State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-EIGHTH SESSION

H. F. No. 1780

04/15/2013 Authored by Huntley
The bill was read for the first time and referred to the Committee on Civil Law
04/19/2013 Adoption of Report: Pass as Amended and re-referred to the Committee on Rules and Legislative Administration

A bill for an act

relating to state government; modifying certain health and human services data practices provisions; establishing community first services and supports and Northstar Care for Children; modifying provisions relating to vital records, reporting suspected maltreatment, child custody, background studies, and fraud investigations; program integrity; waiver provider standards; licensing home care providers; establishing penalties; establishing an advisory council; licensing alkaline hydrolysis facilities; establishing a state-based risk adjustment system assessment; amending Minnesota Statutes 2012, sections 144.051, by adding subdivisions; 243.166, subdivision 7; 245A.11, subdivision 7b; 245C.04, by adding a subdivision; 245C.08, subdivision 1; 245D.05; 245D.06; 245D.10; 256.01, by adding a subdivision; 256B.69, by adding a subdivision; 626.557, subdivisions 4, 9, 9e; proposing coding for new law in Minnesota Statutes, chapters 144A; 149A; 245D; 256B.

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

ARTICLE 1

REDESIGNING HOME AND COMMUNITY-BASED SERVICES

Section 1. **[256B.85] COMMUNITY FIRST SERVICES AND SUPPORTS.**

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

(b) CFSS is a participant-controlled method of selecting and providing services and supports that allows the participant maximum control of the services and supports. Participants may choose the degree to which they direct and manage their supports by choosing to have a significant and meaningful role in the management of services and

supports including by directly employing support workers with the necessary supports to perform that function.

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

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

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

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

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

(d) "Behavior" means a category to determine the home care rating and is based on the criteria in section 256B.0659. "Level I behavior" means physical aggression towards self, others, or destruction of property that requires the immediate response of another person.

(e) "Complex health-related needs" means a category to determine the home care rating and is based on the criteria in section 256B.0659.

(f) "Community first services and supports" or "CFSS" means the assistance and supports program under this section needed for accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance to complete the task or supervision and cueing to complete the task, or the purchase of goods as defined in subdivision 7, paragraph (a), clause (2), that replace the need for human assistance.

(g) "Community first services and supports service delivery plan" or "service delivery plan" means a written summary of the services and supports, that is based on the community support plan identified in section 256B.0911 and coordinated services and support plan

and budget identified in section 256B.0915, subdivision 6, if applicable, that is determined by the participant to meet the assessed needs, using a person-centered planning process.

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

(i) "Dependency" in activities of daily living means a person requires assistance to begin and complete one or more of the activities of daily living.

(j) "Financial management services contractor or vendor" means a qualified organization having a written contract with the department to provide services necessary to use the flexible spending model under subdivision 13, that include but are not limited to: participant education and technical assistance; CFSS service delivery planning and budgeting; billing, making payments, and monitoring of spending; and assisting the participant in fulfilling employer-related requirements in accordance with Section 3504 of the IRS code and the IRS Revenue Procedure 70-6.

(k) "Flexible spending model" means a service delivery method of CFSS that uses an individualized CFSS service delivery plan and service budget and assistance from the financial management services contractor to facilitate participant employment of support workers and the acquisition of supports and goods.

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

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

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

(o) "Medication assistance" means providing verbal or visual reminders to take regularly scheduled medication and includes any of the following supports:

(1) under the direction of the participant or the participant's representative, bringing medications to the participant including medications given through a nebulizer, opening a container of previously set up medications, emptying the container into the participant's

hand, opening and giving the medication in the original container to the participant, or bringing to the participant liquids or food to accompany the medication;

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

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

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

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

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

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

(q) "Person-centered planning process" means a process that is driven by the participant for discovering and planning services and supports that ensures the participant makes informed choices and decisions. The person-centered planning process must:

(1) include people chosen by the participant;

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

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

(4) reflect cultural considerations of the participant;

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

(6) offers choices to the participant regarding the services and supports they receive and from whom;

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

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

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

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

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

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

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

(t) "Support worker" means an employee of the agency provider or of the participant who has direct contact with the participant and provides services as specified within the participant's service delivery plan.

(u) "Wages and benefits" means the hourly wages and salaries, the employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers' compensation, mileage reimbursement, health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, contributions to employee retirement accounts, or other forms of employee compensation and benefits.

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

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

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

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

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

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

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

(2) is not a recipient under the family support grant under section 252.32;

(3) lives in the person's own apartment or home including a family foster care setting licensed under chapter 245A, but not in corporate foster care under chapter 245A; or a noncertified boarding care or boarding and lodging establishments under chapter 157; unless transitioning into the community from an institution; and

(4) has not been excluded or disenrolled from the flexible spending model.

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

(1) when a participant has been restricted by the Minnesota restricted recipient program, the participant may be excluded for a specified time period;

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

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

(d) A participant may appeal in writing to the department to contest the department's decision under paragraph (c), clause (3), to remove or exclude the participant from the flexible spending model.

Subd. 4. **Eligibility for other services.** Selection of CFSS by a participant must not restrict access to other medically necessary care and services furnished under the state plan medical assistance benefit or other services available through alternative care.

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) include individually identified goals and desired outcomes;

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

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

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

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

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

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

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

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

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

Subd. 7. **Community first services and supports; covered services.** Services and supports covered under CFSS include:

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

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

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

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

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

(iii) fit within the annual limit of the participant's approved service allocation or budget;

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

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

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

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

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

(6) transition costs, including:

(i) deposits for rent and utilities;

(ii) first month's rent and utilities;

(iii) bedding;

(iv) basic kitchen supplies;

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

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

(7) services by a support specialist defined under subdivision 2 that are chosen by the participant.

Subd. 8. **Determination of CFSS service methodology.** (a) All community first services and supports must be authorized by the commissioner or the commissioner's designee before services begin except for the assessments established in section 256B.0911. The authorization for CFSS must be completed within 30 days after receiving a complete request.

(b) The amount of CFSS authorized must be based on the recipient's home care rating. The home care rating shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner identifying the following for a recipient:

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

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

(3) the presence of Level I behavior as defined in subdivision 2.

(c) For purposes meeting the criteria in paragraph (b), the methodology to determine the total minutes for CFSS for each home care rating is based on the median paid units

per day for each home care rating from fiscal year 2007 data for the PCA program. Each home care rating has a base number of minutes assigned. Additional minutes are added through the assessment and identification of the following:

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

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

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

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

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

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

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

(4) supplant natural unpaid supports that are provided voluntarily to the participant and are selected by the participant in lieu of a support worker and appropriately meeting the participant's needs;

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

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

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

(1) those that are not for the direct benefit of the participant;

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

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

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

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

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

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

(8) medical supplies and equipment;

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

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

(11) experimental treatments;

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

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

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

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

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

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

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

(2) comply with medical assistance provider enrollment requirements;

(3) demonstrate compliance with law and policies of CFSS as determined by the commissioner;

(4) comply with background study requirements under chapter 245C;

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

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

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

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

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

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

(11) report suspected neglect and abuse to the common entry point according to sections 256B.0651 and 626.557; and

(12) provide the participant with a copy of the service-related rights under subdivision 19 at the start of services and supports.

(b) The commissioner shall develop policies and procedures designed to ensure program integrity and fiscal accountability for goods and services provided in this section.

Subd. 11. **Agency-provider model.** (a) The agency-provider model is limited to the services provided by support workers and support specialists who are employed by an agency-provider that is licensed according to chapter 245A or meets other criteria established by the commissioner, including required training.

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

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

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

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

(f) The agency-provider model must be used by individuals who have been restricted by the Minnesota restricted recipient program.

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

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

(2) proof of surety bond coverage in the amount of $50,000 or ten percent of the provider's payments from Medicaid in the previous year, whichever is less;

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

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

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

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

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

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

(ii) the CFSS provider agency's template for the CFSS care plan; and

(iii) the CFSS provider agency's template for the written agreement in subdivision 21 for recipients using the CFSS choice option, if applicable;

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

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

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

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

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

(14) documentation that the agency does not burden recipients' free exercise of their right to choose service providers by requiring personal care assistants to sign an agreement not to work with any particular CFSS recipient or for another CFSS provider agency after

leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

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

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

Subd. 13. **Flexible spending model.** (a) Under the flexible spending model participants can exercise more responsibility and control over the services and supports described and budgeted within the CFSS service delivery plan. Under this model:

(1) participants directly employ support workers;

(2) participants may use a budget allocation to obtain supports and goods as defined in subdivision 7; and

(3) from the financial management services (FMS) contractor the participant may choose a range of support assistance services relating to:

(i) planning, budgeting, and management of services and support;

(ii) the participant's employment, training, supervision, and evaluation of workers;

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

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

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

(c) The FMS contractor shall not provide CFSS services and supports under the agency-provider service model. The FMS contractor shall provide service functions as determined by the commissioner that include but are not limited to:

(1) information and consultation about CFSS;

(2) assistance with the development of the service delivery plan and flexible spending model as requested by the participant;

(3) billing and making payments for flexible spending model expenditures;

(4) assisting participants in fulfilling employer-related requirements according to Internal Revenue Code Procedure 70-6, section 3504, Agency Employer Tax Liability, regulation 137036-08, which includes assistance with filing and paying payroll taxes, and obtaining worker compensation coverage;

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

(6) other duties established in the contract with the department.

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

(e) The FMS contractor shall:

(1) not limit or restrict the participant's choice of service or support providers or service delivery models as authorized by the commissioner;

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

(3) be knowledgeable of state and federal employment regulations under the Fair Labor Standards Act of 1938, and comply with the requirements under the Internal Revenue Service Revenue Code Procedure 70-6, Section 35-4, Agency Employer Tax Liability for vendor or fiscal employer agent, and any requirements necessary to process employer and employee deductions, provide appropriate and timely submission of employer tax liabilities, and maintain documentation to support medical assistance claims;

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

(5) assume fiscal accountability for state funds designated for the program; and

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

(f) The commissioner of human services shall:

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

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

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

(g) Participants who are disenrolled from the model shall be transferred to the agency-provider model.

Subd. 14. **Participant's responsibilities under flexible spending model.** (a) A participant using the flexible spending model must use a FMS contractor or vendor that is under contract with the department. Upon a determination of eligibility and completion of the assessment and community support plan, the participant shall choose a FMS contractor from a list of eligible vendors maintained by the department.

(b) When the participant, participant's representative, or legal representative chooses to be the employer of the support worker, they are responsible for recruiting, interviewing, hiring, training, scheduling, supervising, and discharging direct support workers.

(c) In addition to the employer responsibilities in paragraph (b), the participant, participant's representative, or legal representative is responsible for:

(1) tracking the services provided and all expenditures for goods or other supports;

(2) preparing and submitting time sheets, signed by both the participant and support worker, to the FMS contractor on a regular basis and in a timely manner according to the FMS contractor's procedures;

(3) notifying the FMS contractor within ten days of any changes in circumstances affecting the CFSS service plan or in the participant's place of residence including, but not limited to, any hospitalization of the participant or change in the participant's address, telephone number, or employment;

(4) notifying the FMS contractor of any changes in the employment status of each participant support worker; and

(5) reporting any problems resulting from the quality of services rendered by the support worker to the FMS contractor. If the participant is unable to resolve any problems resulting from the quality of service rendered by the support worker with the assistance of the FMS contractor, the participant shall report the situation to the department.

Subd. 15. **Documentation of support services provided.** (a) Support services provided to a participant by a support worker employed by either an agency-provider or the participant acting as the employer must be documented daily by each support worker, on a time sheet form approved by the commissioner. All documentation may be

Web-based, electronic, or paper documentation. The completed form must be submitted on a monthly basis to the provider or the participant and the FMS contractor selected by the participant to provide assistance with meeting the participant's employer obligations and kept in the recipient's health record.

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

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

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

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

(3) full name of the participant;

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

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

(6) personal signature of the support worker;

(7) any shared care provided, if applicable;

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

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

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

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

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

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

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

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

(4) not be a participant of CFSS;

(5) complete the basic standardized training as determined by the commissioner before completing enrollment. The training must be available in languages other than

English and to those who need accommodations due to disabilities. Support worker training must include successful completion of the following training components: basic first aid, vulnerable adult, child maltreatment, OSHA universal precautions, basic roles and responsibilities of support workers including information about basic body mechanics, emergency preparedness, orientation to positive behavioral practices, orientation to responding to a mental health crisis, fraud issues, time cards and documentation, and an overview of person-centered planning and self-direction. Upon completion of the training components, the support worker must pass the certification test to provide assistance to participants;

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

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

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

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

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

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

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

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

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

Subd. 17. **Support specialist requirements and payments.** The commissioner shall develop qualifications, scope of functions, and payment rates and service limits for a support specialist that may provide additional or specialized assistance necessary to plan, implement, arrange, augment, or evaluate services and supports.

Subd. 18. **Service unit and budget allocation requirements.** (a) For the agency-provider model, services will be authorized in units of service. The total service unit amount must be established based upon the assessed need for CFSS services, and must not exceed the maximum number of units available as determined by section 256B.0652, subdivision 6. The unit rate established by the commissioner is used with assessed units to determine the maximum available CFSS allocation.

(b) For the flexible spending model, services and supports are authorized under a budget limit.

(c) The maximum available CFSS participant budget allocation shall be established by multiplying the number of units authorized under subdivision 8 by the payment rate established by the commissioner.

Subd. 19. **Support system.** (a) The commissioner shall provide information, consultation, training, and assistance to ensure the participant is able to manage the services and supports and budgets, if applicable. This support shall include individual consultation on how to select and employ workers, manage responsibilities under CFSS, and evaluate personal outcomes.

(b) The commissioner shall provide assistance with the development of risk management agreements.

Subd. 20. **Service-related rights.** Participants must be provided with adequate information, counseling, training, and assistance, as needed, to ensure that the participant is able to choose and manage services, models, and budgets. This support shall include information regarding: (1) person-centered planning; (2) the range and scope of individual choices; (3) the process for changing plans, services and budgets; (4) the grievance process; (5) individual rights; (6) identifying and assessing appropriate services; (7) risks and responsibilities; and (8) risk management. A participant who appeals a reduction in previously authorized CFSS services may continue previously authorized services pending an appeal under section 256.045. The commissioner must ensure that the participant has a copy of the most recent service delivery plan that contains a detailed explanation of which areas of covered CFSS are reduced, and provide notice of the amount of the budget reduction, and the reasons for the reduction in the participant's notice of denial, termination, or reduction.

Subd. 21. **Development and Implementation Council.** The commissioner shall establish a Development and Implementation Council of which the majority of members are individuals with disabilities, elderly individuals, and their representatives. The commissioner shall consult and collaborate with the council when developing and implementing this section.

Subd. 22. **Quality assurance and risk management system.** (a) The commissioner shall establish quality assurance and risk management measures for use in developing and implementing CFSS including those that (1) recognize the roles and responsibilities of those involved in obtaining CFSS, and (2) ensure the appropriateness of such plans and budgets based upon a recipient's resources and capabilities. Risk management measures must include background studies, and backup and emergency plans, including disaster planning.

(b) The commissioner shall provide ongoing technical assistance and resource and educational materials for CFSS participants.

(c) Performance assessment measures, such as a participant's satisfaction with the services and supports, and ongoing monitoring of health and well-being shall be identified in consultation with the council established in subdivision 21.

Subd. 23. **Commissioner's access.** When the commissioner is investigating a possible overpayment of Medicaid funds, the commissioner must be given immediate access without prior notice to the agency provider or FMS contractor's office during regular business hours and to documentation and records related to services provided and submission of claims for services provided. Denying the commissioner access to records is cause for immediate suspension of payment and terminating the agency provider's enrollment according to section 256B.064 or terminating the FMS contract.

Subd. 24. **CFSS agency-providers; background studies.** CFSS agency-providers enrolled to provide personal care assistance services under the medical assistance program shall comply with the following:

(1) owners who have a five percent interest or more and all managing employees are subject to a background study as provided in chapter 245C. This applies to currently enrolled CFSS agency-providers and those agencies seeking enrollment as a CFSS agency-provider. "Managing employee" has the same meaning as Code of Federal Regulations, title 42, section 455. An organization is barred from enrollment if:

(i) the organization has not initiated background studies on owners managing employees; or

(ii) the organization has initiated background studies on owners and managing employees, but the commissioner has sent the organization a notice that an owner or managing employee of the organization has been disqualified under section 245C.14, and the owner or managing employee has not received a set-aside of the disqualification under section 245C.22;

(2) a background study must be initiated and completed for all support specialists; and

(3) a background study must be initiated and completed for all support workers.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when this occurs.

Sec. 2. Minnesota Statutes 2012, section 626.557, subdivision 4, is amended to read:

Subd. 4. **Reporting.** (a) Except as provided in paragraph (b), a mandated reporter shall immediately make an oral report to the common entry point. The common entry point may accept electronic reports submitted through a Web-based reporting system

established by the commissioner. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under sections 144.291 to 144.298, to the extent necessary to comply with this subdivision.

(b) A boarding care home that is licensed under sections 144.50 to 144.58 and certified under Title 19 of the Social Security Act, a nursing home that is licensed under section 144A.02 and certified under Title 18 or Title 19 of the Social Security Act, or a hospital that is licensed under sections 144.50 to 144.58 and has swing beds certified under Code of Federal Regulations, title 42, section 482.66, may submit a report electronically to the common entry point instead of submitting an oral report. The report may be a duplicate of the initial report the facility submits electronically to the commissioner of health to comply with the reporting requirements under Code of Federal Regulations, title 42, section 483.13. The commissioner of health may modify these reporting requirements to include items required under paragraph (a) that are not currently included in the electronic reporting form.

EFFECTIVE DATE. This section is effective July 1, 2014.

Sec. 3. Minnesota Statutes 2012, section 626.557, subdivision 9, is amended to read:

Subd. 9. **Common entry point designation.** (a) ~~Each county board shall designate a common entry point for reports of suspected maltreatment. Two or more county boards may jointly designate a single~~ The commissioner of human services shall establish a common entry point effective July 1, 2014. The common entry point is the unit responsible for receiving the report of suspected maltreatment under this section.

(b) The common entry point must be available 24 hours per day to take calls from reporters of suspected maltreatment. The common entry point shall use a standard intake form that includes:

(1) the time and date of the report;

(2) the name, address, and telephone number of the person reporting;

(3) the time, date, and location of the incident;

(4) the names of the persons involved, including but not limited to, perpetrators, alleged victims, and witnesses;

(5) whether there was a risk of imminent danger to the alleged victim;

(6) a description of the suspected maltreatment;

(7) the disability, if any, of the alleged victim;

(8) the relationship of the alleged perpetrator to the alleged victim;

(9) whether a facility was involved and, if so, which agency licenses the facility;

(10) any action taken by the common entry point;

(11) whether law enforcement has been notified;

(12) whether the reporter wishes to receive notification of the initial and final reports; and

(13) if the report is from a facility with an internal reporting procedure, the name, mailing address, and telephone number of the person who initiated the report internally.

(c) The common entry point is not required to complete each item on the form prior to dispatching the report to the appropriate lead investigative agency.

(d) The common entry point shall immediately report to a law enforcement agency any incident in which there is reason to believe a crime has been committed.

(e) If a report is initially made to a law enforcement agency or a lead investigative agency, those agencies shall take the report on the appropriate common entry point intake forms and immediately forward a copy to the common entry point.

(f) The common entry point staff must receive training on how to screen and dispatch reports efficiently and in accordance with this section.

(g) The commissioner of human services shall maintain a centralized database for the collection of common entry point data, lead investigative agency data including maltreatment report disposition, and appeals data. The common entry point shall have access to the centralized database and must log the reports into the database and immediately identify and locate prior reports of abuse, neglect, or exploitation.

(h) When appropriate, the common entry point staff must refer calls that do not allege the abuse, neglect, or exploitation of a vulnerable adult to other organizations that might resolve the reporter's concerns.

(i) a common entry point must be operated in a manner that enables the commissioner of human services to:

(1) track critical steps in the reporting, evaluation, referral, response, disposition, and 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;

(4) set standards, priorities, and policies to maximize the efficiency and effectiveness of the common entry point; and

(5) track and manage consumer complaints related to the common entry point.

(j) The commissioners of human services and health shall collaborate on the creation of a system for referring reports to the lead investigative agencies. This system shall enable the commissioner of human services to track critical steps in the reporting, evaluation, referral, response, disposition, investigation, notification, determination, and appeal processes.

Sec. 4. Minnesota Statutes 2012, section 626.557, subdivision 9e, is amended to read:

Subd. 9e. **Education requirements.** (a) The commissioners of health, human services, and public safety shall cooperate in the development of a joint program for education of lead investigative agency investigators in the appropriate techniques for investigation of complaints of maltreatment. This program must be developed by July 1, 1996. The program must include but need not be limited to the following areas: (1) information collection and preservation; (2) analysis of facts; (3) levels of evidence; (4) conclusions based on evidence; (5) interviewing skills, including specialized training to interview people with unique needs; (6) report writing; (7) coordination and referral to other necessary agencies such as law enforcement and judicial agencies; (8) human relations and cultural diversity; (9) the dynamics of adult abuse and neglect within family systems and the appropriate methods for interviewing relatives in the course of the assessment or investigation; (10) the protective social services that are available to protect alleged victims from further abuse, neglect, or financial exploitation; (11) the methods by which lead investigative agency investigators and law enforcement workers cooperate in conducting assessments and investigations in order to avoid duplication of efforts; and (12) data practices laws and procedures, including provisions for sharing data.

(b) The commissioner of human services shall conduct an outreach campaign to promote the common entry point for reporting vulnerable adult maltreatment. This campaign shall use the Internet and other means of communication.

~~(b)~~ (c) The commissioners of health, human services, and public safety shall offer at least annual education to others on the requirements of this section, on how this section is implemented, and investigation techniques.

~~(c)~~ (d) The commissioner of human services, in coordination with the commissioner of public safety shall provide training for the common entry point staff as required in this subdivision and the program courses described in this subdivision, at least four times per year. At a minimum, the training shall be held twice annually in the seven-county metropolitan area and twice annually outside the seven-county metropolitan area. The commissioners shall give priority in the program areas cited in paragraph (a) to persons currently performing assessments and investigations pursuant to this section.

~~(d)~~ (e) The commissioner of public safety shall notify in writing law enforcement personnel of any new requirements under this section. The commissioner of public safety shall conduct regional training for law enforcement personnel regarding their responsibility under this section.

~~(e)~~ (f) Each lead investigative agency investigator must complete the education program specified by this subdivision within the first 12 months of work as a lead investigative agency investigator.

A lead investigative agency investigator employed when these requirements take effect must complete the program within the first year after training is available or as soon as training is available.

All lead investigative agency investigators having responsibility for investigation duties under this section must receive a minimum of eight hours of continuing education or in-service training each year specific to their duties under this section.

ARTICLE 2

DEPARTMENT OF HUMAN SERVICES PROGRAM INTEGRITY

Section 1. Minnesota Statutes 2012, section 243.166, subdivision 7, is amended to read:

Subd. 7. **Use of data.** (a) Except as otherwise provided in subdivision 7a or sections 244.052 and 299C.093, the data provided under this section is private data on individuals under section 13.02, subdivision 12.

(b) The data may be used only ~~for~~ by law enforcement and corrections agencies for law enforcement and corrections purposes.

(c) The commissioner of human services is authorized to have access to the data for:

(1) state-operated services, as defined in section 246.014, ~~are also authorized to have access to the data~~ for the purposes described in section 246.13, subdivision 2, paragraph (b); and

(2) purposes of completing background studies under chapter 245C.

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

Subd. 4a. **Agency background studies.** (a) The commissioner shall develop and implement an electronic process for the regular transfer of new criminal history information that is added to the Minnesota court information system. The commissioner's system must include for review only information that relates to individuals who have been the subject of a background study under this chapter that remain affiliated with the agency that initiated the background study. For purposes of this paragraph, an individual remains affiliated with an agency that initiated the background study until the agency informs the commissioner that the individual is no longer affiliated. When any individual no longer affiliated according to this paragraph returns to a position requiring a background study under this chapter, the agency with whom the individual is again affiliated shall initiate a new background study regardless of the length of time the individual was no longer affiliated with the agency.

(b) The commissioner shall develop and implement an online system for agencies that initiate background studies under this chapter to access and maintain records of background studies initiated by that agency. The system must show all active background study subjects affiliated with that agency and the status of each individual's background study. Each agency that initiates background studies must use this system to notify the commissioner of discontinued affiliation for purposes of the processes required under paragraph (a).

Sec. 3. Minnesota Statutes 2012, section 245C.08, subdivision 1, is amended to read:

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

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

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

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

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

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

(6) for a background study related to a child foster care application for licensure or adoptions, the commissioner shall also review:

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

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

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

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

ARTICLE 3

WAIVER PROVIDER STANDARDS

Section 1. Minnesota Statutes 2012, section 245A.11, subdivision 7b, is amended to read:

Subd. 7b. **Adult foster care data privacy and security.** (a) An adult foster care or community residential setting license holder who creates, collects, records, maintains, stores, or discloses any individually identifiable recipient data, whether in an electronic or any other format, must comply with the privacy and security provisions of applicable privacy laws and regulations, including:

(1) the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-1; and the HIPAA Privacy Rule, Code of Federal Regulations, title 45, part 160, and subparts A and E of part 164; and

(2) the Minnesota Government Data Practices Act as codified in chapter 13.

(b) For purposes of licensure, the license holder shall be monitored for compliance with the following data privacy and security provisions:

(1) the license holder must control access to data on ~~foster care recipients~~ residents served by the program according to the definitions of public and private data on individuals under section 13.02; classification of the data on individuals as private under section

13.46, subdivision 2; and control over the collection, storage, use, access, protection, and contracting related to data according to section 13.05, in which the license holder is assigned the duties of a government entity;

(2) the license holder must provide each ~~foster care recipient~~ resident served by the program with a notice that meets the requirements under section 13.04, in which the license holder is assigned the duties of the government entity, and that meets the requirements of Code of Federal Regulations, title 45, part 164.52. The notice shall describe the purpose for collection of the data, and to whom and why it may be disclosed pursuant to law. The notice must inform the ~~recipient~~ individual that the license holder uses electronic monitoring and, if applicable, that recording technology is used;

(3) the license holder must not install monitoring cameras in bathrooms;

(4) electronic monitoring cameras must not be concealed from the ~~foster care recipients~~ residents served by the program; and

(5) electronic video and audio recordings of ~~foster care recipients~~ residents served by the program shall be stored by the license holder for five days unless: (i) a ~~foster care recipient~~ resident served by the program or legal representative requests that the recording be held longer based on a specific report of alleged maltreatment; or (ii) the recording captures an incident or event of alleged maltreatment under section 626.556 or 626.557 or a crime under chapter 609. When requested by a ~~recipient~~ resident served by the program or when a recording captures an incident or event of alleged maltreatment or a crime, the license holder must maintain the recording in a secured area for no longer than 30 days to give the investigating agency an opportunity to make a copy of the recording. The investigating agency will maintain the electronic video or audio recordings as required in section 626.557, subdivision 12b.

(c) The commissioner shall develop, and make available to license holders and county licensing workers, a checklist of the data privacy provisions to be monitored for purposes of licensure.

Sec. 2. Minnesota Statutes 2012, section 245D.05, is amended to read:

245D.05 HEALTH SERVICES.

Subdivision 1. **Health needs.** (a) The license holder is responsible for ~~providing~~ meeting health ~~services~~ service needs assigned in the coordinated service and support plan ~~and~~ or the coordinated service and support plan addendum, consistent with the person's health needs. The license holder is responsible for promptly notifying ~~the person or~~ the person's legal representative, if any, and the case manager of changes in a person's physical and mental health needs affecting ~~assigned~~ health ~~services~~ service needs assigned

to the license holder in the coordinated service and support plan or the coordinated service and support plan addendum, when discovered by the license holder, unless the license holder has reason to know the change has already been reported. The license holder must document when the notice is provided.

(b) ~~When assigned in the service plan,~~ If responsibility for meeting the person's health service needs has been assigned to the license holder in the coordinated service and support plan or the coordinated service and support plan addendum, the license holder ~~is required to~~ must maintain documentation on how the person's health needs will be met, including a description of the procedures the license holder will follow in order to:

(1) provide medication ~~administration,~~ assistance or medication ~~assistance, or medication management~~ administration according to this chapter;

(2) monitor health conditions according to written instructions from ~~the person's physician or~~ a licensed health professional;

(3) assist with or coordinate medical, dental, and other health service appointments; or

(4) use medical equipment, devices, or adaptive aides or technology safely and correctly according to written instructions from ~~the person's physician or~~ a licensed health professional.

Subd. 1a. **Medication setup.** For the purposes of this subdivision, "medication setup" means the arranging of medications according to instructions from the pharmacy, the prescriber, or a licensed nurse, for later administration when the license holder is assigned responsibility for medication assistance or medication administration in the coordinated service and support plan or the coordinated service and support plan addendum. A prescription label or the prescriber's written or electronically recorded order for the prescription is sufficient to constitute written instructions from the prescriber. The license holder must document in the person's medication administration record: dates of setup, name of medication, quantity of dose, times to be administered, and route of administration at time of setup; and, when the person will be away from home, to whom the medications were given.

Subd. 1b. **Medication assistance.** If responsibility for medication assistance is assigned to the license holder in the coordinated service and support plan or the coordinated service and support plan addendum, the license holder must ensure that the requirements of subdivision 2, paragraph (b), have been met when staff provides medication assistance to enable a person to self-administer medication or treatment when the person is capable of directing the person's own care, or when the person's legal representative is present and able to direct care for the person. For the purposes of this subdivision, "medication assistance" means any of the following:

(1) bringing to the person and opening a container of previously set up medications, emptying the container into the person's hand, or opening and giving the medications in the original container to the person;

(2) bringing to the person liquids or food to accompany the medication; or

(3) providing reminders to take regularly scheduled medication or perform regularly scheduled treatments and exercises.

Subd. 2. **Medication administration.** (a) If responsibility for medication administration is assigned to the license holder in the coordinated service and support plan or the coordinated service and support plan addendum, the license holder must implement the following medication administration procedures to ensure a person takes medications and treatments as prescribed:

(1) checking the person's medication record;

(2) preparing the medication as necessary;

(3) administering the medication or treatment to the person;

(4) documenting the administration of the medication or treatment or the reason for not administering the medication or treatment; and

(5) reporting to the prescriber or a nurse any concerns about the medication or treatment, including side effects, effectiveness, or a pattern of the person refusing to take the medication or treatment as prescribed. Adverse reactions must be immediately reported to the prescriber or a nurse.

(b)(1) The license holder must ensure that the ~~following criteria~~ requirements in clauses (2) to (4) have been met before ~~staff that is not a licensed health professional administers~~ administering medication or treatment~~:~~.

~~(1)~~ (2) The license holder must obtain written authorization ~~has been obtained~~ from the person or the person's legal representative to administer medication or treatment ~~orders;~~ and must obtain reauthorization annually as needed. If the person or the person's legal representative refuses to authorize the license holder to administer medication, the medication must not be administered. The refusal to authorize medication administration must be reported to the prescriber as expediently as possible.

~~(2)~~ (3) The staff person ~~has completed~~ responsible for administering the medication or treatment must complete medication administration training according to section 245D.09, subdivision ~~4, paragraph~~ 4a, paragraphs (a) and (c), ~~clause (2);~~ and, as applicable to the person, paragraph (d).

~~(3) The medication or treatment will be administered under administration procedures established for the person in consultation with a licensed health professional. written instruction from the person's physician may constitute the medication~~

~~administration procedures. A prescription label or the prescriber's order for the prescription is sufficient to constitute written instructions from the prescriber. A licensed health professional may delegate medication administration procedures.~~

(4) For a license holder providing intensive support services, the medication or treatment must be administered according to the license holder's medication administration policy and procedures as required under section 245D.11, subdivision 2, clause (3).

~~(b)~~ (c) The license holder must ensure the following information is documented in the person's medication administration record:

(1) the information on the current prescription label or the prescriber's current written or electronically recorded order or prescription that includes ~~directions for~~ the person's name, description of the medication or treatment to be provided, and the frequency and other information needed to safely and correctly ~~administering~~ administer the medication or treatment to ensure effectiveness;

(2) information on any ~~discomforts,~~ risks~~,~~ or other side effects that are reasonable to expect, and any contraindications to its use. This information must be readily available to all staff administering the medication;

(3) the possible consequences if the medication or treatment is not taken or administered as directed;

(4) instruction ~~from the prescriber~~ on when and to whom to report the following:

(i) if ~~the~~ a dose of medication ~~or treatment~~ is not administered or treatment is not performed as prescribed, whether by error by the staff or the person or by refusal by the person; and

(ii) the occurrence of possible adverse reactions to the medication or treatment;

(5) notation of any occurrence of a dose of medication not being administered or treatment not performed as prescribed, whether by error by the staff or the person or by refusal by the person, or of adverse reactions, and when and to whom the report was made; and

(6) notation of when a medication or treatment is started, administered, changed, or discontinued.

~~(c) The license holder must ensure that the information maintained in the medication administration record is current and is regularly reviewed with the person or the person's legal representative and the staff administering the medication to identify medication administration issues or errors. At a minimum, the review must be conducted every three months or more often if requested by the person or the person's legal representative. Based on the review, the license holder must develop and implement a plan to correct~~

~~medication administration issues or errors. If issues or concerns are identified related to the medication itself, the license holder must report those as required under subdivision 4.~~

~~Subd. 3. **Medication assistance.** The license holder must ensure that the requirements of subdivision 2, paragraph (a), have been met when staff provides assistance to enable a person to self-administer medication when the person is capable of directing the person's own care, or when the person's legal representative is present and able to direct care for the person.~~

Subd. 4. **Reviewing and reporting medication and treatment issues.** ~~The following medication administration issues must be reported to the person or the person's legal representative and case manager as they occur or following timelines established in the person's service plan or as requested in writing by the person or the person's legal representative, or the case manager:~~ (a) When assigned responsibility for medication administration, the license holder must ensure that the information maintained in the medication administration record is current and is regularly reviewed to identify medication administration errors. At a minimum, the review must be conducted every three months, or more frequently as directed in the coordinated service and support plan or coordinated service and support plan addendum or as requested by the person or the person's legal representative. Based on the review, the license holder must develop and implement a plan to correct patterns of medication administration errors when identified.

(b) If assigned responsibility for medication assistance or medication administration, the license holder must report the following to the person's legal representative and case manager as they occur or as otherwise directed in the coordinated service and support plan or the coordinated service and support plan addendum:

(1) any reports made to the person's physician or prescriber required under subdivision 2, paragraph ~~(b)~~ (c), clause (4);

(2) a person's refusal or failure to take or receive medication or treatment as prescribed; or

(3) concerns about a person's self-administration of medication or treatment.

Subd. 5. **Injectable medications.** Injectable medications may be administered according to a prescriber's order and written instructions when one of the following conditions has been met:

(1) a registered nurse or licensed practical nurse will administer the subcutaneous or intramuscular injection;

(2) a supervising registered nurse with a physician's order has delegated the administration of subcutaneous injectable medication to an unlicensed staff member and has provided the necessary training; or

(3) there is an agreement signed by the license holder, the prescriber, and the person or the person's legal representative specifying what subcutaneous injections may be given, when, how, and that the prescriber must retain responsibility for the license holder's giving the injections. A copy of the agreement must be placed in the person's service recipient record.

Only licensed health professionals are allowed to administer psychotropic medications by injection.

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

Sec. 3. **[245D.051] PSYCHOTROPIC MEDICATION USE AND MONITORING.**

Subdivision 1. **Conditions for psychotropic medication administration.** (a) When a person is prescribed a psychotropic medication and the license holder is assigned responsibility for administration of the medication in the person's coordinated service and support plan or the coordinated service and support plan addendum, the license holder must ensure that the requirements in paragraphs (b) to (d) and section 245D.05, subdivision 2, are met.

(b) Use of the medication must be included in the person's coordinated service and support plan or in the coordinated service and support plan addendum and based on a prescriber's current written or electronically recorded prescription.

(c) The license holder must develop, implement, and maintain the following documentation in the person's coordinated service and support plan addendum according to the requirements in sections 245D.07 and 245D.071:

(1) a description of the target symptoms that the psychotropic medication is to alleviate; and

(2) documentation methods the license holder will use to monitor and measure changes in the target symptoms that are to be alleviated by the psychotropic medication if required by the prescriber. The license holder must collect and report on medication and symptom-related data as instructed by the prescriber. The license holder must provide the monitoring data to the expanded support team for review every three months, or as otherwise requested by the person or the person's legal representative.

For the purposes of this section, "target symptom" refers to any perceptible diagnostic criteria for a person's diagnosed mental disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition Text Revision (DSM-IV-TR) or successive editions that has been identified for alleviation.

(d) If a person is prescribed a psychotropic medication, monitoring the use of the psychotropic medication must be assigned to the license holder in the coordinated service

and support plan or the coordinated service and support plan addendum. The assigned license holder must monitor the psychotropic medication as required by this section.

Subd. 2. **Refusal to authorize psychotropic medication.** If the person or the person's legal representative refuses to authorize the administration of a psychotropic medication as ordered by the prescriber, the license holder must follow the requirement in section 245D.05, subdivision 2, paragraph (b), clause (2). After reporting the refusal to the prescriber, the license holder must follow any directives or orders given by the prescriber. A court order must be obtained to override the refusal. Refusal to authorize administration of a specific psychotropic medication is not grounds for service termination and does not constitute an emergency. A decision to terminate services must be reached in compliance with section 245D.10, subdivision 3.

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

Sec. 4. Minnesota Statutes 2012, section 245D.06, is amended to read:

245D.06 PROTECTION STANDARDS.

Subdivision 1. **Incident response and reporting.** (a) The license holder must respond to ~~all~~ incidents under section 245D.02, subdivision 11, that occur while providing services to protect the health and safety of and minimize risk of harm to the person.

(b) The license holder must maintain information about and report incidents to the person's legal representative or designated emergency contact and case manager within 24 hours of an incident occurring while services are being provided, ~~or~~ within 24 hours of discovery or receipt of information that an incident occurred, unless the license holder has reason to know that the incident has already been reported, or as otherwise directed in a person's coordinated service and support plan or coordinated service and support plan addendum. An incident of suspected or alleged maltreatment must be reported as required under paragraph (d), and an incident of serious injury or death must be reported as required under paragraph (e).

(c) When the incident involves more than one person, the license holder must not disclose personally identifiable information about any other person when making the report to each person and case manager unless the license holder has the consent of the person.

(d) Within 24 hours of reporting maltreatment as required under section 626.556 or 626.557, the license holder must inform the case manager of the report unless there is reason to believe that the case manager is involved in the suspected maltreatment. The license holder must disclose the nature of the activity or occurrence reported and the agency that received the report.

(e) The license holder must report the death or serious injury of the person ~~to the legal representative, if any, and case manager,~~ as required in paragraph (b) and to the Department of Human Services Licensing Division, and the Office of Ombudsman for Mental Health and Developmental Disabilities as required under section 245.94, subdivision 2a, within 24 hours of the death, or receipt of information that the death occurred, unless the license holder has reason to know that the death has already been reported.

(f) When a death or serious injury occurs in a facility certified as an intermediate care facility for persons with developmental disabilities, the death or serious injury must be reported to the Department of Health, Office of Health Facility Complaints, and the Office of Ombudsman for Mental Health and Developmental Disabilities, as required under sections 245.91 and 245.94, subdivision 2a, unless the license holder has reason to know that the death has already been reported.

~~(f)~~ (g) The license holder must conduct ~~a~~ an internal review of incident reports of deaths and serious injuries that occurred while services were being provided and that were not reported by the program as alleged or suspected maltreatment, for identification of incident patterns, and implementation of corrective action as necessary to reduce occurrences. The review must include an evaluation of whether related policies and procedures were followed, whether the policies and procedures were adequate, whether there is a need for additional staff training, whether the reported event is similar to past events with the persons or the services involved, and whether there is a need for corrective action by the license holder to protect the health and safety of persons receiving services. Based on the results of this review, the license holder must develop, document, and implement a corrective action plan designed to correct current lapses and prevent future lapses in performance by staff or the license holder, if any.

(h) The license holder must verbally report the emergency use of manual restraint of a person as required in paragraph (b), within 24 hours of the occurrence. The license holder must ensure the written report and internal review of all incident reports of the emergency use of manual restraints are completed according to the requirements in section 245D.061.

Subd. 2. **Environment and safety.** The license holder must:

(1) ensure the following when the license holder is the owner, lessor, or tenant of ~~the~~ an unlicensed service site:

(i) the service site is a safe and hazard-free environment;

(ii) ~~doors are locked or~~ toxic substances or dangerous items ~~normally accessible~~ are inaccessible to persons served by the program ~~are stored in locked cabinets, drawers, or containers~~ only to protect the safety of a person receiving services and not as a substitute for staff supervision or interactions with a person who is receiving services. 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~~ are made inaccessible, the license holder must ~~justify and document how this determination was made in consultation with the person or person's legal representative, and how access will otherwise be provided to the person and all other affected persons receiving services; and~~ document an assessment of the physical plant, its environment, and its population identifying the risk factors which require toxic substances or dangerous items to be inaccessible and a statement of specific measures to be taken to minimize the safety risk to persons receiving services;

(iii) doors are locked from the inside to prevent a person from exiting only when necessary to protect the safety of a person receiving services and not as a substitute for staff supervision or interactions with the person. If doors are locked from the inside, the license holder must document an assessment of the physical plant, the environment and the population served, identifying the risk factors which require the use of locked doors, and a statement of specific measures to be taken to minimize the safety risk to persons receiving services at the service site; and

~~(iii)~~ (iv) a staff person is available on site who is trained in basic first aid and, when required in a person's coordinated service and support plan or coordinated service and support plan addendum, cardiopulmonary resuscitation, whenever persons are present and staff are required to be at the site to provide direct service. The training must include in-person instruction, hands-on practice, and an observed skills assessment under the direct supervision of a first aid instructor;

(2) maintain equipment, vehicles, supplies, and materials owned or leased by the license holder in good condition when used to provide services;

(3) follow procedures to ensure safe transportation, handling, and transfers of the person and any equipment used by the person, when the license holder is responsible for transportation of a person or a person's equipment;

(4) be prepared for emergencies and follow emergency response procedures to ensure the person's safety in an emergency; and

(5) follow universal precautions and sanitary practices, including hand washing, for infection prevention and control, and to prevent communicable diseases.

~~Subd. 3. **Compliance with fire and safety codes.** When services are provided at a service site licensed according to chapter 245A or where the license holder is the owner, lessor, or tenant of the service site, the license holder must document compliance with applicable building codes, fire and safety codes, health rules, and zoning ordinances, or document that an appropriate waiver has been granted.~~

Subd. 4. **Funds and property.** (a) Whenever the license holder assists a person with the safekeeping of funds or other property according to section 245A.04, subdivision 13, the license holder must ~~have~~ obtain written authorization to do so from the person or the person's legal representative and the case manager. Authorization must be obtained within five working days of service initiation and renewed annually thereafter. At the time initial authorization is obtained, the license holder must survey, document, and implement the preferences of the person or the person's legal representative and the case manager for frequency of receiving a statement that itemizes receipts and disbursements of funds or other property. The license holder must document changes to these preferences when they are requested.

(b) A license holder or staff person may not accept powers-of-attorney from a person receiving services from the license holder for any purpose~~, 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 or to staff persons employed by license holders who were acting as ~~power-of-attorney, guardian, or conservator~~ attorney-in-fact for specific individuals prior to ~~April 23, 2012~~ implementation of this chapter. The license holder must maintain documentation of the power-of-attorney~~, guardianship, or conservatorship~~ in the service recipient record.

(c) Upon the transfer or death of a person, any funds or other property of the person must be surrendered to the person or the person's legal representative, or given to the executor or administrator of the estate in exchange for an itemized receipt.

Subd. 5. **Prohibitions.** (a) The license holder is prohibited from using ~~psychotropic medication~~ chemical restraints, mechanical restraint practices, manual restraints, time out, or seclusion as a substitute for adequate staffing, for a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience~~, or for any reason other than as prescribed~~.

~~(b) The license holder is prohibited from using restraints or seclusion under any circumstance, unless the commissioner has approved a variance request from the license holder that allows for the emergency use of restraints and seclusion according to terms and conditions approved in the variance. Applicants and license holders who have reason to believe they may be serving an individual who will need emergency use of restraints or seclusion may request a variance on the application or reapplication, and the commissioner shall automatically review the request for a variance as part of the application or reapplication process. License holders may also request the variance any time after issuance of a license. In the event a license holder uses restraint or seclusion for~~

~~any reason without first obtaining a variance as required, the license holder must report the unauthorized use of restraint or seclusion to the commissioner within 24 hours of the occurrence and request the required variance.~~

(b) For the purposes of this subdivision, "chemical restraint" means the administration of a drug or medication to control the person's behavior or restrict the person's freedom of movement and is not a standard treatment of dosage for the person's medical or psychological condition.

(c) For the purposes of this subdivision, "mechanical restraint practice" means the use of any adaptive equipment or safety device to control the person's behavior or restrict the person's freedom of movement and not as ordered by a licensed health professional. Mechanical restraint practices include, but are not limited to, the use of bed rails or similar devices on a bed to prevent the person from getting out of bed, chairs that prevent a person from rising, or placing a person in a wheelchair so close to a wall that the wall prevents the person from rising. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a person is leaving a room or area do not, in and of themselves, restrict freedom of movement and should not be considered restraints.

(d) A license holder must not use manual restraints, time out, or seclusion under any circumstance, except for emergency use of manual restraints according to the requirements in section 245D.061 or the use of controlled procedures with a person with a developmental disability as governed by Minnesota Rules, parts 9525.2700 to 9525.2810, or its successor provisions. License holders implementing nonemergency use of manual restraint, or any other programmatic use of mechanical restraint, time out, or seclusion with persons who do not have a developmental disability that is not subject to the requirements of Minnesota Rules, parts 9525.2700 to 9525.2810, must submit a variance request to the commissioner for continued use of the procedure within three months of implementation of this chapter.

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

Sec. 5. **[245D.095] 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 and legible according to the requirements of this chapter.

Subd. 2. **Admission and discharge register.** The license holder must keep a written or electronic register, listing in chronological order the dates and names of all persons served by the program who have been admitted, discharged, or transferred, including service terminations initiated by the license holder and deaths.

Subd. 3. **Service recipient record.** (a) The license holder must maintain a record of current services provided to each person on the premises where the services are provided or coordinated. When the services are provided in a licensed facility, the records must be maintained at the facility, otherwise the records must be maintained at the license holder's program office. The license holder must protect service recipient records against loss, tampering, or unauthorized disclosure according to the requirements in sections 13.01 to 13.10 and 13.46.

(b) The license holder must maintain the following information for each person:

(1) an admission form signed by the person or the person's legal representative that includes:

(i) identifying information, including the person's name, date of birth, address, and telephone number; and

(ii) the name, address, and telephone number of the person's legal representative, if any, and a primary emergency contact, the case manager, and family members or others as identified by the person or case manager;

(2) service information, including service initiation information, verification of the person's eligibility for services, documentation verifying that services have been provided as identified in the coordinated service and support plan or coordinated service and support plan addendum according to paragraph (a), and date of admission or readmission;

(3) health information, including medical history, special dietary needs, and allergies, and when the license holder is assigned responsibility for meeting the person's health service needs according to section 245D.05:

(i) current orders for medication, treatments, or medical equipment and a signed authorization from the person or the person's legal representative to administer or assist in administering the medication or treatments, if applicable;

(ii) a signed statement authorizing the license holder to act in a medical emergency when the person's legal representative, if any, cannot be reached or is delayed in arriving;

(iii) medication administration procedures;

(iv) a medication administration record documenting the implementation of the medication administration procedures, the medication administration record reviews, and including any agreements for administration of injectable medications by the license holder according to the requirements in section 245D.05; and

(v) a medical appointment schedule when the license holder is assigned responsibility for assisting with medical appointments;

(4) the person's current coordinated service and support plan or that portion of the plan assigned to the license holder;

(5) copies of the individual abuse prevention plan and assessments as required under section 245D.071, subdivisions 2 and 3;

(6) a record of other service providers serving the person when the person's coordinated service and support plan or coordinated service and support plan addendum 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 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 involving the person, 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, progress review reports as required under section 245D.071, subdivision 5, progress or daily log notes that are recorded by the program, and reports received from other agencies involved in providing services or care to the person; and

(12) discharge summary, including service termination notice and related documentation, when applicable.

Subd. 4. **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 coordinated service and support plan or coordinated service and support plan addendum; and

(4) the county child or adult foster care licensor, when services are also licensed as child or adult foster care.

Subd. 5. **Personnel records.** (a) The license holder must maintain a personnel record of each employee to document and verify staff qualifications, orientation, and training. The personnel record must include:

(1) the employee's date of hire, completed application, an acknowledgement signed by the employee that job duties were reviewed with the employee and the employee understands those duties, and documentation that the employee meets the position requirements as determined by the license holder;

(2) documentation of staff qualifications, orientation, training, and performance evaluations as required under section 245D.09, subdivisions 3 to 5, including the date the training was completed, the number of hours per subject area, and the name of the trainer or instructor; and

(3) a completed background study as required under chapter 245C.

(b) For employees hired after January 1, 2014, the license holder must maintain documentation in the personnel record or elsewhere, sufficient to determine the date of the employee's 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.

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

Sec. 6. Minnesota Statutes 2012, section 245D.10, is amended to read:

245D.10 POLICIES AND PROCEDURES.

Subdivision 1. **Policy and procedure requirements.** ~~The~~ A license holder providing either basic or intensive supports and services must establish, enforce, and maintain policies and procedures as required in this chapter, chapter 245A, and other applicable state and federal laws and regulations governing the provision of home and community-based services licensed according to this chapter.

Subd. 2. **Grievances.** The license holder must establish policies and procedures that ~~provide~~ promote service recipient rights by providing a simple complaint process for persons served by the program and their authorized representatives to bring a grievance that:

(1) provides staff assistance with the complaint process when requested, and the addresses and telephone numbers of outside agencies to assist the person;

(2) allows the person to bring the complaint to the highest level of authority in the program if the grievance cannot be resolved by other staff members, and that provides the name, address, and telephone number of that person;

(3) requires the license holder to promptly respond to all complaints affecting a person's health and safety. For all other complaints, the license holder must provide an initial response within 14 calendar days of receipt of the complaint. All complaints must be resolved within 30 calendar days of receipt or the license holder must document the reason for the delay and a plan for resolution;

(4) requires a complaint review that includes an evaluation of whether:

(i) related policies and procedures were followed and adequate;

(ii) there is a need for additional staff training;

(iii) the complaint is similar to past complaints with the persons, staff, or services involved; and

(iv) there is a need for corrective action by the license holder to protect the health and safety of persons receiving services;

(5) based on the review in clause (4), requires the license holder to develop, document, and implement a corrective action plan designed to correct current lapses and prevent future lapses in performance by staff or the license holder, if any;

(6) provides a written summary of the complaint and a notice of the complaint resolution to the person and case manager that:

(i) identifies the nature of the complaint and the date it was received;

(ii) includes the results of the complaint review;

(iii) identifies the complaint resolution, including any corrective action; and

(7) requires that the complaint summary and resolution notice be maintained in the service recipient record.

Subd. 3. **Service suspension and service termination.** (a) The license holder must establish policies and procedures for temporary service suspension and service termination that promote continuity of care and service coordination with the person and the case manager and with other licensed caregivers, if any, who also provide support to the person.

(b) The policy must include the following requirements:

(1) the license holder must notify the person or the person's legal representative and case manager in writing of the intended termination or temporary service suspension, and the person's right to seek a temporary order staying the termination of service according to the procedures in section 256.045, subdivision 4a, or 6, paragraph (c);

(2) notice of the proposed termination of services, including those situations that began with a temporary service suspension, must be given at least 60 days before the proposed termination is to become effective when a license holder is providing ~~independent living skills training, structured day, prevocational or supported employment services to the person~~ intensive supports and services identified in section 245D.03, subdivision 1, paragraph (c), and 30 days prior to termination for all other services licensed under this chapter;

(3) the license holder must provide information requested by the person or case manager when services are temporarily suspended or upon notice of termination;

(4) prior to giving notice of service termination or temporary service suspension, the license holder must document actions taken to minimize or eliminate the need for service suspension or termination;

(5) during the temporary service suspension or service termination notice period, the license holder will work with the appropriate county agency to develop reasonable alternatives to protect the person and others;

(6) the license holder must maintain information about the service suspension or termination, including the written termination notice, in the service recipient record; and

(7) the license holder must restrict temporary service suspension to situations in which the person's ~~behavior causes immediate and serious danger to the health and safety of the person or others~~ conduct poses an imminent risk of physical harm to self or others and less restrictive or positive support strategies would not achieve safety.

Subd. 4. **Availability of current written policies and procedures.** (a) The license holder must review and update, as needed, the written policies and procedures required under this chapter.

(b)(1) The license holder must inform the person and case manager of the policies and procedures affecting a person's rights under section 245D.04, and provide copies of those policies and procedures, within five working days of service initiation.

(2) If a license holder only provides basic services and supports, this includes the:

(i) grievance policy and procedure required under subdivision 2; and

(ii) service suspension and termination policy and procedure required under subdivision 3.

(3) For all other license holders this includes the:

(i) policies and procedures in clause (2);

(ii) emergency use of manual restraints policy and procedure required under subdivision 3a; and

(iii) data privacy requirements under section 245D.11, subdivision 3.

(c) The license holder must provide a written notice at least 30 days before implementing any ~~revised policies and procedures~~ procedural revisions to policies affecting a person's service-related or protection-related rights under section 245D.04 and maltreatment reporting policies and procedures. The notice must explain the revision that was made and include a copy of the revised policy and procedure. The license holder must document the ~~reason~~ reasonable cause for not providing the notice at least 30 days before implementing the revisions.

(d) Before implementing revisions to required policies and procedures, the license holder must inform all employees of the revisions and provide training on implementation of the revised policies and procedures.

(e) The license holder must annually notify all persons, or their legal representatives, and case managers of any procedural revisions to policies required under this chapter, other than those in paragraph (c). Upon request, the license holder must provide the person, or the person's legal representative, and case manager with copies of the revised policies and procedures.

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

Sec. 7. **[245D.11] POLICIES AND PROCEDURES; INTENSIVE SUPPORT SERVICES.**

Subdivision 1. **Policy and procedure requirements.** A license holder providing intensive support services as identified in section 245D.03, subdivision 1, paragraph (c), must establish, enforce, and maintain policies and procedures as required in this section.

Subd. 2. **Health and safety.** The license holder must establish policies and procedures that promote health and safety by ensuring:

(1) use of universal precautions and sanitary practices in compliance with section 245D.06, subdivision 2, clause (5);

(2) if the license holder operates a residential program, health service coordination and care according to the requirements in section 245D.05, subdivision 1;

(3) safe medication assistance and administration according to the requirements in sections 245D.05, subdivisions 1a, 2, and 5, and 245D.051, that are established in consultation with a registered nurse, nurse practitioner, physician's assistant, or medical doctor and require completion of medication administration training according to the requirements in section 245D.09, subdivision 4a, paragraph (c). Medication assistance and administration includes, but is not limited to:

(i) providing medication-related services for a person;

(ii) medication setup;

(iii) medication administration;

(iv) medication storage and security;

(v) medication documentation and charting;

(vi) verification and monitoring of effectiveness of systems to ensure safe medication handling and administration;

(vii) coordination of medication refills;

(viii) handling changes to prescriptions and implementation of those changes;

(ix) communicating with the pharmacy; and

(x) coordination and communication with prescriber;

(4) safe transportation, when the license holder is responsible for transportation of persons, with provisions for handling emergency situations according to the requirements in section 245D.06, subdivision 2, clauses (2) to (4);

(5) a plan for ensuring the safety of persons served by the program in emergencies as defined in section 245D.02, subdivision 8, and procedures for staff to report emergencies to the license holder. A license holder with a community residential setting or a day service facility license must ensure the policy and procedures comply with the requirements in section 245D.22, subdivision 4;

(6) a plan for responding to all incidents as defined in section 245D.02, subdivision 11; and reporting all incidents required to be reported according to section 245D.06, subdivision 1. The plan must:

(i) provide the contact information of a source of emergency medical care and transportation; and

(ii) require staff to first call 911 when the staff believes a medical emergency may be life threatening, or to call the mental health crisis intervention team when the person is experiencing a mental health crisis; and

(7) a procedure for the review of incidents and emergencies to identify trends or patterns, and corrective action if needed. The license holder must establish and maintain a record-keeping system for the incident and emergency reports. Each incident and emergency report file must contain a written summary of the incident. The license holder must conduct a review of incident reports for identification of incident patterns, and implementation of corrective action as necessary to reduce occurrences. Each incident report must include:

(i) the name of the person or persons involved in the incident. It is not necessary to identify all persons affected by or involved in an emergency unless the emergency resulted in an incident;

(ii) the date, time, and location of the incident or emergency;

(iii) a description of the incident or emergency;

(iv) a description of the response to the incident or emergency and whether a person's coordinated service and support plan addendum or program policies and procedures were implemented as applicable;

(v) the name of the staff person or persons who responded to the incident or emergency; and

(vi) the determination of whether corrective action is necessary based on the results of the review.

Subd. 3. **Data privacy.** The license holder must establish policies and procedures that promote service recipient rights by ensuring data privacy according to the requirements in:

(1) the Minnesota Government Data Practices Act, section 13.46, and all other applicable Minnesota laws and rules in handling all data related to the services provided; and

(2) the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to the extent that the license holder performs a function or activity involving the use of protected health information as defined under Code of Federal Regulations, title 45, section 164.501, including, but not limited to, providing health care services; health care claims processing or administration; data analysis, processing, or administration; utilization review; quality assurance; billing; benefit management; practice management; repricing; or as otherwise provided by Code of Federal Regulations, title 45, section 160.103. The license holder must comply with the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, Code of Federal Regulations, title 45, parts 160 to 164, and all applicable requirements.

Subd. 4. **Admission criteria.** The license holder must establish policies and procedures that promote continuity of care by ensuring that admission or service initiation criteria:

(1) is consistent with the license holder's registration information identified in the requirements in section 245D.031, subdivision 2, and with the service-related rights identified in section 245D.04, subdivisions 2, clauses (4) to (7), and 3, clause (8);

(2) identifies the criteria to be applied in determining whether the license holder can develop services to meet the needs specified in the person's coordinated service and support plan;

(3) requires a license holder providing services in a health care facility to comply with the requirements in section 243.166, subdivision 4b, to provide notification to residents when a registered predatory offender is admitted into the program or to a potential admission when the facility was already serving a registered predatory offender. For purposes of this clause, "health care facility" means a facility licensed by the commissioner as a residential facility under chapter 245A to provide adult foster care or residential services to persons with disabilities; and

(4) requires that when a person or the person's legal representative requests services from the license holder, a refusal to admit the person must be based on an evaluation of the person's assessed needs and the license holder's lack of capacity to meet the needs of

the person. The license holder must not refuse to admit a person based solely on the type of residential services the person is receiving, or solely on the person's severity of disability, orthopedic or neurological handicaps, sight or hearing impairments, lack of communication skills, physical disabilities, toilet habits, behavioral disorders, or past failure to make progress. Documentation of the basis for refusal must be provided to the person or the person's legal representative and case manager upon request.

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

ARTICLE 4

HOME CARE PROVIDERS

Section 1. Minnesota Statutes 2012, section 144.051, is amended by adding a subdivision to read:

Subd. 3. **Data classification; private data.** For providers regulated pursuant to sections 144A.043 to 144A.482, the following data collected, created, or maintained by the commissioner are classified as "private data" as defined in section 13.02, subdivision 12:

(1) data submitted by or on behalf of applicants for licenses prior to issuance of the license;

(2) the identity of complainants who have made reports concerning licensees or applicants unless the complainant consents to the disclosure;

(3) the identity of individuals who provide information as part of surveys and investigations;

(4) Social Security numbers; and

(5) health record data.

Sec. 2. Minnesota Statutes 2012, section 144.051, is amended by adding a subdivision to read:

Subd. 4. **Data classification; public data.** For providers regulated pursuant to sections 144A.043 to 144A.482, the following data collected, created, or maintained by the commissioner are classified as "public data" as defined in section 13.02, subdivision 15:

(1) all application data on licensees, license numbers, license status;

(2) licensing information about licenses previously held under this chapter;

(3) correction orders, including information about compliance with the order and whether the fine was paid;

(4) final enforcement actions pursuant to chapter 14;

(5) orders for hearing, findings of fact and conclusions of law; and

(6) when the licensee and department agree to resolve the matter without a hearing, the agreement and specific reasons for the agreement are public data.

Sec. 3. Minnesota Statutes 2012, section 144.051, is amended by adding a subdivision to read:

Subd. 5. **Data classification; confidential data.** For providers regulated pursuant to sections 144A.043 to 144A.482, the following data collected, created, or maintained by the Department of Health are classified as "confidential data" as defined in section 13.02, subdivision 3: active investigative data relating to the investigation of potential violations of law by licensee including data from the survey process before the correction order is issued by the department.

Sec. 4. Minnesota Statutes 2012, section 144.051, is amended by adding a subdivision to read:

Subd. 6. **Release of private or confidential data.** For providers regulated pursuant to sections 144A.043 to 144A.482, the department may release private or confidential data, except Social Security numbers, to the appropriate state, federal, or local agency and law enforcement office to enhance investigative or enforcement efforts or further public health protective process. Types of offices include, but are not limited to, Adult Protective Services, Office of the Ombudsmen for Long-Term Care and Office of the Ombudsmen for Mental Health and Developmental Disabilities, the health licensing boards, Department of Human Services, county or city attorney's offices, police, and local or county public health offices.

Sec. 5. **[144A.471] HOME CARE PROVIDER AND HOME CARE SERVICES.**

Subdivision 1. **License required.** A home care provider may not open, operate, manage, conduct, maintain, or advertise itself as a home care provider or provide home care services in Minnesota without a temporary or current home care provider license issued by the commissioner of health.

Subd. 2. **Determination of direct home care service.** "Direct home care service" means a home care service provided to a client by the home care provider or its employees, and not by contract. Factors that must be considered in determining whether an individual or a business entity provides at least one home care service directly include, but are not limited to, whether the individual or business entity:

(1) has the right to control, and does control, the types of services provided;

(2) has the right to control, and does control, when and how the services are provided;

(3) establishes the charges;

(4) collects fees from the clients or receives payment from third-party payers on the clients' behalf;

(5) pays individuals providing services compensation on an hourly, weekly, or similar basis;

(6) treats the individuals providing services as employees for the purposes of payroll taxes and workers' compensation insurance; and

(7) holds itself out as a provider of home care services or acts in a manner that leads clients or potential clients to believe that it is a home care provider providing home care services.

None of the factors listed in this subdivision is solely determinative.

Subd. 3. **Determination of regularly engaged.** "Regularly engaged" means providing, or offering to provide, home care services as a regular part of a business. The following factors must be considered by the commissioner in determining whether an individual or a business entity is regularly engaged in providing home care services:

(1) whether the individual or business entity states or otherwise promotes that the individual or business entity provides home care services;

(2) whether persons receiving home care services constitute a substantial part of the individual's or the business entity's clientele; and

(3) whether the home care services provided are other than occasional or incidental to the provision of services other than home care services.

None of the factors listed in this subdivision is solely determinative.

Subd. 4. **Penalties for operating without license.** A person involved in the management, operation, or control of a home care provider that operates without an appropriate license is guilty of a misdemeanor. This section does not apply to a person who has no legal authority to affect or change decisions related to the management, operation, or control of a home care provider.

Subd. 5. **Basic and comprehensive levels of licensure.** An applicant seeking to become a home care provider must apply for either a basic or comprehensive home care license.

Subd. 6. **Basic home care license provider.** Home care services that can be provided with a basic home care license are assistive tasks provided by licensed or unlicensed personnel that include:

(1) assisting with dressing, self-feeding, oral hygiene, hair care, grooming, toileting, and bathing;

(2) providing standby assistance;

(3) providing verbal or visual reminders to the client to take regularly scheduled medication which includes bringing the client previously set-up medication, medication in original containers, or liquid or food to accompany the medication;

(4) providing verbal or visual reminders to the client to perform regularly scheduled treatments and exercises;

(5) preparing modified diets ordered by a licensed health professional; and

(6) assisting with laundry, housekeeping, meal preparation, shopping, or other household chores and services if the provider is also providing at least one of the activities in clauses (1) to (5)

Subd. 7. **Comprehensive home care license provider.** Home care services that may be provided with a comprehensive home care license include any of the basic home care services listed in subdivision 6, and one or more of the following:

(1) services of an advanced practice nurse, registered nurse, licensed practical nurse, physical therapist, respiratory therapist, occupational therapist, speech-language pathologist, dietician or nutritionist, or social worker;

(2) tasks delegated to unlicensed personnel by a registered nurse or assigned by a licensed health professional within the person's scope of practice;

(3) medication management services;

(4) hands-on assistance with transfers and mobility;

(5) assisting clients with eating when the clients have complicating eating problems as identified in the client record or through an assessment such as difficulty swallowing, recurrent lung aspirations, or requiring the use of a tube or parenteral or intravenous instruments to be fed; or

(6) providing other complex or specialty health care services.

Subd. 8. **Exemptions from home care services licensure.** (a) Except as otherwise provided in this chapter, home care services that are provided by the state, counties, or other units of government must be licensed under this chapter.

(b) An exemption under this subdivision does not excuse the exempted individual or organization from complying with applicable provisions of the home care bill of rights in section 144A.44. The following individuals or organizations are exempt from the requirement to obtain a home care provider license:

(1) an individual or organization that offers, provides, or arranges for personal care assistance services under the medical assistance program as authorized under sections 256B.04, subdivision 16; 256B.0625, subdivision 19a; and 256B.0659;

(2) a provider that is licensed by the commissioner of human services to provide semi-independent living services for persons with developmental disabilities under section 252.275 and Minnesota Rules, parts 9525.0900 to 9525.1020;

(3) a provider that is licensed by the commissioner of human services to provide home and community-based services for persons with developmental disabilities under section 256B.092 and Minnesota Rules, parts 9525.1800 to 9525.1930;

(4) an individual or organization that provides only home management services, if the individual or organization is registered under section 144A.482; or

(5) an individual who is licensed in this state as a nurse, dietitian, social worker, occupational therapist, physical therapist, or speech-language pathologist who provides health care services in the home independently and not through any contractual or employment relationship with a home care provider or other organization.

Subd. 9. **Exclusions from home care licensure.** The following are excluded from home care licensure and are not required to provide the home care bill of rights:

(1) an individual or business entity providing only coordination of home care that includes one or more of the following:

(i) determination of whether a client needs home care services, or assisting a client in determining what services are needed;

(ii) referral of clients to a home care provider;

(iii) administration of payments for home care services; or

(iv) administration of a health care home established under section 256B.0751;

(2) an individual who is not an employee of a licensed home care provider if the individual:

(i) only provides services as an independent contractor to one or more licensed home care providers;

(ii) provides no services under direct agreements or contracts with clients; and

(iii) is contractually bound to perform services in compliance with the contracting home care provider's policies and service plans;

(3) a business that provides staff to home care providers, such as a temporary employment agency, if the business:

(i) only provides staff under contract to licensed or exempt providers;

(ii) provides no services under direct agreements with clients; and

(iii) is contractually bound to perform services under the contracting home care provider's direction and supervision;

(4) any home care services conducted by and for the adherents of any recognized church or religious denomination for its members through spiritual means, or by prayer for healing;

(5) an individual who only provides home care services to a relative;

(6) an individual not connected with a home care provider that provides assistance with basic home care needs if the assistance is provided primarily as a contribution and not as a business;

(7) an individual not connected with a home care provider that shares housing with and provides primarily housekeeping or homemaking services to an elderly or disabled person in return for free or reduced-cost housing;

(8) an individual or provider providing home-delivered meal services;

(9) an individual providing senior companion services and other Older American Volunteer Programs (OAVP) established under the Domestic Volunteer Service Act of 1973, United States Code, title 42, chapter 66;

(10) an employee of a nursing home licensed under this chapter or an employee of a boarding care home licensed under sections 144.50 to 144.56 who responds to occasional emergency calls from individuals residing in a residential setting that is attached to or located on property contiguous to the nursing home or boarding care home;

(11) a member of a professional corporation organized under chapter 319B that does not regularly offer or provide home care services as defined in section 144A.43, subdivision 3;

(12) the following organizations established to provide medical or surgical services that do not regularly offer or provide home care services as defined in section 144A.43, subdivision 3: a business trust organized under sections 318.01 to 318.04, a nonprofit corporation organized under chapter 317A, a partnership organized under chapter 323, or any other entity determined by the commissioner;

(13) an individual or agency that provides medical supplies or durable medical equipment, except when the provision of supplies or equipment is accompanied by a home care service;

(14) a physician licensed under chapter 147;

(15) an individual who provides home care services to a person with a developmental disability who lives in a place of residence with a family, foster family, or primary caregiver;

(16) a business that only provides services that are primarily instructional and not medical services or health-related support services;

(17) an individual who performs basic home care services for no more than 14 hours each calendar week to no more than one client;

(18) an individual or business licensed as hospice as defined in sections 144A.75 to 144A.755 who is not providing home care services independent of hospice service;

(19) activities conducted by the commissioner of health or a board of health as defined in section 145A.02, subdivision 2, including communicable disease investigations or testing; or

(20) administering or monitoring a prescribed therapy necessary to control or prevent a communicable disease, or the monitoring of an individual's compliance with a health directive as defined in section 144.4172, subdivision 6.

Sec. 6. **[144A.472] HOME CARE PROVIDER LICENSE; APPLICATION AND RENEWAL.**

Subdivision 1. **License applications.** Each application for a home care provider license must include information sufficient to show that the applicant meets the requirements of licensure, including:

(1) the applicant's name, e-mail address, physical address, and mailing address, including the name of the county in which the applicant resides and has a principal place of business;

(2) the initial license fee in the amount specified in subdivision 7;

(3) the e-mail address, physical address, mailing address, and telephone number of the principal administrative office;

(4) the e-mail address, physical address, mailing address, and telephone number of each branch office, if any;

(5) the names, e-mail and mailing addresses, and telephone numbers of all owners and managerial officials;

(6) documentation of compliance with the background study requirements of section 144A.476 for all persons involved in the management, operation, or control of the home care provider;

(7) documentation of a background study as required by section 144.057 for any individual seeking employment, paid or volunteer, with the home care provider;

(8) evidence of workers' compensation coverage as required by sections 176.181 and 176.182;

(9) documentation of liability coverage, if the provider has it;

(10) identification of the license level the provider is seeking;

(11) documentation that identifies the managerial official who is in charge of day-to-day operations and attestation that the person has reviewed and understands the home care provider regulations;

(12) documentation that the applicant has designated one or more owners, managerial officials, or employees as an agent or agents, which shall not affect the legal responsibility of any other owner or managerial official under this chapter;

(13) the signature of the officer or managing agent on behalf of an entity, corporation, association, or unit of government;

(14) verification that the applicant has the following policies and procedures in place so that if a license is issued, the applicant will implement the policies and procedures and keep them current:

(i) requirements in sections 626.556, reporting of maltreatment of minors, and 626.557, reporting of maltreatment of vulnerable adults;

(ii) conducting and handling background studies on employees;

(iii) orientation, training, and competency evaluations of home care staff, and a process for evaluating staff performance;

(iv) handling complaints from clients, family members, or client representatives regarding staff or services provided by staff;

(v) conducting initial evaluation of clients' needs and the providers' ability to provide those services;

(vi) conducting initial and ongoing client evaluations and assessments and how changes in a client's condition are identified, managed, and communicated to staff and other health care providers as appropriate;

(vii) orientation to and implementation of the home care client bill of rights;

(viii) infection control practices;

(ix) reminders for medications, treatments, or exercises, if provided; and

(x) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; and

(15) other information required by the department.

Subd. 2. **Comprehensive home care license applications.** In addition to the information and fee required in subdivision 1, applicants applying for a comprehensive home care license must also provide verification that the applicant has the following policies and procedures in place so that if a license is issued, the applicant will implement the policies and procedures in this subdivision and keep them current:

(1) conducting initial and ongoing assessments of the client's needs by a registered nurse or appropriate licensed health professional, including how changes in the client's conditions are identified, managed, and communicated to staff and other health care providers, as appropriate;

(2) ensuring that nurses and licensed health professionals have current and valid licenses to practice;

(3) medication and treatment management;

(4) delegation of home care tasks by registered nurses or licensed health professionals;

(5) supervision of registered nurses and licensed health professionals; and

(6) supervision of unlicensed personnel performing delegated home care tasks.

Subd. 3. **License renewal.** (a) Except as provided in section 144A.475, a license may be renewed for a period of one year if the licensee satisfies the following:

(1) submits an application for renewal in the format provided by the commissioner at least 30 days before expiration of the license;

(2) submits the renewal fee in the amount specified in subdivision 7;

(3) has provided home care services within the past 12 months;

(4) complies with sections 144A.43 to 144A.4799;

(5) provides information sufficient to show that the applicant meets the requirements of licensure, including items required under subdivision 1;

(6) provides verification that all policies under subdivision 1 are current; and

(7) provides any other information deemed necessary by the commissioner.

(b) A renewal applicant who holds a comprehensive home care license must also provide verification that policies listed under subdivision 2 are current.

Subd. 4. **Multiple units.** Multiple units or branches of a licensee must be separately licensed if the commissioner determines that the units cannot adequately share supervision and administration of services from the main office.

Subd. 5. **Transfers prohibited; changes in ownership.** Any home care license issued by the commissioner may not be transferred to another party. Before acquiring ownership of a home care provider business, a prospective applicant must apply for a new temporary license. A change of ownership is a transfer of operational control to a different business entity and includes:

(1) transfer of the business to a different or new corporation;

(2) in the case of a partnership, the dissolution or termination of the partnership under chapter 323A, with the business continuing by a successor partnership or other entity;

(3) relinquishment of control of the provider to another party, including to a contract management firm that is not under the control of the owner of the business' assets;

(4) transfer of the business by a sole proprietor to another party or entity; or

(5) in the case of a privately held corporation, the change in ownership or control of 50 percent or more of the outstanding voting stock.

Subd. 6. **Notification of changes of information.** The temporary licensee or licensee shall notify the commissioner in writing within ten working days after any change in the information required in subdivision 1, except the information required in subdivision 1, clause (5), is required at the time of license renewal.

Subd. 7. **Fees; application, change of ownership, and renewal.** (a) An initial applicant seeking a temporary home care licensure must submit the following application fee to the commissioner along with a completed application:

(1) basic home care provider, $2,100; or

(2) comprehensive home care provider, $4,200.

(b) A home care provider who is filing a change of ownership as required under subdivision 5 must submit the following application fee to the commissioner, along with the documentation required for the change of ownership:

(1) basic home care provider, $2,100; or

(2) comprehensive home care provider, $4,200.

(c) A home care provider who is seeking to renew the provider's license 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 following schedule:

License Renewal Fee

Provider Annual Revenue	**Fee**
greater than $1,500,000	$6,625
greater than $1,275,000 and no more than $1,500,000	$5,797
greater than $1,100,000 and no more than $1,275,000	$4,969
greater than $950,000 and no more than $1,100,000	$4,141
greater than $850,000 and no more than $950,000	$3,727
greater than $750,000 and no more than $850,000	$3,313
greater than $650,000 and no more than $750,000	$2,898
greater than $550,000 and no more than $650,000	$2,485
greater than $450,000 and no more than $550,000	$2,070
greater than $350,000 and no more than $450,000	$1,656
greater than $250,000 and no more than $350,000	$1,242

greater than $100,000 and no more than $250,000	$828
greater than $50,000 and no more than $100,000	$500
greater than $25,000 and no more than $50,000	$400
no more than $25,000	$200

(d) If requested, the home care provider shall provide the commissioner information to verify the provider's annual revenues or other information as needed, including copies of documents submitted to the Department of Revenue.

(e) At each annual renewal, a home care provider may elect to pay the highest renewal fee for its license category, and not provide annual revenue information to the commissioner.

(f) A temporary license or license applicant, or temporary licensee or licensee that knowingly provides the commissioner incorrect revenue amounts for the purpose of paying a lower license fee, shall be subject to a civil penalty in the amount of double the fee the provider should have paid.

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

(h) The license renewal fee schedule in this subdivision is effective July 1, 2016.

Sec. 7. **[144A.473] ISSUANCE OF TEMPORARY LICENSE AND LICENSE RENEWAL.**

Subdivision 1. **Temporary license and renewal of license.** (a) The department shall review each application to determine the applicant's knowledge of and compliance with Minnesota home care regulations. Before granting a temporary license or renewing a license, the commissioner may further evaluate the applicant or licensee by requesting additional information or documentation or by conducting an on-site survey of the applicant to determine compliance with sections 144A.43 to 144A.482.

(b) Within 14 calendar 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.

(c) Within 90 days after receiving a complete application, the commissioner shall issue a temporary license, renew the license, or deny the license.

(d) The commissioner shall issue a license that contains the home care provider's name, address, license level, expiration date of the license, and unique license number. All licenses are valid for one year from the date of issuance.

Subd. 2. **Temporary license.** (a) For new license applicants, the commissioner shall issue a temporary license for either the basic or comprehensive home care level. A temporary license is effective for one year from the date of issuance. Temporary licensees must comply with sections 144A.43 to 144A.482.

(b) During the temporary license year, the commissioner shall survey the temporary licensee after the commissioner is notified or has evidence that the temporary licensee is providing home care services.

(c) Within five days of beginning the provision of services, the temporary licensee must notify the commissioner that it is serving clients. The notification to the commissioner may be mailed or e-mailed to the commissioner at the address provided by the commissioner. If the temporary licensee does not provide home care services during the temporary license year, then the temporary license expires at the end of the year and the applicant must reapply for a temporary home care license.

(d) A temporary licensee may request a change in the level of licensure prior to being surveyed and granted a license by notifying the commissioner in writing and providing additional documentation or materials required to update or complete the changed temporary license application. The applicant must pay the difference between the application fees when changing from the basic to the comprehensive level of licensure. No refund will be made if the provider chooses to change the license application to the basic level.

(e) If the temporary licensee notifies the commissioner that the licensee has clients within 45 days prior to the temporary license expiration, the commissioner may extend the temporary license for up to 60 days in order to allow the commissioner to complete the on-site survey required under this section and follow-up survey visits.

Subd. 3. **Temporary licensee survey.** (a) If the temporary licensee is in substantial compliance with the survey, the commissioner shall issue either a basic or comprehensive home care license. If the temporary licensee is not in substantial compliance with the survey, the commissioner shall not issue a basic or comprehensive license and there will be no contested hearing right under chapter 14.

(b) If the temporary licensee whose basic or comprehensive license has been denied disagrees with the conclusions of the commissioner, then the licensee may request a reconsideration by the commissioner or commissioner's designee. The reconsideration request process will be conducted internally by the commissioner or commissioner's designee, and chapter 14 does not apply.

(c) The temporary licensee requesting reconsideration must make the request in writing and must list and describe the reasons why the licensee disagrees with the decision to deny the basic or comprehensive home care license.

(d) A temporary licensee whose license is denied must comply with the requirements for notification and transfer of clients in section 144A.475, subdivision 5.

Sec. 8. **[144A.474] SURVEYS AND INVESTIGATIONS.**

Subdivision 1. **Surveys.** The commissioner shall conduct surveys of each home care provider. By June 30, 2016, the commissioner shall conduct a survey of home care providers on a frequency of at least once every three years. Survey frequency may be based on the license level, the provider's compliance history, number of clients served, or other factors as determined by the department deemed necessary to ensure the health, safety, and welfare of clients and compliance with the law.

Subd. 2. **Types of home care surveys.** (a) "Initial full survey" means the survey of a new temporary licensee conducted after the department is notified or has evidence that the licensee is providing home care services to determine if the provider is in compliance with home care requirements. Initial full surveys must be completed within 14 months after the department's issuance of a temporary basic or comprehensive license.

(b) "Core survey" means periodic inspection of home care providers to determine ongoing compliance with the home care requirements, focusing on the essential health and safety requirements. Core surveys are available to licensed home care providers who have been licensed for three years and surveyed at least once in the past three years with the latest survey having no widespread violations beyond Level 1 as provided in subdivision 11. Providers must also not have had any substantiated licensing complaints, substantiated complaints against the agency under the Vulnerable Adults Act or Maltreatment of Minors Act, or an enforcement action as authorized in section 144A.475 in the past three years.

(1) The core survey for basic license level providers shall review compliance in the following areas:

(i) reporting of maltreatment;

(ii) orientation to and implementation of Home Care Client Bill of Rights;

(iii) statement of home care services;

(iv) initial evaluation of clients and initiation of services;

(v) basic license level client review and monitoring;

(vi) service plan implementation and changes to the service plan;

(vii) client complaint and investigative process;

(viii) competency of unlicensed personnel; and

(ix) infection control.

(2) For comprehensive license level providers, the core survey shall include everything in the basic license level core survey plus these areas:

(i) delegation to unlicensed personnel;

(ii) assessment, monitoring, and reassessment of clients; and

(iii) medication, treatment, and therapy management.

(c) "Full survey" means the periodic inspection of home care providers to determine ongoing compliance with the home care requirements that cover the core survey areas and all the legal requirements for home care providers. A full survey is conducted for all temporary licensees and for providers who do not meet the requirements needed for a core survey, and when a surveyor identifies unacceptable client health or safety risks during a core survey. A full survey shall include all the tasks identified as part of the core survey and any additional review deemed necessary by the department, including additional observation, interviewing, or records review of additional clients and staff.

(d) "Follow-up surveys" means surveys conducted to determine if a home care provider has corrected deficient issues and systems identified during a core survey, full survey, or complaint investigation. Follow-up surveys may be conducted via phone, e-mail, fax, mail, or on-site reviews. Follow-up surveys, other than complaint surveys, shall be concluded with an exit conference and written information provided on the process for requesting a reconsideration of the survey results.

(e) Upon receiving information that a home care provider has violated or is currently violating a requirement of sections 144A.43 to 144A.482, the commissioner shall investigate the complaint according to sections 144A.51 to 144A.54.

Subd. 3. **Survey process.** (a) The survey process for core surveys shall include the following as applicable to the particular licensee and setting surveyed:

(1) presurvey review of pertinent documents and notification to the ombudsman for long-term care;

(2) an entrance conference with available staff;

(3) communication with managerial officials or the registered nurse in charge, if available, and ongoing communication with key staff throughout the survey regarding information needed by the surveyor, clarifications regarding home care requirements, and applicable standards of practice;

(4) presentation of written contact information to the provider about the survey staff conducting the survey, the supervisor, and the process for requesting a reconsideration of the survey results;

(5) a brief tour of a sample of the housing with services establishments in which the provider is providing home care services;

(6) a sample selection of home care clients;

(7) information-gathering through client and staff observations, client and staff interviews, and reviews of records, policies, procedures, practices, and other agency information;

(8) interviews of clients' family members, if available, with clients' consent when the client can legally give consent;

(9) except for complaint surveys conducted by the Office of Health Facilities Complaints, an exit conference, with preliminary findings shared and discussed with the provider and written information provided on the process for requesting a reconsideration of the survey results; and

(10) postsurvey analysis of findings and formulation of survey results, including correction orders when applicable.

Subd. 4. **Scheduling surveys.** Surveys and investigations shall be conducted without advance notice to home care providers. Surveyors may contact the home care provider on the day of a survey to arrange for someone to be available at the survey site. The contact does not constitute advance notice.

Subd. 5. **Information provided by home care provider.** The home care provider shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities.

Subd. 6. **Providing client records.** Upon request of a surveyor, home care providers shall provide a list of current and past clients or client representatives that includes addresses and telephone numbers and any other information requested about the services to clients within a reasonable period of time.

Subd. 7. **Contacting and visiting clients.** Surveyors may contact or visit a home care provider's clients to gather information without notice to the home care provider. Before visiting a client, a surveyor shall obtain the client's or client's representative's permission by telephone, mail, or in person. Surveyors shall inform all clients or client's representatives of their right to decline permission for a visit.

Subd. 8. **Correction orders.** (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a home care provider, a managerial official, or an employee of the provider is not in compliance with sections 144A.43 to 144A.482. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction.

(b) The commissioner shall mail copies of any correction order within 30 calendar days after an exit survey to the last known address of the home care provider. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the home care provider, and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically.

(c) By the correction order date, the home care provider must document in the provider's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the home care provider's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed.

Subd. 9. **Follow-up surveys.** For providers that have Level 3 or Level 4 violations, under subdivision 11, or any violations determined to be widespread, the department shall conduct a follow-up survey within 90 calendar days of the survey. When conducting a follow-up survey, the surveyor will focus on whether the previous violations have been corrected and may also address any new violations that are observed while evaluating the corrections that have been made. If a new violation is identified on a follow-up survey, no fine will be imposed unless it is not corrected on the next follow-up survey.

Subd. 10. **Performance incentive.** A licensee is eligible for a performance incentive if there are no violations identified in a core or full survey. The performance incentive is a ten percent discount on the licensee's next home care renewal license fee.

Subd. 11. **Fines.** (a) Fines and enforcement actions under this subdivision may be assessed based on the level and scope of the violations described in paragraph (c) as follows:

(1) Level 1, no fines or enforcement;

(2) Level 2, fines ranging from $0 to $500, in addition to any of the enforcement mechanisms authorized in section 144A.475 for widespread violations;

(3) Level 3, fines ranging from $500 to $1,000, in addition to any of the enforcement mechanisms authorized in section 144A.475; and

(4) Level 4, fines ranging from $1,000 to $5,000, in addition to any of the enforcement mechanisms authorized in section 144A.475.

(b) Correction orders for violations are categorized by both level and scope and fines shall be assessed as follows:

(1) Level of violation:

(i) Level 1 is a violation that has no potential to cause more than a minimal impact on the client and does not affect health or safety;

(ii) Level 2 is a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death;

(iii) Level 3 is a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death; and

(iv) Level 4 is a violation that results in serious injury, impairment, or death.

(2) Scope of violation:

(i) Isolated, when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally;

(ii) Pattern, when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive; and

(iii) Widespread, when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients.

(c) If the commissioner finds that the applicant or a home care provider required to be licensed under sections 144A.43 to 144A.482 has not corrected violations by the date specified in the correction order or conditional license resulting from a survey or complaint investigation, the commissioner may impose a fine. A notice of noncompliance with a correction order must be mailed to the applicant's or provider's last known address. The noncompliance notice must list the violations not corrected.

(d) The license holder must pay the fines assessed on or before the payment date specified. If the license holder fails to fully comply with the order, the commissioner may issue a second fine or suspend the license until the license holder complies by paying the fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

(e) A license holder shall promptly notify the commissioner in writing when a violation specified in the order is corrected. If upon reinspection the commissioner determines that a violation has not been corrected as indicated by the order, the commissioner may issue a second fine. The commissioner shall notify the license holder by mail to the last known address in the licensing record that a second fine has been assessed. The license holder may appeal the second fine as provided under this subdivision.

(f) A home care provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14.

(g) When a fine has been assessed, the license holder may not avoid payment by closing, selling, or otherwise transferring the licensed program to a third party. In such an event, the license holder shall be liable for payment of the fine.

(h) In addition to any fine imposed under this section, the commissioner may assess costs related to an investigation that results in a final order assessing a fine or other enforcement action authorized by this chapter.

(i) Fines collected under this subdivision shall be deposited in the state government special revenue fund and credited to an account separate from the revenue collected under section 144A.472. Subject to an appropriation by the legislature, the revenue from the fines collected may be used by the commissioner for special projects to improve home care in Minnesota as recommended by the advisory council established in section 144A.4799.

Subd. 12. **Reconsideration.** (a) The commissioner shall make available to home care providers a correction order reconsideration process. This process may be used to challenge the correction order issued, including the level and scope described in subdivision 11, and any fine assessed. During the correction order reconsideration request, the issuance for the correction orders under reconsideration are not stayed, but the department shall post information on the Web site with the correction order that the licensee has requested a reconsideration and that the review is pending.

(b) A licensed home care provider may request from the commissioner, in writing, a correction order reconsideration regarding any correction order issued to the provider. The correction order reconsideration shall not be reviewed by any surveyor, investigator, or supervisor that participated in the writing or reviewing of the correction order being disputed. The correction order reconsiderations may be conducted in person, by telephone, by another electronic form, or in writing, as determined by the commissioner. The commissioner shall respond in writing to the request from a home care provider for a correction order reconsideration within 60 days of the date the provider requests a reconsideration. The commissioner's response shall identify the commissioner's decision regarding each citation challenged by the home care provider.

(c) The findings of a correction order reconsideration process shall be one or more of the following:

(1) supported in full, the correction order is supported in full, with no deletion of findings to the citation;

(2) supported in substance, the correction order is supported, but one or more findings are deleted or modified without any change in the citation;

(3) correction order cited an incorrect home care licensing requirement, the correction order is amended by changing the correction order to the appropriate statutory reference;

(4) correction order was issued under an incorrect citation, the correction order is amended to be issued under the more appropriate correction order citation;

(5) the correction order is rescinded;

(6) fine is amended, it is determined that the fine assigned to the correction order was applied incorrectly; or

(7) the level or scope of the citation is modified based on the reconsideration.

(d) If the correction order findings are changed by the commissioner, the commissioner shall update the correction order Web site.

Subd. 13. **Home care surveyor training.** (a) Before conducting a home care survey, each home care surveyor must receive training on the following topics:

(1) Minnesota home care licensure requirements;

(2) Minnesota Home Care Client Bill of Rights;

(3) Minnesota Vulnerable Adults Act and reporting of maltreatment of minors;

(4) principles of documentation;

(5) survey protocol and processes;

(6) Offices of the Ombudsman roles;

(7) Office of Health Facility Complaints;

(8) Minnesota landlord-tenant and housing with services laws;

(9) types of payors for home care services; and

(10) Minnesota Nurse Practice Act for nurse surveyors.

(b) Materials used for the training in paragraph (a) shall be posted on the department Web site. Requisite understanding of these topics will be reviewed as part of the quality improvement plan in section 28.

Sec. 9. **[144A.475] ENFORCEMENT.**

Subdivision 1. **Conditions.** (a) The commissioner may refuse to grant a temporary license, renew a license, suspend or revoke a license, or impose a conditional license if the home care provider or owner or managerial official of the home care provider:

(1) is in violation of, or during the term of the license has violated, any of the requirements in sections 144A.471 to 144A.482;

(2) permits, aids, or abets the commission of any illegal act in the provision of home care;

(3) performs any act detrimental to the health, safety, and welfare of a client;

(4) obtains the license by fraud or misrepresentation;

(5) 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;

(6) denies representatives of the department access to any part of the home care provider's books, records, files, or employees;

(7) interferes with or impedes a representative of the department in contacting the home care provider's clients;

(8) interferes with or impedes a representative of the department in the enforcement of this chapter or has failed to fully cooperate with an inspection, survey, or investigation by the department;

(9) destroys or makes unavailable any records or other evidence relating to the home care provider's compliance with this chapter;

(10) refuses to initiate a background study under section 144.057 or 245A.04;

(11) fails to timely pay any fines assessed by the department;

(12) violates any local, city, or township ordinance relating to home care services;

(13) has repeated incidents of personnel performing services beyond their competency level; or

(14) has operated beyond the scope of the home care provider's license level.

(b) A violation by a contractor providing the home care services of the home care provider is a violation by the home care provider.

Subd. 2. **Terms to suspension or conditional license.** A suspension or conditional license designation may include terms that must be completed or met before a suspension or conditional license designation is lifted. A conditional license designation may include restrictions or conditions that are imposed on the provider. 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 home care provider's practices and submit reports to the commissioner at the cost of the home care provider;

(2) requiring supervision of the home care provider or staff practices at the cost of the home care 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 home care provider or employees to obtain training at the cost of the home care provider;

(4) requiring the home care provider to submit reports to the commissioner;

(5) prohibiting the home care provider from taking any new clients for a period of time; or

(6) any other action reasonably required to accomplish the purpose of this subdivision and section 144A.45, subdivision 2.

Subd. 3. **Notice.** 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 90 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 home care provider;

(2) after notice, the home care 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 90 days.

Subd. 4. **Time limits for appeals.** To appeal the assessment of civil penalties under section 144A.45, subdivision 2, clause (5), and an action against a license under this section, a provider must request a hearing no later than 15 days after the provider receives notice of the action.

Subd. 5. **Plan required.** (a) The process of suspending or revoking a license must include a plan for transferring affected clients to other providers by the home care provider, which will be monitored by the commissioner. Within three business days of being notified of the final revocation or suspension action, the home care 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 representative or emergency contact person, including full names and all contact information on file;

(3) the location or current residence 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 plan, and a list of the types of services being provided.

(b) The revocation or suspension notification requirement is satisfied by mailing the notice to the address in the license record. The home care 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 home care provider must notify and disclose to each of the home care provider's clients, or the client's representative or emergency contact persons, that

the commissioner is taking action against the home care provider's license by providing a copy of the revocation or suspension notice issued by the commissioner.

Subd. 6. **Owners and managerial officials; refusal to grant license.** (a) The owner and managerial officials of a home care provider whose Minnesota license has not been renewed or that has been revoked because of noncompliance with applicable laws or rules shall not be eligible to apply for nor will be granted a home care license, including other licenses under this chapter, or be given status as an enrolled personal care assistance provider agency or personal care assistant by the Department of Human Services under 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.

(b) The commissioner shall not issue a license to a home care provider for five years following the effective date of license nonrenewal or revocation if the owner or managerial official, including any individual who was an owner or managerial official of another home care provider, had a Minnesota license that was not renewed or was revoked as described in paragraph (a).

(c) Notwithstanding subdivision 1, the commissioner shall not renew, or shall suspend or revoke, the license of any home care provider that 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 (a) for five years following the effective date of the nonrenewal or revocation.

(d) 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 the 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 with 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.

Subd. 7. **Request for hearing.** A request for a hearing must be in writing and must:

(1) be mailed or delivered to the department or the commissioner's designee;

(2) contain a brief and plain statement describing every matter or issue contested; and

(3) contain a brief and plain statement of any new matter that the applicant or home care provider believes constitutes a defense or mitigating factor.

Subd. 8. **Informal conference.** At any time, the applicant or home care provider and the commissioner may hold an informal conference to exchange information, clarify issues, or resolve issues.

Subd. 9. **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.482. 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. 10. **Subpoena.** In matters pending before the commissioner under sections 144A.43 to 144A.482, 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 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 on a named person anywhere in 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 a 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.

Sec. 10. **[144A.476] BACKGROUND STUDIES.**

Subdivision 1. **Prior criminal convictions; owner and managerial officials.** (a) Before the commissioner issues a temporary license or renews a license, an owner or managerial official is required to complete a background study under section 144.057. No person may be involved in the management, operation, or control of a home care provider if the person has been disqualified under chapter 245C. If an individual is disqualified under section 144.056 or chapter 245C, the individual may request reconsideration of the disqualification. If the individual requests reconsideration and the commissioner sets aside or rescinds the disqualification, the individual is eligible to be involved in the management, operation, or control of the provider. If an individual has a disqualification under section 245C.15, subdivision 1, and the disqualification is affirmed, the individual's disqualification is barred from a set aside, and the individual must not be involved in the management, operation, or control of the provider.

(b) 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.

(c) For the purposes of this section, managerial officials subject to the background check requirement are individuals who provide direct contact as defined in section 245C.02, subdivision 11, or 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.

(d) The department shall not issue any license if the applicant or owner or managerial official has been unsuccessful in having a background study disqualification set aside under section 144.057 and chapter 245C; if the owner or managerial official, as an owner or managerial official of another home care provider, was substantially responsible for the other home care provider's failure to substantially comply with sections 144A.43 to

144A.482; or if an owner that has ceased doing business, either individually or as an owner of a home care provider, was issued a correction order for failing to assist clients in violation of this chapter.

Subd. 2. **Employees, contractors, and volunteers.** (a) Employees, contractors, and volunteers of a home care provider are subject to the background study required by section 144.057, and may be disqualified under chapter 245C. Nothing in this section shall be construed to prohibit a home care provider from requiring self-disclosure of criminal conviction information.

(b) Termination of an employee in good faith reliance on information or records obtained under paragraph (a) or subdivision 1, regarding a confirmed conviction does not subject the home care provider to civil liability or liability for unemployment benefits.

Sec. 11. **[144A.477] COMPLIANCE.**

Subdivision 1. **Medicare-certified providers; 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 if Medicare certification is based on compliance with the federal conditions of participation and on survey and enforcement by the Department of Health as agent for the United States Department of Health and Human Services.

Subd. 2. **Medicare-certified providers; equivalent requirements.** For home care providers licensed to provide comprehensive home care services that are also certified for participation in Medicare as a home health agency under Code of Federal Regulations, title 42, part 484, the following state licensure regulations are considered equivalent to the federal requirements:

(1) quality management, section 144A.479, subdivision 3;

(2) personnel records, section 144A.479, subdivision 7;

(3) acceptance of clients, section 144A.4791, subdivision 4;

(4) referrals, section 144A.4791, subdivision 5;

(5) client assessment, sections 144A.4791, subdivision 8, and 144A.4792, subdivisions 2 and 3;

(6) individualized monitoring and reassessment, sections 144A.4791, subdivision 8, and 144A.4792, subdivisions 2 and 3;

(7) individualized service plan, sections 144A.4791, subdivision 9, 144A.4792, subdivision 5, and 144A.4793, subdivision 3;

(8) client complaint and investigation process, section 144A.4791, subdivision 11;

(9) prescription orders, section 144A.4792, subdivisions 13 to 16;

(10) client records, section 144A.4794, subdivisions 1 to 3;

(11) qualifications for unlicensed personnel performing delegated tasks, section 144A.4795;

(12) training and competency staff, section 144A.4795;

(13) training and competency for unlicensed personnel, section 144A.4795, subdivision 7;

(14) delegation of home care services, section 144A.4795, subdivision 4;

(15) availability of contact person, section 144A.4797, subdivision 1; and

(16) supervision of staff, section 144A.4797, subdivisions 2 and 3.

Violations of requirements in clauses (1) to (16) may lead to enforcement actions under section 144A.474.

Sec. 12. **[144A.478] INNOVATION VARIANCE.**

Subdivision 1. **Definition.** For purposes of this section, "innovation variance" means a specified alternative to a requirement of this chapter. An innovation variance may be granted to allow a home care 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. The innovative variance cannot change any of the client's rights under section 144A.44, home care bill of rights.

Subd. 2. **Conditions.** The commissioner may impose conditions on the granting of an innovation variance that the commissioner considers necessary.

Subd. 3. **Duration and renewal.** The commissioner may limit the duration of any innovation variance and may renew a limited innovation variance.

Subd. 4. **Applications; innovation variance.** An application for innovation 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:

(1) the statute or law from which the innovation variance is requested;

(2) the time period for which the innovation variance is requested;

(3) the specific alternative action that the licensee proposes;

(4) the reasons for the request; and

(5) justification that an innovation variance will not impair the services provided, will not adversely affect the health, safety, or welfare of clients, and is likely to improve the services provided.

The commissioner may require additional information from the home care provider before acting on the request.

Subd. 5. **Grants and denials.** The commissioner shall grant or deny each request for an innovation variance in writing within 45 days of receipt of a complete request. Notice of a denial shall contain the reasons for the denial. The terms of a requested innovation variance may be modified upon agreement between the commissioner and the home care provider.

Subd. 6. **Violation of innovation variances.** A failure to comply with the terms of an innovation variance shall be deemed to be a violation of this chapter.

Subd. 7. **Revocation or denial of renewal.** The commissioner shall revoke or deny renewal of an innovation variance if:

(1) it is determined that the innovation variance is adversely affecting the health, safety, or welfare of the licensee's clients;

(2) the home care provider has failed to comply with the terms of the innovation variance;

(3) the home care provider notifies the commissioner in writing that it wishes to relinquish the innovation variance and be subject to the statute previously varied; or

(4) the revocation or denial is required by a change in law.

Sec. 13. **[144A.479] HOME CARE PROVIDER RESPONSIBILITIES; BUSINESS OPERATION.**

Subdivision 1. **Display of license.** The original current license must be displayed in the home care providers' principal business office and copies must be displayed in any branch office. The home care provider must provide a copy of the license to any person who requests it.

Subd. 2. **Advertising.** Home care providers shall not use false, fraudulent, or misleading advertising in the marketing of services. For purposes of this section, advertising includes any verbal, written, or electronic means of communicating to potential clients about the availability, nature, or terms of home care services.

Subd. 3. **Quality management.** The home care provider shall engage in quality management appropriate to the size of the home care provider and relevant to the type of services the home care provider provides. The quality management activity means evaluating the quality of care by periodically reviewing client services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to clients. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal.

Subd. 4. **Provider restrictions.** (a) This subdivision does not apply to licensees that are Minnesota counties or other units of government.

(b) A home care provider or staff cannot accept powers-of-attorney from clients for any purpose, and may not accept appointments as guardians or conservators of clients.

(c) A home care provider cannot serve as a client's representative.

Subd. 5. **Handling of client's finances and property.** (a) A home care provider may assist clients with household budgeting, including paying bills and purchasing household goods, but may not otherwise manage a client's property. A home care provider 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 home care provider must maintain records of all such transactions.

(b) A home care provider or staff may not borrow a client's funds or personal or real property, nor in any way convert a client's property to the home care provider's or staff's possession.

(c) Nothing in this section precludes a home care provider or staff from accepting gifts of minimal value, or precludes the acceptance of donations or bequests made to a home care provider that are exempt from income tax under section 501(c) of the Internal Revenue Code of 1986.

Subd. 6. **Reporting maltreatment of vulnerable adults and minors.** (a) All home care providers must comply with requirements for the reporting of maltreatment of minors in section 626.556 and the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. Home care providers must report suspected maltreatment of minors and vulnerable adults to the common entry point. Each home care provider must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported.

(b) Each home care provider must develop and implement an individual abuse prevention plan for each vulnerable minor or adult for whom home care services are provided by a home care provider. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults or minors; the person's risk of abusing other vulnerable adults or minors; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults or minors. For purposes of the abuse prevention plan, the term abuse includes self-abuse.

Subd. 7. **Employee records.** The home care provider must maintain current records of each paid employee, regularly scheduled volunteers providing home care services, and

of each individual contractor providing home care services. The records must include the following information:

(1) evidence of current professional licensure, registration, or certification, if licensure, registration, or certification is required by this statute, or other rules;

(2) records of orientation, required annual training and infection control training, and competency evaluations;

(3) current job description, including qualifications, responsibilities, and identification of staff providing supervision;

(4) documentation of annual performance reviews which identify areas of improvement needed and training needs;

(5) for individuals providing home care services, verification that required health screenings under section 144A.4798 have taken place and the dates of those screenings; and

(6) documentation of the background study as required under section 144.057.

Each employee record must be retained for at least three years after a paid employee, home care volunteer, or contractor ceases to be employed by or under contract with the home care provider. If a home care provider ceases operation, employee records must be maintained for three years.

Sec. 14. **[144A.4791] HOME CARE PROVIDER RESPONSIBILITIES WITH RESPECT TO CLIENTS.**

Subdivision 1. **Home care bill of rights; notification to client.** (a) The home care provider shall provide the client or the client's representative a written notice of the rights under section 144A.44 in a language that the client or the client's representative can understand before the initiation of services to that client. If a written version is not available, the home care bill of rights must be communicated to the client or client's representative in a language they can understand.

(b) In addition to the text of the home care bill of rights in section 144A.44, subdivision 1, the notice shall also contain the following statement describing how to file a complaint with these offices.

"If you have a complaint about the provider or the person providing your home care services, you may call, write, or visit the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities."

The statement should include the telephone number, Web site address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at

the Minnesota Department of Health, the Office of the Ombudsman for Long-Term Care, and the Office of the Ombudsman for Mental Health and Developmental Disabilities. The statement should also include the home care provider's name, address, e-mail, telephone number, and name or title of the person at the provider to whom problems or complaints may be directed. It must also include a statement that the home care provider will not retaliate because of a complaint.

(c) The home care provider shall obtain written acknowledgment of the client's receipt of the home care bill of rights or shall document why an acknowledgment cannot be obtained. The acknowledgment may be obtained from the client or the client's representative. Acknowledgment of receipt shall be retained in the client's record.

Subd. 2. **Notice of services for dementia, Alzheimer's disease, or related disorders.** The home care provider that provides services to clients with dementia shall provide in written or electronic form, to clients and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. This information satisfies the disclosure requirements in section 325F.72, subdivision 2, clause (4).

Subd. 3. **Statement of home care services.** Prior to the initiation of services, a home care provider must provide to the client or the client's representative a written statement which identifies if they have a basic or comprehensive home care license, the services they are authorized to provide, and which services they cannot provide under the scope of their license. The home care provider shall obtain written acknowledgment from the clients that they have provided the statement or must document why they could not obtain the acknowledgment.

Subd. 4. **Acceptance of clients.** No home care provider may accept a person as a client unless the home care provider has staff, sufficient in qualifications, competency, and numbers, to adequately provide the services agreed to in the service plan and that are within the provider's scope of practice.

Subd. 5. **Referrals.** If a home care provider reasonably believes that a client is in need of another medical or health service, including a licensed health professional, or social service provider, the home care provider shall:

(1) determine the client's preferences with respect to obtaining the service; and

(2) inform the client of resources available, if known, to assist the client in obtaining services.

Subd. 6. **Initiation of services.** When a provider initiates services and the individualized review or assessment required in subdivisions 7 and 8 has not been

completed, the provider must complete a temporary plan and agreement with the client for services.

Subd. 7. **Basic individualized client review and monitoring.** (a) When services being provided are basic home care services, an individualized initial review of the client's needs and preferences must be conducted at the client's residence with the client or client's representative. This initial review must be completed within 30 days after the initiation of the home care services.

(b) Client monitoring and review must be conducted as needed based on changes in the needs of the client and cannot exceed 90 days from the date of the last review. The monitoring and review may be conducted at the client's residence or through the utilization of telecommunication methods based on practice standards that meet the individual client's needs.

Subd. 8. **Comprehensive assessment, monitoring, and reassessment.** (a) When the services being provided are comprehensive home care services, an individualized initial assessment must be conducted in-person by a registered nurse. When the services are provided by other licensed health professionals, the assessment must be conducted by the appropriate health professional. This initial assessment must be completed within five days after initiation of home care services.

(b) Client monitoring and reassessment must be conducted in the client's home no more than 14 days after initiation of services.

(c) Ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client and cannot exceed 90 days from the last date of the assessment. The monitoring and reassessment may be conducted at the client's residence or through the utilization of telecommunication methods based on practice standards that meet the individual client's needs.

Subd. 9. **Service plan, implementation, and revisions to service plan.** (a) No later than 14 days after the initiation of services, a home care provider shall finalize a current written service plan.

(b) The service plan and any revisions must include a signature or other authentication by the home care provider and by the client or the client's representative documenting agreement on the services to be provided. The service plan must be revised, if needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide information to the client about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care.

(c) The home care provider must implement and provide all services required by the current service plan.

(d) The service plan and revised service plan must be entered into the client's record, including notice of a change in a client's fees when applicable.

(e) Staff providing home care services must be informed of the current written service plan.

(f) The service plan must include:

(1) a description of the home care services to be provided, the fees for services, and the frequency of each service, according to the client's current review or assessment and client preferences;

(2) the identification of the staff or categories of staff who will provide the services;

(3) the schedule and methods of monitoring reviews or assessments of the client;

(4) the frequency of sessions of supervision of staff and type of personnel who will supervise staff; and

(5) a contingency plan that includes:

(i) the action to be taken by the home care provider and by the client or client's representative if the scheduled service cannot be provided;

(ii) information and method for a client or client's representative to contact the home care provider;

(iii) names and contact information of persons the client wishes to have notified in an emergency or if there is a significant adverse change in the client's condition, including identification of and information as to who has authority to sign for the client in an emergency; and

(iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the client under those chapters.

Subd. 10. **Termination of service plan.** (a) If a home care provider terminates a service plan with a client, and the client continues to need home care services, the home care provider shall provide the client and the client's representative, if any, with a written notice of termination which includes the following information:

(1) the effective date of termination;

(2) the reason for termination;

(3) a list of known licensed home care providers in the client's immediate geographic area;

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

(5) the name and contact information of a person employed by the home care provider with whom the client may discuss the notice of termination; and

(6) if applicable, a statement that the notice of termination of home care services does not constitute notice of termination of the housing with services contract with a housing with services establishment.

(b) When the home care provider voluntarily discontinues services to all clients, the home care provider must notify the commissioner, lead agencies, and the ombudsman for long-term care about its clients and comply with the requirements in this subdivision.

Subd. 11. **Client complaint and investigative process.** (a) The home care provider must have a written policy and system for receiving, investigating, reporting, and attempting to resolve complaints from its clients or clients' representatives. The policy should clearly identify the process by which clients may file a complaint or concern about home care services and an explicit statement that the home care provider will not discriminate or retaliate against a client for expressing concerns or complaints. A home care provider must have a process in place to conduct investigations of complaints made by the client or the client's representative about the services in the client's plan that are or are not being provided or other items covered in the client's home care bill of rights. This complaint system must provide reasonable accommodations for any special needs of the client or client's representative if requested.

(b) The home care provider must document the complaint, name of the client, investigation, and resolution of each complaint filed. The home care provider must maintain a record of all activities regarding complaints received, including the date the complaint was received, and the home care provider's investigation and resolution of the complaint. This complaint record must be kept for each event for at least two years after the date of entry and must be available to the commissioner for review.

(c) The required complaint system must provide for written notice to each client or client's representative that includes:

(1) the client's right to complain to the home care provider about the services received;

(2) the name or title of the person or persons with the home care provider to contact with complaints;

(3) the method of submitting a complaint to the home care provider; and

(4) a statement that the provider is prohibited against retaliation according to paragraph (d).

(d) A home care provider must not take any action that negatively affects a client in retaliation for a complaint made or a concern expressed by the client or the client's representative.

Subd. 12. **Disaster planning and emergency preparedness plan.** The home care provider must have a written plan of action to facilitate the management of the client's care and services in response to a natural disaster, such as flood and storms, or other emergencies that may disrupt the home care provider's ability to provide care or services. The licensee must provide adequate orientation and training of staff on emergency preparedness.

Subd. 13. **Request for discontinuation of life-sustaining treatment.** (a) If a client, family member, or other caregiver of the client requests that an employee or other agent of the home care provider discontinue a life-sustaining treatment, the employee or agent receiving the request:

(1) shall take no action to discontinue the treatment; and

(2) shall promptly inform their supervisor or other agent of the home care provider of the client's request.

(b) Upon being informed of a request for termination of treatment, the home care provider shall promptly:

(1) inform the client that the request will be made known to the physician who ordered the client's treatment;

(2) inform the physician of the client's request; and

(3) work with the client and the client's physician to comply with the provisions of the Health Care Directive Act in chapter 145C.

(c) This section does not require the home care provider to discontinue treatment, except as may be required by law or court order.

(d) This section does not diminish the rights of clients to control their treatments, refuse services, or terminate their relationships with the home care provider.

(e) This section shall be construed in a manner consistent with chapter 145B or 145C, whichever applies, and declarations made by clients under those chapters.

Sec. 15. **[144A.4792] MEDICATION MANAGEMENT.**

Subdivision 1. **Medication management services; comprehensive home care license.** (a) This subdivision applies only to home care providers with a comprehensive home care license that provides medication management services to clients. Medication management services may not be provided by a home care provider that has a basic home care license.

(b) A comprehensive home care provider who provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the

supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines.

(c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and client and client representative, if any; disposing of unused medications; and educating clients and client representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 22.

Subd. 2. **Provision of medication management services.** (a) For each client who requests medication management services, the comprehensive home care provider shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the client. The assessment must include an identification and review of all medications the client is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.

(b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the client or others who may have access to the medications. "Diversion of medications" means the misuse, theft, or illegal or improper disposition of medications.

Subd. 3. **Individualized medication monitoring and reassessment.** The comprehensive home care provider must monitor and reassess the client's medication management services as needed under subdivision 14 when the client presents with symptoms or other issues that may be medication-related and, at a minimum, annually.

Subd. 4. **Client refusal.** The home care provider must document in the client's record any refusal for an assessment for medication management by the client. The provider must discuss with the client the possible consequences of the client's refusal and document the discussion in the client's record.

Subd. 5. **Individualized medication management plan.** (a) For each client receiving medication management services, the comprehensive home care provider must prepare and include in the service plan a written statement of the medication management

services that will be provided to the client. The provider must develop and maintain a current individualized medication management record for each client based on the client's assessment that must contain the following:

(1) a statement describing the medication management services that will be provided;

(2) a description of storage of medications based on the client's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;

(3) documentation of specific client instructions relating to the administration of medications;

(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;

(5) identification of medication management tasks that may be delegated to unlicensed personnel;

(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and

(7) any client-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.

(b) The medication management record must be current and updated when there are any changes.

Subd. 6. **Administration of medication.** Medications may be administered by a nurse, physician, or other licensed health practitioner authorized to administer medications or by unlicensed personnel who have been delegated medication administration tasks by a registered nurse.

Subd. 7. **Delegation of medication administration.** When administration of medications is delegated to unlicensed personnel, the comprehensive home care provider must ensure that the registered nurse has:

(1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated ability to competently follow the procedures;

(2) specified, in writing, specific instructions for each client and documented those instructions in the client's records; and

(3) communicated with the unlicensed personnel about the individual needs of the client.

Subd. 8. **Documentation of administration of medications.** Each medication administered by comprehensive home care provider staff must be documented in the client's record. The documentation must include the signature and title of the person

who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the client's needs when medication was not administered as prescribed and in compliance with the client's medication management plan.

Subd. 9. **Documentation of medication set-up.** Documentation of dates of medication set-up, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication set-up must be done at time of set-up.

Subd. 10. **Medication management for clients who will be away from home.** (a) A home care provider that is providing medication management services to the client and controls the client's access to the medications must develop and implement policies and procedures for giving accurate and current medications to clients for planned or unplanned times away from home according to the client's individualized medication management plan. The policy and procedures must state that:

(1) for planned time away, the medications must be obtained from the pharmacy or set up by the registered nurse according to appropriate state and federal laws and nursing standards of practice;

(2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall give the client or client's representative medications in amounts and dosages needed for the length of the anticipated absence, not to exceed 120 hours;

(3) the client, or the client's representative, must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances;

(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the client's name and the dates and times that the medications are scheduled; and

(5) the client or client's representative must be provided in writing the home care provider's name and information on how to contact the home care provider.

(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:

(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to clients;

(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the client. The procedures must address:

(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;

(ii) how the container or containers must be labeled;

(iii) the written information about the medications to be given to the client or client's representative;

(iv) how the unlicensed staff must document in the client's record that medications have been given to the client or the client's representative, including documenting the date the medications were given to the client or the client's representative and who received the medications, the person who gave the medications to the client, the number of medications that were given to the client, and other required information;

(v) how the registered nurse shall be notified that medications have been given to the client or client's representative and whether the registered nurse needs to be contacted before the medications are given to the client or the client's representative; and

(vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel.

Subd. 11. **Prescribed and nonprescribed medication.** The comprehensive home care provider must determine whether the comprehensive home care provider shall require a prescription for all medications the provider manages. The comprehensive home care provider must inform the client or the client's representative whether the comprehensive home care provider requires a prescription for all over-the-counter and dietary supplements before the comprehensive home care provider agrees to manage those medications.

Subd. 12. **Medications; over-the-counter; dietary supplements not prescribed.** A comprehensive home care provider providing medication management services for over-the-counter drugs or dietary supplements must retain those items in the original labeled container with directions for use prior to setting up for immediate or later administration. The provider must verify that the medications are up-to-date and stored as appropriate.

Subd. 13. **Prescriptions.** There must be a current written or electronically recorded prescription as defined in Minnesota Rules, part 6800.0100, subpart 11a, for all prescribed medications that the comprehensive home care provider is managing for the client.

Subd. 14. **Renewal of prescriptions.** Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152.

Subd. 15. **Verbal prescription orders.** Verbal prescription orders from an authorized prescriber must be received by a nurse or pharmacist. The order must be handled according to Minnesota Rules, part 6800.6200.

Subd. 16. **Written or electronic prescription.** When a written or electronic prescription is received, it must be communicated to the registered nurse in charge and recorded or placed in the client's record.

Subd. 17. **Records confidential.** A prescription or order received verbally, in writing, or electronically must be kept confidential according to sections 144.291 to 144.298 and 144A.44.

Subd. 18. **Medications provided by client or family members.** When the comprehensive home care provider is aware of any medications or dietary supplements that are being used by the client and are not included in the assessment for medication management services, the staff must advise the registered nurse and document that in the client's record.

Subd. 19. **Storage of medications.** A comprehensive home care provider providing storage of medications outside of the client's private living space must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.

Subd. 20. **Prescription drugs.** A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.

Subd. 21. **Prohibitions.** No prescription drug supply for one client may be used or saved for use by anyone other than the client.

Subd. 22. **Disposition of medications.** (a) Any current medications being managed by the comprehensive home care provider must be given to the client or the client's representative when the client's service plan ends or medication management services are no longer part of the service plan. Medications that have been stored in the client's private living space for a client that is deceased or that have been discontinued or that have expired may be given to the client or the client's representative for disposal.

(b) The comprehensive home care provider will dispose of any medications remaining with the comprehensive home care provider that are discontinued or expired or upon the termination of the service contract or the client's death according to state and federal regulations for disposition of medications and controlled substances.

(c) Upon disposition, the comprehensive home care provider must document in the client's record the disposition of the medication including the medication's name, strength,

prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.

Subd. 23. **Loss or spillage.** (a) Comprehensive home care providers providing medication management must develop and implement procedures for loss or spillage of all controlled substances defined in Minnesota Rules, part 6800.4220. These procedures must require that when a spillage of a controlled substance occurs, a notation must be made in the client's record explaining the spillage and the actions taken. The notation must be signed by the person responsible for the spillage and include verification that any contaminated substance was disposed of according to state or federal regulations.

(b) The procedures must require the comprehensive home care provider of medication management to investigate any known loss or unaccounted for prescription drugs and take appropriate action required under state or federal regulations and document the investigation in required records.

Sec. 16. **[144A.4793] TREATMENT AND THERAPY MANAGEMENT SERVICES.**

Subdivision 1. **Providers with a comprehensive home care license.** This section applies only to home care providers with a comprehensive home care license that provide treatment or therapy management services to clients. Treatment or therapy management services cannot be provided by a home care provider that has a basic home care license.

Subd. 2. **Policies and procedures.** (a) A comprehensive home care provider who provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines.

(b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting of treatment or therapy activities, educating and communicating with clients about treatments or therapy they are receiving, monitoring and evaluating the treatment and therapy, and communicating with the prescriber.

Subd. 3. **Individualized treatment or therapy management plan.** For each client receiving management of ordered or prescribed treatments or therapy services, the comprehensive home care provider must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the client. The

provider must also develop and maintain a current individualized treatment and therapy management record for each client which must contain at least the following:

(1) a statement of the type of services that will be provided;

(2) documentation of specific client instructions relating to the treatments or therapy administration;

(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;

(4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and

(5) any client-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.

Subd. 4. **Administration of treatments and therapy.** Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the home care provider must ensure that the registered nurse or authorized licensed health professional has:

(1) instructed the unlicensed personnel in the proper methods with respect to each client and the unlicensed personnel has demonstrated the ability to competently follow the procedures;

(2) specified, in writing, specific instructions for each client and documented those instructions in the client's record; and

(3) communicated with the unlicensed personnel about the individual needs of the client.

Subd. 5. **Documentation of administration of treatments and therapies.** Each treatment or therapy administered by a comprehensive home care provider must be documented in the client's record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the client's needs.

Subd. 6. **Orders or prescriptions.** There must be an up-to-date written or electronically recorded order or prescription for all treatments and therapies. The order must contain the name of the client, description of the treatment or therapy to be provided, and the frequency and other information needed to administer the treatment or therapy.

Sec. 17. **[144A.4794] CLIENT RECORD REQUIREMENTS.**

Subdivision 1. **Client record.** (a) The home care provider must maintain records for each client for whom it is providing services. Entries in the client records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry.

(b) Client records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The home care provider shall establish and implement written procedures to control use, storage, and security of client's records and establish criteria for release of client information.

(c) The home care provider may not disclose to any other person any personal, financial, medical, or other information about the client, except:

(1) as may be required by law;

(2) to employees or contractors of the home care provider, another home care provider, other health care practitioner or provider, or inpatient facility needing information in order to provide services to the client, but only such information that is necessary for the provision of services;

(3) to persons authorized in writing by the client or the client's representative to receive the information, including third-party payers; and

(4) to representatives of the commissioner authorized to survey or investigate home care providers under this chapter or federal laws.

Subd. 2. **Access to records.** The home care provider must ensure that the appropriate records are readily available to employees or contractors authorized to access the records. Client records must be maintained in a manner that allows for timely access, printing, or transmission of the records.

Subd. 3. **Contents of client record.** Contents of a client record include the following for each client:

(1) identifying information, including the client's name, date of birth, address, and telephone number;

(2) the name, address, and telephone number of an emergency contact, family members, client's representative, if any, or others as identified;

(3) names, addresses, and telephone numbers of the client's health and medical service providers and other home care providers, if known;

(4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records;

(5) client's advance directives, if any;

(6) the home care provider's current and previous assessments and service plans;

(7) all records of communications pertinent to the client's home care services;

(8) documentation of significant changes in the client's status and actions taken in response to the needs of the client including reporting to the appropriate supervisor or health care professional;

(9) documentation of incidents involving the client and actions taken in response to the needs of the client including reporting to the appropriate supervisor or health care professional;

(10) documentation that services have been provided as identified in the service plan;

(11) documentation that the client has received and reviewed the home care bill of rights;

(12) documentation that the client has been provided the statement of disclosure on limitations of services under section 144A.4791, subdivision 3;

(13) documentation of complaints received and resolution;

(14) discharge summary, including service termination notice and related documentation, when applicable; and

(15) other documentation required under this chapter and relevant to the client's services or status.

Subd. 4. **Transfer of client records.** If a client transfers to another home care provider or other health care practitioner or provider, or is admitted to an inpatient facility, the home care provider, upon request of the client or the client's representative, shall take steps to ensure a coordinated transfer including sending a copy or summary of the client's record to the new home care provider, facility, or the client, as appropriate.

Subd. 5. **Record retention.** Following the client's discharge or termination of services, a home care provider must retain a client's record for at least five years, or as otherwise required by state or federal regulations. Arrangements must be made for secure storage and retrieval of client records if the home care provider ceases business.

Sec. 18. **[144A.4795] HOME CARE PROVIDER RESPONSIBILITIES; STAFF.**

Subdivision 1. **Qualifications, training, and competency.** All staff providing home care services must be trained and competent in the provision of home care services consistent with current practice standards appropriate to the client's needs.

Subd. 2. **Licensed health professionals and nurses.** (a) Licensed health professionals and nurses providing home care services as an employee of a licensed home care provider must possess current Minnesota license or registration to practice.

(b) Licensed health professionals and registered nurses must be competent in assessing client needs, planning appropriate home care services to meet client needs, implementing services, and supervising staff if assigned.

(c) Nothing in this section limits or expands the rights of nurses or licensed health professionals to provide services within the scope of their licenses or registrations, as provided by law.

Subd. 3. **Unlicensed personnel.** (a) Unlicensed personnel providing basic home care services must have:

(1) successfully completed a training and competency evaluation appropriate to the services provided by the home care provider and the topics listed in subdivision 7, paragraph (b); or

(2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and in the topics listed in subdivision 7, paragraph (b); and successfully demonstrate competency of topics in subdivision 7, paragraph (b), clauses (5), (7), and (8), by a practical skills test.

Unlicensed personnel providing home care services for a basic home care provider may not perform delegated nursing or therapy tasks.

(b) Unlicensed personnel performing delegated nursing tasks for a comprehensive home care provider must have:

(1) successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in subdivision 7, paragraphs (b) and (c), and a practical skills test on tasks listed in subdivision 7, paragraphs (b), clauses (5) and (7), and (c), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; or

(2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or section 484.36; or

(3) before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner.

(c) Unlicensed personnel performing therapy or treatment tasks delegated or assigned by a licensed health professional must meet the requirements for delegated

tasks in subdivision 4 and any other training or competency requirements within the licensed health professional scope of practice relating to delegation or assignment of tasks to unlicensed personnel.

Subd. 4. **Delegation of home care tasks.** A registered nurse or licensed health professional may delegate tasks only to staff that are competent and possess the knowledge and skills consistent with the complexity of the tasks and according to the appropriate Minnesota Practice Act. The comprehensive home care provider must establish and implement a system to communicate up-to-date information to the registered nurse or licensed health professional regarding the current available staff and their competency so the registered nurse or licensed health professional has sufficient information to determine the appropriateness of delegating tasks to meet individual client needs and preferences.

Subd. 5. **Individual contractors.** When a home care provider contracts with an individual contractor excluded from licensure under section 144A.471 to provide home care services, the contractor must meet the same requirements required by this section for personnel employed by the home care provider.

Subd. 6. **Temporary staff.** When a home care provider contracts with a temporary staffing agency excluded from licensure under section 144A.471, those individuals must meet the same requirements required by this section for personnel employed by the home care provider and shall be treated as if they are staff of the home care provider.

Subd. 7. **Requirements for instructors, training content, and competency evaluations for unlicensed personnel.** (a) Instructors and competency evaluators must meet the following requirements:

(1) training and competency evaluations of unlicensed personnel providing basic home care services must be conducted by individuals with work experience and training in providing home care services listed in section 144A.471, subdivisions 6 and 7; and

(2) training and competency evaluations of unlicensed personnel providing comprehensive home care services must be conducted by a registered nurse, or another instructor may provide training in conjunction with the registered nurse. If the home care provider is providing services by licensed health professionals only, then that specific training and competency evaluation may be conducted by the licensed health professionals as appropriate.

(b) Training and competency evaluations for all unlicensed personnel must include the following:

(1) documentation requirements for all services provided;

(2) reports of changes in the client's condition to the supervisor designated by the home care provider;

(3) basic infection control, including blood-borne pathogens;

(4) maintenance of a clean and safe environment;

(5) appropriate and safe techniques in personal hygiene and grooming, including:

(i) hair care and bathing;

(ii) care of teeth, gums, and oral prosthetic devices;

(iii) care and use of hearing aids; and

(iv) dressing and assisting with toileting;

(6) training on the prevention of falls for providers working with the elderly or individuals at risk of falls;

(7) standby assistance techniques and how to perform them;

(8) medication, exercise, and treatment reminders;

(9) basic nutrition, meal preparation, food safety, and assistance with eating;

(10) preparation of modified diets as ordered by a licensed health professional;

(11) communication skills that include preserving the dignity of the client and showing respect for the client and the client's preferences, cultural background, and family;

(12) awareness of confidentiality and privacy;

(13) understanding appropriate boundaries between staff and clients and the client's family;

(14) procedures to utilize in handling various emergency situations; and

(15) awareness of commonly used health technology equipment and assistive devices.

(c) In addition to paragraph (b), training and competency evaluation for unlicensed personnel providing comprehensive home care services must include:

(1) observation, reporting, and documenting of client status;

(2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel;

(3) reading and recording temperature, pulse, and respirations of the client;

(4) recognizing physical, emotional, cognitive, and developmental needs of the client;

(5) safe transfer techniques and ambulation;

(6) range of motioning and positioning; and

(7) administering medications or treatments as required.

(d) When the registered nurse or licensed health professional delegates tasks, they must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed the delegated home care task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task

to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the client's record.

Sec. 19. **[144A.4796] ORIENTATION AND ANNUAL TRAINING REQUIREMENTS.**

Subdivision 1. **Orientation of staff and supervisors to home care.** All staff providing and supervising direct home care services must complete an orientation to home care licensing requirements and regulations before providing home care services to clients. The orientation may be incorporated into the training required under subdivision 6. The orientation need only be completed once for each staff person and is not transferable to another home care provider.

Subd. 2. **Content.** The orientation must contain the following topics:

(1) an overview of sections 144A.43 to 144A.4798;

(2) introduction and review of all the provider's policies and procedures related to the provision of home care services;

(3) handling of emergencies and use of emergency services;

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

(5) home care bill of rights, under section 144A.44;

(6) handling of clients' complaints; reporting of complaints and where to report complaints including information on the Office of Health Facility Complaints and the Common Entry Point;

(7) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county managed care advocates, or other relevant advocacy services; and

(8) review of the types of home care services the employee will be providing and the provider's scope of licensure.

Subd. 3. **Verification and documentation of orientation.** Each home care provider shall retain evidence in the employee record of each staff person having completed the orientation required by this section.

Subd. 4. **Orientation to client.** Staff providing home care services must be oriented specifically to each individual client and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically.

Subd. 5. **Training required relating to Alzheimer's disease and related disorders.** For home care providers that provide services for persons with Alzheimer's or related disorders, all direct care staff and supervisors working with those clients must receive training that includes a current explanation of Alzheimer's disease and related disorders, effective approaches to use to problem solve when working with a client's challenging behaviors, and how to communicate with clients who have Alzheimer's or related disorders.

Subd. 6. **Required annual training.** All staff that perform direct home care services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the home care provider or another source and must include topics relevant to the provision of home care services. The annual training must include:

(1) training on reporting of maltreatment of minors under section 626.556 and maltreatment of vulnerable adults under section 626.557, whichever is applicable to the services provided;

(2) review of the home care bill of rights in section 144A.44;

(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting of communicable diseases; and

(4) review of the provider's policies and procedures relating to the provision of home care services and how to implement those policies and procedures.

Subd. 7. **Documentation.** A home care provider must retain documentation in the employee records of the staff that have satisfied the orientation and training requirements of this section.

Sec. 20. **[144A.4797] PROVISION OF SERVICES.**

Subdivision 1. **Availability of contact person to staff.** (a) A home care provider with a basic home care license must have a person available to staff for consultation on items relating to the provision of services or about the client.

(b) A home care provider with a comprehensive home care license must have a registered nurse available for consultation to staff performing delegated nursing tasks and must have an appropriate licensed health professional available if performing other delegated services such as therapies.

(c) The appropriate contact person must be readily available either in person, by telephone, or by other means to the staff at times when the staff is providing services.

Subd. 2. **Supervision of staff; basic home care services.** (a) Staff who perform basic home care services must be supervised periodically where the services are being provided to verify that the work is being performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. The supervision of the unlicensed personnel must be done by staff of the home care provider having the authority, skills, and ability to provide the supervision of unlicensed personnel and who can implement changes as needed, and train staff.

(b) Supervision includes direct observation of unlicensed personnel while they are providing the services and may also include indirect methods of gaining input such as gathering feedback from the client. Supervisory review of staff must be provided at a frequency based on the staff person's competency and performance.

(c) For an individual who is licensed as a home care provider, this section does not apply.

Subd. 3. **Supervision of staff providing delegated nursing or therapy home care tasks.** (a) Staff who perform delegated nursing or therapy home care tasks must be supervised by an appropriate licensed health professional or a registered nurse periodically where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the client.

(b) The direct supervision of staff performing delegated tasks must be provided within 30 days after the individual begins working for the home care provider and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.

Subd. 4. **Documentation.** A home care provider must retain documentation of supervision activities in the personnel records.

Subd. 5. **Exemption.** This section does not apply to an individual licensed under sections 144A.43 to 144A.4799.

Sec. 21. **[144A.4798] EMPLOYEE HEALTH STATUS.**

Subdivision 1. **Tuberculosis (TB) prevention and control.** A home care provider must establish and maintain a TB prevention and control program based on the most

current guidelines issued by the Centers for Disease Control and Prevention (CDC). Components of a TB prevention and control program include screening all staff providing home care services, both paid and unpaid, at the time of hire for active TB disease and latent TB infection, and developing and implementing a written TB infection control plan. The commissioner shall make the most recent CDC standards available to home care providers on the department's Web site.

Subd. 2. **Communicable diseases.** A home care provider must follow current federal or state guidelines for prevention, control, and reporting of human immunodeficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus, or other communicable diseases as defined in Minnesota Rules, part 4605.7040.

Sec. 22. **[144A.4799] DEPARTMENT OF HEALTH LICENSED HOME CARE PROVIDER ADVISORY COUNCIL.**

Subdivision 1. **Membership.** The commissioner of health shall appoint eight persons to a home care provider advisory council consisting of the following:

(1) three public members as defined in section 214.02 who shall be either persons who are currently receiving home care services or have family members receiving home care services, or persons who have family members who have received home care services within five years of the application date;

(2) three Minnesota home care licensees representing basic and comprehensive levels of licensure who may be a managerial official, an administrator, a supervising registered nurse, or an unlicensed personnel performing home care tasks;

(3) one member representing the Minnesota Board of Nursing; and

(4) one member representing the ombudsman for long-term care.

Subd. 2. **Organizations and meetings.** The advisory council shall be organized and administered under section 15.059 with per diems and costs paid within the limits of available appropriations. Meetings will be held quarterly and hosted by the department. Subcommittees may be developed as necessary by the commissioner. Advisory council meetings are subject to the Open Meeting Law under chapter 13D.

Subd. 3. **Duties.** At the commissioner's request, the advisory council shall provide advice regarding regulations of Department of Health licensed home care providers in this chapter such as:

(1) advice to the commissioner regarding community standards for home care practices;

(2) advice to the commissioner on enforcement of licensing standards and whether certain disciplinary actions are appropriate;

(3) advice to the commissioner about ways of distributing information to licensees and consumers of home care;

(4) advice to the commissioner about training standards;

(5) identify emerging issues and opportunities in the home care field, including the use of technology in home and telehealth capabilities; and

(6) perform other duties as directed by the commissioner.

Sec. 23. **[144A.481] HOME CARE LICENSING IMPLEMENTATION FOR NEW LICENSEES AND TRANSITION PERIOD FOR CURRENT LICENSEES.**

Subdivision 1. **Temporary home care licenses and changes of ownership.** (a) Beginning January 1, 2014, all temporary license applicants must apply for either a temporary basic or comprehensive home care license.

(b) Temporary home care licenses issued beginning January 1, 2014, shall be issued to licensees according to sections 144A.43 to 144A.4799, and the fees in section 144A.472. Licensees must comply with the requirements of this chapter.

(c) No temporary licenses will be accepted or issued between October 1, 2013, and December 31, 2013.

(d) Beginning October 1, 2013, changes in ownership applications will require payment of the new fees listed in section 144A.472.

Subd. 2. **Current home care licensees with licenses prior to July 1, 2013.** (a) Beginning July 1, 2014, department licensed home care providers must apply for either the basic or comprehensive home care license on their regularly scheduled renewal date.

(b) By June 30, 2015, all home care providers must either have a basic or comprehensive home care license or temporary license.

Subd. 3. **Renewal application of home care licensure during transition period.** Renewal of home care licenses issued beginning July 1, 2014, will be issued according to sections 144A.43 to 144A.4799 and, upon license renewal, providers must comply with sections 144A.43 to 144A.4799. Prior to renewal, providers must comply with the home care licensure law in effect on June 30, 2013.

The fees charged for licenses renewed between July 1, 2014, and June 30, 2016, shall be the lesser of 200 percent or $1,000, except where the 200 percent or $1,000 increase exceeds the actual renewal fee charged, with a maximum renewal fee of $6,625.

For fiscal year 2014 only, the fees for providers with revenues greater than $25,000 and no more than $100,000 will be $313 and for providers with revenues no more than $25,000 the fee will be $125.

Sec. 24. **[144A.482] REGISTRATION OF HOME MANAGEMENT PROVIDERS.**

(a) For purposes of this section, a home management provider is an individual or organization that provides at least two of the following services: housekeeping, meal preparation, and shopping to a person who is unable to perform these activities due to illness, disability, or physical condition.

(b) A person or organization that provides only home management services 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, mailing and physical addresses, e-mail 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 home care bill of rights provisions contained in section 144A.44. A person or organization applying for a certificate must also provide the name, business address, and telephone number of each of the persons responsible for the management or direction of the organization.

(c) The commissioner shall charge an annual registration fee of $20 for persons and $50 for organizations. The registration fee shall be deposited in the state treasury and credited to the state government special revenue fund.

(d) 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.

(e) An individual 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 home care bill of rights and an orientation on the aging process and the needs and concerns of elderly and disabled persons.

(f) 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 home care 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. Fines collected under this paragraph shall be deposited in the state treasury and credited to the fund specified in the statute or rule in which the penalty was established.

(g) The commissioner may use any of the powers granted in sections 144A.43 to 144A.4799 to administer the registration system and enforce the home care bill of rights under this section.

ARTICLE 5

HEALTH DEPARTMENT

Section 1. **[149A.54] LICENSE TO OPERATE AN ALKALINE HYDROLYSIS FACILITY.**

Subdivision 1. **License requirement.** Except as provided in section 149A.01, subdivision 3, a place or premise shall not be maintained, managed, or operated which is devoted to or used in the holding and alkaline hydrolysis of a dead human body without possessing a valid license to operate an alkaline hydrolysis facility issued by the commissioner of health.

Subd. 2. **Requirements for an alkaline hydrolysis facility.** (a) An alkaline hydrolysis facility licensed under this section must consist of:

(1) a building or structure that complies with applicable local and state building codes, zoning laws and ordinances, wastewater management and environmental standards, containing one or more alkaline hydrolysis vessels for the alkaline hydrolysis of dead human bodies;

(2) a method approved by the commissioner of health to dry the hydrolyzed remains and which is located within the licensed facility;

(3) a means approved by the commissioner of health for refrigeration of dead human bodies awaiting alkaline hydrolysis;

(4) an appropriate means of processing hydrolyzed remains to a granulated appearance appropriate for final disposition; and

(5) an appropriate holding facility for dead human bodies awaiting alkaline hydrolysis.

(b) An alkaline hydrolysis facility licensed under this section may also contain a display room for funeral goods.

Subd. 3. **Application procedure; documentation; initial inspection.** An application to license and operate an alkaline hydrolysis facility shall be submitted to the commissioner of health. A completed application includes:

(1) a completed application form, as provided by the commissioner;

(2) proof of business form and ownership;

(3) proof of liability insurance coverage or other financial documentation, as determined by the commissioner, that demonstrates the applicant's ability to respond in damages for liability arising from the ownership, maintenance management, or operation of an alkaline hydrolysis facility; and

(4) copies of wastewater and other environmental regulatory permits and environmental regulatory licenses necessary to conduct operations.

Upon receipt of the application and appropriate fee, the commissioner shall review and verify all information. Upon completion of the verification process and resolution of any deficiencies in the application information, the commissioner shall conduct an initial inspection of the premises to be licensed. After the inspection and resolution of any deficiencies found and any reinspections as may be necessary, the commissioner shall make a determination, based on all the information available, to grant or deny licensure. If the commissioner's determination is to grant the license, the applicant shall be notified and the license shall issue and remain valid for a period prescribed on the license, but not to exceed one calendar year from the date of issuance of the license. If the commissioner's determination is to deny the license, the commissioner must notify the applicant in writing of the denial and provide the specific reason for denial.

Subd. 4. **Nontransferability of license.** A license to operate an alkaline hydrolysis facility is not assignable or transferable and shall not be valid for any entity other than the one named. Each license issued to operate an alkaline hydrolysis facility is valid only for the location identified on the license. A 50 percent or more change in ownership or location of the alkaline hydrolysis facility automatically terminates the license. Separate licenses shall be required of two or more persons or other legal entities operating from the same location.

Subd. 5. **Display of license.** Each license to operate an alkaline hydrolysis facility must be conspicuously displayed in the alkaline hydrolysis facility at all times. Conspicuous display means in a location where a member of the general public within the alkaline hydrolysis facility will be able to observe and read the license.

Subd. 6. **Period of licensure.** All licenses to operate an alkaline hydrolysis facility issued by the commissioner are valid for a period of one calendar year beginning on July 1 and ending on June 30, regardless of the date of issuance.

Subd. 7. **Reporting changes in license information.** Any change of license information must be reported to the commissioner, on forms provided by the commissioner, no later than 30 calendar days after the change occurs. Failure to report changes is grounds for disciplinary action.

Subd. 8. **Notification to the commissioner.** If the licensee is operating under a wastewater or an environmental permit or license that is subsequently revoked, denied, or terminated, the licensee shall notify the commissioner.

Subd. 9. **Application information.** All information submitted to the commissioner for a license to operate an alkaline hydrolysis facility is classified as licensing data under section 13.41, subdivision 5.

Sec. 2. **[149A.55] RENEWAL OF LICENSE TO OPERATE AN ALKALINE HYDROLYSIS FACILITY.**

Subdivision 1. **Renewal required.** All licenses to operate an alkaline hydrolysis facility issued by the commissioner expire on June 30 following the date of issuance of the license and must be renewed to remain valid.

Subd. 2. **Renewal procedure and documentation.** Licensees who wish to renew their licenses must submit to the commissioner a completed renewal application no later than June 30 following the date the license was issued. A completed renewal application includes:

(1) a completed renewal application form, as provided by the commissioner; and

(2) proof of liability insurance coverage or other financial documentation, as determined by the commissioner, that demonstrates the applicant's ability to respond in damages for liability arising from the ownership, maintenance, management, or operation of an alkaline hydrolysis facility.

Upon receipt of the completed renewal application, the commissioner shall review and verify the information. Upon completion of the verification process and resolution of any deficiencies in the renewal application information, the commissioner shall make a determination, based on all the information available, to reissue or refuse to reissue the license. If the commissioner's determination is to reissue the license, the applicant shall be notified and the license shall issue and remain valid for a period prescribed on the license, but not to exceed one calendar year from the date of issuance of the license. If the commissioner's determination is to refuse to reissue the license, section 149A.09, subdivision 2, applies.

Subd. 3. **Penalty for late filing.** Renewal applications received after the expiration date of a license will result in the assessment of a late filing penalty. The late filing penalty must be paid before the reissuance of the license and received by the commissioner no later than 31 calendar days after the expiration date of the license.

Subd. 4. **Lapse of license.** Licenses to operate alkaline hydrolysis facilities shall automatically lapse when a completed renewal application is not received by the

commissioner within 31 calendar days after the expiration date of a license, or a late filing penalty assessed under subdivision 3 is not received by the commissioner within 31 calendar days after the expiration of a license.

Subd. 5. **Effect of lapse of license.** Upon the lapse of a license, the person to whom the license was issued is no longer licensed to operate an alkaline hydrolysis facility in Minnesota. The commissioner shall issue a cease and desist order to prevent the lapsed license holder from operating an alkaline hydrolysis facility in Minnesota and may pursue any additional lawful remedies as justified by the case.

Subd. 6. **Restoration of lapsed license.** The commissioner may restore a lapsed license upon receipt and review of a completed renewal application, receipt of the late filing penalty, and reinspection of the premises, provided that the receipt is made within one calendar year from the expiration date of the lapsed license and the cease and desist order issued by the commissioner has not been violated. If a lapsed license is not restored within one calendar year from the expiration date of the lapsed license, the holder of the lapsed license cannot be relicensed until the requirements in section 149A.54 are met.

Subd. 7. **Reporting changes in license information.** Any change of license information must be reported to the commissioner, on forms provided by the commissioner, no later than 30 calendar days after the change occurs. Failure to report changes is grounds for disciplinary action.

Subd. 8. **Application information.** All information submitted to the commissioner by an applicant for renewal of licensure to operate an alkaline hydrolysis facility is classified as licensing data under section 13.41, subdivision 5.

Sec. 3. **[149A.941] ALKALINE HYDROLYSIS FACILITIES AND ALKALINE HYDROLYSIS.**

Subdivision 1. **License required.** A dead human body may only be hydrolyzed in this state at an alkaline hydrolysis facility licensed by the commissioner of health.

Subd. 2. **General requirements.** Any building to be used as an alkaline hydrolysis facility must comply with all applicable local and state building codes, zoning laws and ordinances, wastewater management regulations, and environmental statutes, rules, and standards. An alkaline hydrolysis facility must have, on site, a purpose built human alkaline hydrolysis system approved by the commissioner of health, a system approved by the commissioner of health for drying the hydrolyzed remains, a motorized mechanical device approved by the commissioner of health for processing hydrolyzed remains and must have in the building a holding facility approved by the commissioner of health for the retention of dead human bodies awaiting alkaline hydrolysis. The holding facility

must be secure from access by anyone except the authorized personnel of the alkaline hydrolysis facility, preserve the dignity of the remains, and protect the health and safety of the alkaline hydrolysis facility personnel.

Subd. 3. **Lighting and ventilation.** The room where the alkaline hydrolysis vessel is located and the room where the chemical storage takes place shall be properly lit and ventilated with an exhaust fan that provides at least 12 air changes per hour.

Subd. 4. **Plumbing connections.** All plumbing fixtures, water supply lines, plumbing vents, and waste drains shall be properly vented and connected pursuant to the Minnesota Plumbing Code. The alkaline hydrolysis facility shall be equipped with a functional sink with hot and cold running water.

Subd. 5. **Flooring, walls, ceiling, doors, and windows.** The room where the alkaline hydrolysis vessel is located and the room where the chemical storage takes place shall have nonporous flooring, so that a sanitary condition is provided. The walls and ceiling of the room where the alkaline hydrolysis vessel is located and the room where the chemical storage takes place shall run from floor to ceiling and be covered with tile, or by plaster or sheetrock painted with washable paint or other appropriate material so that a sanitary condition is provided. The doors, walls, ceiling, and windows shall be constructed to prevent odors from entering any other part of the building. All windows or other openings to the outside must be screened and all windows must be treated in a manner that prevents viewing into the room where the alkaline hydrolysis vessel is located and the room where the chemical storage takes place. A viewing window for authorized family members or their designees is not a violation of this subdivision.

Subd. 6. **Equipment and supplies.** The alkaline hydrolysis facility must have a functional emergency eye wash and quick drench shower.

Subd. 7. **Access and privacy.** (a) The room where the alkaline hydrolysis vessel is located and the room where the chemical storage takes place must be private and have no general passageway through it. The room shall, at all times, be secure from the entrance of unauthorized persons. Authorized persons are:

(1) licensed morticians;

(2) registered interns or students as described in section 149A.91, subdivision 6;

(3) public officials or representatives in the discharge of their official duties;

(4) trained alkaline hydrolysis facility operators; and

(5) the person(s) with the right to control the dead human body as defined in section 149A.80, subdivision 2, and their designees.

(b) Each door allowing ingress or egress shall carry a sign that indicates that the room is private and access is limited. All authorized persons who are present in or enter

the room where the alkaline hydrolysis vessel is located while a body is being prepared for final disposition must be attired according to all applicable state and federal regulations regarding the control of infectious disease and occupational and workplace health and safety.

Subd. 8. **Sanitary conditions and permitted use.** The room where the alkaline hydrolysis vessel is located and the room where the chemical storage takes place and all fixtures, equipment, instruments, receptacles, clothing, and other appliances or supplies stored or used in the room must be maintained in a clean and sanitary condition at all times.

Subd. 9. **Boiler use.** When a boiler is required by the manufacturer of the alkaline hydrolysis vessel for its operation, all state and local regulations for that boiler must be followed.

Subd. 10. **Occupational and workplace safety.** All applicable provisions of state and federal regulations regarding exposure to workplace hazards and accidents shall be followed in order to protect the health and safety of all authorized persons at the alkaline hydrolysis facility.

Subd. 11. **Licensed personnel.** A licensed alkaline hydrolysis facility must employ a licensed mortician to carry out the process of alkaline hydrolysis of a dead human body. It is the duty of the licensed alkaline hydrolysis facility to provide proper procedures for all personnel, and the licensed alkaline hydrolysis facility shall be strictly accountable for compliance with this chapter and other applicable state and federal regulations regarding occupational and workplace health and safety.

Subd. 12. **Authorization to hydrolyze required.** No alkaline hydrolysis facility shall hydrolyze or cause to be hydrolyzed any dead human body or identifiable body part without receiving written authorization to do so from the person or persons who have the legal right to control disposition as described in section 149A.80 or the person's legal designee. The written authorization must include:

(1) the name of the deceased and the date of death of the deceased;

(2) a statement authorizing the alkaline hydrolysis facility to hydrolyze the body;

(3) the name, address, telephone number, relationship to the deceased, and signature of the person or persons with legal right to control final disposition or a legal designee;

(4) directions for the disposition of any nonhydrolyzed materials or items recovered from the alkaline hydrolysis vessel;

(5) acknowledgment that the hydrolyzed remains will be dried and mechanically reduced to a granulated appearance and placed in an appropriate container and authorization to place any hydrolyzed remains that a selected urn or container will not accommodate into a temporary container;

(6) acknowledgment that, even with the exercise of reasonable care, it is not possible to recover all particles of the hydrolyzed remains and that some particles may inadvertently become commingled with particles of other hydrolyzed remains that remain in the alkaline hydrolysis vessel or other mechanical devices used to process the hydrolyzed remains;

(7) directions for the ultimate disposition of the hydrolyzed remains; and

(8) a statement that includes, but is not limited to, the following information: "During the alkaline hydrolysis process, chemical dissolution using heat, water, and an alkaline solution is used to chemically break down the human tissue and the hydrolyzable alkaline hydrolysis container. After the process is complete, the liquid effluent solution contains the chemical by-products of the alkaline hydrolysis process except for the deceased's bone fragments. The solution is cooled and released according to local environmental regulations. A water rinse is applied to the hydrolyzed remains which are then dried and processed to facilitate inurnment or scattering."

Subd. 13. **Limitation of liability.** A licensed alkaline hydrolysis facility acting in good faith, with reasonable reliance upon an authorization to hydrolyze, pursuant to an authorization to hydrolyze and in an otherwise lawful manner, shall be held harmless from civil liability and criminal prosecution for any actions taken by the alkaline hydrolysis facility.

Subd. 14. **Acceptance of delivery of body.** (a) No dead human body shall be accepted for final disposition by alkaline hydrolysis unless:

(1) encased in an appropriate alkaline hydrolysis container;

(2) accompanied by a disposition permit issued pursuant to section 149A.93, subdivision 3, including a photocopy of the completed death record or a signed release authorizing alkaline hydrolysis of the body received from the coroner or medical examiner; and

(3) accompanied by an alkaline hydrolysis authorization that complies with subdivision 12.

(b) An alkaline hydrolysis facility shall refuse to accept delivery of an alkaline hydrolysis container where there is:

(1) evidence of leakage of fluids from the alkaline hydrolysis container;

(2) a known dispute concerning hydrolysis of the body delivered;

(3) a reasonable basis for questioning any of the representations made on the written authorization to hydrolyze; or

(4) any other lawful reason.

Subd. 15. **Bodies awaiting hydrolysis.** A dead human body must be hydrolyzed within 24 hours of the alkaline hydrolysis facility accepting legal and physical custody of the body.

Subd. 16. **Handling of alkaline hydrolysis containers for dead human bodies.** All alkaline hydrolysis facility employees handling alkaline hydrolysis containers for dead human bodies shall use universal precautions and otherwise exercise all reasonable precautions to minimize the risk of transmitting any communicable disease from the body. No dead human body shall be removed from the container in which it is delivered.

Subd. 17. **Identification of body.** All licensed alkaline hydrolysis facilities shall develop, implement, and maintain an identification procedure whereby dead human bodes can be identified from the time the alkaline hydrolysis facility accepts delivery of the remains until the hydrolyzed remains are released to an authorized party. After hydrolyzation, an identifying disk, tab, or other permanent label shall be placed within the hydrolyzed remains container before the hydrolyzed remains are released from the alkaline hydrolysis facility. Each identification disk, tab, or label shall have a number that shall be recorded on all paperwork regarding the decedent. This procedure shall be designed to reasonably ensure that the proper body is hydrolyzed and that the hydrolyzed remains are returned to the appropriate party. Loss of all or part of the hydrolyzed remains or the inability to individually identify the hydrolyzed remains is a violation of this subdivision.

Subd. 18. **Alkaline hydrolysis vessel for human remains.** A licensed alkaline hydrolysis facility shall knowingly hydrolyze only dead human bodies or human remains in an alkaline hydrolysis vessel, along with the alkaline hydrolysis container used for infectious disease control.

Subd. 19. **Alkaline hydrolysis procedures; privacy.** The final disposition of dead human bodies by alkaline hydrolysis shall be done in privacy. Unless there is written authorization from the person with the legal right to control the disposition, only authorized alkaline hydrolysis facility personnel shall be permitted in the alkaline hydrolysis area while any dead human body is in the alkaline hydrolysis area awaiting alkaline hydrolysis, in the alkaline hydrolysis vessel, being removed from the alkaline hydrolysis vessel, or being processed and placed in a hydrolyzed remains container.

Subd. 20. **Alkaline hydrolysis procedures; commingling of hydrolyzed remains prohibited.** Except with the express written permission of the person with the legal right to control the disposition, no alkaline hydrolysis facility shall hydrolyze more than one dead human body at the same time and in the same alkaline hydrolysis vessel, or introduce a second dead human body into an alkaline hydrolysis vessel until reasonable efforts have been employed to remove all fragments of the preceding hydrolyzed remains, or hydrolyze

a dead human body and other human remains at the same time and in the same alkaline hydrolysis vessel. This section does not apply where commingling of human remains during alkaline hydrolysis is otherwise provided by law. The fact that there is incidental and unavoidable residue in the alkaline hydrolysis vessel used in a prior hydrolyzation is not a violation of this subdivision.

Subd. 21. **Alkaline hydrolysis procedures; removal from alkaline hydrolysis vessel.** Upon completion of the alkaline hydrolysis process, reasonable efforts shall be made to remove from the alkaline hydrolysis vessel all of the recoverable hydrolyzed remains and nonhydrolyzed materials or items. Further, all reasonable efforts shall be made to separate and recover the nonhydrolyzed materials or items from the hydrolyzed human remains and dispose of these materials in a lawful manner, by the alkaline hydrolysis facility. The hydrolyzed human remains shall be placed in an appropriate container to be transported to the processing area.

Subd. 22. **Drying device or mechanical processor procedures; commingling of hydrolyzed remains prohibited.** Except with the express written permission of the person with the legal right to control the final disposition or otherwise provided by law, no alkaline hydrolysis facility shall dry or mechanically process the hydrolyzed human remains of more than one body at a time in the same drying device or mechanical processor, or introduce the hydrolyzed human remains of a second body into a drying device or mechanical processor until processing of any preceding hydrolyzed human remains has been terminated and reasonable efforts have been employed to remove all fragments of the preceding hydrolyzed remains. The fact that there is incidental and unavoidable residue in the drying device, the mechanical processor, or any container used in a prior alkaline hydrolysis process, is not a violation of this provision.

Subd. 23. **Alkaline hydrolysis procedures; processing hydrolyzed remains.** The hydrolyzed human remains shall be dried and then reduced by a motorized mechanical device to a granulated appearance appropriate for final disposition and placed in an alkaline hydrolysis remains container along with the appropriate identifying disk, tab, or permanent label. Processing must take place within the licensed alkaline hydrolysis facility. Dental gold, silver or amalgam, jewelry, or mementos, to the extent that they can be identified, may be removed prior to processing the hydrolyzed remains, only by staff licensed or registered by the commissioner of health; however, any dental gold and silver, jewelry, or mementos that are removed shall be returned to the hydrolyzed remains container unless otherwise directed by the person or persons having the right to control the final disposition. Every person who removes or possesses dental gold or silver, jewelry, or mementos from any hydrolyzed remains without specific written permission of the

person or persons having the right to control those remains is guilty of a misdemeanor. The fact that residue and any unavoidable dental gold or dental silver, or other precious metals remain in the alkaline hydrolysis vessel or other equipment or any container used in a prior hydrolysis is not a violation of this section.

Subd. 24. **Alkaline hydrolysis procedures; container of insufficient capacity.** If a hydrolyzed remains container is of insufficient capacity to accommodate all hydrolyzed remains of a given dead human body, subject to directives provided in the written authorization to hydrolyze, the alkaline hydrolysis facility shall place the excess hydrolyzed remains in a secondary alkaline hydrolysis remains container and attach the second container, in a manner so as not to be easily detached through incidental contact, to the primary alkaline hydrolysis remains container. The secondary container shall contain a duplicate of the identification disk, tab, or permanent label that was placed in the primary container and all paperwork regarding the given body shall include a notation that the hydrolyzed remains were placed in two containers. Keepsake jewelry or similar miniature hydrolyzed remains containers are not subject to the requirements of this subdivision.

Subd. 25. **Disposition procedures; commingling of hydrolyzed remains prohibited.** No hydrolyzed remains shall be disposed of or scattered in a manner or in a location where the hydrolyzed remains are commingled with those of another person without the express written permission of the person with the legal right to control disposition or as otherwise provided by law. This subdivision does not apply to the scattering or burial of hydrolyzed remains at sea or in a body of water from individual containers, to the scattering or burial of hydrolyzed remains in a dedicated cemetery, to the disposal in a dedicated cemetery of accumulated residue removed from an alkaline hydrolysis vessel or other alkaline hydrolysis equipment, to the inurnment of members of the same family in a common container designed for the hydrolyzed remains of more than one body, or to the inurnment in a container or interment in a space that has been previously designated, at the time of sale or purchase, as being intended for the inurnment or interment of the hydrolyzed remains of more than one person.

Subd. 26. **Alkaline hydrolysis procedures; disposition of accumulated residue.** Every alkaline hydrolysis facility shall provide for the removal and disposition in a dedicated cemetery of any accumulated residue from any alkaline hydrolysis vessel, drying device, mechanical processor, container, or other equipment used in alkaline hydrolysis. Disposition of accumulated residue shall be according to the regulations of the dedicated cemetery and any applicable local ordinances.

Subd. 27. **Alkaline hydrolysis procedures; release of hydrolyzed remains.** Following completion of the hydrolyzation, the inurned hydrolyzed remains shall be

released according to the instructions given on the written authorization to hydrolyze. If the hydrolyzed remains are to be shipped, they must be securely packaged and transported by a method which has an internal tracing system available and which provides for a receipt signed by the person accepting delivery. Where there is a dispute over release or disposition of the hydrolyzed remains, an alkaline hydrolysis facility may deposit the hydrolyzed remains with a court of competent jurisdiction pending resolution of the dispute or retain the hydrolyzed remains until the person with the legal right to control disposition presents satisfactory indication that the dispute is resolved.

Subd. 28. **Unclaimed hydrolyzed remains.** If, after 30 calendar days following the inurnment, the hydrolyzed remains are not claimed or disposed of according to the written authorization to hydrolyze, the alkaline hydrolysis facility or funeral establishment may give written notice, by certified mail, to the person with the legal right to control the final disposition or a legal designee, that the hydrolyzed remains are unclaimed and requesting further release directions. Should the hydrolyzed remains be unclaimed 120 calendar days following the mailing of the written notification, the alkaline hydrolysis facility or funeral establishment may dispose of the hydrolyzed remains in any lawful manner deemed appropriate.

Subd. 29. **Required records.** Every alkaline hydrolysis facility shall create and maintain on its premises or other business location in Minnesota an accurate record of every hydrolyzation provided. The record shall include all of the following information for each hydrolyzation:

(1) the name of the person or funeral establishment delivering the body for alkaline hydrolysis;

(2) the name of the deceased and the identification number assigned to the body;

(3) the date of acceptance of delivery;

(4) the names of the alkaline hydrolysis vessel, drying device, and mechanical processor operator;

(5) the time and date that the body was placed in and removed from the alkaline hydrolysis vessel;

(6) the time and date that processing and inurnment of the hydrolyzed remains was completed;

(7) the time, date, and manner of release of the hydrolyzed remains;

(8) the name and address of the person who signed the authorization to hydrolyze;

(9) all supporting documentation, including any transit or disposition permits, a photocopy of the death record, and the authorization to hydrolyze; and

(10) the type of alkaline hydrolysis container.

Subd. 30. **Retention of records.** Records required under subdivision 29 shall be maintained for a period of three calendar years after the release of the hydrolyzed remains. Following this period and subject to any other laws requiring retention of records, the alkaline hydrolysis facility may then place the records in storage or reduce them to microfilm, microfiche, laser disc, or any other method that can produce an accurate reproduction of the original record, for retention for a period of ten calendar years from the date of release of the hydrolyzed remains. At the end of this period and subject to any other laws requiring retention of records, the alkaline hydrolysis facility may destroy the records by shredding, incineration, or any other manner that protects the privacy of the individuals identified.

Sec. 4. **STATE-BASED RISK ADJUSTMENT SYSTEM ASSESSMENT.**

(a) The commissioners of health, human services, and commerce, and the board of MNsure, shall study whether Minnesota-based risk adjustment of the individual and small group insurance market, using either the federal risk adjustment model or a state-based alternative, can be more cost-effective and perform better than risk adjustment conducted by federal agencies. The study shall assess the policies, infrastructure, and resources necessary to satisfy the requirements of Code of Federal Regulations, title 45, section 153, subpart D. The study shall also evaluate the extent to which Minnesota-based risk adjustment could meet requirements established in Code of Federal Regulations, title 45, section 153.330, including:

(1) explaining the variation in health care costs of a given population;

(2) linking risk factors to daily clinical practices and that which is clinically meaningful to providers;

(3) encouraging favorable behavior among health care market participants and discouraging unfavorable behavior;

(4) whether risk adjustment factors are relatively easy for stakeholders to understand and participate in;

(5) providing stable risk scores over time and across health plan products;

(6) minimizing administrative costs;

(7) accounting for risk selection across metal levels;

(8) aligning each of the elements of the methodology; and

(9) having a per-member cost equal to or lower than the projected cost of the federal risk adjustment model.

(b) In conducting the study, and notwithstanding Minnesota Rules, chapter 4653, and as part of responsibilities under Minnesota Statutes, section 62U.04, subdivision

4, paragraph (b), the commissioner of health shall collect from health carriers in the individual and small group health insurance market, beginning on January 1, 2014, and for service dates in calendar year 2014, all data required for conducting risk adjustment with standard risk adjusters such as the Adjusted Clinical Groups or the Hierarchical Condition Category System, including but not limited to:

(1) an indicator identifying the health plan product under which an enrollee is covered;

(2) an indicator identifying whether an enrollee's policy is an individual or small group market policy;

(3) an indicator identifying, if applicable, the metal level of an enrollee's health plan product, and whether the policy is a catastrophic policy; and

(4) additional identified demographic data necessary to link individuals' data across carriers and insurance affordability programs with 95 percent accuracy. The commissioner shall not collect more than the last four digits of an individual's Social Security number.

(c) The commissioner of health shall also assess the extent to which data collected under paragraph (b) and under Minnesota Statutes, section 62U.04, subdivision 4, paragraph (a), are sufficient for developing and operating a state alternative risk adjustment methodology consistent with applicable federal rules by evaluating:

(1) if the data submitted are adequately complete, accurate, and timely;

(2) if the data should be further enriched by nontraditional risk adjusters that help in better explaining variation in health care costs of a given population and account for risk selection across metal levels;

(3) whether additional data or identifiers have the potential to strengthen a Minnesota-based risk adjustment approach; and

(4) what, if any, changes to the technical infrastructure will be necessary to effectively perform state-based risk adjustment.

For purposes of this paragraph, the commissioner of health shall have the authority to use identified data to validate and audit a statistically valid sample of data for each health carrier in the individual and small group market. In conducting the study, the commissioners shall contract with entities that do not have an economic interest in the outcome of Minnesota-based risk adjustment but do have demonstrated expertise in actuarial science or health economics and demonstrated experience with designing and implementing risk adjustment models.

(d) The commissioner of human services shall evaluate opportunities to maximize federal funding under section 1331 of the federal Patient Protection and Affordable Care Act, Public Law 111-148, and further defined through amendments to the act and regulations issued under the act. The commissioner of human services shall make

recommendations on risk adjustment strategies to maximize federal funding to the state of Minnesota.

(e) The commissioners and board of MNsure shall submit to the legislature by March 15, 2014, an interim report with preliminary findings from the assessment conducted in paragraphs (c) and (d). The interim report shall include legislative recommendations for any necessary changes to Minnesota Statutes, section 62Q.03. A final report shall be submitted by the commissioners and board of MNsure to the legislature by October 1, 2015. The final report must include findings from the overall assessment and a recommendation whether to conduct state-based risk adjustment.

(f) For purposes of this section, "board of MNsure" means the board established under Minnesota Statutes, section 62V.03.

ARTICLE 6

CONTINUING CARE

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

Subd. 35. **Commissioner must annually report certain prepaid medical assistance plan data.** (a) The commissioners of human services and education may share private or nonpublic data to allow the commissioners to analyze the screening, diagnosis, and treatment of children with autism spectrum disorder and other developmental conditions. The commissioners may share the individual-level data necessary to:

(1) measure the prevalence of autism spectrum disorder and other developmental conditions;

(2) analyze the effectiveness of existing policies and procedures in the early identification of children with autism spectrum disorder and other developmental conditions;

(3) assess the effectiveness of screening, diagnosis, and treatment to allow children with autism spectrum disorder and other developmental conditions to meet developmental and social-emotional milestones;

(4) identify and address disparities in screening, diagnosis, and treatment related to the native language or race and ethnicity of the child;

(5) measure the effectiveness of public health care programs in addressing the medical needs of children with autism spectrum disorder and other developmental conditions; and

(6) determine the capacity of educational and health care systems to meet the needs of children with autism spectrum disorder and other developmental conditions.

(b) The commissioner of human services shall use the data shared with the commissioner of education under this subdivision to improve public health care program performance in early screening, diagnosis, and treatment for children once data are available and shall report on the results and any summary data, as defined in section 13.02, subdivision 19, on the department's Web site by September 30 of each year.

Sec. 2. **[256B.0949] AUTISM EARLY INTENSIVE INTERVENTION BENEFIT.**

Subdivision 1. **Purpose.** This section creates a new benefit available under the medical assistance state plan when federal approval consistent with the provisions in subdivision 11 is obtained for a 1915(i) waiver pursuant to the Affordable Care Act, section 2402(c), amending United States Code, title 42, section 1396n(i)(1), or other option to provide early intensive intervention to a child with an autism spectrum disorder diagnosis. This benefit must provide coverage for diagnosis, multidisciplinary assessment, ongoing progress evaluation, and medically necessary treatment of autism spectrum disorder.

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

(b) "Autism spectrum disorder diagnosis" is defined by diagnostic code 299 in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

(c) "Child" means a person under the age of seven, or for two years at any age under age 18 if the person was not diagnosed with autism spectrum disorder before age five, or a person under age 18 pursuant to subdivision 12.

(d) "Commissioner" means the commissioner of human services, unless otherwise specified.

(e) "Early intensive intervention benefit" means autism treatment options based in behavioral and developmental science, which may include modalities such as applied behavior analysis, developmental treatment approaches, and naturalistic and parent training models.

(f) "Generalizable goals" means results or gains that are observed during a variety of activities with different people, such as providers, family members, other adults, and children, and in different environments including but not limited to clinics, homes, schools, and the community.

Subd. 3. **Initial eligibility.** This benefit is available to a child enrolled in medical assistance who:

(1) has an autism spectrum disorder diagnosis;

(2) has had a diagnostic assessment described in subdivision 5 that recommends early intensive intervention services;

(3) meets the criteria for medically necessary autism early intensive intervention services; and

(4) declines to enroll in the state services described in section 252.27.

Subd. 4. **Diagnosis.** (a) A diagnosis must:

(1) be based on current DSM criteria including direct observations of the child and reports from parents or primary caregivers;

(2) be completed by a professional who has expertise and training in autism spectrum disorder and child development and who is a licensed physician, nurse practitioner, or licensed mental health professional until the commissioner's assessment required in subdivision 8, clause (7), shows there are adequate professionals to avoid access problems or delays in diagnosis for young children if two professionals are required for a diagnosis pursuant to clause (3); and

(3) be completed by both a medical and mental health professional who have expertise and training in autism spectrum disorder and child development when the assessment in subdivision 8, clause (7), demonstrates that there are sufficient professionals available.

(b) Additional diagnostic assessment information including from special education evaluations and licensed school personnel, and from professionals licensed in the fields of medicine, speech and language, psychology, occupational therapy, and physical therapy may be considered.

Subd. 5. **Diagnostic assessment.** The following information and assessments must be performed, reviewed, and relied upon for the eligibility determination, treatment and services recommendations, and treatment plan development for the child:

(1) an assessment of the child's developmental skills, functional behavior, needs, and capacities based on direct observation of the child that must be administered by a licensed mental health professional and may also include observations from family members, licensed school personnel, child care providers, or other caregivers, as well as any medical or assessment information from other licensed professionals such as the child's physician, rehabilitation therapists, or mental health professionals; and

(2) an assessment of parental or caregiver capacity to participate in therapy including the type and level of parental or caregiver involvement and training recommended.

Subd. 6. **Treatment plan.** (a) Each child's treatment plan must be:

(1) based on the diagnostic assessment information specified in subdivisions 4 and 5;

(2) coordinated with medically necessary occupational, physical, and speech and language therapies, special education, and other services the child and family are receiving;

(3) family-centered;

(4) culturally sensitive; and

(5) individualized based on the child's developmental status and the child's and family's identified needs.

(b) The treatment plan must specify the:

(1) child's goals, that are developmentally appropriate, functional, and generalizable;

(2) treatment modality;

(3) treatment intensity;

(4) setting; and

(5) level and type of parental or caregiver involvement.

(c) The treatment must be supervised by a professional with expertise and training in autism and child development who is a licensed physician, nurse practitioner, or mental health professional.

(d) The treatment plan must be submitted to the commissioner for approval in a manner determined by the commissioner.

(e) Services authorized must be consistent with the child's approved treatment plan.

Subd. 7. **Ongoing eligibility.** (a) An independent progress evaluation conducted by a licensed mental health professional with expertise and training in autism spectrum disorder and child development must be completed after each six months of treatment, or more frequently as determined by the commissioner, to determine if progress is being made toward achieving generalizable gains and meeting functional goals contained in the treatment plan.

(b) The progress evaluation must include:

(1) the treating provider's report;

(2) parental or caregiver input;

(3) an independent observation of the child, that can be performed by the child's licensed special education staff;

(4) any treatment plan modifications; and

(5) recommendations for continued treatment services.

(c) Progress evaluations must be submitted to the commissioner in a manner determined by the commissioner.

(d) A child who continues to achieve generalizable gains and treatment goals as specified in the treatment plan is eligible to continue receiving this benefit.

(e) A child's treatment shall continue during the progress evaluation and during an appeal if continuation of services pending appeal has been requested pursuant to section 256.045, subdivision 10.

Subd. 8. **Refining benefit with stakeholders.** The commissioner must develop the implementation details of the benefit in consultation with stakeholders and consider

recommendations from the Health Services Advisory Council, the Department of Human Services Autism Spectrum Disorder Advisory Council, the Legislative Autism Spectrum Disorder Task Force, and the Interagency Task Force of the Departments of Health, Education, and Human Services. The commissioner must release these details for a 30-day public comment period prior to submission to the federal government for approval. The implementation details include, but are not limited to, the following components:

(1) a definition of the qualifications, standards, and roles of the treatment team, including recommendations after stakeholder consultation on whether board-certified behavior analysts and other types of professionals trained in autism spectrum disorder and child development should be added as mental health or other professionals for treatment supervision or other function under medical assistance;

(2) development of initial, uniform parameters for comprehensive multidisciplinary diagnostic assessment information and progress evaluation standards;

(3) the design of an effective and consistent process for assessing parent and caregiver capacity to participate in the child's early intervention treatment and methods of involving the parents in the treatment of the child;

(4) formulation of a collaborative process in which professionals have opportunities to collectively inform the comprehensive, multidisciplinary diagnostic assessment and progress evaluation processes and standards to support quality improvement of early intensive intervention services;

(5) coordination of this benefit and its interaction with other services provided by the Departments of Human Services, Health, and Education;

(6) evaluation, on an ongoing basis, of research regarding the program and treatment modalities provided to children under this benefit; and

(7) determination of the availability of licensed medical and mental health professionals with expertise and training in autism spectrum disorder throughout the state in order to assess whether there are sufficient professionals to require involvement of both a medical and mental health professional to provide access and prevent delay in the diagnosis and treatment of young children so as to implement subdivision 4, paragraph (a), and to ensure treatment is effective, timely, and accessible.

Subd. 9. **Revision of treatment options.** (a) The commissioner may revise covered treatment options as needed based on outcome data and other evidence.

(b) Before the changes become effective, the commissioner must provide public notice of the changes, the reasons for the changes, and a 30-day public comment period to those who request notice through an electronic list accessible to the public on the department's Web site.

Subd. 10. **Coordination between agencies.** The commissioners of human services and education must develop the capacity to coordinate services and information including diagnostic, functional, developmental, medical, and educational assessments; service delivery; and progress evaluations across health and education sectors.

Subd. 11. **Federal approval of autism benefit.** The provisions of subdivision 9 shall apply to state plan services under title XIX of the Social Security Act when federal approval is granted under a 1915(i) waiver or other authority that allows children eligible for medical assistance through the TEFRA option under section 256B.055, subdivision 12, to qualify and includes children eligible for medical assistance in families over 150 percent of the federal poverty guidelines.

Subd. 12. **Local school districts option to continue treatment.** (a) A local school district may contract with the commissioner of human services to pay the state share of the benefits described under this section to continue the treatment as part of the special education services offered to all students in the district diagnosed with autism spectrum disorder.

(b) A local school district may utilize third-party billing to seek reimbursement for the district for any services paid by the district under this section for which private insurance coverage was available to the child.

EFFECTIVE DATE. The autism benefit under subdivisions 1 to 7, 9, and 12 is effective upon federal approval for the benefit under a 1915(i) waiver or other federal authority needed to meet the requirements of subdivision 11, but no earlier than March 1, 2014. Subdivisions 8, 10, and 11 are effective July 1, 2013.

Sec. 3. Minnesota Statutes 2012, section 256B.69, is amended by adding a subdivision to read:

Subd. 32a. **Initiatives to improve early screening, diagnosis, and treatment of children with autism spectrum disorder and other developmental conditions.** (a) The commissioner shall require managed care plans and county-based purchasing plans, as a condition of contract, to implement strategies that facilitate access for young children between the ages of one and three years to periodic developmental and social-emotional screenings, as recommended by the Minnesota Interagency Developmental Screening Task Force, and that those children who do not meet milestones are provided access to appropriate evaluation and assessment, including treatment recommendations, expected to improve the child's functioning, with the goal of meeting milestones by age five.

(b) The managed care plans must report the following data annually:

(1) the number of children who received a diagnostic assessment;

(2) the total number of children ages one to six with a diagnosis of autism spectrum disorder who received treatments;

(3) the number of children identified under clause (2) reported by each 12-month age group beginning with age one and ending with age six;

(4) the types of treatments provided to children identified under clause (2), listed by billing code, including the number of units billed for each child;

(5) barriers to providing screening, diagnosis, and treatment of young children between the ages of one and three years and any strategies implemented to address those barriers; and

(6) recommendations on how to measure and report on the effectiveness of the strategies implemented to facilitate access for young children to provide developmental and social-emotional screening, diagnosis, and treatment.

Sec. 4. **NURSING HOME LEVEL OF CARE REPORT.**

(a) The commissioner of human services shall report on the impact of the nursing home level of care implementation including the following:

(1) the number of individuals who lost waivered services and medical assistance;

(2) the result of the loss of services;

(3) information on where individuals were living before and after the nursing home level of care changes took effect, to show the impact on an individual's ability to maintain independence in the community; and

(4) utilization data before and after nursing home level of care implementation for those who retained medical assistance, including which essential community support and personal care assistant services were used and to what extent the $400 essential community support grant was sufficient to meet needs.

(b) The commissioner of human services shall report to the chairs of the legislative committees with jurisdiction over health and human services policy and finance with the information required under paragraph (a) on October 1, 2014, and annually thereafter.

ARTICLE 7

HOME AND COMMUNITY-BASED SERVICES DISABILITY RATE SETTING

Section 1. **[256B.4914] HOME AND COMMUNITY-BASED SERVICES WAIVERS; RATE SETTING.**

Subdivision 1. **Application.** The payment methodologies in this section apply to home and community-based services waivers under sections 256B.092 and 256B.49. This section does not change existing waiver policies and procedures.

Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them, unless the context clearly indicates otherwise.

(b) "Commissioner" means the commissioner of human services.

(c) "Component value" means underlying factors that are part of the cost of providing services that are built into the waiver rates methodology to calculate service rates.

(d) "Customized living tool" means a methodology for setting service rates which delineates and documents the amount of each component service included in a recipient's customized living service plan.

(e) "Disability waiver rates system" means a statewide system which establishes rates that are based on uniform processes and captures the individualized nature of waiver services and recipient needs.

(f) "Lead agency" means a county, partnership of counties, or tribal agency charged with administering waivered services under sections 256B.092 and 256B.49.

(g) "Median" means the amount that divides distribution into two equal groups, one-half above the median and one-half below the median.

(h) "Payment or rate" means reimbursement to an eligible provider for services provided to a qualified individual based on an approved service authorization.

(i) "Rates management system" means a Web-based software application that uses a framework and component values, as determined by the commissioner, to establish service rates.

(j) "Recipient" means a person receiving home and community-based services funded under any of the disability waivers.

Subd. 3. **Applicable services.** Applicable services are those authorized under the state's home and community-based services waivers under sections 256B.092 and 256B.49 including, as defined in the federally approved home and community-based services plan:

(1) 24-hour customized living;

(2) adult day care;

(3) adult day care bath;

(4) behavioral programming;

(5) companion services;

(6) customized living;

(7) day training and habilitation;

(8) housing access coordination;

(9) independent living skills;

(10) in-home family support;

(11) night supervision;

(12) personal support;

(13) prevocational services;

(14) residential care services;

(15) residential support services;

(16) respite services;

(17) structured day services;

(18) supported employment services;

(19) supported living services;

(20) transportation services; and

(21) other services as approved by the federal government in the state home and community-based services plan.

Subd. 4. **Data collection for rate determination.** (a) Rates for all applicable home and community-based waivered services, including rate exceptions under subdivision 12, are set via the rates management system.

(b) Only data and information in the rates management system may be used to calculate an individual's rate.

(c) Service providers, with information from the community support plan, shall enter values and information needed to calculate an individual's rate into the rates management system. These values and information include:

(1) shared staffing hours;

(2) individual staffing hours;

(3) staffing ratios;

(4) information to document variable levels of service qualification for variable levels of reimbursement in each framework;

(5) shared or individualized arrangements for unit-based services, including the staffing ratio; and

(6) number of trips and miles for transportation services.

(d) Updates to individual data shall include:

(1) data for each individual that is updated annually when renewing service plans; and

(2) requests by individuals or lead agencies to update a rate whenever there is a change in an individual's service needs, with accompanying documentation.

(e) Lead agencies shall review and approve values to calculate the final payment rate for each individual. Lead agencies must notify the individual and the service provider of the final agreed upon values and rate. If a value used was mistakenly or erroneously entered and used to calculate a rate, a provider may petition lead agencies to correct it. Lead agencies must respond to these requests.

Subd. 5. **Base wage index and standard component values.** (a) The base wage index is established to determine staffing costs associated with providing services to individuals receiving home and community-based services. For purposes of developing and calculating the proposed base wage, Minnesota-specific wages taken from job descriptions and standard occupational classification (SOC) codes from the Bureau of Labor Statistics, as defined in the most recent edition of the Occupational Handbook, shall be used. The base wage index shall be calculated as follows:

(1) for residential direct care basic staff, 50 percent of the median wage for personal and home health aide (SOC code 39-9021); 30 percent of the median wage for nursing aide (SOC code 31-1012); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(2) for residential direct care intensive staff, 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing aide (SOC code 21-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(3) for day services, 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services code (SOC code 21-1093);

(4) for residential asleep overnight staff, the wage shall be $7.66 per hour, except in a family foster care setting the wage is $2.80 per hour;

(5) for behavior program analyst staff, 100 percent of the median wage for mental health counselors (SOC code 21-1014);

(6) for behavior program professional staff, 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(7) for behavior program specialist staff, 100 percent of the median wage for psychiatric technicians (SOC code 29-2053);

(8) for supportive living services staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(9) for housing access coordination staff, 50 percent of the median wage for community and social services specialist (SOC code 21-1099); and 50 percent of the median wage for social and human services aide (SOC code 21-1093);

(10) for in-home family support staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 30 percent of community social service specialist (SOC code

21-1099); 40 percent of the median wage for social and human services aide (SOC code 21-1093); and 10 percent of the median wage for psychiatric technician (SOC code 29-2053);

(11) for independent living skills staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and 10 percent of the median wage for psychiatric technician (SOC code 29-2053);

(12) for supported employment staff, 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(13) for adult companion staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides, orderlies, and attendants (SOC code 31-1012);

(14) for night supervision staff, 20 percent of the median wage for home health aide (SOC code 31-1011); 20 percent of the median wage for personal and home health aide (SOC code 39-9021); 20 percent of the median wage for nursing aide (SOC code 31-1012); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(15) for respite staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides, orderlies, and attendants (SOC code 31-1012);

(16) for personal support staff, 50 percent of the median wage for personal and home care aide (SOC code 39-9021); and 50 percent of the median wage for nursing aides, orderlies, and attendants (SOC code 31-1012); and

(17) for supervisory staff, the basic wage is $17.43 per hour with exception of the supervisor of behavior analyst and behavior specialists which shall be $30.75 per hour.

(b) Component values for residential support services, excluding family foster care, are:

(1) supervisory span of control ratio, 11 percent;

(2) employee vacation, sick, and training allowance ratio, 8.71 percent;

(3) employee-related cost ratio, 23.6 percent;

(4) general administrative support ratio, 13.25 percent;

(5) program-related expense ratio, 1.3 percent; and

(6) absence and utilization factor ratio, 3.9 percent.

(c) Component values for family foster care are:

(1) supervisory span of control ratio, 11 percent;

(2) employee vacation, sick, and training allowance ratio, 8.71 percent;

(3) employee-related cost ratio, 23.6 percent;

(4) general administrative support ratio, 3.3 percent; and

(5) program-related expense ratio, 1.3 percent.

(d) Component values for day services for all services are:

(1) supervisory span of control ratio, 11 percent;

(2) employee vacation, sick, and training allowance ratio, 8.71 percent;

(3) employee-related cost ratio, 23.6 percent;

(4) program plan support ratio, 5.6 percent;

(5) client programming and support ratio, 10 percent;

(6) general administrative support ratio, 13.25 percent;

(7) program-related expense ratio, 1.8 percent; and

(8) absence and utilization factor ratio, 3.9 percent.

(e) Component values for unit-based services with program services are:

(1) supervisory span of control ratio, 11 percent;

(2) employee vacation, sick, and training allowance ratio, 8.71 percent;

(3) employee-related cost ratio, 23.6 percent;

(4) program plan supports ratio, 3.1 percent;

(5) client programming and support ratio, 8.6 percent;

(6) general administrative support ratio, 13.25 percent;

(7) program-related expense ratio, 6.1 percent; and

(8) absence and utilization factor ratio, 3.9 percent.

(f) Component values for unit-based services without programming except respite are:

(1) supervisory span of control ratio, 11 percent;

(2) employee vacation, sick, and training allowance ratio, 8.71 percent;

(3) employee-related cost ratio, 23.6 percent;

(4) program plan support ratio, 3.1 percent;

(5) client programming and support ratio, 8.6 percent;

(6) general administrative support ratio, 13.25 percent;

(7) program-related expense ratio, 6.1 percent; and

(8) absence and utilization factor ratio, 3.9 percent.

(g) Component values for unit-based services without programming for respite are:

(1) supervisory span of control ratio, 11 percent;

(2) employee vacation, sick, and training allowance ratio, 8.71 percent;

(3) employee-related cost ratio, 23.6 percent;

(4) general administrative support ratio, 13.25 percent;

(5) program-related expense ratio, 6.1 percent; and

(6) absence and utilization factor ratio, 3.9 percent.

(h) On July 1, 2017, the commissioner shall update the base wage index in paragraph (a) based on the wage data by SOC from the Bureau of Labor Statistics available on December 31, 2016. The commissioner shall publish these updated values and load them into the rates management system. This adjustment shall occur every five years. For adjustments in 2021 and later, the commissioner shall use the data available on December 31 of the calendar year five years prior.

(i) On July 1, 2017, the commissioner shall update the framework components in paragraph (c) for changes in the Consumer Price Index. The commissioner must adjust these values higher or lower by the percentage change in the Consumer Price Index-All Items (United States city average) (CPI-U) from January 1, 2014, to January 1, 2017. The commissioner shall publish these updated values and load them into the rates management system. This adjustment shall occur every five years. For adjustments in 2021 and later, the commissioner shall use the data available on January 1 of the calendar year four years prior and January 1 of the current calendar year.

Subd. 6. **Payments for residential support services.** (a) Payments for residential support services, as defined in sections 256B.092, subdivision 11, and 256B.49, subdivision 22, must be calculated as follows:

(1) determine the number of units of service to meet a recipient's needs;

(2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics national and Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5. This is defined as the direct care rate;

(3) for a recipient requiring customization for deaf or hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct care rate;

(4) multiply the number of residential services direct staff hours by the appropriate staff wage in subdivision 5, paragraph (a), or the customized direct care rate;

(5) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (b), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (17);

(6) combine the results of clauses (4) and (5) and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (b), clause (2). This is defined as the direct staffing cost;

(7) for employee-related expenses, multiply the direct staffing cost by one plus the employee-related cost ratio in subdivision 5, paragraph (b), clause (3);

(8) for client programming and supports, the commissioner shall add $2,179; and

(9) for transportation, if provided, the commissioner shall add $1,680, or $3,000 if customized for adapted transport per year.

(b) The total rate shall be calculated using the following steps:

(1) subtotal paragraph (a), clauses (7) to (9);

(2) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization ratio; and

(3) divide the result of clause (1) by one minus the result of clause (2). This is the total payment amount.

Subd. 7. **Payments for day programs.** Payments for services with day programs including adult day care, day treatment and habilitation, prevocational services, and structured day services must be calculated as follows:

(1) determine the number of units of service to meet a recipient's needs;

(2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) for a recipient requiring customization for deaf or hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct care rate;

(4) multiply the number of day program direct staff hours by the appropriate staff wage in subdivision 5, paragraph (a), or the customized direct care rate;

(5) multiply the number of day program direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (d), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (17);

(6) combine the results of clauses (4) and (5) and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (d), clause (2). This is defined as the direct staffing rate;

(7) for program plan support, multiply the result of clause (6) by one plus the program plan support ratio in subdivision 5, paragraph (d), clause (4);

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio in subdivision 5, paragraph (d), clause (3);

(9) for client programming and supports, multiply the result of clause (8) by one plus the client programming and support ratio in subdivision 5, paragraph (d), clause (5);

(10) for program facility costs, add $8.30 per week with consideration of staffing ratios to meet individual needs;

(11) for adult day bath services, add $7.01 per 15-minute unit;

(12) this is the subtotal rate;

(13) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(14) divide the result of clause (12) by one minus the result of clause (13). This is the total payment amount;

(15) for transportation provided as part of day training and habilitation for an individual who does not require a lift, add:

(i) $10.50 for a trip between zero and ten miles for a nonshared ride in a vehicle without a lift, $8.83 for a shared ride in a vehicle without a lift, and $9.25 for a shared ride in a vehicle with a lift;

(ii) $15.75 for a trip between 11 and 20 miles for a nonshared ride in a vehicle without a lift, $10.58 for a shared ride in a vehicle without a lift, and $11.88 for a shared ride in a vehicle with a lift;

(iii) $25.75 for a trip between 21and 50 miles for a nonshared ride in a vehicle without a lift, $13.92 for a shared ride in a vehicle without a lift, and $16.88 for a shared ride in a vehicle with a lift; or

(iv) $33.50 for a trip of 51 miles or more for a nonshared ride in a vehicle without a lift, $16.50 for a shared ride in a vehicle without a lift, and $20.75 for a shared ride in a vehicle with a lift;

(16) for transportation provided as part of day training and habilitation for an individual who does require a lift, add:

(i) $19.05 for a trip between zero and ten miles for a nonshared ride in a vehicle with a lift, and $15.05 for a shared ride in a vehicle with a lift;

(ii) $32.16 for a trip between 11 and 20 miles for a nonshared ride in a vehicle with a lift, and $28.16 for a shared ride in a vehicle with a lift;

(iii) $58.76 for a trip between 21 and 50 miles for a nonshared ride in a vehicle with a lift, and $58.76 for a shared ride in a vehicle with a lift; or

(iv) $80.93 for a trip of 51 miles or more for a nonshared ride in a vehicle with a lift, and $80.93 for a shared ride in a vehicle with a lift.

Subd. 8. **Payments for unit-based services with programming.** Payments for unit-based services with programming, including behavior programming, housing access coordination, in-home family support, independent living skills training, hourly supported living services, and supported employment provided to an individual outside of any day or residential service plan, must be calculated as follows, unless the services are authorized separately under subdivision 6 or 7:

(1) determine the number of units of service to meet a recipient's needs;

(2) personnel hourly wage rate must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) for a recipient requiring customization for deaf or hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct care rate;

(4) multiply the number of direct staff hours by the appropriate staff wage in subdivision 5, paragraph (a), or the customized direct care rate;

(5) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (e), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (17);

(6) combine the results of clauses (4) and (5) and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (e), clause (2). This is defined as the direct staffing rate;

(7) for program plan support, multiply the result of clause (6) by one plus the program plan supports ratio in subdivision 5, paragraph (e), clause (4);

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio in subdivision 5, paragraph (e), clause (3);

(9) for client programming and supports, multiply the result of clause (8) by one plus the client programming and supports ratio in subdivision 5, paragraph (e), clause (5);

(10) this is the subtotal rate;

(11) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio; and

(12) divide the result of clause (10) by one minus the result of clause (11). This is the total payment amount.

Subd. 9. **Payments for unit-based services without programming.** Payments for unit-based services without programming including night supervision, personal support, respite, and companion care provided to an individual outside of any day or residential service plan must be calculated as follows unless the services are authorized separately under subdivision 6 or 7:

(1) for all services except respite, determine the number of units of service to meet a recipient's needs;

(2) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(3) for a recipient requiring customization for deaf or hard-of-hearing language accessibility under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (2). This is defined as the customized direct care rate;

(4) multiply the number of direct staff hours by the appropriate staff wage in subdivision 5 or the customized direct care rate;

(5) multiply the number of direct staff hours by the product of the supervision span of control ratio in subdivision 5, paragraph (f), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (17);

(6) combine the results of clauses (4) and (5) and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (f), clause (2). This is defined as the direct staffing rate;

(7) for program plan support, multiply the result of clause (6) by one plus the program plan support ratio in subdivision 5, paragraph (f), clause (4);

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio in subdivision 5, paragraph (f), clause (3);

(9) for client programming and supports, multiply the result of clause (8) by one plus the client programming and support ratio in subdivision 5, paragraph (f), clause (5);

(10) this is the subtotal rate;

(11) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio;

(12) divide the result of clause (10) by one minus the result of clause (11). This is the total payment amount;

(13) for respite services, determine the number of daily units of service to meet an individual's needs;

(14) personnel hourly wage rates must be based on the 2009 Bureau of Labor Statistics Minnesota-specific rates or rates derived by the commissioner as provided in subdivision 5;

(15) for a recipient requiring deaf or hard-of-hearing customization under subdivision 12, add the customization rate provided in subdivision 12 to the result of clause (14). This is defined as the customized direct care rate;

(16) multiply the number of direct staff hours by the appropriate staff wage in subdivision 5, paragraph (a);

(17) multiply the number of direct staff hours by the product of the supervisory span of control ratio in subdivision 5, paragraph (g), clause (1), and the appropriate supervision wage in subdivision 5, paragraph (a), clause (17);

(18) combine the results of clauses (16) and (17) and multiply the result by one plus the employee vacation, sick, and training allowance ratio in subdivision 5, paragraph (g), clause (2). This is defined as the direct staffing rate;

(19) for employee-related expenses, multiply the result of clause (18) by one plus the employee-related cost ratio in subdivision 5, paragraph (g), clause (3).

(20) this is the subtotal rate;

(21) sum the standard general and administrative rate, the program-related expense ratio, and the absence and utilization factor ratio; and

(22) divide the result of clause (20) by one minus the result of clause (21). This is the total payment amount.

Subd. 10. **Updating payment values and additional information.** (a) The commissioner shall develop and implement uniform procedures to refine terms and update or adjust values used to calculate payment rates in this section. For calendar year 2014, the commissioner shall use the values, terms, and procedures provided in this section.

(b) The commissioner shall work with stakeholders to assess efficacy of values and payment rates. The commissioner shall report back to the legislature with proposed changes for component values and recommendations for revisions on the schedule provided in paragraphs (c) and (d).

(c) The commissioner shall work with stakeholders to continue refining a subset of component values, which are to be referred to as interim values, and report recommendations to the legislature by February 15, 2014. Interim component values are: transportation rates for day training and habilitation; transportation for adult day, structured day, and prevocational services; geographic difference factor; day program facility rate; services where monitoring technology replaces staff time; shared services for independent living skills training; and supported employment and billing for indirect services.

(d) The commissioner shall report and make recommendations to the legislature on: February 15, 2015, February 15, 2017, February 15, 2019, and February 15, 2021. After 2021, reports shall be provided on a four-year cycle.

(e) The commissioner shall provide a public notice via list serve in October of each year beginning October 1, 2014. The notice shall contain information detailing legislatively approved changes in: calculation values including derived wage rates and related employee and administrative factors; services utilization; county and tribal allocation changes; and information on adjustments to be made to calculation values and timing of those adjustments. Information in this notice shall be effective January 1 of the following year.

Subd. 11. **Payment implementation.** Upon implementation of the payment methodologies under this section, those payment rates supersede rates established in county contracts for recipients receiving waiver services under section 256B.092 or 256B.49.

Subd. 12. **Customization of rates for individuals.** (a) For persons determined to have higher needs based on being deaf or hard-of-hearing, the direct care costs must be increased by an adjustment factor prior to calculating the rate under subdivisions 6 to 9. The customization rate with respect to deaf or hard-of-hearing persons shall be $2.50 per hour for waiver recipients who meet the respective criteria as determined by the commissioner.

(b) For the purposes of this section, "deaf or hard-of-hearing" means:

(1)(i) the person has a developmental disability and an assessment score that indicates a hearing impairment that is severe or that the person has no useful hearing;

(ii) the person has a developmental disability and an expressive communications score that indicates the person uses single signs or gestures, uses an augmentative communication aid, or does not have functional communication, or the person's expressive communications are unknown; and

(iii) the person has a developmental disability and a communication score that indicates the person comprehends signs, gestures, and modeling prompts or does not comprehend verbal, visual, or gestural communication or that the person's receptive communications score is unknown; or

(2)(i) the person receives long-term care services and has an assessment score that indicates they hear only very loud sounds, have no useful hearing, or a determination cannot be made; and

(ii) the person receives long-term care services and has an assessment score that indicates the person communicates needs with sign language, symbol board, written messages, gestures, or an interpreter; communicates with inappropriate content; makes garbled sounds or displays echolalia; or does not communicate needs.

Subd. 13. **Transportation.** The commissioner shall require that the purchase of transportation services be cost-effective and be limited to market rates where the transportation mode is generally available and accessible.

Subd. 14. **Exceptions.** (a) In a format prescribed by the commissioner, lead agencies must identify individuals with exceptional needs that cannot be met under the disability waiver rate system. The commissioner shall use that information to evaluate and, if necessary, approve an alternative payment rate for those individuals.

(b) Lead agencies must submit exception requests to the state.

(c) An application for a rate exception may be submitted for the following criteria:

(1) an individual has service needs that cannot be met through additional units of service; or

(2) an individual's rate determined under subdivisions 6 to 9 results in an individual being discharged.

(d) Exception requests must include the following information:

(1) the service needs required by each individual that are not accounted for in subdivisions 6 to 9;

(2) the service rate requested and the difference from the rate determined in subdivisions 6 to 9;

(3) a basis for the underlying costs used for the rate exception and any accompanying documentation;

(4) the duration of the rate exception; and

(5) any contingencies for approval.

(e) Approved rate exceptions shall be managed within lead agency allocations under sections 256B.092 and 256B.49.

(f) Individual disability waiver recipients may request that a lead agency submit an exception request. A lead agency that denies such a request shall notify the individual waiver recipient of its decision and the reasons for denying the request in writing no later than 30 days after the individual's request has been made.

(g) The commissioner shall determine whether to approve or deny an exception request no more than 30 days after receiving the request. If the commissioner denies the request, the commissioner shall notify the lead agency and the individual disability waiver recipient in writing of the reasons for the denial.

(h) The individual disability waiver recipient may appeal any denial of an exception request by either the lead agency or the commissioner, pursuant to sections 256.045 and 256.0451. If the denial of an exception request results in the proposed demission of a waiver recipient from a residential or day habilitation program, the commissioner shall issue a temporary stay of demission, when requested by the disability waiver recipient, consistent with the provisions of section 256.045, subdivisions 4a and 6, paragraph (c). The temporary stay shall remain in effect until the lead agency can provide an informed choice of appropriate, alternative services to the disability waiver.

(i) Providers may petition lead agencies to update values that were entered incorrectly or erroneously into the rate management system, based on past service level discussions and determination in subdivision 4, without applying for a rate exception.

Subd. 15. **County or tribal allocations.** (a) Upon implementation of the disability waiver rates management system on January 1, 2014, the commissioner shall establish

a method of tracking and reporting the fiscal impact of the disability waiver rates management system on individual lead agencies.

(b) Beginning on January 1, 2014, and continuing through full implementation on December 31, 2017, the commissioner shall make annual adjustments to lead agencies' home and community-based waivered service budget allocations to adjust for rate differences and the resulting impact on county allocations upon implementation of the disability waiver rates system.

Subd. 16. **Budget neutrality adjustment.** The commissioner shall calculate the total spending for all home and community-based waiver services under the payments as defined in subdivisions 6 to 9 for all recipients as of July 1, 2013, and compare it to spending for services defined for subdivisions 6 to 9 under current law. If spending for services in one particular subdivision differs, there will be a percentage adjustment to increase or decrease individual rates for the services defined in each subdivision so aggregate spending matches projections under current law.

Subd. 17. **Implementation.** (a) On January 1, 2014, the commissioner shall fully implement the calculation of rates for waivered services under sections 256B.092 and 256B.49, without additional legislative approval.

(b) The commissioner shall phase in the application of rates determined in subdivisions 6 to 9 for two years.

(c) The commissioner shall preserve rates in effect on December 31, 2013, for the two-year period.

(d) The commissioner shall calculate and measure the difference in cost per individual using the historical rate and the rates under subdivisions 6 to 9 for all individuals enrolled as of December 31, 2013. This measurement shall occur statewide and for individuals in every county. The commissioner shall provide the results of this analysis, by county for calendar year 2014, to the legislative committees with jurisdiction over health and human services finance by February 15, 2015.

(e) The commissioner shall calculate the average rate per unit for each service by county. For individuals enrolled after January 1, 2014, individuals will receive the higher of the rate produced under subdivisions 6 to 9, or the by-county average rate.

(f) On January 1, 2016, the rates determined in subdivisions 6 to 9 shall be applied.

APPENDIX
Article locations in H1780-1