinnesotaCare from the date the person is determined to be in need of chemical dependency treatment. Upon renewal, the family is responsible for any premiums owed under section 256L.15. If the family is not currently enrolled in MinnesotaCare, the local county human services agency shall determine whether the family appears to meet the eligibility requirements and shall assist the family in applying for the MinnesotaCare program.

Subd. 5. **Voluntary disenrollment for members of military.** Notwithstanding section 256L.05, subdivision 3b, MinnesotaCare enrollees who are members of the military and their families, who choose to voluntarily disenroll from the program when one or more family members are called to active duty, may reenroll during or following that member's tour of active duty.

APPENDIX

Repealed Minnesota Statutes: S1034-1

Those individuals and families shall be considered to have good cause for voluntary termination under section 256L.06, subdivision 3, paragraph (d). Income and asset increases reported at the time of reenrollment shall be disregarded. All provisions of sections 256L.01 to 256L.18 shall apply to individuals and families enrolled under this subdivision upon 12-month renewal.

Subd. 8. **Automatic eligibility for certain children.** Any child who was residing in foster care or a juvenile residential correctional facility on the child's 18th birthday is automatically deemed eligible for MinnesotaCare upon termination or release until the child reaches the age of 21, and is exempt from the requirements of this section and section 256L.15. To be enrolled under this section, a child must complete an initial application for MinnesotaCare. The commissioner shall contact individuals enrolled under this section annually to ensure the individual continues to reside in the state and is interested in continuing MinnesotaCare coverage.

Subd. 9. **Firefighters; volunteer ambulance attendants.** (a) For purposes of this subdivision, "qualified individual" means:

(1) a volunteer firefighter with a department as defined in section 299N.01, subdivision 2, who has passed the probationary period; and

(2) a volunteer ambulance attendant as defined in section 144E.001, subdivision 15.

(b) A qualified individual who documents to the satisfaction of the commissioner status as a qualified individual by completing and submitting a one-page form developed by the commissioner is eligible for MinnesotaCare without meeting other eligibility requirements of this chapter, but must pay premiums equal to the average expected capitation rate for adults with no children paid under section 256L.12. Individuals eligible under this subdivision shall receive coverage for the benefit set provided to adults with no children.

256L.09 RESIDENCY.

Subdivision 1. **Findings and purpose.** The legislature finds that the enactment of a comprehensive health plan for uninsured Minnesotans creates a risk that persons needing medical care will migrate to the state for the primary purpose of obtaining medical care subsidized by the state. The risk of migration undermines the state's ability to provide to legitimate state residents a valuable and necessary health care program which is an important component of the state's comprehensive cost containment and health care system reform plan. Intent-based residency requirements, which are expressly authorized under decisions of the United States Supreme Court, are an unenforceable and ineffective method of denying benefits to those persons the Supreme Court has stated may legitimately be denied eligibility for state programs. If the state is unable to limit eligibility to legitimate permanent residents of the state, the state faces a significant risk that it will be forced to reduce the eligibility and benefits it would otherwise provide to Minnesotans. The legislature finds that a durational residence requirement is a legitimate, objective, enforceable standard for determining whether a person is a permanent resident of the state. The legislature also finds low-income persons who have not lived in the state for the required time period will have access to necessary health care services through the general assistance medical care program, the medical assistance program, and public and private charity care programs.

Subd. 4. **Eligibility as Minnesota resident.** (a) For purposes of this section, a permanent Minnesota resident is a person who has demonstrated, through persuasive and objective evidence, that the person is domiciled in the state and intends to live in the state permanently.

(b) To be eligible as a permanent resident, an applicant must demonstrate the requisite intent to live in the state permanently by:

(1) showing that the applicant maintains a residence at a verified address, through the use of evidence of residence described in section 256D.02, subdivision 12a, paragraph (b), clause (2);

(2) demonstrating that the applicant has been continuously domiciled in the state for no less than 180 days immediately before the application; and

(3) signing an affidavit declaring that (A) the applicant currently resides in the state and intends to reside in the state permanently; and (B) the applicant did not come to the state for the primary purpose of obtaining medical coverage or treatment.

(c) A person who is temporarily absent from the state does not lose eligibility for MinnesotaCare. "Temporarily absent from the state" means the person is out of the state for a temporary purpose and intends to return when the purpose of the absence has been accomplished. A person is not temporarily absent from the state if another state has determined that the person is a resident for any purpose. If temporarily absent from the state, the person must follow the requirements of the health plan in which the person is enrolled to receive services.

Subd. 5. **Persons excluded as permanent residents.** An individual or family that moved to Minnesota primarily to obtain medical treatment or health coverage for a preexisting condition is not a permanent resident.

APPENDIX

Repealed Minnesota Statutes: S1034-1

Subd. 6. **12-month preexisting exclusion.** If the 180-day requirement in subdivision 4, paragraph (b), clause (2), is determined by a court to be unconstitutional, the commissioner of human services shall impose a 12-month preexisting condition exclusion on coverage for persons who have been domiciled in the state for less than 180 days.

Subd. 7. **Effect of a court determination.** If any paragraph, sentence, clause, or phrase of this section is for any reason determined by a court to be unconstitutional, the decision shall not affect the validity of the remaining portions of the section. The legislature declares that it would have passed each paragraph, sentence, clause, and phrase in this section, irrespective of the fact that any one or more paragraphs, sentences, clauses, or phrases is declared unconstitutional.

256L.11 PROVIDER PAYMENT.

Subd. 2a. **Payment rates; services for families and children under the MinnesotaCare health care reform waiver.** Subdivision 2 shall not apply to services provided to families with children who are eligible according to section 256L.04, subdivision 1, paragraph (a).

Subd. 5. **Enrollees younger than 18.** Payment for inpatient hospital services provided to MinnesotaCare enrollees who are younger than 18 years old on the date of admission to the inpatient hospital shall be at the medical assistance rate.

Subd. 6. **Enrollees 18 or older.** Payment by the MinnesotaCare program for inpatient hospital services provided to MinnesotaCare enrollees eligible under section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and 2, with family gross income that exceeds 175 percent of the federal poverty guidelines and who are not pregnant, who are 18 years old or older on the date of admission to the inpatient hospital must be in accordance with paragraphs (a) and (b). Payment for adults who are not pregnant and are eligible under section 256L.04, subdivisions 1 and 2, and whose incomes are equal to or less than 175 percent of the federal poverty guidelines, shall be as provided for under paragraph (c).

(a) If the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4, is less than or equal to the amount remaining in the enrollee's benefit limit under section 256L.03, subdivision 3, payment must be the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4. The hospital must not seek payment from the enrollee in addition to the co-payment. The MinnesotaCare payment plus the co-payment must be treated as payment in full.

(b) If the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4, is greater than the amount remaining in the enrollee's benefit limit under section 256L.03, subdivision 3, payment must be the lesser of:

- (1) the amount remaining in the enrollee's benefit limit; or
- (2) charges submitted for the inpatient hospital services less any co-payment established under section 256L.03, subdivision 4.

The hospital may seek payment from the enrollee for the amount by which usual and customary charges exceed the payment under this paragraph. If payment is reduced under section 256L.03, subdivision 3, paragraph (b), the hospital may not seek payment from the enrollee for the amount of the reduction.

(c) For admissions occurring on or after July 1, 2011, for single adults and households without children who are eligible under section 256L.04, subdivision 7, the commissioner shall pay hospitals directly, up to the medical assistance payment rate, for inpatient hospital benefits up to the \$10,000 annual inpatient benefit limit, minus any co-payment required under section 256L.03, subdivision 5. Inpatient services paid directly by the commissioner under this paragraph do not include chemical dependency hospital-based and residential treatment.

256L.12 MANAGED CARE.

Subdivision 1. **Selection of vendors.** In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall, where possible, contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for managed care plans which may include: prepaid capitation programs, competitive bidding programs, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided.

Subd. 2. **Geographic area.** The commissioner shall designate the geographic areas in which eligible individuals must receive services through managed care plans.

APPENDIX

Repealed Minnesota Statutes: S1034-1

Subd. 3. **Limitation of choice.** Persons enrolled in the MinnesotaCare program who reside in the designated geographic areas must enroll in a managed care plan to receive their health care services. Enrollees must receive their health care services from health care providers who are part of the managed care plan provider network, unless authorized by the managed care plan, in cases of medical emergency, or when otherwise required by law or by contract.

If only one managed care option is available in a geographic area, the managed care plan may require that enrollees designate a primary care provider from which to receive their health care. Enrollees will be permitted to change their designated primary care provider upon request to the managed care plan. Requests to change primary care providers may be limited to once annually. If more than one managed care plan is offered in a geographic area, enrollees will be enrolled in a managed care plan for up to one year from the date of enrollment, but shall have the right to change to another managed care plan once within the first year of initial enrollment. Enrollees may also change to another managed care plan during an annual 30-day open enrollment period. Enrollees shall be notified of the opportunity to change to another managed care plan before the start of each annual open enrollment period.

Enrollees may change managed care plans or primary care providers at other than the above designated times for cause as determined through an appeal pursuant to section 256.045.

Subd. 4. **Exemptions to limitations on choice.** All contracts between the Department of Human Services and prepaid health plans to serve medical assistance, general assistance medical care, and MinnesotaCare recipients must comply with the requirements of United States Code, title 42, section 1396a (a)(23)(B), notwithstanding any waivers authorized by the United States Department of Health and Human Services pursuant to United States Code, title 42, section 1315.

Subd. 5. **Eligibility for other state programs.** MinnesotaCare enrollees who become eligible for medical assistance will remain in the same managed care plan if the managed care plan has a contract for that population. MinnesotaCare enrollees who were formerly eligible for general assistance medical care pursuant to section 256D.03, subdivision 3, within six months of MinnesotaCare enrollment and were enrolled in a prepaid health plan pursuant to section 256D.03, subdivision 4, paragraph (c), must remain in the same managed care plan if the managed care plan has a contract for that population. Managed care plans must participate in the MinnesotaCare program under a contract with the Department of Human Services in service areas where they participate in the medical assistance program.

Subd. 6. **Co-payments and benefit limits.** Enrollees are responsible for all co-payments in section 256L.03, subdivision 5, and shall pay co-payments to the managed care plan or to its participating providers. The enrollee is also responsible for payment of inpatient hospital charges which exceed the MinnesotaCare benefit limit.

Subd. 7. **Managed care plan vendor requirements.** The following requirements apply to all counties or vendors who contract with the Department of Human Services to serve MinnesotaCare recipients. Managed care plan contractors:

(1) shall authorize and arrange for the provision of the full range of services listed in section 256L.03 in order to ensure appropriate health care is delivered to enrollees;

(2) shall accept the prospective, per capita payment or other contractually defined payment from the commissioner in return for the provision and coordination of covered health care services for eligible individuals enrolled in the program;

(3) may contract with other health care and social service practitioners to provide services to enrollees;

(4) shall provide for an enrollee grievance process as required by the commissioner and set forth in the contract with the department;

(5) shall retain all revenue from enrollee co-payments;

(6) shall accept all eligible MinnesotaCare enrollees, without regard to health status or previous utilization of health services;

(7) shall demonstrate capacity to accept financial risk according to requirements specified in the contract with the department. A health maintenance organization licensed under chapter 62D, or a nonprofit health plan licensed under chapter 62C, is not required to demonstrate financial risk capacity, beyond that which is required to comply with chapters 62C and 62D; and

(8) shall submit information as required by the commissioner, including data required for assessing enrollee satisfaction, quality of care, cost, and utilization of services.

Subd. 8. **Chemical dependency assessments.** The managed care plan shall be responsible for assessing the need and placement for chemical dependency services according to criteria set forth in Minnesota Rules, parts 9530.6600 to 9530.6660.

Subd. 9a. **Rate setting; ratable reduction.** For services rendered on or after October 1, 2003, the total payment made to managed care plans under the MinnesotaCare program is reduced

APPENDIX

Repealed Minnesota Statutes: S1034-1

1.0 percent. This provision excludes payments for mental health services added as covered benefits after December 31, 2007.

Subd. 9b. **Rate setting; ratable reduction.** In addition to the reduction in subdivision 9a, the total payment made to managed care plans under the MinnesotaCare program shall be reduced for services provided on or after January 1, 2006, to reflect a 6.0 percent reduction in reimbursement for inpatient hospital services.

256L.17 ASSET REQUIREMENT FOR MINNESOTACARE.

Subdivision 1. **Definitions.** For purposes of this section, the following definitions apply.

(a) "Asset" means cash and other personal property, as well as any real property, that a family or individual owns which has monetary value.

(b) "Homestead" means the home that is owned by, and is the usual residence of, the family or individual, together with the surrounding property which is not separated from the home by intervening property owned by others. Public rights-of-way, such as roads that run through the surrounding property and separate it from the home, will not affect the exemption of the property. "Usual residence" includes the home from which the family or individual is temporarily absent due to illness, employment, or education, or because the home is temporarily not habitable due to casualty or natural disaster.

(c) "Net asset" means the asset's fair market value minus any encumbrances including, but not limited to, liens and mortgages.

Subd. 2. **Limit on total assets.** (a) Effective July 1, 2002, or upon federal approval, whichever is later, in order to be eligible for the MinnesotaCare program, a household of two or more persons must not own more than \$20,000 in total net assets, and a household of one person must not own more than \$10,000 in total net assets.

(b) For purposes of this subdivision, assets are determined according to section 256B.056, subdivision 3c, except that workers' compensation settlements received due to a work-related injury shall not be considered.

(c) State-funded MinnesotaCare is not available for applicants or enrollees who are otherwise eligible for medical assistance but fail to verify assets. Enrollees who become eligible for federally funded medical assistance shall be terminated from state-funded MinnesotaCare and transferred to medical assistance.

Subd. 3. **Documentation.** (a) The commissioner of human services shall require individuals and families, at the time of application or renewal, to indicate on a form developed by the commissioner whether they satisfy the MinnesotaCare asset requirement.

(b) The commissioner may require individuals and families to provide any information the commissioner determines necessary to verify compliance with the asset requirement, if the commissioner determines that there is reason to believe that an individual or family has assets that exceed the program limit.

Subd. 4. **Penalties.** Individuals or families who are found to have knowingly misreported the amount of their assets as described in this section shall be subject to the penalties in section 256.98. The commissioner shall present recommendations on additional penalties to the 1998 legislature.

Subd. 5. **Exemption.** This section does not apply to pregnant women or children. For purposes of this subdivision, a woman is considered pregnant for 60 days postpartum.

485.14 VITAL STATISTICS, RECORDS RECEIVED FOR PRESERVATION.

The court administrators of the district court may, at their option as county registrars of vital statistics, receive for preservation records or certificates of live birth, death or stillbirth from town clerks, statutory city clerks, city agents of a board of health as authorized under section 145A.04 of cities which do not maintain local registration of vital statistics under section 144.214, or other local officers, who may have lawful custody and possession thereof in their respective counties. The court administrators taking possession of such records and certificates shall with regard to them be subject to all applicable provisions of sections 144.211 to 144.227.

609.093 JUVENILE PROSTITUTES; DIVERSION OR CHILD PROTECTION PROCEEDINGS.

Subdivision 1. **First-time prostitution offense; applicability; procedure.** (a) This section applies to a 16 or 17 year old child alleged to have engaged in prostitution as defined in section 609.321, subdivision 9, who:

(1) has not been previously adjudicated delinquent for engaging in prostitution as defined in section 609.321, subdivision 9;

APPENDIX

Repealed Minnesota Statutes: S1034-1

(2) has not previously participated in or completed a diversion program for engaging in prostitution as defined in section 609.321, subdivision 9;

(3) has not previously been placed on probation without an adjudication or received a continuance under section 260B.198, subdivision 7, for engaging in prostitution as defined in section 609.321, subdivision 9;

(4) has not previously been found to be a child in need of protection or services for engaging in prostitution as defined in section 609.321, subdivision 9, or because the child is a sexually exploited youth as defined in section 260C.007, subdivision 31, clause (1); and

(5) agrees to successfully complete a diversion program under section 388.24 or fully comply with a disposition order under sections 260C.201, 260C.202, and 260C.204.

(b) The prosecutor shall refer a child described in paragraph (a) to a diversion program under section 388.24 or file a petition under section 260C.141 alleging the child to be in need of protection or services.

Subd. 2. **Failure to comply.** If a child fails to successfully complete diversion or fails to fully comply with a disposition order under sections 260C.201, 260C.202, and 260C.204, the child may be referred back to the court for further proceedings under chapter 260B.

Subd. 3. **Dismissal of charge.** The court shall dismiss the charge against the child if any of the following apply:

(1) the prosecutor referred the child to a diversion program and the prosecutor notifies the court that the child successfully completed the program;

(2) the prosecutor filed a petition under section 260C.141 and the court does not find that the child is in need of protection or services; or

(3) the prosecutor filed a petition under section 260C.141, the court entered an order under sections 260C.201, 260C.202, and 260C.204, and the child fully complied with the order.

Laws 2011, First Special Session chapter 9, article 6, section 97, subdivision 6

Sec. 97. REPEALER.

Subd. 6. **MinnesotaCare provider taxes.** Minnesota Statutes 2010, sections 13.4967, subdivision 3; 295.50, subdivisions 1, 1a, 2, 2a, 3, 4, 6, 6a, 7, 9b, 9c, 10a, 10b, 12b, 13, 14, and 15; 295.51, subdivisions 1 and 1a; 295.52, subdivisions 1, 1a, 2, 3, 4, 4a, 5, 6, and 7; 295.53, subdivisions 1, 2, 3, and 4a; 295.54; 295.55; 295.56; 295.57; 295.58; 295.581; 295.582; and 295.59, are repealed effective for gross revenues received after December 31, 2019.

Laws 2011, First Special Session chapter 9, article 7, section 54, as amended by Laws 2012, chapter 247, article 4, section 42; as amended by Laws 2012, chapter 298, section 3

Sec. 42. Laws 2011, First Special Session chapter 9, article 7, section 54, is amended to read:

Sec. 54. **CONTINGENCY PROVIDER RATE AND GRANT REDUCTIONS.**

(a) Notwithstanding any other rate reduction in this article, if the commissioner of human services has not received federal approval before July 1, 2013, of the long-term care realignment waiver application submitted under Laws 2011, First Special Session chapter 9, article 7, section 52, or only receives approval to implement portions of the waiver request, the commissioner shall decrease grants, allocations, reimbursement rates, individual limits, and rate limits, as applicable, by 1.67 percent effective July 1, 2013, for services rendered from July 1, 2013, through December 31, 2013. The commissioner shall prorate the reduction in the event that only portions of the waiver request are approved and after application of the continuing care provider payment delay provision in article 6, section 2, subdivision 4, paragraph (f). County or tribal contracts for services specified in this section must be amended to pass through these rate reductions within 60 days of the effective date of the decrease, and must be retroactive from the effective date of the rate decrease.

(b) The rate changes described in this section must be provided to:

(1) home and community-based waived services for persons with developmental disabilities or related conditions, including consumer-directed community supports, under Minnesota Statutes, section 256B.501;

(2) home and community-based waived services for the elderly, including consumer-directed community supports, under Minnesota Statutes, section 256B.0915;

(3) waived services under community alternatives for disabled individuals, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(4) community alternative care waived services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(5) traumatic brain injury waived services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(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) day training and habilitation services for adults with developmental disabilities or related conditions, under Minnesota Statutes, sections 252.40 to 252.46, including the additional cost of rate adjustments on day training and habilitation services, provided as a social service under Minnesota Statutes, section 256M.60; and

(10) alternative care services under Minnesota Statutes, section 256B.0913.

(c) A managed care plan receiving state payments for the services in this section must include these decreases in their payments to providers. To implement the rate reductions in this section, capitation rates paid by the commissioner to managed care organizations under Minnesota Statutes, section 256B.69, shall reflect up to a 1.67 percent reduction for the specified services for the period of July 1, 2013, through December 31, 2013.

The above payment rate reduction, allocation rates, and rate limits shall expire for services rendered on December 31, 2013.

4668.0002 APPLICABILITY, AUTHORITY, AND SCOPE.

This chapter implements the licensing of home care providers under Minnesota Statutes, sections 144A.43 to 144A.47, under the authority of Minnesota Statutes, sections 144A.45, subdivision 1, and 144A.4605. Unless otherwise provided, all licensed home care providers must meet the requirements of this chapter. Provisions that apply only to specified classes of licensees are identified by those provisions. The commissioner may delegate any authority or responsibility to an agent of the department. This chapter must be read together with Minnesota Statutes, sections 144A.43 to 144A.47.

4668.0003 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 4668.0002 to 4668.0870, the terms in subparts 2 to 45 have the meanings given them.

Subp. 2. **Ambulatory.** "Ambulatory" means the ability to move about and transfer between locations without the assistance of another person, either with or without the assistance of a walking device or wheel chair.

Subp. 2a. **Assistance with self-administration of medication.** "Assistance with self-administration of medication" means performing a task to enable a client to self-administer medication, including:

- A. bringing the medication to the client;
- B. opening a container containing medications set up by a nurse, physician, or pharmacist;
- C. emptying the contents from the container into the client's hand;
- D. providing liquids or nutrition to accompany medication that a client is self-administering; or
- E. reporting information to a nurse regarding concerns about a client's self-administration of medication.

Subp. 2b. **Class F home care provider.** "Class F home care provider" has the meaning given in Minnesota Statutes, section 144A.4605, subdivision 1.

Subp. 2c. **Assisted living home care service.** "Assisted living home care service" means a nursing service, delegated nursing service, other service performed by an unlicensed person, or central storage of medications provided solely for a resident of a housing with services establishment registered under Minnesota Statutes, chapter 144D.

Subp. 3. **Assisted living services.** "Assisted living services," as provided under a class E home care license, means individualized home care aide tasks or home management tasks provided to clients of a residential center in their living units, and provided either by the management of the residential center or by providers under contract with the management. In this subpart, "individualized" means chosen and designed specifically for each client's needs, rather than provided or offered to all clients regardless of their illnesses, disabilities, or physical conditions.

Subp. 4. **Business.** "Business" means an individual or other legal entity that provides services to persons in their homes.

Subp. 5. **Client.** "Client" means a person to whom a home care provider provides home care services.

Subp. 6. **Commissioner.** "Commissioner" means the commissioner of health.

Subp. 7. **Contract.** "Contract" means a legally binding agreement, whether in writing or not.

Subp. 8. **Department.** "Department" means the Minnesota Department of Health.

Subp. 9. **Home care aide tasks.** "Home care aide tasks" means those services specified in part 4668.0110, subpart 1.

Subp. 10. **Home care provider or provider.** "Home care provider" or "provider" has the meaning given to home care provider by Minnesota Statutes, section 144A.43, subdivision 4.

Subp. 11. **Home care service.** "Home care service" has the meaning given it in Minnesota Statutes, section 144A.43, subdivision 3.

Subp. 12. **Home health aide tasks.** "Home health aide tasks" means those tasks allowed in part 4668.0100, subpart 1.

Subp. 13. **Home management services.** "Home management services" has the meaning given it in Minnesota Statutes, section 144A.43, subdivision 3, clause (8).

Subp. 14. **Home management tasks.** "Home management tasks" means all home management services that are not home health aide or home care aide tasks.

APPENDIX
Repealed Minnesota Rule: S1034-1

Subp. 15. [Repealed, 28 SR 1639]

Subp. 16. **Hospital.** "Hospital" means a facility licensed as a hospital under chapter 4640 and Minnesota Statutes, sections 144.50 to 144.56.

Subp. 17. **Inpatient facility.** "Inpatient facility" means a hospital or nursing home.

Subp. 17a. **Legend drug.** "Legend drug" has the meaning given in Minnesota Statutes, section 151.01, subdivision 17.

Subp. 18. **Licensee.** "Licensee" means a home care provider that is licensed under parts 4668.0002 to 4668.0870 and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 19. **Licensed practical nurse.** "Licensed practical nurse" has the meaning given it by Minnesota Statutes, section 148.171, subdivision 8.

Subp. 20. **Managerial official.** "Managerial official" means a director, officer, trustee, or employee of a provider, however designated, who has the authority to establish or control business policy.

Subp. 21. **Medical social work or medical social services.** "Medical social work" or "medical social services" means social work related to the medical, health, or supportive care of clients.

Subp. 21a. **Medication administration.** "Medication administration" means performing a task to ensure a client takes a medication, and includes the following tasks, performed in the following order:

- A. checking the client's medication record;
- B. preparing the medication for administration;
- C. administering the medication to the client;
- D. documenting after administration, or the reason for not administering the medication as ordered; and
- E. reporting information to a nurse regarding concerns about the medication or the client's refusal to take the medication.

Subp. 21b. **Medication reminder.** "Medication reminder" means providing a verbal or visual reminder to a client to take medication.

Subp. 22. **Nurse.** "Nurse" means a registered nurse or licensed practical nurse.

Subp. 23. **Nursing home.** "Nursing home" means a facility licensed under Minnesota Statutes, sections 144A.01 to 144A.16.

Subp. 24. **Nutritional services.** "Nutritional services" means the services provided by a dietitian, including evaluation of a client's nutritional status and recommendation for changes in nutritional care; planning, organizing, and coordinating nutritional parts of other health services; adapting a medically ordered diet to the needs and understanding of the client; and translating the recommendations for nutritional care into appropriate food selection and food preparation guidelines.

Subp. 25. **Occupational therapist.** "Occupational therapist" means a person who performs occupational therapy.

Subp. 26. **Occupational therapy.** "Occupational therapy" means services designed to assist a client, who has functional disabilities related to developmental, restorative, or health needs, to adapt the client's environment and skills to aid in the performance of daily living tasks.

Subp. 26a. **Oral hygiene.** "Oral hygiene" means care of teeth, gums, and oral prosthetic devices.

Subp. 26b. **Over-the-counter drug.** "Over-the-counter drug" means a drug that is not required by federal law to bear the statement "Caution: Federal law prohibits dispensing without prescription," and as a result, may be sold without a prescription.

Subp. 27. **Owner.** "Owner" means a:

- A. proprietor;
- B. general partner;
- C. limited partner who has five percent or more of equity interest in a limited partnership;
- D. person who owns or controls voting stock in a corporation in an amount equal to or greater than five percent of the shares issued and outstanding; or
- E. corporation that owns an equity interest in a licensee or applicant for a license.

Subp. 28. **Paraprofessional.** "Paraprofessional" means a person who performs home health aide, home care aide, or home management tasks.

APPENDIX
Repealed Minnesota Rule: S1034-1

Subp. 28a. **Pharmacist.** "Pharmacist" means a person currently licensed under Minnesota Statutes, chapter 151.

Subp. 29. **Physical therapist.** "Physical therapist" has the meaning given by Minnesota Statutes, section 148.65, subdivision 2.

Subp. 30. **Physical therapy.** "Physical therapy" has the meaning given by Minnesota Statutes, section 148.65, subdivision 1.

Subp. 31. **Physician.** "Physician" means a person licensed under Minnesota Statutes, chapter 147.

Subp. 32. **Prescriber.** "Prescriber" means a person who is authorized by law to prescribe legend drugs.

Subp. 33. **Registered nurse.** "Registered nurse" has the meaning given it by Minnesota Statutes, section 148.171, subdivision 20.

Subp. 34. **Regularly scheduled.** "Regularly scheduled" means ordered or planned to be completed at predetermined times or according to a predetermined routine.

Subp. 35. **Residential center.** "Residential center" means a building or complex of contiguous or adjacent buildings in which clients rent or own distinct living units.

Subp. 36. **Respiratory therapist.** "Respiratory therapist" means a person who performs respiratory therapy.

Subp. 37. **Respiratory therapy.** "Respiratory therapy" means therapeutic services provided under medical orders for the assessment, treatment, management, diagnostic evaluation, and care of clients with deficiencies, abnormalities, and diseases of the cardiopulmonary system.

Subp. 38. **Responsible person.** "Responsible person" means a person who, because of the client's incapacity, makes decisions about the client's care on behalf of the client. A responsible person may be a guardian, conservator, attorney-in-fact, family member, or other agent of the client. Nothing in this chapter expands or diminishes the rights of persons to act on behalf of clients under other law.

Subp. 39. **Social work.** "Social work" has the meaning of "social work practice" as defined by Minnesota Statutes, section 148B.18, subdivision 11.

Subp. 40. **Speech therapy.** "Speech therapy" means diagnostic, screening, preventive, or corrective services for clients with speech, hearing, and language disorders.

Subp. 41. **Survey.** "Survey" means an inspection of a licensee or applicant for licensure for compliance with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47. Surveys include investigations of complaints.

Subp. 42. **Surveyor.** "Surveyor" means a representative of the department authorized by the commissioner to conduct surveys of licensees.

Subp. 43. **Therapist.** "Therapist" means a respiratory therapist, physical therapist, occupational therapist, speech therapist, or provider of nutritional services.

Subp. 44. **Unit of government.** "Unit of government" means every city, county, town, school district, other political subdivisions of the state, and any agency of the state or the United States, and includes any instrumentality of a unit of government.

Subp. 44a. **Unlicensed person.** "Unlicensed person" means a person who is employed by the licensee and who is not a nurse. Unlicensed person does not include nonemployee family members, nonemployee significant others, and nonemployee responsible persons.

Subp. 45. **Verbal.** "Verbal" means oral and not in writing.

4668.0005 PROFESSIONAL LICENSES.

Nothing in this chapter limits or expands the rights of health care professionals to provide services within the scope of their licenses or registrations, as provided by Minnesota law.

4668.0008 SERVICES INCLUDED IN AND EXCLUDED FROM LICENSURE.

Subpart 1. **Purpose.** This part implements Minnesota Statutes, section 144A.43, and establishes a process for determining what businesses are subject to licensure under this chapter. This part must be read together with Minnesota Statutes, section 144A.43. A business that is not required to be licensed under this chapter may obtain a license for the purpose of excluding individual contractors under subpart 6 or for other lawful purposes.

Subp. 2. **Determination of direct services.** As defined in Minnesota Statutes, section 144A.43, subdivision 4, a home care provider is a business that provides at least one home care

APPENDIX
Repealed Minnesota Rule: S1034-1

service directly. A service that is provided directly means a service provided to a client by the provider or employees of the provider, and not by contract with an independent contractor. The administration of a contract for home care services is not in itself a direct service. Factors that shall be considered in determining whether a business provides home care services directly include whether the business:

- A. has the right to control and does control the types of services provided;
- B. has the right to control and does control when and how the services are provided;
- C. establishes the charges;
- D. collects fees from the clients or receives payment from third party payers on the clients' behalf;
- E. pays compensation on an hourly, weekly, or similar time basis;
- F. treats the individuals as employees for purposes of payroll taxes and workers' compensation insurance; and
- G. holds itself out as a provider of services or acts in a manner that leads clients or potential clients reasonably to believe that it is a provider of services.

None of the factors listed in items A to G is solely determinative.

Subp. 3. **Contract services.** If a licensee contracts for a home care service with a business that is not subject to licensure under this chapter, it must require, in the contract, that the business comply with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 4. **Coordination of providers of home care services.** The coordination of home care services is not itself a home care service. Coordination of home care services means one or more of the following:

- A. Determination whether a client needs home care services, what services are needed, and whether existing services need to continue or be modified.
- B. Referral of clients to home care providers.
- C. Administration of payments for home care services.

Subp. 5. **Determination of regularly engaged.** As used in Minnesota Statutes, section 144A.43, subdivision 4, "regularly engaged" means providing, or offering to provide, home care services as a regular part of a provider's business. The following factors shall be considered by the commissioner in determining whether a person is regularly engaged in providing home care services:

- A. whether the person markets services specifically to individuals whose illnesses, disabilities, or physical conditions create needs for the services;
- B. whether the services are designed and intended specifically to assist the individuals;
- C. whether the individuals constitute a substantial part of the person's clientele; and
- D. whether the home care services are other than occasional or incidental to the provision of services that are not home care services.

None of the factors listed in items A to D is solely determinative.

Subp. 6. **Exclusion for a paraprofessional not regularly engaged in delivering home care services.** For purposes of subpart 5, an individual who performs home care aide tasks or home management tasks for no more than 14 hours each calendar week to no more than one client, is not regularly engaged in the delivery of home care services, and is not subject to licensure under this chapter.

Subp. 7. **Exclusion of individual contractors.** An individual who is not an employee of a licensed provider need not be licensed under this chapter, if the person:

- A. only provides services as an independent contractor with one or more licensed providers;
- B. provides no services under direct agreements with clients; and
- C. is contractually bound to perform services in compliance with the contracting providers' policies and service agreements.

Individuals excluded from licensure under this subpart must comply with the same requirements of this chapter as employees of the contracting licensee.

Subp. 8. **Governmental providers.** Except as otherwise provided in this chapter or in law, home care services that are provided by the state, counties, or other units of government must be licensed under this chapter.

APPENDIX
Repealed Minnesota Rule: S1034-1

Subp. 9. **Exclusion of certain instructional and incidental services.** A business is not subject to Minnesota Statutes, sections 144A.43 to 144A.47, and is not required to be licensed under this chapter if the business only provides services that are primarily instructional and not medical services or health-related support services.

Subp. 10. **Temporary staffing agencies.** A business that provides staff to home care providers, such as temporary employment agencies, is not required to be licensed under this chapter if the business:

- A. only provides staff under contract to licensed or exempt providers;
- B. provides no services under direct agreements with clients; and
- C. is contractually bound to perform services under the contracting providers' direction and supervision.

Subp. 11. **Status of temporary staff.** For purposes of this chapter, staff of businesses excluded from licensure under subpart 10 shall be treated as if they are employees of the contracting licensee.

Subp. 12. **Medical equipment provider.** A provider of medical supplies and equipment is subject to this chapter only if:

- A. the provider provides a home care service;
- B. the provider makes more than one visit to a client's residence to provide the home care service; and
- C. the supplies or equipment are ordered by a physician, osteopath, dentist, podiatrist, chiropractor, or other prescriber.

In this subpart, home care service does not include maintenance of supplies or equipment or instruction in their use.

4668.0012 LICENSURE.

Subpart 1. **License issued.** If a provider complies with the requirements of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47, the commissioner shall issue to the provider a certificate of licensure that will contain:

- A. the provider's name and address;
- B. the class of license as provided in subpart 3;
- C. the beginning and expiration dates; and
- D. a unique license number.

Subp. 2. **Multiple units.** Multiple units of a provider must share the same management that supervises and administers services provided by all units. Multiple units of a provider must be separately licensed if the commissioner determines that the units cannot adequately share supervision and administration of services with the main office because of distinct organizational structures.

Subp. 3. **Classes of licenses.** In issuing a license under this part, the commissioner shall assign a license classification according to items A and B. A provider performing only home management tasks must be registered according to Minnesota Statutes, section 144A.461, and need not obtain a home care license.

A. A provider must apply for one of the classes of the home care license listed in subitems (1) to (5).

(1) Class A, or professional home care agency license. Under this license, a provider may provide all home care services in a place of residence, including a residential center, at least one of which is nursing, physical therapy, speech therapy, respiratory therapy, occupational therapy, nutritional services, medical social services, home health aide tasks, or the provision of medical supplies and equipment when accompanied by the provision of a home care service.

(2) Class B, or paraprofessional agency license. Under this license, a provider may perform home care aide tasks and home management tasks, as provided by parts 4668.0110 and 4668.0120.

(3) Class C, or individual paraprofessional license. Under this license, a provider may perform home health aide, home care aide, and home management tasks.

(4) Class E, or assisted living programs license. Under this license, a provider may only provide assisted living services to residents of a residential center.

APPENDIX
Repealed Minnesota Rule: S1034-1

(5) Class F home care provider license. Under this license, a provider may provide assisted living home care services solely for residents of one or more registered housing with services establishments, as provided by Minnesota Statutes, section 144A.4605.

B. If a provider meets the requirements of more than one license class, the commissioner shall issue to the provider a separate license for each applicable class of home care licensure.

Subp. 4. Applicability of rules to classes.

A. A class A licensee must comply with parts 4668.0002 to 4668.0180, and 4668.0218 to 4668.0240, except that one certified for Medicare as a home health agency under Code of Federal Regulations, title 42, part 484, need not comply with the requirements listed in part 4668.0180, subpart 10.

B. A class B licensee must comply with parts 4668.0002 to 4668.0080, 4668.0110 to 4668.0170, 4668.0190, and 4668.0218 to 4668.0240.

C. A class C licensee must comply with parts 4668.0002 to 4668.0035, 4668.0050 to 4668.0065, 4668.0075 to 4668.0170, 4668.0200, and 4668.0218 to 4668.0240.

D. A class E licensee must comply with parts 4668.0002 to 4668.0080, 4668.0110 to 4668.0170, 4668.0215, and 4668.0218 to 4668.0240.

E. A class F home care provider licensee must comply with parts 4668.0002 to 4668.0050, 4668.0065, 4668.0070, 4668.0170, 4668.0218 to 4668.0240, and 4668.0800 to 4668.0870.

Subp. 5. New license. A license shall be issued to an applicant that is not currently licensed if the applicant completes the application, pays the fee in full, and complies with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47. A license is effective for one year after the date the license is issued.

Subp. 6. License application. To apply for a license under this chapter, an applicant must follow the procedures in items A and B.

A. An applicant for a license under this chapter must provide the following information on forms provided by the commissioner:

(1) the applicant's name and address, including the name of the county in which the applicant resides or has its principal place of business;

(2) address and telephone number of the principal administrative office;

(3) address and telephone number of each branch office, if any;

(4) names and addresses of all owners and managerial officials;

(5) documentation of compliance with the background study requirements of Minnesota Statutes, section 144A.46, subdivision 5, for all persons involved in the management, operation, or control of a provider;

(6) evidence of workers' compensation coverage, as required by Minnesota Statutes, sections 176.181 and 176.182;

(7) in the case of class C applicants, proof that the applicant is not contagious with tuberculosis, as required by part 4668.0065, subparts 1 and 2;

(8) in the case of class C applicants, proof that the applicant has met any applicable training and supervision requirements for paraprofessionals, as provided by parts 4668.0100 and 4668.0110; and

(9) a list of those home care services listed in Minnesota Statutes, section 144A.43, subdivision 3, or 144A.4605, that will be made available to clients.

B. An application on behalf of a corporation, association, or unit of government must be signed by an officer or managing agent.

Subp. 7. Agent. Each application for a home care provider license or for renewal of a home care provider license shall designate one or more owners, managerial officials, or employees, as an agent:

A. who is authorized to transact business with the commissioner of health on all matters provided for in this chapter and Minnesota Statutes, sections 144A.43 to 144A.47; and

B. upon whom all notices and orders shall be served, and who is authorized to accept service of notices and orders on behalf of the licensee, in proceedings under this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

The designation of one or more persons under this subpart shall not affect the legal responsibility of any other owner or managerial official under this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

APPENDIX

Repealed Minnesota Rule: S1034-1

Subp. 8. **Notification of changes in information.** The licensee shall notify the commissioner in writing within ten working days after any change in the information required to be provided by subparts 6 and 7, except for the information required by subpart 6, item A, subitem (4), which will be required at the time of license renewal, and except for services reported under subpart 6, item A, subitem (9), that are discontinued for less than 90 days.

Subp. 9. **Application processing.** The commissioner shall process an application in the manner provided by Minnesota Statutes, section 144A.46, subdivision 1, paragraph (b). No application shall be processed without payment of the license fee in full, in the amount provided by subpart 18.

Subp. 10. **Prelicensing survey.** Before granting a license, the commissioner may investigate the applicant for compliance with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 11. **Denial of license.** A license shall be denied if:

A. the applicant; an owner of the applicant, individually or as an owner of another home care provider; or another home care provider of which an owner of the applicant also was or is an owner; has ever been issued a correction order for failing to assist its clients, in violation of part 4668.0050, subpart 2, upon the licensee's decision to cease doing business as a home care provider;

B. the applicant is not in compliance with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;

C. the applicant is disqualified under Minnesota Statutes, sections 144.057 and 245A.04;

D. the applicant or an owner or managerial official has been unsuccessful in having a disqualification under Minnesota Statutes, section 144.057 or 245A.04, set aside; or

E. the commissioner determines that an owner or managerial official, as an owner or managerial official of another licensee, was substantially responsible for the other licensee's failure to substantially comply with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 12. **Change of classification.** A licensee may change to a different class of license under subpart 3, by submitting a new application under subpart 6 and meeting all applicable requirements of this chapter. An application under this subpart shall be accompanied by the fee provided by subpart 18.

Subp. 13. **License renewals.** Except as provided in subpart 14 or 15, a license will be renewed for a period of one year if the licensee satisfies items A to C. The licensee must:

A. submit an application for renewal on forms provided by the commissioner at least 30 days before expiration of the license;

B. submit the renewal fee, in the amount provided by subpart 18; and

C. comply with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 14. **Conditional license.** If a licensee is not in full compliance with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47, at the time of expiration of its license, and the violations do not warrant denial of renewal of the license, the commissioner shall issue a license for a limited period conditioned on the licensee achieving full compliance within the term of the license or the term of any correction orders.

Subp. 15. **Suspension, revocation, or denial of renewal of license.** The commissioner may deny renewal of a license, or may suspend, revoke, or make conditional a license, if the licensee, or an owner or managerial official of the licensee:

A. is in violation, or during the term of the license has violated, any of the requirements of this chapter or Minnesota Statutes, sections 144A.43 to 144A.47;

B. permits, aids, or abets the commission of any illegal act in the provision of home care;

C. performs any act detrimental to the welfare of a client;

D. obtained the license by fraud or misrepresentation;

E. knowingly made or makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;

F. denies representatives of the commissioner access to any part of the provider, its books, records, or files, or employees;

G. interferes with or impedes a representative of the commissioner in contacting the provider's clients;

H. interferes with or impedes a representative of the commissioner in the enforcement of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;

APPENDIX
Repealed Minnesota Rule: S1034-1

I. destroys or makes unavailable any records or other evidence relating to the licensee's compliance with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;

J. refuses to initiate a background study under Minnesota Statutes, section 144.057 or 245A.04; or

K. has failed to timely pay any fines assessed under part 4668.0230 or 4668.0800, subpart 6.

Subp. 16. **Transfers prohibited; changes in ownership.** A license issued under this part may not be transferred to another party. Before changing ownership, a prospective provider must apply for a new license under this part. A change of ownership means a transfer of operational control to a different business entity, and includes:

A. transfer of the business to a different or new corporation;

B. in the case of a partnership, the dissolution or termination of the partnership under Minnesota Statutes, chapter 323A, with the business continuing by a successor partnership or other entity;

C. relinquishment of control of the provider by the licensee to another party, including to a contract management firm that is not under the control of the owner of the business' assets;

D. transfer of the business by a sole proprietor to another party or entity; or

E. in the case of a privately held corporation, the change in ownership or control of 50 percent or more of the outstanding voting stock.

Subp. 17. **Display of license.** The original license must be displayed in the provider's principal business office and copies must be displayed in all other offices. The licensee must provide a copy of the license to any person who requests it.

Subp. 18. **Fees.** Each application for a license must include payment in full of the fee according to the schedule in chapter 4669.

4668.0016 WAIVERS AND VARIANCES.

Subpart 1. **Definitions.** For purposes of this part:

A. "waiver" means an exemption from compliance with a requirement of this chapter; and

B. "variance" means a specified alternative to a requirement of this chapter.

Subp. 2. **Criteria for waiver or variance.** Upon application of a licensee, the commissioner shall waive or vary any provision of this chapter, except for those provisions relating to criminal disqualification, part 4668.0020, and to the home care bill of rights, part 4668.0030, if the commissioner finds that:

A. the waiver or variance is necessary because of the unavailability of services or resources in the provider's geographic area; or

B. enforcement of a requirement would result in unreasonable hardship on the licensee; and

C. the waiver or variance will not adversely affect the health, safety, or welfare of any client.

Subp. 3. **Experimental variance.** A variance may be granted to allow a provider to offer home care services of a type or in a manner that is innovative, will not impair the services provided, will not adversely affect the health, safety, or welfare of the clients, and is likely to improve the services provided.

Subp. 4. **Conditions.** The commissioner may impose conditions on the granting of a waiver or variance that the commissioner considers necessary.

Subp. 5. **Duration and renewal.** The commissioner may limit the duration of any waiver or variance, and may renew a limited waiver or variance.

Subp. 6. **Applications.** An application for waiver or variance from the requirements of this chapter may be made at any time, must be made in writing to the commissioner, and must specify the following:

A. the rule from which the waiver or variance is requested;

B. the time period for which the waiver or variance is requested;

C. if the request is for a variance, the specific alternative action that the licensee proposes;

D. the reasons for the request; and

E. justification that subpart 2 or 3 will be satisfied.

APPENDIX
Repealed Minnesota Rule: S1034-1

The commissioner may require additional information from the licensee before acting on the request.

Subp. 7. **Grants and denials.** The commissioner shall grant or deny each request for waiver or variance in writing. Notice of a denial shall contain the reasons for the denial. The terms of a requested variance may be modified upon agreement between the commissioner and a licensee.

Subp. 8. **Violation of variances.** A failure to comply with the terms of a variance shall be deemed to be a violation of this chapter.

Subp. 9. **Revocation or denial of renewal.** The commissioner shall revoke or deny renewal of a waiver or variance if:

- A. it is determined that the waiver or variance is adversely affecting the health, safety, or welfare of the licensee's clients;
- B. the licensee has failed to comply with the terms of the variance;
- C. the licensee notifies the commissioner in writing that it wishes to relinquish the waiver or variance and be subject to the rule previously waived or varied; or
- D. the revocation or denial is required by a change in law.

Subp. 10. **Hearings.** A denial of a waiver or variance may be contested by requesting a hearing as provided by part 4668.0017. The licensee bears the burden of proving that the denial of a waiver or variance was in error.

4668.0017 HEARINGS.

Subpart 1. **Hearing rights.** An applicant for a license or a licensee that has been assessed a fine under part 4668.0230 or 4668.0800, subpart 6, that has had a waiver or variance denied or revoked under part 4668.0016, or that has a right to a hearing under Minnesota Statutes, section 144A.46, subdivision 3, may request a hearing to contest that action or decision according to the rights and procedures provided by Minnesota Statutes, chapter 14, and this part.

Subp. 2. **Request for hearing.** A request for a hearing shall be in writing and shall:

- A. be mailed or delivered to the commissioner or the commissioner's designee;
- B. contain a brief and plain statement describing every matter or issue contested; and
- C. contain a brief and plain statement of any new matter that the licensee believes constitutes a defense or mitigating factor.

Subp. 3. **Informal conference.** At any time, the licensee and the commissioner may hold an informal conference to exchange information, clarify issues, or resolve any or all issues.

4668.0019 ADVERTISING.

Licensees shall not use false, fraudulent, or misleading advertising in the marketing of services. For purposes of this part, advertising includes any means of communicating to potential clients the availability, nature, or terms of home care services.

4668.0030 HOME CARE BILL OF RIGHTS.

Subpart 1. **Scope and enforcement against those exempt from licensure.** All home care providers, including those exempt from licensure under Minnesota Statutes, section 144A.46, subdivision 2, must comply with this part and the home care bill of rights, as provided by Minnesota Statutes, section 144A.44. The commissioner shall enforce this part and the home care bill of rights against providers exempt from licensure in the same manner as against licensees.

Subp. 2. **Notification of client.** The provider shall give a written copy of the home care bill of rights, as required by Minnesota Statutes, section 144A.44, to each client or each client's responsible person.

Subp. 3. **Time of notice.** The provider shall deliver the bill of rights at the time that the provider and the client or the client's responsible person agree to a service agreement, or before services are initiated, whichever is earlier.

Subp. 4. **Content of notice.** In addition to the text of the bill of rights in Minnesota Statutes, section 144A.44, subdivision 1, the written notice to the client must include the following:

- A. a statement, printed prominently in capital letters, that is substantially the same as the following:

IF YOU HAVE A COMPLAINT ABOUT THE AGENCY OR PERSON PROVIDING
YOU HOME CARE SERVICES, YOU MAY CALL, WRITE, OR VISIT THE OFFICE OF

APPENDIX
Repealed Minnesota Rule: S1034-1

HEALTH FACILITY COMPLAINTS, MINNESOTA DEPARTMENT OF HEALTH. YOU
MAY ALSO CONTACT THE OMBUDSMAN FOR OLDER MINNESOTANS.

B. the telephone number, mailing address, and street address, of the Office of Health Facility Complaints;

C. the telephone number and address of the office of the ombudsman for older Minnesotans; and

D. the licensee's name, address, telephone number, and name or title of the person to whom problems or complaints may be directed.

The information required by items B and C shall be provided by the commissioner to licensees upon issuance of licenses and whenever changes are made.

Subp. 5. **Acknowledgment of receipt.** The provider shall obtain written acknowledgment of the client's receipt of the bill of rights or shall document why an acknowledgment cannot be obtained. The acknowledgment may be obtained from the client or the client's responsible person.

Subp. 6. **Documentation.** The licensee shall retain in the client's record documentation of compliance with this part.

Subp. 7. **Prohibition against waivers.** The licensee may not request nor obtain from clients any waiver of any of the rights enumerated in Minnesota Statutes, section 144A.44, subdivision 1. Any waiver obtained in violation of this subpart is void.

4668.0035 HANDLING OF CLIENTS' FINANCES AND PROPERTY.

Subpart 1. **Powers-of-attorney.** A licensee may not accept powers-of-attorney from clients for any purpose, and may not accept appointments as guardians or conservators of clients, unless the licensee maintains a clear organizational separation between the home care service and the program that accepts guardianship or conservatorship appointments. This subpart does not apply to licensees that are Minnesota counties or other units of government.

Subp. 2. **Handling clients' finances.** A licensee may assist clients with household budgeting, including paying bills and purchasing household goods, but may not otherwise manage a client's property. A licensee must provide a client with receipts for all transactions and purchases paid with the clients' funds. When receipts are not available, the transaction or purchase must be documented. A licensee must maintain records of all such transactions.

Subp. 3. **Security of clients' property.** A licensee may not borrow a client's property, nor in any way convert a client's property to the licensee's possession, except in payment of a fee at the fair market value of the property.

Subp. 4. **Gifts and donations.** Nothing in this part precludes a licensee or its staff from accepting bona fide gifts of minimal value, or precludes the acceptance of donations or bequests made to a licensee that are exempt from income tax under section 501(c) of the Internal Revenue Code of 1986.

4668.0040 COMPLAINT PROCEDURE.

Subpart 1. **Complaint procedure.** A licensee that has more than one direct care staff person must establish a system for receiving, investigating, and resolving complaints from its clients.

Subp. 2. **Informing clients.** The system required by subpart 1 must provide written notice to each client that includes:

- A. the client's right to complain to the licensee about the services received;
- B. the name or title of the person or persons to contact with complaints;
- C. the method of submitting a complaint to the licensee;
- D. the right to complain to the Minnesota Department of Health, Office of Health Facility Complaints; and

E. a statement that the provider will in no way retaliate because of a complaint.

Subp. 3. **Prohibition against retaliation.** A licensee must not take any action that negatively affects a client in retaliation for a complaint made by the client.

Subp. 4. **Scope.** This part applies to all licensees except class C licensees.

4668.0050 ACCEPTANCE, RETENTION, DISCONTINUATION OF SERVICES, AND DISCHARGE OF CLIENTS.

Subpart 1. **Acceptance of clients.** No licensee may accept a person as a client unless the licensee has staff, sufficient in qualifications and numbers, to adequately provide the services

APPENDIX
Repealed Minnesota Rule: S1034-1

agreed to in the service agreement, under part 4668.0140 for class A, B, and C licensees, or the service plan, under part 4668.0815, for class F home care provider licensees.

Subp. 2. **Assistance upon discontinuance of services.** If the licensee discontinues a home care service to a client for any reason and the client continues to need the home care service, the licensee shall provide to the client a list of home care providers that provide similar services in the client's geographic area.

This subpart does not apply to a licensee that discontinues a service to a client because of the client's failure to pay for the service.

4668.0060 ADMINISTRATION.

Subpart 1. **Services by contract.** The licensee may contract for services to be provided to its clients. Personnel providing services under contract must meet the same requirements required by this chapter of personnel employed by the licensee.

Subp. 2. **Responsibility of licensee for contractors.** A violation of this chapter by a contractor of the licensee will be considered to be a violation by the licensee.

Subp. 3. **Fulfillment of services.** The licensee shall provide all services required by the client's service agreement, required by part 4668.0140.

Subp. 4. **Scheduled appointments for nonessential services.** If a licensee, contractor, or employee of a licensee is unable, for any reason, to keep a scheduled appointment for a service that is not essential for medical or safety reasons, the licensee shall:

- A. follow the procedure, if any, established in the service agreement;
- B. provide a replacement person; or
- C. notify the client that the appointment will not be kept, and schedule a new appointment or arrange for some other reasonable alternative.

Subp. 5. **Scheduled appointments for essential services.** If, for medical or safety reasons, a service to be provided must be completed at the scheduled time, and the licensee, contractor, or employee of a licensee is unable, for any reason, to keep the scheduled appointment, the licensee shall make arrangements to complete the service through a contract with another provider or through other reasonable means.

Subp. 6. **Availability of contact person.** Every class A or class B licensee that provides home health aide or home care aide tasks, must have a contact person available for consultation whenever a paraprofessional is performing home health aide or home care aide tasks for a client. The contact person must be available to the paraprofessional in person, by telephone, or by other means.

4668.0065 INFECTION CONTROL.

Subpart 1. **Tuberculosis screening.** No person who is contagious with tuberculosis may provide services that require direct contact with clients. All individual licensees and employees and contractors of licensees must document the following before providing services that require direct contact with clients:

- A. the person must provide documentation of having received a negative reaction to a Mantoux test administered within the 12 months before working in a position involving direct client contact, and no later than every 24 months after the most recent Mantoux test; or
- B. if the person has had a positive reaction to a Mantoux test upon employment or within the two years before working in a position involving direct client contact, or has a positive reaction to a Mantoux test in repeat testing during the course of employment, the person must provide:
 - (1) documentation of a negative chest x-ray administered within the three months before working in a position involving direct client contact; or
 - (2) documentation of a negative chest x-ray administered each 12 months, for two years after the positive reaction to a Mantoux test or documentation of completing or currently taking a course of tuberculosis preventative therapy; or
- C. if the person has had a positive reaction to a Mantoux test more than two years before working in a position involving direct client contact, the person must provide documentation of a negative chest x-ray taken within the previous 12 months or documentation of completing or currently taking a course of tuberculosis preventative therapy.

In this subpart, "Mantoux test" means a Mantoux tuberculin skin test.

APPENDIX
Repealed Minnesota Rule: S1034-1

Subp. 2. **Exposure to tuberculosis.** In addition to the requirements of subpart 1, a person who has been exposed to active tuberculosis must document a negative result of a Mantoux test or chest x-ray administered no earlier than ten weeks and no later than 14 weeks after the exposure.

Subp. 3. **Infection control in-service training.** For each 12 months of employment, all licensees and employees and contractors of licensees who have contact with clients in their residences, and their supervisors, shall complete in-service training about infection control techniques used in the home. This subpart does not apply to a person who performs only home management tasks. The training must include:

- A. hand washing techniques;
- B. the need for and use of protective gloves, gowns, and masks;
- C. disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades;
- D. disinfecting reusable equipment; and
- E. disinfecting environmental surfaces.

4668.0070 PERSONNEL RECORDS.

Subpart 1. **Scope.** This part applies to all licensees except class C licensees.

Subp. 2. **Personnel records.** The licensee must maintain a record of each employee, of each individual contractor excluded under part 4668.0008, subpart 7, and of other individual contractors. The record must include the following information:

- A. evidence of current professional licensure, registration, or certification, if licensure, registration, or certification is required by this chapter, statute, or other rules;
- B. records of training required by this chapter; and
- C. evidence of licensure under this chapter, if required.

Subp. 3. **Job descriptions.** The licensee shall maintain current job descriptions, including qualifications, responsibilities, and identification of supervisors, if any, for each job classification.

Subp. 4. **Retention of personnel records.** Each personnel record must be retained for at least three years after an employee or contractor ceases to be employed by the licensee.

4668.0075 ORIENTATION TO HOME CARE REQUIREMENTS.

Subpart 1. **Orientation.** Every individual applicant for a license, and every person who provides direct care, supervision of direct care, or management of services for a licensee, shall complete an orientation to home care requirements before providing home care services to clients. This orientation may be incorporated into the training required of paraprofessionals under part 4668.0130. This orientation need only be completed once.

Subp. 2. **Content.** The orientation required by subpart 1 must contain the following topics:

- A. an overview of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;
- B. handling of emergencies and use of emergency services;
- C. reporting the maltreatment of vulnerable minors or adults under Minnesota Statutes, sections 626.556 and 626.557;
- D. home care bill of rights;
- E. handling of clients' complaints and reporting of complaints to the Office of Health Facility Complaints; and
- F. services of the ombudsman for older Minnesotans.

Subp. 3. **Sources of orientation.** The orientation training required by this part may be provided by the licensee or may be obtained from other sources. The commissioner shall provide a curriculum and materials that may be used to present the orientation.

Subp. 4. **Verification and documentation.** Each licensee shall retain evidence that each person required under subpart 1, has completed the orientation training required by this part.

Subp. 5. **Transferability.** Licensees may accept from another provider written verification that a person has completed the orientation.

4668.0080 QUALIFICATIONS OF PROFESSIONAL PERSONNEL.

Subpart 1. **Occupational therapy.** A person who provides occupational therapy as a licensee or as an employee or contractor of a licensee must:

APPENDIX
Repealed Minnesota Rule: S1034-1

A. have earned a baccalaureate degree from an occupational therapy program accredited jointly by the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Occupational Therapy Association;

B. be registered as an occupational therapist by the American Occupational Therapy Certification Board; or

C. meet the standards established for registration by the American Occupational Therapy Certification Board, in effect on June 1, 1990.

Subp. 2. **Speech therapy.** A person who provides speech therapy as a licensee or as an employee or contractor of a licensee must be registered with the department as a speech- language pathologist, under parts 4750.0010 to 4750.0700.

Subp. 3. **Respiratory therapy.** A person who provides respiratory therapy as a licensee or as an employee or contractor of a licensee must have completed a respiratory care program accredited by the American Medical Association's Committee on Allied Health Education and Accreditation and the Joint Review Committee for Respiratory Therapy Education or by an accrediting agency approved by the commissioner.

Subp. 4. **Dietitians.** A person who provides nutritional services as a licensee or as an employee or contractor of a licensee, must have a baccalaureate degree in nutrition or a comparable program, including at least six months of supervised experience, or be registered by the Commission on Dietetic Registration of the American Dietetic Association.

Subp. 5. **Physical therapy.** A person who provides physical therapy as an employee or contractor of a licensee must be registered as a physical therapist with the Board of Medical Practice under Minnesota Statutes, sections 148.65 to 148.78.

4668.0100 HOME HEALTH AIDE TASKS.

Subpart 1. **Home health aide tasks.** For a class A or C licensee, a registered nurse may delegate medical or nursing services as tasks or a therapist may assign therapy services as tasks only to a person who satisfies the requirements of subpart 5. These delegated or assigned tasks, as set forth in this part, include home care aide tasks as set forth in part 4668.0110. Class A licensees providing home care aide tasks must satisfy the training and supervision requirements of this part, and not part 4668.0110. These tasks include:

- A. administration of medications, as provided by subpart 2;
- B. performing routine delegated medical or nursing or assigned therapy procedures, as provided by subpart 4, except items C to H;
- C. assisting with body positioning or transfers of clients who are not ambulatory;
- D. feeding of clients who, because of their condition, are at risk of choking;
- E. assistance with bowel and bladder control, devices, and training programs;
- F. assistance with therapeutic or passive range of motion exercises;
- G. providing skin care, including full or partial bathing and foot soaks; and
- H. during episodes of serious disease or acute illness, providing services performed for a client or to assist a client to maintain the hygiene of the client's body and immediate environment, to satisfy nutritional needs, and to assist with the client's mobility, including movement, change of location, and positioning, and bathing, oral hygiene, dressing, hair care, toileting, bedding changes, basic housekeeping, and meal preparation. Oral hygiene means care of teeth, gums, and oral prosthetic devices.

Subp. 2. **Administration of medications.** A person who satisfies the requirements of subpart 5 may administer medications, whether oral, suppository, eye drops, ear drops, inhalant, topical, or administered through a gastrostomy tube, if:

- A. the medications are regularly scheduled;
- B. in the case of pro re nata medications, the administration of the medication is reported to a registered nurse either:
 - (1) within 24 hours after its administration; or
 - (2) within a time period that is specified by a registered nurse prior to the administration;
- C. prior to the administration, the person is instructed by a registered nurse in the procedures to administer the medications to each client;
- D. a registered nurse specifies, in writing, and documents in the clients' records, the procedures to administer the medications; and

APPENDIX
Repealed Minnesota Rule: S1034-1

E. prior to the administration, the person demonstrates to a registered nurse the person's ability to competently follow the procedure.

For purposes of this subpart, "pro re nata medication," commonly called p.r.n. medication, means a medication that is ordered to be administered to or taken by a client as necessary.

Subp. 3. **Limitations on administering medications.** A person who administers medications under subpart 2 may not inject medications into veins, muscle, or skin.

Subp. 4. **Performance of routine procedures.** A person who satisfies the requirements of subpart 5 may perform delegated medical or nursing and assigned therapy procedures, if:

A. prior to performing the procedures, the person is instructed by a registered nurse or therapist, respectively, in the proper methods to perform the procedures with respect to each client;

B. a registered nurse or therapist, respectively, specifies, in writing, specific instructions for performing the procedures for each client;

C. prior to performing the procedures, the person demonstrates to a registered nurse or therapist, respectively, the person's ability to competently follow the procedures; and

D. the procedures for each client are documented in the clients' records.

Subp. 5. **Qualifications for persons who perform home health aide tasks.** A person may only offer or perform home health aide tasks, or be employed to perform home health aide tasks, if the person has:

A. successfully completed the training and passed the competency evaluation required by part 4668.0130, subpart 1;

B. passed the competency evaluation required by part 4668.0130, subpart 3;

C. successfully completed training in another jurisdiction substantially equivalent to that required by item A;

D. satisfied the requirements of Medicare for training or competency of home health aides, as provided by Code of Federal Regulations, title 42, section 484.36;

E. satisfied subitems (1) and (2):

(1) meets the requirements of title XVIII of the Social Security Act for nursing assistants in nursing facilities certified for participation in the Medicare program, or has successfully completed a nursing assistant training program approved by the state; and

(2) has had at least 20 hours of supervised practical training or experience performing home health aide tasks in a home setting under the supervision of a registered nurse, or completes the supervised practical training or experience within one month after beginning work performing home health aide tasks, except that a class C licensee must have completed this supervised training or experience before a license will be issued; or

F. before April 19, 1993, completed a training course of at least 60 hours for home health aides that had been approved by the department.

Subp. 6. **In-service training and demonstration of competence.** For each person who performs home health aide tasks, the licensee must comply with items A to C.

A. For each 12 months of employment, each person who performs home health aide tasks shall complete at least eight hours of in-service training in topics relevant to the provision of home care services, including that required by part 4668.0065, subpart 3, obtained from the licensee or another source.

B. Licensees shall retain documentation of satisfying this part and shall provide documentation to persons who have completed the in-service training.

C. If a person has not performed home health aide tasks for a continuous period of 24 consecutive months, the person must demonstrate to a registered nurse competence in the skills listed in part 4668.0130, subpart 3, item A, subitem (1).

Subp. 7. **Documentation.** Class A licensees shall verify that persons employed or contracted by the licensees to perform home health aide tasks have satisfied the requirements of this part and shall retain documentation in the personnel records. Persons who perform home health aide tasks must provide documentation to the employing or contracting licensees of satisfying this part. Class C licensees shall retain documentation of satisfying this part.

Subp. 8. **Initiation of home health aide tasks.** Prior to the initiation of home health aide tasks, a registered nurse or therapist shall orient each person who is to perform home health aide tasks to each client and to the tasks to be performed.

Subp. 9. **Periodic supervision of home health aide tasks.** After the orientation required by subpart 8, a therapist or a registered nurse shall supervise, or a licensed practical nurse, under

APPENDIX
Repealed Minnesota Rule: S1034-1

the direction of a registered nurse, shall monitor persons who perform home health aide tasks at the client's residence to verify that the work is being performed adequately, to identify problems, and to assess the appropriateness of the care to the client's needs. This supervision or monitoring must be provided no less often than the following schedule:

- A. within 14 days after initiation of home health aide tasks; and
- B. every 14 days thereafter, or more frequently if indicated by a clinical assessment, for home health aide tasks described in subparts 2 to 4; or
- C. every 60 days thereafter, or more frequently if indicated by a clinical assessment, for all home health aide tasks other than those described in subparts 2 to 4.

If monitored by a licensed practical nurse, the client must be supervised at the residence by a registered nurse at least every other visit, and the licensed practical nurse must be under the direction of a registered nurse, according to Minnesota Statutes, sections 148.171 to 148.285.

4668.0110 HOME CARE AIDE TASKS.

Subpart 1. **Home care aide tasks.** For a class B or C licensee, only a person who satisfies the requirements of subpart 2 or part 4668.0100, subpart 5, may perform the following services for clients:

- A. preparing modified diets, such as diabetic or low sodium diets;
- B. reminding clients to take regularly scheduled medications or perform exercises;
- C. household chores in the presence of technically sophisticated medical equipment or episodes of acute illness or infectious disease;
- D. household chores when the client's care requires the prevention of exposure to infectious disease or containment of infectious disease; and
- E. assisting with dressing, oral hygiene, hair care, grooming, and bathing, if the client is ambulatory, and if the client has no serious acute illness or infectious disease. Oral hygiene means care of teeth, gums, and oral prosthetic devices.

Subp. 2. **Qualifications for persons who perform home care aide tasks.** No person may offer or perform home care aide tasks, or be employed to perform home care aide tasks, unless the person has:

- A. successfully completed training and passed the competency evaluation required by part 4668.0130, subpart 1;
- B. passed the competency evaluation required by part 4668.0130, subpart 3;
- C. successfully completed training in another jurisdiction comparable to that required by item A; or
- D. satisfied the requirements of part 4668.0100.

Subp. 3. **Documentation.** Class B licensees shall verify that the persons employed or contracted by the licensees to perform home care aide tasks have satisfied the requirements of this part and shall retain documentation in the personnel records. Persons who perform home care aide tasks must provide documentation to the employing or contracting licensees of satisfying this part. Class C licensees shall retain documentation of satisfying this part.

Subp. 4. **In-service training.** For each person who performs home care aide tasks, the licensee must comply with items A to C.

A. For each 12 months of employment, each person who performs home care aide tasks must complete at least six hours of in-service training in topics relevant to the provision of home care services, including that required by part 4668.0065, subpart 3, obtained from the licensee or another source.

B. Licensees shall retain documentation of satisfying this part and shall provide documentation to persons who have completed the in-service training.

Subp. 5. [Repealed, L 2009 c 174 art 2 s 12]

Subp. 6. **Class E visits.** A class E licensee must visit the client and observe the provision of home care services every 60 days after initiation of home care aide tasks to verify that the work is being performed adequately and to identify problems.

4668.0120 HOME MANAGEMENT TASKS.

Subpart 1. **Home management tasks.** Any person may perform services that are not listed in part 4668.0100, subpart 1, or part 4668.0110, subpart 1, including housekeeping, meal preparation, and shopping.

APPENDIX
Repealed Minnesota Rule: S1034-1

Subp. 2. **Training of persons who perform home management tasks.** Except for the orientation training required by Minnesota Statutes, section 144A.461, no training is required of persons who perform home management tasks.

4668.0130 TRAINING AND COMPETENCY EVALUATION FOR PERSONS WHO PERFORM HOME HEALTH AIDE AND HOME CARE AIDE TASKS.

Subpart 1. **Scope of training course and instructor.** The training required by part 4668.0100, subpart 5, and by part 4668.0110, subpart 2, must:

- A. include the topics and course requirements specified in subpart 2 and use a curriculum approved by the commissioner;
- B. be taught by a registered nurse with experience or training in home care, except that specific topics required by subpart 2 may be taught by another instructor in conjunction with the registered nurse; and
- C. include a competency evaluation required by subpart 3.

Subp. 2. **Curriculum.** The training required in part 4668.0100, subpart 5 for home health aide tasks must contain the topics described in items A to N, and must contain no less than 75 hours of classroom and laboratory instruction. The training required in part 4668.0110, subpart 2 for home care aide tasks, must contain the topics described in items A to G, and must contain no less than 24 hours of classroom and laboratory instruction. The required topics are:

- A. those topics required in the orientation training required by part 4668.0075;
- B. observation, reporting, and documentation of client status and of the care or services provided;
- C. basic infection control;
- D. maintenance of a clean, safe, and healthy environment;
- E. medication reminders;
- F. appropriate and safe techniques in personal hygiene and grooming, including bathing and skin care, the care of teeth, gums, and oral prosthetic devices, and assisting with toileting;
- G. adequate nutrition and fluid intake including basic meal preparation and special diets;
- H. communication skills;
- I. reading and recording temperature, pulse, and respiration;
- J. basic elements of body functioning and changes in body function that must be reported to an appropriate health care professional;
- K. recognition of and handling emergencies;
- L. physical, emotional, and developmental needs of clients, and ways to work with clients who have problems in these areas, including respect for the client, the client's property, and the client's family;
- M. safe transfer techniques and ambulation; and
- N. range of motion and positioning.

Subp. 3. **Competency evaluation.** The competency evaluation tests must be approved by the commissioner.

- A. To qualify to perform home health aide tasks, the person must pass the following:
 - (1) a practical skill test, administered by a registered nurse, that tests the subjects described in subpart 2, items E, F, I, M, and N; and
 - (2) a written, oral, or practical test of the topics listed in subpart 2, items A to D, G, H, and J to L.
- B. To qualify to perform home care aide tasks, the person must pass the competency evaluation for home health aide tasks, or the following:
 - (1) a practical skill test, administered by a registered nurse, that tests the subjects described in subpart 2, items E and F; and
 - (2) a written, oral, or practical test of the topics in subpart 2, items A to D and G.

Subp. 4. **Evidence of qualifications.** A licensee that provides the training and the competency evaluation required by this part shall provide each person who completes the training or passes the competency evaluation with written certification of satisfying this part.

4668.0140 SERVICE AGREEMENTS.

APPENDIX
Repealed Minnesota Rule: S1034-1

Subpart 1. **Service agreements.** No later than the second visit to a client, a licensee shall enter into a written service agreement with the client or the client's responsible person. Any modifications of the service agreement must be in writing and agreed to by the client or the client's responsible person.

Subp. 2. **Contents of service agreement.** The service agreement required by subpart 1 must include:

- A. a description of the services to be provided, and their frequency;
- B. identification of the persons or categories of persons who are to provide the services;
- C. the schedule or frequency of sessions of supervision or monitoring required, if any;
- D. fees for services;
- E. a plan for contingency action that includes:
 - (1) the action to be taken by the licensee, client, and responsible persons, if scheduled services cannot be provided;
 - (2) the method for a client or responsible person to contact a representative of the licensee whenever staff are providing services;
 - (3) who to contact in case of an emergency or significant adverse change in the client's condition;
 - (4) the method for the licensee to contact a responsible person of the client, if any; and
 - (5) circumstances in which emergency medical services are not to be summoned, consistent with the Adult Health Care Decisions Act, Minnesota Statutes, chapter 145B, and declarations made by the client under that act.

Class C licensees need not comply with items B and C and this item, subitems (2) and (5). Subitems (3) and (5) are not required for clients receiving only home management services.

4668.0150 MEDICATION AND TREATMENT ORDERS.

Subpart 1. **Scope.** This part applies to medications and treatments that are ordered by a physician, osteopath, dentist, podiatrist, chiropractor, or other prescriber to be administered by the licensee.

Subp. 2. **Medication and treatment orders.** Medications and treatments must be administered by a nurse or therapist qualified to perform the order or by a person who performs home health aide tasks under the direction and supervision of the nurse or therapist consistent with part 4668.0100, subparts 2 to 4.

Subp. 3. **Authorizations.** All orders for medications and treatments must be dated and signed by the prescriber, except as provided by subpart 5.

Subp. 4. **Content of orders.** All orders for medications must contain the name of the drug, dosage, and directions for use.

Subp. 5. **Verbal orders.** Upon receiving an order verbally from a prescriber, the nurse or therapist shall:

- A. record and sign the order; and
- B. forward the written order to the prescriber for the prescriber's signature no later than seven days after receipt of the verbal order.

Subp. 6. **Renewal of orders.** All orders must be renewed at least every three months.

4668.0160 CLIENT RECORDS.

Subpart 1. **Maintenance of client record.** The licensee shall maintain a record for each client.

Subp. 2. **Security.** The licensee shall establish written procedures to control use and removal of client records from the provider's offices and for security in client residences and to establish criteria for release of information. The client record must be readily accessible to personnel authorized by the licensee to use the client record.

Subp. 3. **Retention.** A client's record must be retained for at least five years following discharge. Arrangements must be made for secure storage and retrieval of client records if the licensee ceases business.

Subp. 4. **Transfer of client.** If a client transfers to another home care provider, other health care practitioner or provider, or is admitted to an inpatient facility, the licensee, upon request of the client, shall send a copy or summary of the client's record to the new provider or facility or to the client.

APPENDIX
Repealed Minnesota Rule: S1034-1

Subp. 5. **Form of entries.** All entries in the client record must be:

- A. legible, permanently recorded in ink, dated, and authenticated with the name and title of the person making the entry; or
- B. recorded in an electronic media in a secure manner.

Subp. 6. **Content of client record.** The client record must contain:

- A. the following information about the client:
 - (1) name;
 - (2) address;
 - (3) telephone number;
 - (4) date of birth;
 - (5) dates of the beginning and end of services; and
 - (6) names, addresses, and telephone numbers of any responsible persons;
- B. a service agreement as required by part 4668.0140;
- C. medication and treatment orders, if any;
- D. notes summarizing each contact with the client in the client's residence, signed by each individual providing service including volunteers, and entered in the record no later than two weeks after the contact;
- E. names, addresses, and telephone numbers of the client's medical services providers and other home care providers, if known;
- F. a summary following the termination of services, which includes the reason for the initiation and termination of services, and the client's condition at the termination of services.

Class C licensees need only include the information required by items A, B, and E. Class E licensees need only include the information required by items A, B, D, and E.

Subp. 7. **Confidentiality.** The licensee shall not disclose to any other person any personal, financial, medical, or other information about the client, except:

- A. as may be required by law;
- B. to staff, contractors of the licensee, another home care provider, other health care practitioner or provider, or inpatient facility who require information in order to provide services to the client, but only such information that is necessary to the provision of services;
- C. to persons authorized in writing by the client or the client's responsible person to receive the information, including third-party payers; and
- D. representatives of the commissioner authorized to survey or investigate home care providers.

4668.0170 REQUEST BY CLIENT FOR DISCONTINUATION OF LIFE SUSTAINING TREATMENT.

Subpart 1. **Action by person receiving request.** If a client, family member, or other caregiver of the client requests that an employee or other agent of the licensee discontinue a life sustaining treatment, the employee or other agent of the licensee receiving the request:

- A. shall take no action to discontinue the treatment; and
- B. shall promptly inform the person's supervisor or other representative of the licensee of the client's request.

Subp. 2. **Action by licensee.** Upon being informed of a request for termination of treatment, the licensee shall promptly:

- A. inform the client that the request will be made known to the physician who ordered the client's treatment; and
- B. inform the physician of the client's request.

Subp. 3. **Right to maintain treatment.** This part does not require the licensee to discontinue treatment, except as may be required by law or court order.

Subp. 4. **Rights of clients.** This part does not diminish the rights of clients to control their treatments or terminate their relationships with providers.

Subp. 5. **Health care declarations.** This part shall be construed in a manner consistent with the Adult Health Care Decisions Act, Minnesota Statutes, chapter 145B, and declarations made by clients under that act.

4668.0180 CLASS A PROVIDER, PROFESSIONAL HOME CARE AGENCY.

Subpart 1. **Scope.** This part applies only to a professional home care agency with a class A license under part 4668.0012, subpart 3.

Subp. 2. **Required services.** The licensee shall provide at least one of the following home care services directly:

- A. professional nursing;
- B. physical therapy;
- C. speech therapy;
- D. respiratory therapy;
- E. occupational therapy;
- F. nutritional services;
- G. medical social services;
- H. home health aide tasks; or
- I. provision of medical supplies and equipment when accompanied by the provision of a home care service.

Subp. 3. **Scope of services.** The licensee may provide all home care services, except that the licensee may provide a hospice program only if licensed as a hospice program under part 4664.0010, as provided by Minnesota Statutes, section 144A.753, subdivision 1.

Subp. 4. **Medical social services.** If provided, medical social services must be provided in compliance with Minnesota Statutes, sections 148B.18 to 148B.28.

Subp. 5. **Nursing services.** If provided, nursing services must be provided according to Minnesota Statutes, sections 148.171 to 148.285.

Subp. 6. **Physical therapy.** If provided, physical therapy must be provided according to Minnesota Statutes, sections 148.65 to 148.78.

Subp. 7. **Other services.** Other services not addressed in this chapter may be provided.

Subp. 8. **Referrals.** If a licensee reasonably believes that a client is in need of another medical or health service, including that of a physician, osteopath, dentist, podiatrist, chiropractor, other health professional, or social service provider, the licensee shall:

- A. inform the client of the possible need;
- B. determine the client's preferences with respect to obtaining the service; and
- C. if the client desires the service, inform the client about available providers or referral services.

Subp. 9. **Quality assurance.** The licensee shall establish and implement a quality assurance plan, described in writing, in which the licensee must:

- A. monitor and evaluate two or more selected components of its services at least once every 12 months; and
- B. document the collection and analysis of data and the action taken as a result.

Subp. 10. **Equivalent requirements for certified providers.** A class A licensee that is certified for participation in Medicare as a home health agency under Code of Federal Regulations, title 42, part 484, need not comply with this part, or with the following items, if the Medicare certification is based on compliance with the federal conditions of participation, and on survey and enforcement by the Minnesota Department of Health as agent for the United States Department of Health and Human Services:

- A. part 4668.0040;
- B. part 4668.0050;
- C. part 4668.0060, subparts 1, 2, 3, and 6;
- D. part 4668.0070, subparts 2 and 3;
- E. part 4668.0080, subparts 1 and 2;
- F. part 4668.0100, subparts 1 and 4 to 9;
- G. part 4668.0110;
- H. part 4668.0130;
- I. part 4668.0140, subparts 1 and 2, items A to D;
- J. part 4668.0150;

APPENDIX
Repealed Minnesota Rule: S1034-1

- K. part 4668.0160;
- L. part 4668.0180, subparts 1 to 9.

4668.0190 CLASS B PROVIDER, PARAPROFESSIONAL AGENCY.

A paraprofessional agency with a class B license under part 4668.0012, subpart 3, may perform home care aide tasks and home management tasks.

4668.0200 CLASS C PROVIDER, INDIVIDUAL PARAPROFESSIONALS.

Subpart 1. **Scope.** This part applies only to a paraprofessional with a class C license under part 4668.0012, subpart 3.

Subp. 2. **Services.** The licensee may perform:

- A. home health aide tasks;
- B. home care aide tasks; and
- C. home management tasks.

Subp. 3. **Training.** The licensee who performs home health aide tasks or home care aide tasks must meet the requirements of part 4668.0130 before a license will be issued.

Subp. 4. **Record of supervision.** The licensee who performs home health aide tasks must maintain a record of the supervision required by part 4668.0100, subpart 9.

Subp. 5. **Records.** The licensee must maintain a written record of the services provided at each visit to clients.

Subp. 6. **Notice of clientele.** Upon request of the commissioner, class C licensees shall provide the name, address, and telephone numbers of all or specified clients and the clients' responsible persons.

4668.0218 INFORMATION AND REFERRAL SERVICES.

The commissioner shall request from licensees information necessary to establish and maintain information and referral services required by Minnesota Statutes, section 144A.47, and licensees shall provide the requested information. This information may be required to be provided together with the licensing information required by part 4668.0012, or may be required to be provided separately.

4668.0220 SURVEYS AND INVESTIGATIONS.

Subpart 1. **Surveys.** Except as provided in subpart 3 or 10, the commissioner may survey each applicant or licensee before issuing a new license or renewing an existing license. An applicant for a license that is certified and surveyed by the Minnesota Department of Health for Medicare or medical assistance shall be surveyed at the time of its next certification survey. Applicants and licensees shall provide any and all information requested by the surveyor or investigator that is within the scope of licensure.

Subp. 2. **Coordination of surveys.** If feasible, the commissioner shall survey licensees to determine compliance with this chapter at the same time as surveys for certification for Medicare and medical assistance if Medicare certification is based on compliance with the federal conditions of participation and on survey and enforcement by the Minnesota Department of Health as agent for the United States Department of Health and Human Services.

Subp. 3. **Biennial surveys.** A licensee that has been licensed for at least two consecutive years and that has been in substantial compliance with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47, and has had no serious violations in that period, may be surveyed every second license term rather than during each license term.

Subp. 4. **Complaint investigations.** Upon receiving information that a licensee may be violating or may have violated a requirement of this chapter or Minnesota Statutes, sections 144A.43 to 144A.47, the commissioner shall investigate the complaint.

Subp. 5. **Scheduling surveys.** Surveys and investigations shall be conducted without advance notice to licensees. Surveyors may contact licensees on the day of a survey to arrange for someone to be available at the survey site. The contact does not constitute advance notice.

Subp. 6. **Contacting and visiting clients.** Surveyors may contact or visit a licensee's clients without notice to the licensee. Licensees shall provide a list of current and past clients and responsible persons with addresses and telephone numbers upon request of a surveyor. Before visiting a client, a surveyor shall obtain the client's or responsible person's permission by

APPENDIX
Repealed Minnesota Rule: S1034-1

telephone, by mail, or in person. Surveyors shall inform all clients and responsible persons of their right to decline permission for a visit.

Subp. 7. **Information from clients.** The commissioner may solicit information from clients by telephone, mail, or other means.

Subp. 8. **Client information.** Upon the commissioner's request, licensees shall provide to the commissioner information identifying some or all of its clients and any other information about the licensee's services to the clients.

Subp. 9. **Sampling of clientele.** The commissioner may conduct a written survey of all or a sampling of home care clients to determine their satisfaction with the services provided.

Subp. 10. **Surveys of class C licensees.** The commissioner may survey class C licensees by telephoning, visiting, or writing to the licensees' clients. Office visits may be conducted, but are not required.

4668.0230 FINES FOR UNCORRECTED VIOLATIONS.

Subpart 1. **Authority.** The fines provided under this part are under the authority of Minnesota Statutes, sections 144.653, subdivision 6, and 144A.45, subdivision 2, clause (4).

Subp. 2. **Fines for license classes.** Class A and class B licensees shall be assessed fines at 100 percent of the amounts provided in subpart 3. Class C licensees shall be assessed fines at 25 percent of the amounts provided in subpart 3.

Subp. 3. **Schedule of fines for violations of statutory provisions.** For each violation of a statutory provision subject to a fine under Minnesota Statutes, section 144.653, subdivision 6, the following fines shall be assessed for the respective provision that was violated in Minnesota Statutes:

- A. section 144A.44, subdivision 1, clause (1), \$250;
- B. section 144A.44, subdivision 1, clause (2), \$250;
- C. section 144A.44, subdivision 1, clause (3), \$50;
- D. section 144A.44, subdivision 1, clause (4), \$350;
- E. section 144A.44, subdivision 1, clause (5), \$250;
- F. section 144A.44, subdivision 1, clause (6), \$250;
- G. section 144A.44, subdivision 1, clause (7), \$50;
- H. section 144A.44, subdivision 1, clause (8), \$250;
- I. section 144A.44, subdivision 1, clause (9), \$250;
- J. section 144A.44, subdivision 1, clause (10), \$250;
- K. section 144A.44, subdivision 1, clause (11), \$350;
- L. section 144A.44, subdivision 1, clause (12), \$250;
- M. section 144A.44, subdivision 1, clause (13), \$500;
- N. section 144A.44, subdivision 1, clause (14), \$250;
- O. section 144A.44, subdivision 1, clause (15), \$350;
- P. section 144A.44, subdivision 1, clause (16), \$250;
- Q. section 144A.44, subdivision 1, clause (17), \$500; and
- R. section 144A.44, subdivision 2, \$250.

Subp. 4. **Schedule of fines for violations of Vulnerable Adults Act.** For each violation of a statutory provision subject to a fine under Minnesota Statutes, section 626.557, the following fines shall be assessed:

- A. subdivision 3, \$250;
- B. subdivision 3a, \$100;
- C. subdivision 4, \$250;
- D. subdivision 9, \$250; and
- E. subdivision 17, \$250.

Subp. 5. **Schedule of fines for violations of rules.** For each violation of a rule provision subject to a fine under Minnesota Statutes, section 144.653, subdivision 6, the following fines shall be assessed for the respective rule that was violated:

- A. part 4668.0008, subpart 3, \$300;
- B. for providing false information required by part 4668.0012, subpart 6, \$500;

APPENDIX
Repealed Minnesota Rule: S1034-1

- C. part 4668.0012, subpart 8, \$100;
- D. part 4668.0012, subpart 17, \$50;
- E. a variance, under part 4668.0016, subpart 8, the fine shall be the amount of the fine established for the rule that was varied;
- F. part 4668.0019, \$250;
- G. part 4668.0030, subpart 2, \$250;
- H. part 4668.0030, subpart 3, \$50;
- I. part 4668.0030, subpart 4, \$50;
- J. part 4668.0030, subpart 5, \$50;
- K. part 4668.0030, subpart 6, \$50;
- L. part 4668.0030, subpart 7, \$250;
- M. part 4668.0035, subpart 1, \$250;
- N. part 4668.0035, subpart 2, \$100;
- O. part 4668.0035, subpart 3, \$100;
- P. part 4668.0040, subpart 1, \$250;
- Q. part 4668.0040, subpart 2, \$50;
- R. part 4668.0040, subpart 3, \$250;
- S. part 4668.0050, subpart 1, \$350;
- T. part 4668.0050, subpart 2, \$100;
- U. part 4668.0060, subpart 1, \$50;
- V. part 4668.0060, subpart 3, \$350;
- W. part 4668.0060, subpart 4, \$350;
- X. part 4668.0060, subpart 5, \$500;
- Y. part 4668.0060, subpart 6, \$300;
- Z. part 4668.0065, subpart 1, \$500;
- AA. part 4668.0065, subpart 2, \$500;
- BB. part 4668.0065, subpart 3, \$300;
- CC. part 4668.0070, subpart 2, \$50;
- DD. part 4668.0070, subpart 3, \$50;
- EE. part 4668.0070, subpart 4, \$50;
- FF. part 4668.0075, subpart 1, \$300;
- GG. part 4668.0075, subpart 2, \$100;
- HH. part 4668.0075, subpart 4, \$50;
- II. part 4668.0080, subpart 1, \$300;
- JJ. part 4668.0080, subpart 2, \$300;
- KK. part 4668.0080, subpart 3, \$300;
- LL. part 4668.0080, subpart 4, \$300;
- MM. part 4668.0080, subpart 5, \$300;
- NN. part 4668.0100, subpart 1, \$350;
- OO. part 4668.0100, subpart 2, \$350;
- PP. part 4668.0100, subpart 3, \$500;
- QQ. part 4668.0100, subpart 4, \$350;
- RR. part 4668.0100, subpart 5, \$300;
- SS. part 4668.0100, subpart 6, \$300;
- TT. part 4668.0100, subpart 7, \$50;
- UU. part 4668.0100, subpart 8, \$350;
- VV. part 4668.0100, subpart 9, \$350;
- WW. part 4668.0110, subpart 1, \$350;
- XX. part 4668.0110, subpart 2, \$300;
- YY. part 4668.0110, subpart 3, \$50;
- ZZ. part 4668.0110, subpart 4, \$300;

APPENDIX
Repealed Minnesota Rule: S1034-1

AAA. part 4668.0110, subpart 5, \$350;
BBB. part 4668.0110, subpart 6, \$350;
CCC. part 4668.0120, subpart 2, \$50;
DDD. part 4668.0130, subpart 1, \$300;
EEE. part 4668.0130, subpart 2, \$300;
FFF. part 4668.0130, subpart 3, \$300;
GGG. part 4668.0130, subpart 4, \$50;
HHH. part 4668.0140, subpart 1, \$250;
III. part 4668.0140, subpart 2, \$50;
JJJ. part 4668.0150, subpart 2, \$350;
KKK. part 4668.0150, subpart 3, \$350;
LLL. part 4668.0150, subpart 4, \$350;
MMM. part 4668.0150, subpart 5, \$350;
NNN. part 4668.0150, subpart 6, \$350;
OOO. part 4668.0160, subpart 1, \$100;
PPP. part 4668.0160, subpart 2, \$100;
QQQ. part 4668.0160, subpart 3, \$50;
RRR. part 4668.0160, subpart 4, \$100;
SSS. part 4668.0160, subpart 5, \$50;
TTT. part 4668.0160, subpart 6, \$100;
UUU. part 4668.0160, subpart 7, \$350;
VVV. part 4668.0170, subpart 1, \$500;
WWW. part 4668.0170, subpart 2, \$500;
XXX. part 4668.0180, subpart 3, \$500;
YYY. part 4668.0180, subpart 4, \$300;
ZZZ. part 4668.0180, subpart 5, \$300;
AAAA. part 4668.0180, subpart 6, \$300;
BBBB. part 4668.0180, subpart 8, \$200;
CCCC. part 4668.0180, subpart 9, \$100;
DDDD. part 4668.0190, \$500;
EEEE. part 4668.0200, subpart 2, \$500;
FFFF. part 4668.0200, subpart 4, \$100;
GGGG. part 4668.0200, subpart 5, \$50;
HHHH. part 4668.0200, subpart 6, \$500;
IIII. part 4668.0220, subpart 6, \$500; and
JJJJ. part 4668.0220, subpart 8, \$500.

4668.0240 FAILURE TO CORRECT DEFICIENCY AFTER FINE HAS BEEN IMPOSED.

If, upon subsequent reinspection after a fine has been imposed under part 4668.0230, the deficiency has still not been corrected, another fine shall be assessed. This fine shall be double the amount of the previous fine.

4668.0800 CLASS F HOME CARE PROVIDER.

Subpart 1. **Scope of license.** A class F home care provider licensee may provide nursing services, delegated nursing services, other services performed by unlicensed personnel, or central storage of medications, solely for residents of one or more housing with services establishments registered under Minnesota Statutes, chapter 144D.

Subp. 2. **Required services.** A class F home care provider licensee must provide at least one of the following assisted living home care services directly:

- A. professional nursing services;
- B. delegated nursing services;
- C. non-nursing services performed by unlicensed personnel; or
- D. central storage of medications.

APPENDIX
Repealed Minnesota Rule: S1034-1

Subp. 3. **Fulfillment of services.** A class F home care provider licensee must provide all services required by a client's service plan under part 4668.0815.

Subp. 4. **Referrals.** If a class F home care provider licensee reasonably believes that a client is in need of another medical or health service, including that of a physician, osteopath, dentist, podiatrist, chiropractor, other health professional, or social service provider, the licensee must:

- A. inform the client of the possible need;
- B. determine the client's preferences with respect to obtaining the service; and
- C. if the client desires the service, inform the client about available providers or referral services.

Subp. 5. **Availability of contact person.** A class F home care provider licensee must have a contact person available for consultation whenever an unlicensed person employed by the licensee is performing assisted living home care services for a client. The contact person must be available to unlicensed personnel in person, by telephone, or by other means of direct communication.

Subp. 6. **Violations of rules.** For each violation of parts 4668.0800 to 4668.0870 subject to a fine under Minnesota Statutes, section 144.653, subdivisions 5 to 8, a fine shall be assessed according to the schedules established in parts 4668.0800 to 4668.0870.

Subp. 7. **Failure to correct deficiency.** If, upon subsequent reinspection after a fine has been imposed under subpart 6, the deficiency has still not been corrected, another fine must be assessed. This fine must be double the amount of the previous fine.

Subp. 8. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

- A. subpart 3, \$350;
- B. subpart 4, \$200; and
- C. subpart 5, \$300.

4668.0805 ORIENTATION TO HOME CARE REQUIREMENTS.

Subpart 1. **Orientation.** An individual applicant for a class F home care provider license and a person who provides direct care, supervision of direct care, or management of services for a licensee must complete an orientation to home care requirements before providing home care services to clients. The orientation may be incorporated into the training of unlicensed personnel required under part 4668.0835, subpart 2. The orientation need only be completed once.

Subp. 2. **Content.** The orientation required under subpart 1 must contain the following topics:

- A. an overview of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;
- B. handling emergencies and using emergency services;
- C. reporting the maltreatment of vulnerable minors or adults under Minnesota Statutes, sections 626.556 and 626.557;
- D. the home care bill of rights, Minnesota Statutes, section 144A.44;
- E. handling of clients' complaints and how clients and staff may report complaints to the Office of Health Facility Complaints; and
- F. the services of the ombudsman for older Minnesotans.

Subp. 3. **Sources of orientation.** The orientation training required by this part may be provided by a class F home care provider licensee or may be obtained from other sources. The commissioner must provide a curriculum and materials that may be used to present the orientation.

Subp. 4. **Verification and documentation.** A class F home care provider licensee must retain evidence that each person has completed the orientation training required under this part.

Subp. 5. **Transferability.** A class F home care provider licensee may accept written verification from another provider that a person has completed the orientation required under this part.

Subp. 6. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

- A. subpart 1, \$300;
- B. subpart 2, \$100; and
- C. subpart 4, \$50.

4668.0810 CLIENT RECORDS.

APPENDIX
Repealed Minnesota Rule: S1034-1

Subpart 1. **Maintenance of client record.** A class F home care provider licensee must maintain a record for each client at the housing with services establishment where the services are provided. The client record must be readily accessible to personnel authorized by the licensee to use the client record.

Subp. 2. **Security.** A class F home care provider licensee must establish and implement written procedures for security of client records, including:

- A. the use of client records;
- B. the removal of client records from the establishment; and
- C. the criteria for release of client information.

Subp. 3. **Retention.** A class F home care provider licensee must retain a client's record for at least five years following the client's discharge or discontinuation of services. Arrangements must be made for secure storage and retrieval of client records if the licensee ceases business.

Subp. 4. **Transfer of client.** If a client transfers to another home care provider or other health care practitioner or provider or is admitted to an inpatient facility, a class F home care provider licensee, upon request of the client, must send a copy or summary of the client's record to the new provider or facility or to the client.

Subp. 5. **Form of entries.** Except as required by subpart 6, items F and G, documentation of a class F home care service must be created and signed by the staff person providing the service no later than the end of the work period. The documentation must be entered into the client record no later than two weeks after the end of the day service was provided. All entries in the client record must be:

- A. legible, permanently recorded in ink, dated, and authenticated with the name and title of the person making the entry; or
- B. recorded in an electronic media in a manner that ensures the confidentiality and security of the electronic information, according to current standards of practice in health information management, and that allows for a printed copy to be created.

Subp. 6. **Content of client record.** The client record must be accurate, up to date, and available to all persons responsible for assessing, planning, and providing assisted living home care services. The record must contain:

- A. the following information about the client:
 - (1) name;
 - (2) address;
 - (3) telephone number;
 - (4) date of birth;
 - (5) dates of the beginning and end of services;
 - (6) names, addresses, and telephone numbers of any responsible persons;
 - (7) primary diagnosis and any other relevant current diagnoses;
 - (8) allergies, if any; and
 - (9) the client's advance directive, if any;
- B. an evaluation and service plan as required under part 4668.0815;
- C. a nursing assessment for nursing services, delegated nursing services, or central storage of medications, if any;
- D. medication and treatment orders, if any;
- E. the client's current tuberculosis infection status, if known;
- F. documentation of each instance of assistance with self-administration of medication and of medication administration, if any;
- G. documentation on the day of occurrence of any significant change in the client's status or any significant incident, including a fall or a refusal to take medications, and any actions by staff in response to the change or incident;
- H. documentation at least weekly of the client's status and the home care services provided, if not addressed under item F or G;
- I. the names, addresses, and telephone numbers of the client's medical services providers and other home care providers, if known;

APPENDIX
Repealed Minnesota Rule: S1034-1

J. a summary following the discontinuation of services, which includes the reason for the initiation and discontinuation of services and the client's condition at the discontinuation of services; and

K. any other information necessary to provide care for each individual client.

Subp. 7. **Confidentiality.** A Class F home care provider licensee must not disclose to any other person any personal, financial, medical, or other information about the client, except:

A. as may be required by law;

B. to staff, another home care provider, a health care practitioner or provider, or an inpatient facility that requires information to provide services to the client, but only the information that is necessary to provide services;

C. to persons authorized in writing by the client or the client's responsible person to receive the information, including third-party payers; or

D. to representatives of the commissioner authorized to survey or investigate home care providers.

Subp. 8. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

A. subpart 1, \$100;

B. subpart 2, \$100;

C. subpart 3, \$50;

D. subpart 4, \$100;

E. subpart 5, \$50;

F. subpart 6, \$100; and

G. subpart 7, \$350.

4668.0815 EVALUATION AND SERVICE PLAN.

Subpart 1. **Evaluation; documentation.** No later than two weeks after the initiation of assisted living home care services to a client, a registered nurse must complete an individualized evaluation of the client's needs and must establish, with the client or the client's responsible person, a suitable and up-to-date service plan for providing assisted living home care services in accordance with accepted standards of practice for professional nursing. The service plan must be in writing and include a signature or other authentication by the class F home care provider licensee and by the client or the client's responsible person documenting agreement on the services to be provided.

Subp. 2. **Reevaluation.** A registered nurse must review and revise a client's evaluation and service plan at least annually or more frequently when there is a change in the client's condition that requires a change in services.

Subp. 3. **Modifications.** A modification of the service plan must be in writing and agreed to by the client or the client's responsible person before the modification is initiated. A modification must be authenticated by the client or the client's responsible person and must be entered into the client's record no later than two weeks after the modification is initiated.

Subp. 4. **Contents of service plan.** The service plan required under subpart 1 must include:

A. a description of the assisted living home care service or services to be provided and the frequency of each service, according to the individualized evaluation required under subpart 1;

B. the identification of the persons or categories of persons who are to provide the services;

C. the schedule or frequency of sessions of supervision or monitoring required by law, rule, or the client's condition for the services or the persons providing those services, if any;

D. the fees for each service; and

E. a plan for contingency action that includes:

(1) the action to be taken by the class F home care provider licensee, client, and responsible person if scheduled services cannot be provided;

(2) the method for a client or responsible person to contact a representative of the class F home care provider licensee whenever staff are providing services;

(3) the name and telephone number of the person to contact in case of an emergency or significant adverse change in the client's condition;

APPENDIX
Repealed Minnesota Rule: S1034-1

(4) the method for the class F home care provider licensee to contact a responsible person of the client, if any; and

(5) the circumstances in which emergency medical services are not to be summoned, consistent with Minnesota Statutes, chapters 145B and 145C, and declarations made by the client under those chapters.

Subp. 5. **Scheduled appointments for nonessential services.** If a class F home care provider licensee or employee of a licensee is unable, for any reason, to keep a scheduled appointment for a service that is not essential for medical or safety reasons, the licensee must:

- A. follow the procedure established in the service plan;
- B. provide a replacement person; or
- C. notify the client that the appointment will not be kept and schedule a new appointment or arrange for some other reasonable alternative.

Subp. 6. **Scheduled appointments for essential services.** If, for medical or safety reasons, a service to be provided must be completed at the scheduled time and the class F home care provider licensee or employee of a licensee is unable, for any reason, to keep the scheduled appointment, the licensee must make arrangements to complete the service through a contract with another provider or through other reasonable means.

Subp. 7. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

- A. subpart 1, \$250;
- B. subpart 2, \$250;
- C. subpart 3, \$250;
- D. subpart 4, \$50;
- E. subpart 5, \$350; and
- F. subpart 6, \$500.

4668.0820 NURSING SERVICES.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides nursing services.

Subp. 2. **Compliance with Minnesota Nurse Practice Act.** Nursing services must be provided according to Minnesota Statutes, sections 148.171 to 148.285, and rules adopted thereunder.

4668.0825 DELEGATED NURSING SERVICES.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides nursing services delegated to unlicensed personnel.

Subp. 2. **Nursing assessment and service plan.** Before initiating delegated nursing services for a client, a registered nurse must conduct a nursing assessment of the client's functional status and need for nursing services and must develop a service plan for providing the services according to the client's needs and preferences. The service plan must include the frequency of supervision of the task and of the person providing the service for the client according to part 4668.0845. The service plan for delegated nursing services must be maintained as part of the service plan required under part 4668.0815.

Subp. 3. **Nursing services delegated to unlicensed personnel.** A registered nurse may delegate the nursing services specified in items A to I only to a person who satisfies the requirements of part 4668.0835 and possesses the knowledge and skills consistent with the complexity of the nursing task being delegated, only in accordance with Minnesota Statutes, sections 148.171 to 148.285. Nursing services that may be delegated are:

- A. performing assistance with self-administration of medication and medication administration according to part 4668.0855;
- B. performing routine delegated medical or nursing procedures, as provided under subpart 4;
- C. assisting with body positioning or transfer of a client;
- D. feeding a client who, because of the client's condition, is at risk of choking;
- E. assisting with bowel and bladder control, devices, and training programs;
- F. assisting with therapeutic or passive range of motion exercises;

APPENDIX
Repealed Minnesota Rule: S1034-1

- G. providing skin care, including full or partial bathing and foot soaks;
- H. during episodes of serious disease or acute illness, providing the following services or assisting a client to:
 - (1) maintain the hygiene of the client's body and immediate environment;
 - (2) satisfy nutritional needs;
 - (3) assist with the client's mobility, including movement, change of location, and positioning;
 - (4) bathe;
 - (5) maintain oral hygiene;
 - (6) dress;
 - (7) care for hair;
 - (8) use the toilet;
 - (9) change bedding;
 - (10) perform basic housekeeping; and
 - (11) prepare meals; and
- I. providing central storage of medications, according to part 4668.0865.

Subp. 4. **Performance of routine procedures.** A person who satisfies the requirements of part 4668.0835, subpart 2, may perform delegated nursing procedures if:

- A. before performing the procedures, the person is instructed by a registered nurse in the proper methods to perform the procedures with respect to each client;
- B. a registered nurse specifies in writing specific instructions for performing the procedures for each client;
- C. before performing the procedures, the person demonstrates to a registered nurse the person's ability to competently follow the procedures;
- D. the procedures for each client are documented in the client's record; and
- E. the class F home care provider licensee retains documentation by the registered nurse regarding the person's demonstrated competency.

Subp. 5. **Information to determine delegation.** The licensee must establish and implement policies to communicate up-to-date information to the registered nurse regarding the current available unlicensed personnel and their training and qualifications, so the registered nurse has sufficient information to determine the appropriateness of delegating tasks in individual situations.

Subp. 6. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

- A. subpart 2, \$250;
- B. subpart 3, \$350;
- C. subpart 4, \$350; and
- D. subpart 5, \$350.

4668.0830 OTHER SERVICES PERFORMED BY UNLICENSED PERSONNEL.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides other services performed by unlicensed personnel.

Subp. 2. **Other services.** A person who satisfies the requirements of part 4668.0835 may perform services in the registered housing with services establishment including:

- A. preparing modified diets, including diabetic or low sodium diets;
- B. providing medication reminders;
- C. performing household chores in the presence of technically sophisticated medical equipment or episodes of acute illness or infectious disease;
- D. performing household chores when the client's care requires the prevention of exposure to infectious disease or containment of infectious disease;
- E. assisting with dressing, oral hygiene, hair care, grooming, and bathing; and
- F. performing home management tasks.

Subp. 3. **Schedule of fines.** A fine of \$350 shall be assessed for a violation of subpart 2.

4668.0835 QUALIFICATIONS FOR UNLICENSED PERSONNEL WHO PERFORM ASSISTED LIVING HOME CARE SERVICES.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides assisted living home care services using unlicensed personnel.

Subp. 2. **Qualifications.** An unlicensed person may offer to perform, or be employed to perform nursing services delegated to unlicensed personnel as provided under part 4668.0825, other services performed by unlicensed personnel as provided under part 4668.0830, or central storage of medications as provided under part 4668.0865, only if the person has:

A. successfully completed the training and passed the competency evaluation according to part 4668.0840, subpart 2;

B. successfully completed the training under part 4668.0840, subpart 3, and passed a competency evaluation according to part 4668.0840, subpart 4; or

C. satisfied the requirements of part 4668.0100, subpart 5.

Subp. 3. **In-service training and demonstration of competency.** For each unlicensed person who performs assisted living home care services, a class F home care provider licensee must comply with items A to C.

A. For each 12 months of employment, a person who performs assisted living home care services must complete at least eight hours of in-service training in topics relevant to the provision of home care services, including training in infection control required under part 4668.0065, subpart 3, obtained from the licensee or another source.

B. If a person has not performed assisted living home care services for a continuous period of 24 consecutive months, the person must demonstrate to a registered nurse competence according to part 4668.0840, subpart 4, item C.

C. A licensee must retain documentation of satisfying this part and must provide documentation to a person who completes the in-service training.

Subp. 4. **Documentation.**

A. An unlicensed person who performs assisted living home care services must provide documentation to the employing licensee of satisfying this part.

B. A class F home care provider licensee must verify that unlicensed persons employed by the licensee to perform assisted living home care services have satisfied the requirements of this part, and must retain documentation in the personnel records.

Subp. 5. **Initiation of services by unlicensed personnel.** Before initiating delegated nursing services by unlicensed personnel, a registered nurse must orient each person who is to perform assisted living home care services to each client and to the assisted living home care services to be performed. Based on the professional judgment of the registered nurse and on the individual needs of the client, the orientation may occur onsite, verbally, or in writing.

Subp. 6. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

A. subpart 2, \$300;

B. subpart 3, \$300;

C. subpart 4, \$50; and

D. subpart 5, \$350.

4668.0840 TRAINING AND COMPETENCY EVALUATION FOR UNLICENSED PERSONNEL.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides assisted living home care services using unlicensed personnel.

Subp. 2. **Scope of training course and instructor.** The training required under part 4668.0835, subpart 2, must:

A. include each assisted living home care service offered to clients that the unlicensed person will perform, taught by a registered nurse with experience or training in the subject being taught;

B. include the core training requirements specified in subpart 3;

C. include the competency evaluation required under subpart 4; and

D. use a curriculum that meets the requirements of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

APPENDIX
Repealed Minnesota Rule: S1034-1

Subp. 3. Core training of unlicensed personnel.

A. An unlicensed person performing assisted living home care services must successfully complete training or demonstrate competency in the topics described in subitems (1) to (12). The required topics are:

- (1) an overview of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;
- (2) recognizing and handling emergencies and using emergency services;
- (3) reporting maltreatment of vulnerable minors or adults under Minnesota Statutes, sections 626.556 and 626.557;
- (4) the home care bill of rights, Minnesota Statutes, section 144A.44;
- (5) handling clients' complaints and reporting complaints to the Office of Health Facility Complaints;
- (6) the services of the ombudsman for older Minnesotans;
- (7) communication skills;
- (8) observing, reporting, and documenting client status and the care or services provided;
- (9) basic infection control;
- (10) maintaining a clean, safe, and healthy environment;
- (11) basic elements of body functioning and changes in body function that must be reported to an appropriate health care professional; and
- (12) physical, emotional, and developmental needs of clients, and ways to work with clients who have problems in these areas, including respect for the client, the client's property, and the client's family.

B. The core training of unlicensed personnel must be taught by a registered nurse with experience or training in home care, except that item A, subitems (1) to (7), may be taught by another instructor under the direction of the registered nurse.

C. The core training curriculum must meet the requirements of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 4. Competency evaluation.

A. The competency evaluation tests required under part 4668.0835, subpart 2, items A and B, must meet the requirements of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

B. A registered nurse must complete and document each competency evaluation.

C. To qualify to perform assisted living home care services, a person must demonstrate competency by successfully completing:

- (1) a written, oral, or practical test of the topics in subpart 3; and
- (2) a written, oral, or practical test of all assisted living home care provider services that the person will perform.

Subp. 5. Evidence of qualifications. A class F home care provider licensee that provides the training and the competency evaluation required by this part must provide each person who successfully completes the training or passes the competency evaluation with written verification of satisfying this part.

Subp. 6. Schedule of fines. For a violation of the following subparts, the stated fine shall be assessed:

- A. subpart 2, \$300;
- B. subpart 3, \$300;
- C. subpart 4, \$300; and
- D. subpart 5, \$50.

4668.0845 PERIODIC SUPERVISION OF UNLICENSED PERSONNEL.

Subpart 1. Scope. This part applies to a class F home care provider licensee that provides assisted living home care services using unlicensed personnel.

Subp. 2. Services that require supervision by a registered nurse.

A. After the orientation required under part 4668.0835, subpart 5, a registered nurse must supervise, or a licensed practical nurse under the direction of a registered nurse must monitor, unlicensed persons who perform assisted living home care services that require supervision by

APPENDIX
Repealed Minnesota Rule: S1034-1

a registered nurse at the housing with services establishment, to verify that the work is being performed adequately, identify problems, and assess the appropriateness of the care to the client's needs. Supervision or monitoring must be provided no less often than the following schedule:

(1) within 14 days after initiation of assisted living home care services that require supervision by a registered nurse; and

(2) at least every 62 days thereafter, or more frequently if indicated by a nursing assessment and the client's individualized service plan.

B. If the unlicensed person is monitored by a licensed practical nurse, the client must be supervised by a registered nurse at the housing with services establishment at least every other visit and the licensed practical nurse must be under the direction of a registered nurse, according to Minnesota Statutes, sections 148.171 to 148.285.

Subp. 3. **Services that do not require supervision by a registered nurse.** After the orientation required under part 4668.0835, subpart 5, unlicensed persons who perform services listed under part 4668.0830, subpart 2, or other assisted living home care services that do not require supervision by a registered nurse must be supervised at the housing with services establishment, to verify that the work is being performed adequately, identify problems, and assess the appropriateness of the care to the client's needs. The service plan developed under part 4668.0815 must address the frequency of the supervision of each service and the appropriate person to perform the supervision.

Subp. 4. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

A. subpart 2, \$350; and

B. subpart 3, \$300.

4668.0855 MEDICATION ADMINISTRATION AND ASSISTANCE WITH SELF-ADMINISTRATION OF MEDICATION.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides medication administration or assistance with self-administration of medication by unlicensed personnel.

Subp. 2. **Nursing assessment and service plan.** For each client who will be provided with assistance with self-administration of medication or medication administration, a registered nurse must conduct a nursing assessment of each client's functional status and need for assistance with self-administration of medication or medication administration, and develop a service plan for the provision of the services according to the client's needs and preferences. The service plan must include the frequency of supervision of the task and of the person providing the service for the client according to part 4668.0845, and must be maintained as part of the service plan required under part 4668.0815.

Subp. 3. **Delegation by a registered nurse.** A registered nurse may delegate medication administration or assistance with self-administration of medication only to a person who satisfies the requirements of part 4668.0835, subpart 2, and possesses the knowledge and skills consistent with the complexity of medication administration or assistance with self-administration of medication, only in accordance with Minnesota Statutes, sections 148.171 to 148.285.

Subp. 4. **Training for assistance with self-administration of medication or medication administration.** Before the registered nurse delegates the task of assistance with self-administration of medication or the task of medication administration, a registered nurse must instruct the unlicensed person on the following:

A. the complete procedure for checking a client's medication record;

B. preparation of the medication for administration;

C. administration of the medication to the client;

D. assistance with self-administration of medication;

E. documentation, after assistance with self-administration of medication or medication administration, of the date, time, dosage, and method of administration of all medications, or the reason for not assisting with self-administration of medication or medication administration as ordered, and the signature of the nurse or authorized person who assisted or administered and observed the same; and

F. the type of information regarding assistance with self-administration of medication and medication administration reportable to a nurse.

APPENDIX
Repealed Minnesota Rule: S1034-1

Subp. 5. **Administration of medications.** A person who satisfies the requirements of subpart 4 and has been delegated the responsibility by a registered nurse, may administer medications, orally, by suppository, through eye drops, through ear drops, by use of an inhalant, topically, by injection, or through a gastrostomy tube, if:

- A. the medications are regularly scheduled; and
- B. in the case of pro re nata medications, the administration of the medication is reported to a registered nurse either:
 - (1) within 24 hours after its administration; or
 - (2) within a time period that is specified by a registered nurse prior to the administration.

Subp. 6. **Limitations on administering medications.** A person who administers medications under subpart 3 may not draw up injectables. Medication administered by injection under subpart 5 is limited to insulin.

Subp. 7. **Performance of routine procedures.** A person who satisfies the training requirements of subpart 4 may perform assistance with self-administration of medication or medication administration if:

- A. before performing the procedures, the person is instructed by a registered nurse in the proper methods to perform the procedures with respect to each client;
- B. a registered nurse specifies in writing specific instructions for performing the procedures for each client;
- C. before performing the procedures, the person demonstrates to a registered nurse the person's ability to competently follow the procedures;
- D. the procedures for each client are documented in the client's records; and
- E. the class F home care provider licensee retains documentation by the registered nurse regarding the person's demonstrated competency.

Subp. 8. **Documentation.** A class F home care provider licensee must retain documentation in the personnel records of the unlicensed personnel who have satisfied the training requirements of this part.

Subp. 9. **Medication records.** The name, date, time, quantity of dosage, and the method of administration of all prescribed legend and over-the-counter medications, and the signature and title of the authorized person who provided assistance with self-administration of medication or medication administration must be recorded in the client's record following the assistance with self-administration of medication or medication administration. If assistance with self-administration of medication or medication administration was not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided.

Subp. 10. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

- A. subpart 2, \$350;
- B. subpart 3, \$350;
- C. subpart 4, \$300;
- D. subpart 5, \$350;
- E. subpart 6, \$500;
- F. subpart 7, \$350;
- G. subpart 8, \$50; and
- H. subpart 9, \$300.

4668.0860 MEDICATION AND TREATMENT ORDERS.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee when an authorized prescriber orders a medication or treatment to be administered by the licensee.

Subp. 2. **Prescriber's order required.** There must be a written prescriber's order for a drug for which a class F home care provider licensee provides assistance with self-administration of medication or medication administration, including an over-the-counter drug.

Subp. 3. **Medication and treatment orders.** A medication or treatment must be administered by a nurse qualified to implement the order or by an unlicensed person under the direction of a nurse and the supervision of a registered nurse, according to part 4668.0845.

APPENDIX

Repealed Minnesota Rule: S1034-1

Subp. 4. **Authorizations.** An order for medication or treatment must be dated and signed by the prescriber, except as provided by subparts 6 and 7, and must be current and consistent with the nursing assessment required under part 4668.0855, subpart 2.

Subp. 5. **Content of medication orders.** An order for medication must contain the name of the drug, dosage indication, and directions for use.

Subp. 6. **Verbal orders.** Upon receiving an order verbally from a prescriber, a nurse must:

- A. record and sign the order; and
- B. forward the written order to the prescriber for the prescriber's signature no later than seven days after receipt of the verbal order.

Subp. 7. **Electronically transmitted orders.**

A. An order received by telephone, facsimile machine, or other electronic means must be kept confidential according to Minnesota Statutes, sections 144.291 to 144.298 and 144A.44.

B. An order received by telephone, facsimile machine, or other electronic means must be communicated to the supervising registered nurse within one hour of receipt.

C. An order received by electronic means, not including facsimile machine, must be immediately recorded or placed in the client's record by a nurse and must be countersigned by the prescriber within 62 days.

D. An order received by facsimile machine must have been signed by the prescriber and must be immediately recorded or a durable copy placed in the client's record by a person authorized by the class F home care provider licensee.

Subp. 8. **Implementation of order.** When an order is received, the class F home care provider licensee or an employee of the licensee must take action to implement the order within 24 hours of receipt of the order.

Subp. 9. **Renewal of orders.** A medication or treatment order must be renewed at least every 12 months or more frequently as indicated by the nursing assessment required under part 4668.0855, subpart 2.

Subp. 10. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

- A. subpart 2, \$350;
- B. subpart 3, \$350;
- C. subpart 4, \$350;
- D. subpart 5, \$350;
- E. subpart 6, \$350;
- F. subpart 7, item A, \$250;
- G. subpart 7, item B, \$300;
- H. subpart 7, item C, \$300;
- I. subpart 7, item D, \$300;
- J. subpart 8, \$500 per day; and
- K. subpart 9, \$100.

4668.0865 CENTRAL STORAGE OF MEDICATION.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides central storage of medications.

Subp. 2. **Nursing assessment and service plan.** For a client for whom medications will be centrally stored, a registered nurse must conduct a nursing assessment of a client's functional status and need for central medication storage, and develop a service plan for the provision of that service according to the client's needs and preferences. The service plan must include the frequency of supervision of the task and of the person providing the service for the client according to part 4668.0845. The service plan for central storage of medication must be maintained as part of the service plan required under part 4668.0815.

Subp. 3. **Control of medications.**

A. A registered nurse or pharmacist must establish and maintain a system that addresses the control of medications, handling of medications, medication containers, medication records, and disposition of medications.

- B. The system must contain at least the following provisions:

APPENDIX
Repealed Minnesota Rule: S1034-1

- (1) a statement of whether the staff will provide medication reminders, assistance with self-administration of medication, medication administration, or a combination of those services;
- (2) a description of how the distribution and storage of medications will be handled, including a description of suitable storage facilities;
- (3) the procedures for recording medications that clients are taking;
- (4) the procedures for storage of legend and over-the-counter drugs;
- (5) a method of refrigeration of biological medications; and
- (6) the procedures for notifying a registered nurse when a problem with administration, record keeping, or storage of medications is discovered.

Subp. 4. **Over-the-counter drugs.** An over-the-counter drug may be retained in general stock supply and must be kept in the original labeled container.

Subp. 5. **Legend drugs.** A legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of a time-dated drug, directions for use, client's name, prescriber's name, date of issue, and the name and address of the licensed pharmacy that issued the medications.

Subp. 6. **Medication samples.** A sample of medication provided to a client by an authorized prescriber may be used by that client, and must be kept in its original container bearing the original label with legible directions for use. If assistance with self-administration of medication or medication administration is provided by the class F home care provider licensee, a client's plan of care must address the use of a medication sample.

Subp. 7. **Prohibitions.** No legend drug supply for one client may be used or saved for the use of another client.

Subp. 8. **Storage of drugs.** A class F home care provider licensee providing central storage of medications must store all drugs in locked compartments under proper temperature controls and permit only authorized nursing personnel to have access to keys.

Subp. 9. **Storage of Schedule II drugs.** A class F home care provider licensee providing central storage of medications must provide separately locked compartments, permanently affixed to the physical plant or medication cart, for storage of controlled drugs listed in Minnesota Statutes, section 152.02, subdivision 3.

Subp. 10. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

- A. subpart 2, \$350;
- B. subpart 3, \$300;
- C. subpart 4, \$300;
- D. subpart 5, \$300;
- E. subpart 6, \$300;
- F. subpart 7, \$300;
- G. subpart 8, \$300; and
- H. subpart 9, \$300.

4668.0870 DISPOSITION OF MEDICATIONS.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides central storage of medications.

Subp. 2. **Drugs given to discharged clients.** Current medications belonging to a client must be given to the client, or the client's responsible person, when the client is discharged or moves from the housing with services establishment. A class F home care provider licensee must document in the client's record to whom the medications were given.

Subp. 3. **Disposition of medications.**

A. Unused portions of a controlled substance remaining in a housing with services establishment after death or discharge of the client for whom the controlled substance was prescribed, or any controlled substance discontinued permanently, must be disposed of by contacting the Minnesota Board of Pharmacy, which shall furnish the necessary instructions and forms, a copy of which shall be kept on file by the class F home care provider licensee for two years.

APPENDIX
Repealed Minnesota Rule: S1034-1

B. Unused portions of a legend drug remaining in a housing with services establishment after the death or discharge of the client for whom the legend drug was prescribed, or any legend drug permanently discontinued, must be destroyed by the class F home care provider licensee or a designee of the licensee, in the presence of a pharmacist or nurse who shall witness the destruction. A notation of the destruction listing the date, quantity, name of drug, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded in the client's record.

Subp. 4. **Loss or spillage.** When a loss or spillage of a Schedule II drug occurs, an explanatory notation must be made in the client's record. The notation must be signed by the person responsible for the loss or spillage and by one witness who must also observe the destruction of any remaining contaminated drug by flushing into the sewer system or wiping up the spill.

Subp. 5. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

- A. subpart 2, \$300;
- B. subpart 3, \$300; and
- C. subpart 4, \$300.

4669.0001 AUTHORITY.

This chapter establishes fees for the licensing of home care providers, as required by Minnesota Statutes, section 144A.46, subdivision 1, paragraph (c), and part 4668.0012, subpart 18.

4669.0010 DEFINITIONS.

Subpart 1. **Applicant.** "Applicant" means a provider of home care services that applies for a new license or renewal license under chapter 4668.

Subp. 2. **Commissioner.** "Commissioner" means the commissioner of the Department of Health.

Subp. 3. **Provider.** "Provider" means a home care provider required to be licensed under Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 4. **Revenues.** "Revenues" means all money or the value of property or services received by a registrant and derived from the provision of home care services, including fees for services, grants, bequests, gifts, donations, appropriations of public money, and earned interest or dividends.

4669.0020 LICENSE FEE.

An applicant for a new license or renewal license under chapter 4668 shall pay a fee to the commissioner based on revenues derived from the provision of home care services during the calendar year prior to the year in which the application is submitted, according to the formula in part 4669.0050.

4669.0030 PROCEDURE FOR PAYING LICENSE FEE.

Subpart 1. **Payment of fee.** An applicant shall submit the fee required by part 4669.0050 to the commissioner together with the application for the license.

Subp. 2. **Verification of revenues.** Under a circumstance listed in item A or B, the commissioner shall require each applicant to verify its revenues by providing a copy of an income tax return; informational tax return, such as an Internal Revenue Service form 1065 partnership return or form 990 tax-exempt organization return; Medicare cost report; certified financial statement; or other documentation that verifies the accuracy of the revenues derived from the provision of home care services for the reporting period on which the fee is based if either:

- A. the commissioner has received information that a revenue report may be inaccurate; or
- B. the provider has been randomly selected for compliance verification.

4669.0040 FEE LIMITATION.

A provider is subject to one license fee, regardless of the number of distinct programs through which home care services are provided unless the provider operates under multiple units as set forth in part 4668.0012, subpart 2. The fee shall be based on the total revenue of all home care services.

APPENDIX
Repealed Minnesota Rule: S1034-1

4669.0050 FEE SCHEDULE.

Subpart 1. **Fees for classes A and B.** The amount of the fee for class A and class B providers shall be determined according to the following schedule:

- A. for revenues greater than \$1,500,000, \$4,000;
- B. for revenues greater than \$1,275,000 and no more than \$1,500,000, \$3,500;
- C. for revenues greater than \$1,100,000 and no more than \$1,275,000, \$3,000;
- D. for revenues greater than \$950,000 and no more than \$1,100,000, \$2,500;
- E. for revenues greater than \$850,000 and no more than \$950,000, \$2,250;
- F. for revenues greater than \$750,000 and no more than \$850,000, \$2,000;
- G. for revenues greater than \$650,000 and no more than \$750,000, \$1,750;
- H. for revenues greater than \$550,000 and no more than \$650,000, \$1,500;
- I. for revenues greater than \$450,000 and no more than \$550,000, \$1,250;
- J. for revenues greater than \$350,000 and no more than \$450,000, \$1,000;
- K. for revenues greater than \$250,000 and no more than \$350,000, \$750;
- L. for revenues greater than \$100,000 and no more than \$250,000, \$500;
- M. for revenues greater than \$25,000 and no more than \$100,000, \$250; and
- N. for revenues no more than \$25,000, \$100.

Subp. 2. **Fees for class C.** The amount of the fee for class C providers shall be as follows:

- A. for revenues greater than \$1,000, \$50; and
- B. for revenues no more than \$1,000, \$20.

Subp. 3. **Fees for class E.** The amount of the fee for class E providers is \$500.

Subp. 4. **Fees for medical equipment vendors.** Regardless of the class under which it is licensed, a provider whose principal business is medical supplies and equipment shall pay an annual fee of \$500.