State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-EIGHTH SESSION

H. F. No. 1233

03/04/2013 Authored by Huntley; Moran; Ward, J.E., and Isaacson
The bill was read for the first time and referred to the Committee on Rules and Legislative Administration
03/11/2013 Adoption of Report: Pass and re-referred to the Committee on Health and Human Services Finance
04/15/2013 Adoption of Report: Pass as Amended and re-referred to the Committee on Ways and Means

A bill for an act

relating to state government; establishing the health and human services budget; modifying provisions related to health care, continuing care, human services licensing, chemical and mental health, managed care organizations, waiver provider standards, home care, and the Department of Health; redesigning home and community-based services; establishing payment methodologies for home and community-based services; adjusting nursing and ICF/DD facility rates; setting and modifying fees; modifying autism coverage; making technical changes; requiring studies; requiring reports; appropriating money; amending Minnesota Statutes 2012, sections 16A.152, subdivision 2; 16A.724, subdivisions 2, 3; 16C.10, subdivision 5; 16C.155, subdivision 1; 62J.692, subdivision 4; 62Q.19, subdivision 1; 103I.005, by adding a subdivision; 103I.521; 119B.13, subdivision 7; 144.051, by adding subdivisions; 144.0724, subdivision 4; 144.123, subdivision 1; 144.125, subdivision 1; 144.966, subdivisions 2, 3a; 144.98, subdivisions 3, 5, by adding subdivisions; 144.99, subdivision 4; 144A.351; 144A.43; 144A.44; 144A.45; 144D.01, subdivision 4; 145.986; 145C.01, subdivision 7; 148E.065, subdivision 4a; 149A.02, subdivisions 1a, 2, 3, 4, 5, 16, 23, 27, 34, 35, 37, by adding subdivisions; 149A.03; 149A.65, by adding subdivisions; 149A.70, subdivisions 1, 2, 3, 5; 149A.71, subdivisions 2, 4; 149A.72, subdivisions 3, 9, by adding a subdivision; 149A.73, subdivisions 1, 2, 4; 149A.74; 149A.91, subdivision 9; 149A.93, subdivisions 3, 6; 149A.94; 149A.96, subdivision 9; 174.30, subdivision 1; 214.40, subdivision 1; 243.166, subdivisions 4b, 7; 245.4661, subdivisions 5, 6; 245.4682, subdivision 2; 245A.02, subdivisions 1, 9, 10, 14; 245A.03, subdivisions 7, 8, 9; 245A.04, subdivision 13; 245A.042, subdivision 3; 245A.07, subdivision 3; 245A.08, subdivision 2a; 245A.10; 245A.11, subdivisions 2a, 7, 7a, 7b, 8; 245A.1435; 245A.16, subdivision 1; 245C.04, by adding a subdivision; 245C.08, subdivision 1; 245D.02; 245D.03; 245D.04; 245D.05; 245D.06; 245D.07; 245D.09; 245D.10; 246.18, subdivision 8, by adding a subdivision; 246.54; 254B.04, subdivision 1; 254B.13; 256.01, subdivisions 2, 24, 34, by adding subdivisions; 256.9657, subdivisions 2, 3a; 256.9685, subdivision 2; 256.969, subdivisions 3a, 29; 256.975, subdivision 7, by adding subdivisions; 256.9754, subdivision 5, by adding subdivisions; 256B.02, by adding subdivisions; 256B.021, by adding subdivisions; 256B.04, subdivisions 18, 21, by adding a subdivision; 256B.055, subdivisions 3a, 6, 10, 14, 15, by adding a subdivision; 256B.056, subdivisions 1, 1c, 3, 4, as amended, 5c, 10, by adding a subdivision; 256B.057, subdivisions 1, 8, 10, by adding a subdivision; 256B.06, subdivision 4; 256B.0623, subdivision 2; 256B.0625, subdivisions 9, 13e, 19c, 31, 39, 48, 58, by adding subdivisions; 256B.0631, subdivision 1; 256B.064, subdivisions 1a, 1b, 2; 256B.0659,

subdivision 21; 256B.0755, subdivision 3; 256B.0756; 256B.0911, subdivisions 1, 1a, 3a, 4d, 6, 7, by adding a subdivision; 256B.0913, subdivision 4, by adding a subdivision; 256B.0915, subdivisions 3a, 5, by adding a subdivision; 256B.0916, by adding a subdivision; 256B.0917, subdivisions 6, 13, by adding subdivisions; 256B.092, subdivisions 11, 12, by adding subdivisions; 256B.0946; 256B.095; 256B.0951, subdivisions 1, 4; 256B.0952, subdivisions 1, 5; 256B.097, subdivisions 1, 3; 256B.431, subdivision 44; 256B.434, subdivision 4, by adding a subdivision; 256B.437, subdivision 6; 256B.439, subdivisions 1, 2, 3, 4, by adding a subdivision; 256B.441, subdivisions 13, 53; 256B.49, subdivisions 11a, 12, 14, 15, by adding subdivisions; 256B.4912, subdivisions 1, 2, 3, 7, by adding subdivisions; 256B.4913, subdivisions 5, 6, by adding a subdivision; 256B.492; 256B.493, subdivision 2; 256B.5011, subdivision 2; 256B.5012, by adding subdivisions; 256B.69, subdivisions 5c, 31, by adding a subdivision; 256B.694; 256B.76, subdivisions 2, 4, by adding a subdivision; 256B.761; 256B.764; 256B.766; 256I.04, subdivision 3; 256I.05, subdivision 1e, by adding a subdivision; 256J.35; 256K.45; 256L.01, subdivisions 3a, 5, by adding subdivisions; 256L.02, subdivision 2, by adding subdivisions; 256L.03, subdivisions 1, 1a, 3, 5, 6, by adding a subdivision; 256L.04, subdivisions 1, 7, 8, 10, by adding subdivisions; 256L.05, subdivisions 1, 2, 3; 256L.06, subdivision 3; 256L.07, subdivisions 1, 2, 3; 256L.09, subdivision 2; 256L.11, subdivision 6; 256L.15, subdivisions 1, 2; 257.0755, subdivision 1; 260B.007, subdivisions 6, 16; 260C.007, subdivisions 6, 31; 471.59, subdivision 1; 626.556, subdivisions 2, 3, 10d; 626.557, subdivisions 4, 9, 9a, 9e; 626.5572, subdivision 13; Laws 1998, chapter 407, article 6, section 116; Laws 2011, First Special Session chapter 9, article 2, section 27; article 10, section 3, subdivision 3, as amended; proposing coding for new law in Minnesota Statutes, chapters 62A; 62D; 144; 144A; 145; 149A; 214; 245; 245D; 254B; 256; 256B; 256L; repealing Minnesota Statutes 2012, sections 103I.005, subdivision 20; 144.123, subdivision 2; 144A.46; 144A.461; 149A.025; 149A.20, subdivision 8; 149A.30, subdivision 2; 149A.40, subdivision 8; 149A.45, subdivision 6; 149A.50, subdivision 6; 149A.51, subdivision 7; 149A.52, subdivision 5a; 149A.53, subdivision 9; 245A.655; 245B.01; 245B.02; 245B.03; 245B.031; 245B.04; 245B.05, subdivisions 1, 2, 3, 5, 6, 7; 245B.055; 245B.06; 245B.07; 245B.08; 245D.08; 256B.055, subdivisions 3, 5, 10b; 256B.056, subdivision 5b; 256B.057, subdivisions 1c, 2; 256B.0911, subdivisions 4a, 4b, 4c; 256B.0917, subdivisions 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 14; 256B.096, subdivisions 1, 2, 3, 4; 256B.14, subdivision 3a; 256B.49, subdivision 16a; 256B.4913, subdivisions 1, 2, 3, 4; 256B.5012, subdivision 13; 256J.24, subdivision 6; 256K.45, subdivision 2; 256L.01, subdivision 4a; 256L.031; 256L.04, subdivisions 1b, 9, 10a; 256L.05, subdivision 3b; 256L.07, subdivisions 5, 8, 9; 256L.11, subdivision 5; 256L.12; 256L.17, subdivisions 1, 2, 3, 4, 5; 485.14; 609.093; Laws 2011, First Special Session chapter 9, article 7, section 54, as amended; Minnesota Rules, parts 4668.0002; 4668.0003; 4668.0005; 4668.0008; 4668.0012; 4668.0016; 4668.0017; 4668.0019; 4668.0030; 4668.0035; 4668.0040; 4668.0050; 4668.0060; 4668.0065; 4668.0070; 4668.0075; 4668.0080; 4668.0100; 4668.0110; 4668.0120; 4668.0130; 4668.0140; 4668.0150; 4668.0160; 4668.0170; 4668.0180; 4668.0190; 4668.0200; 4668.0218; 4668.0220; 4668.0230; 4668.0240; 4668.0800; 4668.0805; 4668.0810; 4668.0815; 4668.0820; 4668.0825; 4668.0830; 4668.0835; 4668.0840; 4668.0845; 4668.0855; 4668.0860; 4668.0865; 4668.0870; 4669.0001; 4669.0010; 4669.0020; 4669.0030; 4669.0040; 4669.0050.

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

ARTICLE 1

AFFORDABLE CARE ACT IMPLEMENTATION; BETTER HEALTH CARE FOR MORE MINNESOTANS

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

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

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

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

Subdivision 1. **Eligibility.** (a) Persons eligible for benefits under Code of Federal Regulations, title 25, part 20, persons eligible for medical assistance benefits under sections 256B.055, 256B.056, and 256B.057, subdivisions 1, ~~2,~~ 5, and 6, or who meet the income standards of section 256B.056, subdivision 4, and persons eligible for general assistance medical care under section 256D.03, subdivision 3, are entitled to chemical dependency fund services. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

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

(b) A person not entitled to services under paragraph (a), but with family income that is less than 215 percent of the federal poverty guidelines for the applicable family

size, shall be eligible to receive chemical dependency fund services within the limit of funds appropriated for this group for the fiscal year. If notified by the state agency of limited funds, a county must give preferential treatment to persons with dependent children who are in need of chemical dependency treatment pursuant to an assessment under section 626.556, subdivision 10, or a case plan under section 260C.201, subdivision 6, or 260C.212. A county may spend money from its own sources to serve persons under this paragraph. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

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

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

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

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

(2) Medicaid funding; and

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

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

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

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

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

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

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

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

(e) The commissioner shall report progress on implementing this subdivision to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by December 1, 2014.

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

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

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

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

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

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

(1) medical assistance under this chapter;

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 6. **Pregnant women; needy unborn child.** Medical assistance may be paid for a pregnant woman who ~~has written verification of a positive pregnancy test from a physician or licensed registered nurse, who~~ meets the other eligibility criteria of this section and whose unborn child would be eligible as a needy child under subdivision 10 if born and living with the woman. In accordance with Code of Federal Regulations, title

42, section 435.956, the commissioner must accept self-attestation of pregnancy unless the agency has information that is not reasonably compatible with such attestation. For purposes of this subdivision, a woman is considered pregnant for 60 days postpartum.

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

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

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

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

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

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

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

(2) not pregnant;

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

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

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

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

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

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

Subd. 17. **Adults who were in foster care at the age of 18.** Medical assistance may be paid for a person under 26 years of age who was in foster care under the commissioner's responsibility on the date of attaining 18 years of age, and who was enrolled in medical

assistance under the state plan or a waiver of the plan while in foster care, in accordance with section 2004 of the Affordable Care Act.

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

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

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

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

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

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

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

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

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

(c) If the four-month disregard in paragraph (b) has been applied to the wage earner's income for four months, the disregard shall not be applied again until the wage

earner's income has not been considered in determining medical assistance eligibility for 12 consecutive months.

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

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

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

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

(1) household goods and personal effects are not considered;

(2) capital and operating assets of a trade or business that the local agency determines are necessary to the person's ability to earn an income are not considered;

(3) motor vehicles are excluded to the same extent excluded by the supplemental security income program;

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

(5) for a person who no longer qualifies as an employed person with a disability due to loss of earnings, assets allowed while eligible for medical assistance under section 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month

of ineligibility as an employed person with a disability, to the extent that the person's total assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (d);

(6) when a person enrolled in medical assistance under section 256B.057, subdivision 9, is age 65 or older and has been enrolled during each of the 24 consecutive months before the person's 65th birthday, the assets owned by the person and the person's spouse must be disregarded, up to the limits of section 256B.057, subdivision 9, paragraph (d), when determining eligibility for medical assistance under section 256B.055, subdivision 7. The income of a spouse of a person enrolled in medical assistance under section 256B.057, subdivision 9, during each of the 24 consecutive months before the person's 65th birthday must be disregarded when determining eligibility for medical assistance under section 256B.055, subdivision 7. Persons eligible under this clause are not subject to the provisions in section 256B.059. A person whose 65th birthday occurs in 2012 or 2013 is required to have qualified for medical assistance under section 256B.057, subdivision 9, prior to age 65 for at least 20 months in the 24 months prior to reaching age 65; and

(7) effective July 1, 2009, certain assets owned by American Indians are excluded as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. For purposes of this clause, an American Indian is any person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

~~(b) No asset limit shall apply to persons eligible under section 256B.055, subdivision 15.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) The commissioner shall utilize information obtained through the electronic service established by the secretary of the United States Department of Health and Human Services and other available electronic data sources in Code of Federal Regulations, title 42, sections 435.940 to 435.956, to verify eligibility requirements. The commissioner shall establish standards to define when information obtained electronically is reasonably compatible with information provided by applicants and enrollees, including use of

self-attestation, to accomplish real-time eligibility determinations and maintain program integrity.

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

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

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

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

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

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

~~(3) An amount equal to the amount of earned income exceeding 275 percent of the federal poverty guideline, up to a maximum of the amount by which the combined total of 185 percent of the federal poverty guideline plus the earned income disregards and deductions allowed under the state's AFDC plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Act of 1996 (PRWORA), Public~~

~~Law 104-193, exceeds 275 percent of the federal poverty guideline will be deducted for pregnant women and infants less than one year of age.~~

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

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

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

Sec. 20. Minnesota Statutes 2012, section 256B.057, subdivision 8, is amended to read:

Subd. 8. **Children under age two.** Medical assistance may be paid for a child under two years of age whose countable family income is above 275 percent of the federal poverty guidelines for the same size family but less than or equal to 280 percent of the federal poverty guidelines for the same size family or an equivalent standard when converted using modified adjusted gross income methodology as required under the Affordable Care Act.

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

Sec. 21. Minnesota Statutes 2012, section 256B.057, subdivision 10, is amended to read:

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

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

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

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

(4) is under age 65;

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

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

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

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

Sec. 22. Minnesota Statutes 2012, section 256B.057, is amended by adding a subdivision to read:

Subd. 12. **Presumptive eligibility determinations made by qualified hospitals.** The commissioner shall establish a process to qualify hospitals that are participating providers under the medical assistance program to determine presumptive eligibility for medical assistance for applicants who may have a basis of eligibility using the modified adjusted gross income methodology as defined in section 256B.056, subdivision 1a, paragraph (b), clause (1).

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

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

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

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

(1) admitted for lawful permanent residence according to United States Code, title 8;

(2) admitted to the United States as a refugee according to United States Code, title 8, section 1157;

(3) granted asylum according to United States Code, title 8, section 1158;

(4) granted withholding of deportation according to United States Code, title 8, section 1253(h);

(5) paroled for a period of at least one year according to United States Code, title 8, section 1182(d)(5);

(6) granted conditional entrant status according to United States Code, title 8, section 1153(a)(7);

(7) determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;

(8) is a child of a noncitizen determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill, Public Law 104-200; or

(9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public Law 96-422, the Refugee Education Assistance Act of 1980.

(c) All qualified noncitizens who were residing in the United States before August 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance with federal financial participation.

(d) Beginning December 1, 1996, qualified noncitizens who entered the United States on or after August 22, 1996, and who otherwise meet the eligibility requirements of this chapter are eligible for medical assistance with federal participation for five years if they meet one of the following criteria:

(1) refugees admitted to the United States according to United States Code, title 8, section 1157;

(2) persons granted asylum according to United States Code, title 8, section 1158;

(3) persons granted withholding of deportation according to United States Code, title 8, section 1253(h);

(4) veterans of the United States armed forces with an honorable discharge for a reason other than noncitizen status, their spouses and unmarried minor dependent children; or

(5) persons on active duty in the United States armed forces, other than for training, their spouses and unmarried minor dependent children.

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

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

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

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

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

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

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

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

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

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

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

(iii) services for routine prenatal care;

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

(v) elective surgery;

(vi) outpatient prescription drugs, unless the drugs are administered or dispensed as part of an emergency room visit;

(vii) preventative health care and family planning services;

(viii) dialysis;

(ix) chemotherapy or therapeutic radiation services;

(x) rehabilitation services;

(xi) physical, occupational, or speech therapy;

(xii) transportation services;

(xiii) case management;

(xiv) prosthetics, orthotics, durable medical equipment, or medical supplies;

(xv) dental services;

(xvi) hospice care;

(xvii) audiology services and hearing aids;

(xviii) podiatry services;

(xix) chiropractic services;

(xx) immunizations;

(xxi) vision services and eyeglasses;

(xxii) waiver services;

(xxiii) individualized education programs; or

(xxiv) chemical dependency treatment.

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

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

(k) Noncitizens who are lawfully present in the United States as defined in Code of Federal Regulations, title 8, section 103.12, who are not children or pregnant women as defined in paragraph (d), and who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance without federal financial participation. These individuals must cooperate with the United States Citizenship and Immigration Services to pursue any applicable immigration status, including citizenship, that would qualify them for medical assistance with federal financial participation.

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

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

Subd. 3. **Accountability.** (a) Health care delivery systems must accept responsibility for the quality of care based on standards established under subdivision 1, paragraph (b),

clause (10), and the cost of care or utilization of services provided to its enrollees under subdivision 1, paragraph (b), clause (1).

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

(c) A health care delivery system must demonstrate how its services will be coordinated with other services affecting its attributed patients' health, quality of care, and cost of care that are provided by other providers and county agencies in the local service area. The health care delivery system must: (1) document how other providers and counties, including county-based purchasing plans, will provide services to persons attributed to the health care delivery system; (2) document how other providers and counties, including county-based purchasing plans, participated in developing the application; (3) provide verification that other providers and counties, including county-based purchasing plans, support the project and are willing to participate; and (4) document how it will address applicable local needs, priorities, and public health goals.

EFFECTIVE DATE. This section applies to health care delivery system contracts entered into or renewed on or after July 1, 2013.

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 28. Minnesota Statutes 2012, section 256L.01, is amended by adding a subdivision to read:

Subd. 4b. **Minnesota Insurance Marketplace.** "Minnesota Insurance Marketplace" means the Minnesota Insurance Marketplace as defined in Minnesota Statutes, section 62V.02.

Sec. 29. Minnesota Statutes 2012, section 256L.01, subdivision 5, is amended to read:

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

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

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

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

Subd. 8. **Participating entity.** "Participating entity" means a health carrier as defined in section 62A.011, subdivision 2; a county-based purchasing plan established under section 256B.692; an accountable care organization or other entity operating a health care delivery systems demonstration project authorized under section 256B.0755; an entity operating a county integrated health care delivery network pilot project authorized under section 256B.0756; or a network of health care providers established to offer services under MinnesotaCare.

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

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

Subd. 2. **Commissioner's duties.** The commissioner shall establish an office for the state administration of this plan. The plan shall be used to provide covered health services for eligible persons. Payment for these services shall be made to all ~~eligible providers~~ participating entities under contract with the commissioner. The commissioner shall adopt rules to administer the MinnesotaCare program. Nothing in this chapter is intended to violate the requirements of the Affordable Care Act. The commissioner shall not implement any provision of this chapter if the provision is found to violate the Affordable Care Act. The commissioner shall establish marketing efforts to encourage potentially eligible persons to receive information about the program and about other medical care programs administered or supervised by the Department of Human Services. A toll-free telephone number and Web site must be used to provide information about medical programs and to promote access to the covered services.

EFFECTIVE DATE. This section is effective January 1, 2014, or upon federal approval, whichever is later, except that the amendment related to "participating entities" is effective January 1, 2015. The commissioner of human services shall notify the revisor when federal approval is obtained.

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

Subd. 6. **Federal approval.** (a) The commissioner of human services shall seek federal approval to implement the MinnesotaCare program under this chapter as a basic health program. In any agreement with the Centers for Medicare and Medicaid Services to operate MinnesotaCare as a basic health program, the commissioner shall seek to include procedures to ensure that federal funding is predictable, stable, and sufficient to sustain ongoing operation of MinnesotaCare. These procedures must address issues related to the timing of federal payments, payment reconciliation, enrollee risk adjustment, and minimization of state financial risk. The commissioner shall consult with the commissioner of management and budget when developing the proposal for establishing MinnesotaCare as a basic health program to be submitted to the Centers for Medicare and Medicaid Services.

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

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

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

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

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

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

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

Subdivision 1. **Covered health services.** (a) "Covered health services" means the health services reimbursed under chapter 256B, and all essential health benefits required under section 1302 of the Affordable Care Act, with the exception of ~~inpatient hospital services,~~ special education services, private duty nursing services, adult dental care services other than services covered under section 256B.0625, subdivision 9, orthodontic services, nonemergency medical transportation services, personal care assistance and case management services, and nursing home or intermediate care facilities services~~, inpatient mental health services, and chemical dependency services~~.

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

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

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

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

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

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

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

Subd. 3. **Inpatient hospital services.** (a) Covered health services shall include inpatient hospital services, including inpatient hospital mental health services and inpatient hospital and residential chemical dependency treatment, subject to those limitations necessary to coordinate the provision of these services with eligibility under the medical assistance spenddown. ~~The inpatient hospital benefit for adult enrollees who qualify under section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and 2, with family gross income that exceeds 200 percent of the federal poverty guidelines or 215 percent of the federal poverty guidelines on or after July 1, 2009, and who are not pregnant, is subject to an annual limit of $10,000.~~

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

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

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

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

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

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

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

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

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

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

(2) $3 per prescription for adult enrollees;

(3) $25 for eyeglasses for adult enrollees;

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

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

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

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

(c) Paragraph (a) does not apply to ~~pregnant women and~~ children under the age of 21.

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

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

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

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

~~(h)~~ (g) The commissioner, through the contracting process under section 256L.12, may allow managed care plans and county-based purchasing plans to waive the family deductible under paragraph (a), clause (6). The value of the family deductible shall not be included in the capitation payment to managed care plans and county-based purchasing

plans. Managed care plans and county-based purchasing plans shall certify annually to the commissioner the dollar value of the family deductible.

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 1c. **General requirements.** To be eligible for coverage under MinnesotaCare, a person must meet the eligibility requirements of this section. A person eligible for MinnesotaCare shall not be treated as a qualified individual under section 1312 of the Affordable Care Act, and is not eligible for enrollment in a qualified health plan offered through the health benefit exchange under section 1331 of the Affordable Care Act.

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

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

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

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

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

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

Subd. 8. **Applicants potentially eligible for medical assistance.** (a) Individuals who receive supplemental security income or retirement, survivors, or disability benefits due to a disability, or other disability-based pension, who qualify under subdivision 7, but who are potentially eligible for medical assistance without a spenddown shall be allowed to enroll in MinnesotaCare for a period of 60 days, so long as the applicant meets all other conditions of eligibility. The commissioner shall identify and refer the applications of

such individuals to their county social service agency. The county and the commissioner shall cooperate to ensure that the individuals obtain medical assistance coverage for any months for which they are eligible.

(b) The enrollee must cooperate with the county social service agency in determining medical assistance eligibility within the 60-day enrollment period. Enrollees who do not cooperate with medical assistance within the 60-day enrollment period shall be disenrolled from the plan within one calendar month. Persons disenrolled for nonapplication for medical assistance may not reenroll until they have obtained a medical assistance eligibility determination. Persons disenrolled for noncooperation with medical assistance may not reenroll until they have cooperated with the county agency and have obtained a medical assistance eligibility determination.

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

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

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

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

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

(b) Eligible persons include individuals who are lawfully present and ineligible for medical assistance by reason of immigration status, who have family income equal to or less than 200 percent of the federal poverty guidelines for the applicable family size.

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

Sec. 45. Minnesota Statutes 2012, section 256L.04, is amended by adding a subdivision to read:

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

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

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

Sec. 46. Minnesota Statutes 2012, section 256L.05, subdivision 1, is amended to read:

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

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

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

Sec. 47. Minnesota Statutes 2012, section 256L.05, subdivision 2, is amended to read:

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

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

Sec. 48. Minnesota Statutes 2012, section 256L.05, subdivision 3, is amended to read:

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

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

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

~~(d)~~ (c) Notwithstanding any other law to the contrary, benefits under sections 256L.01 to 256L.18 are secondary to a plan of insurance or benefit program under which an eligible person may have coverage and the commissioner shall use cost avoidance

techniques to ensure coordination of any other health coverage for eligible persons. The commissioner shall identify eligible persons who may have coverage or benefits under other plans of insurance or who become eligible for medical assistance.

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

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

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

Sec. 49. Minnesota Statutes 2012, section 256L.06, subdivision 3, is amended to read:

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

(b) The commissioner shall develop and implement procedures to: (1) require enrollees to report changes in income; (2) adjust sliding scale premium payments, based upon both increases and decreases in enrollee income, at the time the change in income is reported; and (3) disenroll enrollees from MinnesotaCare for failure to pay required premiums. Failure to pay includes payment with a dishonored check, a returned automatic bank withdrawal, or a refused credit card or debit card payment. The commissioner may demand a guaranteed form of payment, including a cashier's check or a money order, as the only means to replace a dishonored, returned, or refused payment.

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

(d) Nonpayment of the premium will result in disenrollment from the plan effective for the calendar month for which the premium was due. ~~Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll until four calendar months have elapsed.~~ Persons disenrolled for nonpayment who pay

all past due premiums as well as current premiums due, including premiums due for the period of disenrollment, within 20 days of disenrollment, shall be reenrolled retroactively to the first day of disenrollment. ~~Persons disenrolled for nonpayment or who voluntarily terminate coverage from the program may not reenroll for four calendar months unless the person demonstrates good cause for nonpayment. Good cause does not exist if a person chooses to pay other family expenses instead of the premium. The commissioner shall define good cause in rule.~~

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

Sec. 50. Minnesota Statutes 2012, section 256L.07, subdivision 1, is amended to read:

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

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

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

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

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

Sec. 51. Minnesota Statutes 2012, section 256L.07, subdivision 2, is amended to read:

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

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

~~(c) For purposes of this requirement, subsidized health coverage means health coverage for which the employer pays at least 50 percent of the cost of coverage for the employee or dependent, or a higher percentage as specified by the commissioner. Children are eligible for employer-subsidized coverage through either parent, including the noncustodial parent. The commissioner must treat employer contributions to Internal Revenue Code Section 125 plans and any other employer benefits intended to pay health care costs as qualified employer subsidies toward the cost of health coverage for employees for purposes of this subdivision.~~

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

Sec. 52. Minnesota Statutes 2012, section 256L.07, subdivision 3, is amended to read:

Subd. 3. **Other health coverage.** (a) ~~Families and individuals enrolled in the MinnesotaCare program must have no~~ To be eligible, a family must not have minimum essential health coverage ~~while enrolled~~, as defined by section 5000A of the Internal Revenue Code. ~~Children with family gross incomes equal to or greater than 200 percent of federal poverty guidelines, and adults, must have had no health coverage for at least~~

~~four months prior to application and renewal. Children enrolled in the original children's health plan and children in families with income equal to or less than 200 percent of the federal poverty guidelines, who have other health insurance, are eligible if the coverage:~~

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

~~(i) basic hospital insurance;~~

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

~~(iii) prescription drug coverage;~~

~~(iv) dental coverage; or~~

~~(v) vision coverage;~~

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

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

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

~~(b) Coverage purchased as provided under section 256L.031, subdivision 2, medical assistance, and the Civilian Health and Medical Program of the Uniformed Service, CHAMPUS, or other coverage provided under United States Code, title 10, subtitle A, part II, chapter 55, are not considered insurance or health coverage for purposes of the four-month requirement described in this subdivision.~~

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

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

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

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

Sec. 53. Minnesota Statutes 2012, section 256L.09, subdivision 2, is amended to read:

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

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

Sec. 54. Minnesota Statutes 2012, section 256L.11, subdivision 6, is amended to read:

Subd. 6. ~~**Enrollees 18 or older**~~ **Reimbursement of inpatient hospital services.** Payment by the MinnesotaCare program for inpatient hospital services provided to MinnesotaCare enrollees eligible under section 256L.04, subdivision 7, or who qualify under section 256L.04, ~~subdivisions~~ subdivision 1 ~~and 2, with family gross income that exceeds 175 percent of the federal poverty guidelines and who are not pregnant, who are 18 years old or older on the date of admission to the inpatient hospital must be in accordance with paragraphs (a) and (b). Payment for adults who are not pregnant and are eligible under section 256L.04, subdivisions 1 and 2, and whose incomes are equal to or less than 175 percent of the federal poverty guidelines, shall be as provided for under paragraph (c).~~, shall be at the medical assistance rate minus any co-payment required under section 256L.03, subdivision 5. The hospital must not seek payment from the enrollee in addition to the co-payment. The MinnesotaCare payment plus the co-payment must be treated as payment in full.

~~(a) If the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4, is less than or equal to the amount remaining in the enrollee's benefit limit under section 256L.03, subdivision 3, payment must be the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4. The hospital must not seek payment from the enrollee in addition to the co-payment. The MinnesotaCare payment plus the co-payment must be treated as payment in full.~~

~~(b) If the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4, is greater than the amount remaining in the enrollee's benefit limit under section 256L.03, subdivision 3, payment must be the lesser of:~~

~~(1) the amount remaining in the enrollee's benefit limit; or~~

~~(2) charges submitted for the inpatient hospital services less any co-payment established under section 256L.03, subdivision 4.~~

~~The hospital may seek payment from the enrollee for the amount by which usual and customary charges exceed the payment under this paragraph. If payment is reduced under section 256L.03, subdivision 3, paragraph (b), the hospital may not seek payment from the enrollee for the amount of the reduction.~~

~~(c) For admissions occurring on or after July 1, 2011, for single adults and households without children who are eligible under section 256L.04, subdivision 7, the commissioner shall pay hospitals directly, up to the medical assistance payment rate, for inpatient hospital benefits up to the $10,000 annual inpatient benefit limit, minus any co-payment required under section 256L.03, subdivision 5. Inpatient services paid directly by the commissioner under this paragraph do not include chemical dependency hospital-based and residential treatment.~~

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

Sec. 55. **[256L.121] SERVICE DELIVERY.**

Subdivision 1. **Competitive process.** The commissioner of human services shall establish a competitive process for entering into contracts with participating entities for the offering of standard health plans through MinnesotaCare. Coverage through standard health plans must be available to enrollees beginning January 1, 2015. Each standard health plan must cover the health services listed in and meet the requirements of section 256L.03. The competitive process must meet the requirements of section 1331 of the Affordable Care Act and be designed to ensure enrollee access to high-quality health care coverage options. The commissioner, to the extent feasible, shall seek to ensure that enrollees have a choice of coverage from more than one participating entity within a geographic area. In rural areas other than metropolitan statistical areas, the commissioner shall use the medical assistance competitive procurement process under section 256B.69, subdivisions 1 to 32, under which selection of entities is based on criteria related to provider network access, coordination of health care with other local services, alignment with local public health goals, and other factors.

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

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

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

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

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

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

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

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

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

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

Sec. 56. Minnesota Statutes 2012, section 256L.15, subdivision 1, is amended to read:

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

~~(b) Pregnant women and children under age two are exempt from the provisions of section 256L.06, subdivision 3, paragraph (b), clause (3), requiring disenrollment for failure to pay premiums. For pregnant women, this exemption continues until the first day of the month following the 60th day postpartum. Women who remain enrolled during pregnancy or the postpartum period, despite nonpayment of premiums, shall be disenrolled on the first of the month following the 60th day postpartum for the penalty period that otherwise applies under section 256L.06, unless they begin paying premiums.~~

~~(c)~~ (b) Members of the military and their families who meet the eligibility criteria for MinnesotaCare upon eligibility approval made within 24 months following the end of the member's tour of active duty shall have their premiums paid by the commissioner. The effective date of coverage for an individual or family who meets the criteria of this

paragraph shall be the first day of the month following the month in which eligibility is approved. This exemption applies for 12 months.

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

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

Sec. 57. Minnesota Statutes 2012, section 256L.15, subdivision 2, is amended to read:

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

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

~~be excluded from the total. The maximum premium for two enrollees shall be twice the maximum premium for one, and the maximum premium for three or more enrollees shall be three times the maximum premium for one.~~

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

~~(d)~~ (c) The following premium scale is established for individuals and families with ~~gross family~~ incomes of ~~275~~ 200 percent of the federal poverty guidelines or less:

Federal Poverty Guideline Range	**Percent of Average Gross Monthly Income**
0-45%	minimum
46-54%	$4 or 1.1% of family income, whichever is greater
55-81%	1.6%
82-109%	2.2%
110-136%	2.9%
137-164%	3.6%
~~165-191~~ 165-200%	4.6%
~~192-219%~~	~~5.6%~~
~~220-248%~~	~~6.5%~~
~~249-275%~~	~~7.2%~~

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

Sec. 58. **DETERMINATION OF FUNDING ADEQUACY.**

The commissioners of revenue and management and budget, in consultation with the commissioner of human services, shall conduct an assessment of health care taxes, including the gross premiums tax, the provider tax, and Medicaid surcharges, and their relationship to the long-term solvency of the health care access fund, as part of the state revenue and expenditure forecast in November 2013. The commissioners shall determine the amount of state funding that will be required after December 31, 2019, in addition to the federal payments made available under section 1331 of the Affordable Care Act, for the MinnesotaCare program. The commissioners shall evaluate the stability and likelihood of long-term federal funding for the MinnesotaCare program under section 1331. The commissioners shall report the results of this assessment to the legislature by January 15,

2014, along with recommendations for changes to state revenue for the health care access fund, if state funding will continue to be required beyond December 31, 2019.

Sec. 59. **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) can be conducted at 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 asses 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 and 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, the board of MNsure means the board established under Minnesota Statutes, section 62V.03.

Sec. 60. **REQUEST FOR FEDERAL AUTHORITY.**

The commissioner of human services shall seek authority from the federal Centers for Medicare and Medicaid Services to allow persons under age 65, participating in a home and community-based services waiver under section 1915(c) of the Social Security Act, to continue to disregard spousal income and assets, in place of the spousal impoverishment provisions under the federal Patient Protection and Affordable Care Act, Public Law 111-148, section 2404, as amended by the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendments to, or regulations and guidance issued under, those acts.

Sec. 61. **REVISOR'S INSTRUCTION.**

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

Sec. 62. **REPEALER.**

(a) Minnesota Statutes 2012, sections 256L.01, subdivision 4a; 256L.031; 256L.04, subdivisions 1b, 9, and 10a; 256L.05, subdivision 3b; 256L.07, subdivisions 5, 8, and 9; 256L.11, subdivision 5; and 256L.17, subdivisions 1, 2, 3, 4, and 5, are repealed effective January 1, 2014.

(b) Minnesota Statutes 2012, section 256L.12, is repealed effective January 1, 2015.

(c) Minnesota Statutes 2012, sections 256B.055, subdivisions 3, 5, and 10b; 256B.056, subdivision 5b; and 256B.057, subdivisions 1c and 2, are repealed effective January 1, 2014.

ARTICLE 2

REFORM 2020; REDESIGNING HOME AND COMMUNITY-BASED SERVICES

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

Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically submit to the commissioner of health case mix assessments that conform

with the assessment schedule defined by Code of Federal Regulations, title 42, section 483.20, and published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, in the Long Term Care Assessment Instrument User's Manual, version 3.0, and subsequent updates when issued by the Centers for Medicare and Medicaid Services. The commissioner of health may substitute successor manuals or question and answer documents published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, to replace or supplement the current version of the manual or document.

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

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

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

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

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

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

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

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

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

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

Subdivision 1. **Report requirements.** The commissioners of health and human services, with the cooperation of counties and in consultation with stakeholders, including persons who need or are using long-term care services and supports, lead agencies, regional entities, senior, disability, and mental health organization representatives, service providers, and community members shall prepare a report to the legislature by August 15,

2013, and biennially thereafter, regarding the status of the full range of long-term care services and supports for the elderly and children and adults with disabilities and mental illnesses in Minnesota. The report shall address:

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

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

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

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

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

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

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

Subd. 2. **Critical access study.** The commissioner shall conduct a onetime study to assess local capacity and availability of home and community-based services for older adults, people with disabilities, and people with mental illnesses. The study must assess critical access at the community level and identify potential strategies to build home and community-based service capacity in critical access areas. The report shall be submitted to the legislature no later than August 15, 2015.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) Act as the agent of and cooperate with the federal government in matters of mutual concern relative to and in conformity with the provisions of Laws 1939, chapter 431, including the administration of any federal funds granted to the state to aid in the performance of any functions of the commissioner as specified in Laws 1939, chapter 431, and including the promulgation of rules making uniformly available medical care benefits to all recipients of public assistance, at such times as the federal government increases its participation in assistance expenditures for medical care to recipients of public assistance, the cost thereof to be borne in the same proportion as are grants of aid to said recipients.

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

(h) Act as designated guardian of both the estate and the person of all the wards of the state of Minnesota, whether by operation of law or by an order of court, without any further act or proceeding whatever, except as to persons committed as developmentally disabled. For children under the guardianship of the commissioner or a tribe in Minnesota recognized by the Secretary of the Interior whose interests would be best served by adoptive placement, the commissioner may contract with a licensed child-placing agency or a Minnesota tribal social services agency to provide adoption services. A contract with a licensed child-placing agency must be designed to supplement existing county efforts and may not replace existing county programs or tribal social services, unless the replacement is agreed to by the county board and the appropriate exclusive bargaining representative, tribal governing body, or the commissioner has evidence that child

placements of the county continue to be substantially below that of other counties. Funds encumbered and obligated under an agreement for a specific child shall remain available until the terms of the agreement are fulfilled or the agreement is terminated.

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

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

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

(l) Have the authority to conduct and administer experimental projects to test methods and procedures of administering assistance and services to recipients or potential recipients of public welfare. To carry out such experimental projects, it is further provided that the commissioner of human services is authorized to waive the enforcement of existing specific statutory program requirements, rules, and standards in one or more counties. The order establishing the waiver shall provide alternative methods and procedures of administration, shall not be in conflict with the basic purposes, coverage, or benefits provided by law, and in no event shall the duration of a project exceed four years. It is further provided that no order establishing an experimental project as authorized by the provisions of this section shall become effective until the following conditions have been met:

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

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

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

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

(1) one-half of the total amount of the disallowance shall be borne by the county boards responsible for administering the programs. For the medical assistance and the AFDC program formerly codified in sections 256.72 to 256.87, disallowances shall be

shared by each county board in the same proportion as that county's expenditures for the sanctioned program are to the total of all counties' expenditures for the AFDC program formerly codified in sections 256.72 to 256.87, and medical assistance programs. For the food stamp program, sanctions shall be shared by each county board, with 50 percent of the sanction being distributed to each county in the same proportion as that county's administrative costs for food stamps are to the total of all food stamp administrative costs for all counties, and 50 percent of the sanctions being distributed to each county in the same proportion as that county's value of food stamp benefits issued are to the total of all benefits issued for all counties. Each county shall pay its share of the disallowance to the state of Minnesota. When a county fails to pay the amount due hereunder, the commissioner may deduct the amount from reimbursement otherwise due the county, or the attorney general, upon the request of the commissioner, may institute civil action to recover the amount due; and

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

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

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

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

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

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

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

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

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

(6) the commissioner may not delay payments, withhold funds, or require repayment under clause (3) or (5) if the county demonstrates that the commissioner failed to provide appropriate forms, guidelines, and technical assistance to enable the county to comply with the requirements. If the county board disagrees with an action taken by the

commissioner under clause (3) or (5), the county board may appeal the action according to sections 14.57 to 14.69; and

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

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

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

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

(u) Have the authority to administer a drug rebate program for drugs purchased pursuant to the prescription drug program established under section 256.955 after the beneficiary's satisfaction of any deductible established in the program. The commissioner shall require a rebate agreement from all manufacturers of covered drugs as defined in section 256B.0625, subdivision 13. Rebate agreements for prescription drugs delivered on or after July 1, 2002, must include rebates for individuals covered under the prescription drug program who are under 65 years of age. For each drug, the amount of the rebate shall be equal to the rebate as defined for purposes of the federal rebate program in United States Code, title 42, section 1396r-8. The manufacturers must provide full payment within 30 days of receipt of the state invoice for the rebate within the terms and conditions used for the federal rebate program established pursuant to section 1927 of title XIX of the Social Security Act. The manufacturers must provide the commissioner with any information necessary to verify the rebate determined per drug. The rebate program shall utilize the terms and conditions used for the federal rebate program established pursuant to section 1927 of title XIX of the Social Security Act.

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

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

(x) Operate the department's communication systems account established in Laws 1993, First Special Session chapter 1, article 1, section 2, subdivision 2, to manage shared communication costs necessary for the operation of the programs the commissioner supervises. A communications account may also be established for each regional treatment center which operates communications systems. Each account must be used to manage shared communication costs necessary for the operations of the programs the commissioner supervises. The commissioner may distribute the costs of operating and maintaining communication systems to participants in a manner that reflects actual usage. Costs may include acquisition, licensing, insurance, maintenance, repair, staff time and other costs as determined by the commissioner. Nonprofit organizations and state, county, and local government agencies involved in the operation of programs the commissioner supervises may participate in the use of the department's communications technology and share in the cost of operation. The commissioner may accept on behalf of the state any gift, bequest, devise or personal property of any kind, or money tendered to the state for any lawful purpose pertaining to the communication activities of the department. Any money received for this purpose must be deposited in the department's communication systems accounts. Money collected by the commissioner for the use of communication systems must be deposited in the state communication systems account and is appropriated to the commissioner for purposes of this section.

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

(z) Designate community information and referral call centers and incorporate cost reimbursement claims from the designated community information and referral call centers into the federal cost reimbursement claiming processes of the department according to federal law, rule, and regulations. Existing information and referral centers provided by Greater Twin Cities United Way or existing call centers for which Greater Twin Cities United Way has legal authority to represent, shall be included in these

designations upon review by the commissioner and assurance that these services are accredited and in compliance with national standards. Any reimbursement is appropriated to the commissioner and all designated information and referral centers shall receive payments according to normal department schedules established by the commissioner upon final approval of allocation methodologies from the United States Department of Health and Human Services Division of Cost Allocation or other appropriate authorities.

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

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

(cc) Have the authority to administer a drug rebate program for drugs purchased for persons eligible for general assistance medical care under section 256D.03, subdivision 3. For manufacturers that agree to participate in the general assistance medical care rebate program, the commissioner shall enter into a rebate agreement for covered drugs as defined in section 256B.0625, subdivisions 13 and 13d. For each drug, the amount of the rebate shall be equal to the rebate as defined for purposes of the federal rebate program in United States Code, title 42, section 1396r-8. The manufacturers must provide payment within the terms and conditions used for the federal rebate program established under section 1927 of title XIX of the Social Security Act. The rebate program shall utilize the terms and conditions used for the federal rebate program established under section 1927 of title XIX of the Social Security Act.

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

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

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

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

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

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

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

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

(2) provide information about state and federal eligibility requirements, benefits, and service options;

(3) provide benefits and options counseling;

(4) make referrals to appropriate support entities;

(5) educate people on their options so they can make well-informed choices and link them to quality profiles;

(6) help support the timely resolution of service access and benefit issues;

(7) inform people of their long-term community services and supports;

(8) provide necessary resources and supports that can lead to employment and increased economic stability of people with disabilities; ~~and~~

(9) serve as the technical assistance and help center for the Web-based tool, Minnesota's Disability Benefits 101.org~~.~~; and

(10) provide preadmission screening for individuals under 60 years of age using the procedures as defined in section 256.975, subdivisions 7a to 7c, and 256B.0911, subdivision 4d.

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

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

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

(1) develop a comprehensive database that includes detailed listings in both consumer- and provider-oriented formats;

(2) make the database accessible on the Internet and through other telecommunication and media-related tools;

(3) link callers to interactive long-term care screening tools and make these tools available through the Internet by integrating the tools with the database;

(4) develop community education materials with a focus on planning for long-term care and evaluating independent living, housing, and service options;

(5) conduct an outreach campaign to assist older adults and their caregivers in finding information on the Internet and through other means of communication;

(6) implement a messaging system for overflow callers and respond to these callers by the next business day;

(7) link callers with county human services and other providers to receive more in-depth assistance and consultation related to long-term care options;

(8) link callers with quality profiles for nursing facilities and other home and community-based services providers developed by the ~~commissioner~~ commissioners of health and human services;

(9) incorporate information about the availability of housing options, as well as registered housing with services and consumer rights within the MinnesotaHelp.info network long-term care database to facilitate consumer comparison of services and costs among housing with services establishments and with other in-home services and to support financial self-sufficiency as long as possible. Housing with services establishments and their arranged home care providers shall provide information that will facilitate price comparisons, including delineation of charges for rent and for services available. The commissioners of health and human services shall align the data elements required by section 144G.06, the Uniform Consumer Information Guide, and this section to provide consumers standardized information and ease of comparison of long-term care options. The commissioner of human services shall provide the data to the Minnesota Board on Aging for inclusion in the MinnesotaHelp.info network long-term care database;

(10) provide long-term care options counseling. Long-term care options counselors shall:

(i) for individuals not eligible for case management under a public program or public funding source, provide interactive decision support under which consumers, family members, or other helpers are supported in their deliberations to determine appropriate long-term care choices in the context of the consumer's needs, preferences, values, and individual circumstances, including implementing a community support plan;

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

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

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

(11) using risk management and support planning protocols, provide long-term care options counseling to current residents of nursing homes deemed appropriate for discharge by the commissioner and older adults who request service after consultation with the Senior LinkAge Line under clause (12). ~~In order to meet this requirement,~~ The Senior

LinkAge Line shall also receive referrals from the residents or staff of nursing homes. The Senior LinkAge Line shall identify and contact residents deemed appropriate for discharge by developing targeting criteria in consultation with the commissioner who shall provide designated Senior LinkAge Line contact centers with a list of nursing home residents that meet the criteria as being appropriate for discharge planning via a secure Web portal. Senior LinkAge Line shall provide these residents, if they indicate a preference to receive long-term care options counseling, with initial assessment~~, review of risk factors, independent living support consultation, or~~ and, if appropriate, a referral to:

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

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

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

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

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

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

(b) A person who has a diagnosis or possible diagnosis of mental illness or developmental disability must receive a preadmission screening before admission regardless of the exemptions outlined in subdivision 7b, paragraphs (a) and (b), to identify the need for further evaluation and specialized services, unless the admission prior to

screening is authorized by the local mental health authority or the local developmental disabilities case manager, or unless authorized by the county agency according to Public Law 101-508.

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

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

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

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

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

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

(d) The local county mental health authority or the state developmental disability authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a nursing facility if the individual does not meet the nursing facility level of care criteria or needs specialized services as defined in Public Law Numbers 100-203 and 101-508. For purposes of this section, "specialized services" for a person with developmental disability means active treatment as that term is defined under Code of Federal Regulations, title 42, section 483.440(a)(1).

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

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

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

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

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

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

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

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

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

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

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

(1) persons described in paragraph (a);

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

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

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

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

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

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

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

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

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

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

Transfer of a patient from an acute care hospital to a nursing facility is not considered an emergency except for a person who has received hospital services in the following situations: hospital admission for observation, care in an emergency room without hospital

admission, or following hospital 24-hour bed care and from whom admission is being sought on a nonworking day.

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

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

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

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

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

(2) the person needs an immediate face-to-face long-term care consultation assessment completed under section 256B.0911, subdivision 3a, 3b, or 4d, by a county, tribe, or managed care organization under contract with the Department of Human Services to determine the need for nursing facility level of care and complete activities required under subdivision 7a; or

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

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

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

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

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

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

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

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

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

Subd. 3a. **Priority for other grants.** The commissioner of health shall give priority to a grantee selected under subdivision 3 when awarding technology-related grants, if the grantee is using technology as part of the proposal unless that priority conflicts with existing state or federal guidance related to grant awards by the Department of Health. The commissioner of transportation shall give priority to a grantee under subdivision 3 when distributing transportation-related funds to create transportation options for older adults unless that preference conflicts with existing state or federal guidance related to grant awards by the Department of Transportation.

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

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

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

Subd. 5. **Grant preference.** The commissioner of human services shall give preference when awarding grants under this section to areas where nursing facility closures have occurred or are occurring or areas with service needs identified by section 144A.351. The commissioner may award grants to the extent grant funds are available

and to the extent applications are approved by the commissioner. Denial of approval of an application in one year does not preclude submission of an application in a subsequent year. The maximum grant amount is limited to $750,000.

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

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

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

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

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

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

Subd. 6. **Work, empower, and encourage independence.** As provided under subdivision 4, paragraph (e), upon federal approval, the commissioner shall establish a demonstration project to provide navigation, employment supports, and benefits planning services to a targeted group of federally funded Medicaid recipients to begin July 1, 2014. This demonstration shall promote economic stability, increase independence, and reduce applications for disability benefits while providing a positive impact on the health and future of participants.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(7)~~ (6) determination of home and community-based waiver and other service eligibility as required under sections 256B.0913, 256B.0915, and 256B.49, including level

of care determination for individuals who need an institutional level of care as determined under section 256B.0911, subdivision ~~4a, paragraph (d)~~ 4e, based on assessment and community support plan development, appropriate referrals to obtain necessary diagnostic information, and including an eligibility determination for consumer-directed community supports;

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

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

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

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

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

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

(ii) section 256B.0657; or

(iii) consumer support grants under section 256.476;

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

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

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

(c) "Long-term care options counseling" means the services provided by the linkage lines as mandated by sections 256.01, subdivision 24, and 256.975, subdivision 7, and

also includes telephone assistance and follow up once a long-term care consultation assessment has been completed.

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

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

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

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

(b) The lead agency may utilize a team of either the social worker or public health nurse, or both. Upon implementation of subdivisions 2b, 2c, and 5, lead agencies shall use certified assessors to conduct the assessment. The consultation team members must confer regarding the most appropriate care for each individual screened or assessed. For a person with complex health care needs, a public health or registered nurse from the team must be consulted.

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

(d) The assessment must be conducted in a face-to-face interview with the person being assessed and the person's legal representative, and other individuals as requested by the person, who can provide information on the needs, strengths, and preferences of the person necessary to develop a community support plan that ensures the person's health and safety, but who is not a provider of service or has any financial interest in the provision of services. For persons who are to be assessed for elderly waiver customized living

services under section 256B.0915, with the permission of the person being assessed or the person's designated or legal representative, the client's current or proposed provider of services may submit a copy of the provider's nursing assessment or written report outlining its recommendations regarding the client's care needs. The person conducting the assessment will notify the provider of the date by which this information is to be submitted. This information shall be provided to the person conducting the assessment prior to the assessment.

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

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

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

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

(4) referral information; and

(5) informal caregiver supports, if applicable.

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

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

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

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

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

(2) documentation that the most cost-effective alternatives available were offered to the individual. For purposes of this clause, "cost-effective" means community services and

living arrangements that cost the same as or less than institutional care. For an individual found to meet eligibility criteria for home and community-based service programs under section 256B.0915 or 256B.49, "cost-effectiveness" has the meaning found in the federally approved waiver plan for each program;

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

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

(5) information about Minnesota health care programs;

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

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

(8) the certified assessor's decision regarding the person's need for institutional level of care as determined under criteria established in section 256B.0911, subdivision ~~4a, paragraph (d)~~ 4e, and the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 1a, paragraphs (a), clause (7), and (b); and

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

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

(j) The effective eligibility start date for programs in paragraph (i) can never be prior to the date of assessment. If an assessment was completed more than 60 days before the effective waiver or alternative care program eligibility start date, assessment

and support plan information must be updated in a face-to-face visit and documented in the department's Medicaid Management Information System (MMIS). Notwithstanding retroactive medical assistance coverage of state plan services, the effective date of eligibility for programs included in paragraph (i) cannot be prior to the date the most recent updated assessment is completed.

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

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

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

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

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

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

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

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

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

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

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

(j) Funding for preadmission screening shall be provided to the Disability Linkage Line for the under 60 population by the Department of Human Services to cover screener salaries and expenses to provide the services described in subdivisions 7a to 7c. The Disability Linkage Line shall employ, or contract with other agencies to employ, within the limits of available funding, sufficient personnel to provide preadmission screening and level of care determination services and shall seek to maximize federal funding for the service as provided under section 256.01, subdivision 2, paragraph (dd).

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

Sec. 21. Minnesota Statutes 2012, section 256B.0911, is amended by adding a subdivision to read:

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

Sec. 22. Minnesota Statutes 2012, section 256B.0911, subdivision 7, is amended to read:

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

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

Sec. 23. Minnesota Statutes 2012, section 256B.0913, subdivision 4, is amended to read:

Subd. 4. **Eligibility for funding for services for nonmedical assistance recipients.** (a) Funding for services under the alternative care program is available to persons who meet the following criteria:

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

(2) the person is age 65 or older;

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

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

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

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

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

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

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

(i) the appointment of a representative payee;

(ii) automatic payment from a financial account;

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

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

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

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

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

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

Sec. 24. Minnesota Statutes 2012, section 256B.0913, is amended by adding a subdivision to read:

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

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

(1) is age 65 or older;

(2) is not eligible for medical assistance;

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

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

(5) has a community support plan; and

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

(i) caregiver support;

(ii) homemaker support;

(iii) chores; or

(iv) a personal emergency response device or system.

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

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

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

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

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

(2) meets one of the following criteria:

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

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

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

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

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

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

Sec. 25. Minnesota Statutes 2012, section 256B.0915, subdivision 3a, is amended to read:

Subd. 3a. **Elderly waiver cost limits.** (a) The monthly limit for the cost of waivered services to an individual elderly waiver client except for individuals described in ~~paragraph~~ paragraphs (b) and (d) shall be the weighted average monthly nursing facility rate of the case mix resident class to which the elderly waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, less the recipient's maintenance needs allowance as described in subdivision 1d, paragraph (a), until the first day of the state fiscal year in which the resident assessment system as described in section 256B.438 for nursing home rate determination is implemented. Effective on the first day of the state fiscal year in which the resident assessment system as described in section 256B.438 for

nursing home rate determination is implemented and the first day of each subsequent state fiscal year, the monthly limit for the cost of waivered services to an individual elderly waiver client shall be the rate of the case mix resident class to which the waiver client would be assigned under Minnesota Rules, parts 9549.0050 to 9549.0059, in effect on the last day of the previous state fiscal year, adjusted by any legislatively adopted home and community-based services percentage rate adjustment.

(b) The monthly limit for the cost of waivered services to an individual elderly waiver client assigned to a case mix classification A under paragraph (a) with:

(1) no dependencies in activities of daily living; or

(2) up to two dependencies in bathing, dressing, grooming, walking, and eating when the dependency score in eating is three or greater as determined by an assessment performed under section 256B.0911

shall be $1,750 per month effective on July 1, 2011, for all new participants enrolled in the program on or after July 1, 2011. This monthly limit shall be applied to all other participants who meet this criteria at reassessment. This monthly limit shall be increased annually as described in paragraph (a).

(c) If extended medical supplies and equipment or environmental modifications are or will be purchased for an elderly waiver client, the costs may be prorated for up to 12 consecutive months beginning with the month of purchase. If the monthly cost of a recipient's waivered services exceeds the monthly limit established in paragraph (a) or (b), the annual cost of all waivered services shall be determined. In this event, the annual cost of all waivered services shall not exceed 12 times the monthly limit of waivered services as described in paragraph (a) or (b).

(d) Effective July 1, 2013, the monthly cost limit of waiver services, including any necessary home care services described in section 256B.0651, subdivision 2, for individuals who meet the criteria as ventilator-dependent given in section 256B.0651, subdivision 1, paragraph (g), shall be the average of the monthly medical assistance amount established for home care services as described in section 256B.0652, subdivision 7, and the annual average contracted amount established by the commissioner for nursing facility services for ventilator-dependent individuals. This monthly limit shall be increased annually as described in paragraph (a).

Sec. 26. Minnesota Statutes 2012, section 256B.0915, is amended by adding a subdivision to read:

Subd. 3j. **Individual community living support.** Upon federal approval, there is established a new service called individual community living support (ICLS) that is

available on the elderly waiver. ICLS providers may not be the landlord of recipients, nor have any interest in the recipient's housing. ICLS must be delivered in a single-family home or apartment where the service recipient or their family owns or rents, as demonstrated by a lease agreement, and maintains control over the individual unit. Case managers or care coordinators must develop individual ICLS plans in consultation with the client using a tool developed by the commissioner. The commissioner shall establish payment rates and mechanisms to align payments with the type and amount of service provided, assure statewide uniformity for payment rates, and assure cost-effectiveness. Licensing standards for ICLS shall be reviewed jointly by the Departments of Health and Human Services to avoid conflict with provider regulatory standards pursuant to section 144A.43 and chapter 245D.

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

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

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

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

Subd. 1a. **Home and community-based services for older adults.** (a) The purpose of projects selected by the commissioner of human services under this section is to make strategic changes in the long-term services and supports system for older adults including statewide capacity for local service development and technical assistance, and statewide availability of home and community-based services for older adult services,

caregiver support and respite care services, and other supports in the state of Minnesota. These projects are intended to create incentives for new and expanded home and community-based services in Minnesota in order to:

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

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

(3) support the informal caregivers of older adults;

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

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

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

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

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

(9) strengthen programs that use volunteers.

(b) The services provided by these projects are available to older adults who are eligible for medical assistance and the elderly waiver under section 256B.0915, the alternative care program under section 256B.0913, or essential community supports grant under subdivision 14, paragraph (b), and to persons who have their own funds to pay for services.

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

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

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

(c) "Core home and community-based services provider" means a Faith in Action, Living at Home Block Nurse, Congregational Nurse, or similar community-based program governed by a board, the majority of whose members reside within the program's service area, that organizes and uses volunteers and paid staff to deliver nonmedical

services intended to assist older adults to identify and manage risks and to maintain their community living and integration in the community.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) identify at-risk caregivers;

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

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

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

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

~~(d) The commissioner shall select grantees based on the following criteria~~ (b) Projects must clearly describe:

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

~~(2) the ability of the proposal to clearly describe how the project~~ (1) how they will achieve ~~the~~ their purpose ~~defined in paragraph (b)~~;

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

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

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

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

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

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

(2) recruit and train volunteer providers;

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

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

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

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

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

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

Subd. 7a. **Core home and community-based services.** The commissioner shall select and contract with core home and community-based services providers for projects to provide services and supports to older adults both with and without family and other informal caregivers using a request for proposals process. Projects must:

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 34. Minnesota Statutes 2012, section 256B.092, is amended by adding a subdivision to read:

Subd. 14. **Reduce avoidable behavioral crisis emergency room, psychiatric inpatient hospitalizations, and commitments to institutions.** (a) Persons receiving home and community-based services authorized under this section who have had two or more admissions within a calendar year to an emergency room, psychiatric unit, or institution must receive consultation from a mental health professional as defined in section 245.462, subdivision 18, or a behavioral professional as defined in the home and community-based services state plan within 30 days of discharge. The mental health professional or behavioral professional must:

(1) conduct a functional assessment of the crisis incident as defined in section 245D.02, subdivision 11, which led to the hospitalization with the goal of developing proactive strategies as well as necessary reactive strategies to reduce the likelihood of future avoidable hospitalizations due to a behavioral crisis;

(2) use the results of the functional assessment to amend the coordinated service and support plan set forth in section 245D.02, subdivision 4b, to address the potential need for additional staff training, increased staffing, access to crisis mobility services, mental

health services, use of technology, and crisis stabilization services in section 256B.0624, subdivision 7; and

(3) identify the need for additional consultation, testing, and mental health crisis intervention team services as defined in section 245D.02, subdivision 20, psychotropic medication use and monitoring under section 245D.051, as well as the frequency and duration of ongoing consultation.

(b) For the purposes of this subdivision, "institution" includes, but is not limited to, the Anoka-Metro Regional Treatment Center and the Minnesota Security Hospital.

Sec. 35. Minnesota Statutes 2012, section 256B.439, subdivision 1, is amended to read:

Subdivision 1. **Development and implementation of quality profiles.** (a) The commissioner of human services, in cooperation with the commissioner of health, shall develop and implement ~~a~~ quality ~~profile system~~ profiles for nursing facilities and, beginning not later than July 1, ~~2004~~ 2014, other providers of long-term care services, except when the quality profile system would duplicate requirements under section 256B.5011, 256B.5012, or 256B.5013. The ~~system~~ quality profiles must be developed ~~and implemented to the extent possible without the collection of significant amounts of new data. To the extent possible, the system~~ using existing data sets maintained by the commissioners of health and human services to the extent possible. The profiles must incorporate or be coordinated with information on quality maintained by area agencies on aging, long-term care trade associations, the ombudsman offices, counties, tribes, health plans, and other entities and the long-term care database maintained under section 256.975, subdivision 7. The ~~system~~ profiles must be designed to provide information on quality to:

(1) consumers and their families to facilitate informed choices of service providers;

(2) providers to enable them to measure the results of their quality improvement efforts and compare quality achievements with other service providers; and

(3) public and private purchasers of long-term care services to enable them to purchase high-quality care.

(b) The ~~system~~ profiles must be developed in consultation with the long-term care task force, area agencies on aging, and representatives of consumers, providers, and labor unions. Within the limits of available appropriations, the commissioners may employ consultants to assist with this project.

Sec. 36. Minnesota Statutes 2012, section 256B.439, subdivision 2, is amended to read:

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

(1) emphasize quality of care and its relationship to quality of life; and

(2) address the needs of various users of long-term care services, including, but not limited to, short-stay residents, persons with behavioral problems, persons with dementia, and persons who are members of minority groups.

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

Sec. 37. Minnesota Statutes 2012, section 256B.439, subdivision 3, is amended to read:

Subd. 3. **Consumer surveys of nursing facilities residents.** Following identification of the quality measurement tool, the commissioners shall conduct surveys of long-term care service consumers of nursing facilities to develop quality profiles of providers. To the extent possible, surveys must be conducted face-to-face by state employees or contractors. At the discretion of the commissioners, surveys may be conducted by telephone or by provider staff. Surveys must be conducted periodically to update quality profiles of individual ~~service~~ nursing facilities providers.

Sec. 38. Minnesota Statutes 2012, section 256B.439, is amended by adding a subdivision to read:

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

Sec. 39. Minnesota Statutes 2012, section 256B.439, subdivision 4, is amended to read:

Subd. 4. **Dissemination of quality profiles.** By July 1, ~~2003~~ 2014, the commissioners shall implement a ~~system~~ public awareness effort to disseminate the quality profiles ~~developed from consumer surveys using the quality measurement tool~~. Profiles

may be disseminated ~~to~~ through the Senior LinkAge Line and Disability Linkage Line and to consumers, providers, and purchasers of long-term care services ~~through all feasible printed and electronic outlets. The commissioners may conduct a public awareness campaign to inform potential users regarding profile contents and potential uses~~.

Sec. 40. Minnesota Statutes 2012, section 256B.49, subdivision 12, is amended to read:

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

Sec. 41. Minnesota Statutes 2012, section 256B.49, subdivision 14, is amended to read:

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

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

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

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

(e) The commissioner shall develop criteria to identify recipients whose level of functioning is reasonably expected to improve and reassess these recipients to establish a baseline assessment. Recipients who meet these criteria must have a comprehensive transitional service plan developed under subdivision 15, paragraphs (b) and (c), and be reassessed every six months until there has been no significant change in the recipient's functioning for at least 12 months. After there has been no significant change in the recipient's functioning for at least 12 months, reassessments of the recipient's strengths, informal support systems, and need for services shall be conducted at least every 12 months and at other times when there has been a significant change in the recipient's functioning. Counties, case managers, and service providers are responsible for conducting these reassessments and shall complete the reassessments out of existing funds.

Sec. 42. Minnesota Statutes 2012, section 256B.49, is amended by adding a subdivision to read:

Subd. 25. **Reduce avoidable behavioral crisis emergency room, psychiatric inpatient hospitalizations, and commitments to institutions.** (a) Persons receiving home and community-based services authorized under this section who have two or more admissions within a calendar year to an emergency room, psychiatric unit, or institution must receive consultation from a mental health professional as defined in section 245.462, subdivision 18, or a behavioral professional as defined in the home and community-based services state plan within 30 days of discharge. The mental health professional or behavioral professional must:

(1) conduct a functional assessment of the crisis incident as defined in section 245D.02, subdivision 11, which led to the hospitalization with the goal of developing proactive strategies as well as necessary reactive strategies to reduce the likelihood of future avoidable hospitalizations due to a behavioral crisis;

(2) use the results of the functional assessment to amend the coordinated service and support plan in section 245D.02, subdivision 4b, to address the potential need for additional staff training, increased staffing, access to crisis mobility services, mental health services, use of technology, and crisis stabilization services in section 256B.0624, subdivision 7; and

(3) identify the need for additional consultation, testing, mental health crisis intervention team services as defined in section 245D.02, subdivision 20, psychotropic

medication use and monitoring under section 245D.051, as well as the frequency and duration of ongoing consultation.

(b) For the purposes of this subdivision, "institution" includes, but is not limited to, the Anoka-Metro Regional Treatment Center and the Minnesota Security Hospital.

Sec. 43. **[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. 44. Minnesota Statutes 2012, section 256I.05, is amended by adding a subdivision to read:

Subd. 1o. **Supplementary service rate; exemptions.** A county agency shall not negotiate a supplementary service rate under this section for any individual that has been determined to be eligible for Housing Stability Services as approved by the Centers for Medicare and Medicaid Services, and who resides in an establishment voluntarily registered under section 144D.025, as a supportive housing establishment or participates in the Minnesota supportive housing demonstration program under section 256I.04, subdivision 3, paragraph (a), clause (4).

Sec. 45. 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. 46. 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. 47. 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.

Sec. 48. **REPEALER.**

(a) Minnesota Statutes 2012, sections 245A.655; and 256B.0917, subdivisions 1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, and 14, are repealed.

(b) Minnesota Statutes 2012, section 256B.0911, subdivisions 4a, 4b, and 4c, are repealed effective October 1, 2013.

Sec. 49. **EFFECTIVE DATE; CONTINGENT SYSTEMS MODERNIZATION APPROPRIATION.**

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

(b) Unless otherwise indicated, "commissioner" means the commissioner of human services.

(c) "Contingent systems modernization appropriation" refers to the appropriation in article 15, section 2.

(d) "Department" means the Department of Human Services.

(e) "Plan" means the plan that outlines how the provisions in this article, and the contingent appropriation for systems modernization, are implemented once federal action on Reform 2020 has occurred.

(f) Unless otherwise indicated, "Reform 2020" means the commissioner's request for any necessary federal approval of provisions in this article that modify or provide new medical assistance services, or that otherwise modify the federal role in the state's long-term care system.

Subd. 2. **Intent; effective dates generally.** (a) Because the changes contained in this article generate savings that are contingent on federal approval of Reform 2020, the legislature has also made an appropriation for systems modernization contingent on federal approval of Reform 2020. The purpose of this section is to outline how this article

and the contingent systems modernization appropriation in article 15 are implemented if Reform 2020 is fully, partially, or incrementally approved or denied.

(b) In order for sections 1 to 48 of this article to be effective, the commissioner must follow the provisions of subdivisions 3 and 4, as applicable, notwithstanding any other effective dates for those sections.

Subd. 3. **Federal approval.** (a) The implementation of this article is contingent on federal approval.

(b) Upon full or partial approval of the waiver application, the commissioner shall develop a plan for implementing the provisions in this article that received federal approval as well as any that do not require federal approval. The plan must:

(1) include fiscal estimates for the 2014-2015 and 2016-2017 biennia;

(2) include the contingent systems modernization appropriation, which cannot exceed $16,992,000 for the biennium ending June 30, 2015; and

(3) include spending estimates that, with federal administrative reimbursement, do not exceed the department's net general fund appropriations for the 2014-2015 biennium.

(c) Upon approval by the commissioner of management and budget, the department may implement the plan.

(d) The commissioner may follow this plan and implement parts of Reform 2020 consistent with federal law if federal approval is denied, received incrementally, or significantly delayed.

(e) The commissioner must notify the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services funding of the plan. The plan must be made publicly available online.

Subd. 4. **Disbursement; implementation.** The commissioner of management and budget shall disburse the appropriations in article 15, section 2, to the commissioner to allow for implementation of the approved plan and make necessary adjustments in the accounting system to reflect any modified funding levels. Notwithstanding Minnesota Statutes, section 16A.11, subdivision 3, paragraph (b), these fiscal estimates must be considered in establishing the appropriation base for the biennium ending June 30, 2017. The commissioner of management and budget shall reflect the modified funding levels in the first fund balance following the approval of the plan.

ARTICLE 3

HOME AND COMMUNITY-BASED SERVICES DISABILITY RATE SETTING

Section 1. Minnesota Statutes 2012, section 256B.4912, subdivision 2, is amended to read:

Subd. 2. **Payment methodologies.** (a) The commissioner shall establish, as defined under section 256B.4914, statewide payment methodologies that meet federal waiver requirements for home and community-based waiver services for individuals with disabilities. The payment methodologies must abide by the principles of transparency and equitability across the state. The methodologies must involve a uniform process of structuring rates for each service and must promote quality and participant choice.

(b) As of January 1, 2012, counties shall not implement changes to established processes for rate-setting methodologies for individuals using components of or data from research rates.

Sec. 2. Minnesota Statutes 2012, section 256B.4912, subdivision 3, is amended to read:

Subd. 3. **Payment requirements.** The payment methodologies established under this section shall accommodate:

(1) supervision costs;

(2) ~~staffing patterns~~ staff compensation;

(3) staffing and supervisory patterns;

~~(3)~~ (4) program-related expenses;

~~(4)~~ (5) general and administrative expenses; and

~~(5)~~ (6) consideration of recipient intensity.

Sec. 3. Minnesota Statutes 2012, section 256B.4913, is amended by adding a subdivision to read:

Subd. 4a. **Rate stabilization adjustment.** (a) The commissioner of human services shall adjust individual reimbursement rates by no more than 1.0 percent per year effective January 1, 2016. Rates determined under section 256B.4914 must be adjusted so that the unit rate varies no more than 1.0 percent per year from the rate effective December 1 of the prior calendar year. This adjustment is made annually for three calendar years from the date of implementation.

(b) Rate stabilization adjustment applies to services that are authorized in a recipient's service plan prior to January 1, 2016.

(c) Exemptions shall be made only when there is a significant change in the recipient's assessed needs which results in a service authorization change. Exemption adjustments shall be limited to the difference in the authorized framework rate specific to change in assessed need. Exemptions shall be managed within lead agencies' budgets per existing allocation procedures.

(d) This subdivision expires January 1, 2019.

Sec. 4. Minnesota Statutes 2012, section 256B.4913, subdivision 5, is amended to read:

Subd. 5. **Stakeholder consultation.** The commissioner shall continue consultation on regular intervals with the existing stakeholder group established as part of the rate-setting methodology process and others, to gather input, concerns, and data, ~~and exchange ideas for the legislative proposals for~~ to assist in the full implementation of the new rate payment system and to make pertinent information available to the public through the department's Web site.

Sec. 5. Minnesota Statutes 2012, section 256B.4913, subdivision 6, is amended to read:

Subd. 6. **Implementation.** (a) The commissioner ~~may~~ shall implement changes ~~no sooner than~~ on January 1, 2014, to payment rates for individuals receiving home and community-based waivered services after the enactment of legislation that establishes specific payment methodology frameworks, processes for rate calculations, and specific values to populate the ~~payment methodology frameworks~~ disability waiver rates system.

(b) On January 1, 2014, all new service authorizations must use the disability waiver rates system. Beginning January 1, 2014, all renewing individual service plans must use the disability waiver rates system as reassessment and reauthorization occurs. By December 31, 2014, data for all recipients must be entered into the disability waiver rates system.

Sec. 6. **[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, half above the median and 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 will 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 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 standard occupational code (SOC) from the Bureau of Labor Statistics available on December 31, 2016. The commissioner shall publish these updated values and load them into the rate management system. This adjustment shall

occur every five years. For adjustments in 2021 and beyond, 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 rate management system. This adjustment shall occur every five years. For adjustments in 2021 and beyond, 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 provide 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 without program services 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 rate 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 rate 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 sections 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, 7, 8, and 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 which 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 which 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 which 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 which 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, 7, 8, and 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, 7, 8, and 9;

(2) the service rate requested and the difference from the rate determined in subdivisions 6, 7, 8, and 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. When 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 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, 7, 8, and 9 for all recipients as of July 1, 2013, and compare it to spending for services defined for subdivisions 6, 7, 8, and 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.

Sec. 7. **REPEALER.**

Minnesota Statutes 2012, section 256B.4913, subdivisions 1, 2, 3, and 4, are repealed.

ARTICLE 4

STRENGTHENING CHEMICAL AND MENTAL HEALTH SERVICES

Section 1. Minnesota Statutes 2012, section 245.4661, subdivision 5, is amended to read:

Subd. 5. **Planning for pilot projects.** (a) Each local plan for a pilot project, with the exception of the placement of a Minnesota specialty treatment facility as defined in paragraph (c), must be developed under the direction of the county board, or multiple county boards acting jointly, as the local mental health authority. The planning process for each pilot shall include, but not be limited to, mental health consumers, families, advocates, local mental health advisory councils, local and state providers, representatives of state and local public employee bargaining units, and the department of human services. As part of the planning process, the county board or boards shall designate a managing entity responsible for receipt of funds and management of the pilot project.

(b) For Minnesota specialty treatment facilities, the commissioner shall issue a request for proposal for regions in which a need has been identified for services.

(c) For purposes of this section, Minnesota specialty treatment facility is defined as an intensive rehabilitative mental health service under section 256B.0622, subdivision 2, paragraph (b).

Sec. 2. Minnesota Statutes 2012, section 245.4661, subdivision 6, is amended to read:

Subd. 6. **Duties of commissioner.** (a) For purposes of the pilot projects, the commissioner shall facilitate integration of funds or other resources as needed and requested by each project. These resources may include:

(1) residential services funds administered under Minnesota Rules, parts 9535.2000 to 9535.3000, in an amount to be determined by mutual agreement between the project's managing entity and the commissioner of human services after an examination of the county's historical utilization of facilities located both within and outside of the county and licensed under Minnesota Rules, parts 9520.0500 to 9520.0690;

(2) community support services funds administered under Minnesota Rules, parts 9535.1700 to 9535.1760;

(3) other mental health special project funds;

(4) medical assistance, general assistance medical care, MinnesotaCare and group residential housing if requested by the project's managing entity, and if the commissioner determines this would be consistent with the state's overall health care reform efforts; ~~and~~

(5) regional treatment center resources consistent with section 246.0136, subdivision 1.; and

(6) funds transferred from section 246.18, subdivision 8, for grants to providers to participate in mental health specialty treatment services, awarded to providers through a request for proposal process.

(b) The commissioner shall consider the following criteria in awarding start-up and implementation grants for the pilot projects:

(1) the ability of the proposed projects to accomplish the objectives described in subdivision 2;

(2) the size of the target population to be served; and

(3) geographical distribution.

(c) The commissioner shall review overall status of the projects initiatives at least every two years and recommend any legislative changes needed by January 15 of each odd-numbered year.

(d) The commissioner may waive administrative rule requirements which are incompatible with the implementation of the pilot project.

(e) The commissioner may exempt the participating counties from fiscal sanctions for noncompliance with requirements in laws and rules which are incompatible with the implementation of the pilot project.

(f) The commissioner may award grants to an entity designated by a county board or group of county boards to pay for start-up and implementation costs of the pilot project.

Sec. 3. Minnesota Statutes 2012, section 245.4682, subdivision 2, is amended to read:

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

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

(2) bring to the legislature, and the State Advisory Council on Mental Health, by January 15, 2008, recommendations for legislation to update the role of counties and to clarify the case management roles, functions, and decision-making authority of health plans and counties, and to clarify county retention of the responsibility for the delivery of social services as required under subdivision 3, paragraph (a);

(3) withhold implementation of any recommended changes in case management roles, functions, and decision-making authority until after the release of the report due January 15, 2008;

(4) ensure continuity of care for persons affected by these reforms including ensuring client choice of provider by requiring broad provider networks and developing mechanisms to facilitate a smooth transition of service responsibilities;

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

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

(7) make budget transfers necessary to implement the reallocation of services and client responsibilities between counties and health care programs that do not increase the state and county costs and efficiently allocate state funds.

(b) When making transfers under paragraph (a) necessary to implement movement of responsibility for clients and services between counties and health care programs, the commissioner, in consultation with counties, shall ensure that any transfer of state grants to health care programs, including the value of case management transfer grants under section 256B.0625, subdivision 20, does not exceed the value of the services being transferred for the latest 12-month period for which data is available. The commissioner

may make quarterly adjustments based on the availability of additional data during the first four quarters after the transfers first occur. If case management transfer grants under section 256B.0625, subdivision 20, are repealed and the value, based on the last year prior to repeal, exceeds the value of the services being transferred, the difference becomes an ongoing part of each county's adult ~~and children's~~ mental health grants under sections 245.4661~~, 245.4889,~~ and 256E.12.

(c) This appropriation is not authorized to be expended after December 31, 2010, unless approved by the legislature.

Sec. 4. Minnesota Statutes 2012, section 246.18, subdivision 8, is amended to read:

Subd. 8. **State-operated services account.** (a) The state-operated services account is established in the special revenue fund. Revenue generated by new state-operated services listed under this section established after July 1, 2010, that are not enterprise activities must be deposited into the state-operated services account, unless otherwise specified in law:

(1) intensive residential treatment services;

(2) foster care services; and

(3) psychiatric extensive recovery treatment services.

(b) Funds deposited in the state-operated services account are available to the commissioner of human services for the purposes of:

(1) providing services needed to transition individuals from institutional settings within state-operated services to the community when those services have no other adequate funding source;

(2) grants to providers participating in mental health specialty treatment services under section 245.4661; and

(3) to fund the operation of the Intensive Residential Treatment Service program in Willmar.

Sec. 5. Minnesota Statutes 2012, section 246.18, is amended by adding a subdivision to read:

Subd. 9. **Transfers.** The commissioner may transfer state mental health grant funds to the account in subdivision 8 for noncovered allowable costs of a provider certified and licensed under section 256B.0622, and operating under section 246.014.

Sec. 6. Minnesota Statutes 2012, section 254B.13, is amended to read:

254B.13 PILOT PROJECTS; CHEMICAL HEALTH CARE.

Subdivision 1. **Authorization for navigator pilot projects.** The commissioner may approve and implement navigator pilot projects developed under the planning process required under Laws 2009, chapter 79, article 7, section 26, to provide alternatives to and enhance coordination of the delivery of chemical health services required under section 254B.03.

Subd. 2. **Program design and implementation.** (a) The commissioner and counties participating in the navigator pilot projects shall continue to work in partnership to refine and implement the navigator pilot projects initiated under Laws 2009, chapter 79, article 7, section 26.

(b) The commissioner and counties participating in the navigator pilot projects shall complete the planning phase ~~by June 30, 2010,~~ and, if approved by the commissioner for implementation, enter into agreements governing the operation of the navigator pilot projects ~~with implementation scheduled no earlier than July 1, 2010~~.

Subd. 2a. **Eligibility for navigator pilot program.** (a) To be considered for participation in a navigator pilot program, an individual must:

(1) be a resident of a county with an approved navigator program;

(2) be eligible for consolidated chemical dependency treatment fund services;

(3) be a voluntary participant in the navigator program;

(4) satisfy one of the following items:

(i) have at least one severity rating of three or above in dimension four, five, or six in a comprehensive assessment under Minnesota Rules, part 9530.6422; or

(ii) have at least one severity rating of two or above in dimension four, five, or six in a comprehensive assessment under Minnesota Rules, part 9530.6422, and be currently participating in a Rule 31 treatment program under Minnesota Rules, parts 9530.6405 to 9530.6505, or be within 60 days following discharge after participation in a Rule 31 treatment program; and

(5) have had at least two treatment episodes in the past two years, not limited to episodes reimbursed by the consolidated chemical dependency treatment funds. An admission to an emergency room, a detoxification program, or a hospital may be substituted for one treatment episode if it resulted from the individual's substance use disorder.

(b) New eligibility criteria may be added as mutually agreed upon by the commissioner and participating navigator programs.

Subd. 3. **Program evaluation.** The commissioner shall evaluate navigator pilot projects under this section and report the results of the evaluation to the chairs and ranking minority members of the legislative committees with jurisdiction over chemical health issues by January 15, 2014. Evaluation of the navigator pilot projects must be

based on outcome evaluation criteria negotiated with the navigator pilot projects prior to implementation.

Subd. 4. **Notice of navigator project discontinuation.** Each county's participation in the navigator pilot project may be discontinued for any reason by the county or the commissioner of human services after 30 days' written notice to the other party. ~~Any unspent funds held for the exiting county's pro rata share in the special revenue fund under the authority in subdivision 5, paragraph (d), shall be transferred to the consolidated chemical dependency treatment fund following discontinuation of the pilot project.~~

Subd. 5. **Duties of commissioner.** (a) Notwithstanding any other provisions in this chapter, the commissioner may authorize navigator pilot projects to use chemical dependency treatment funds to pay for nontreatment navigator pilot services:

(1) in addition to those authorized under section 254B.03, subdivision 2, paragraph (a); and

(2) by vendors in addition to those authorized under section 254B.05 when not providing chemical dependency treatment services.

(b) For purposes of this section, "nontreatment navigator pilot services" include navigator services, peer support, family engagement and support, housing support, rent subsidies, supported employment, and independent living skills.

(c) State expenditures for chemical dependency services and nontreatment navigator pilot services provided by or through the navigator pilot projects must not be greater than the chemical dependency treatment fund expected share of forecasted expenditures in the absence of the navigator pilot projects. The commissioner may restructure the schedule of payments between the state and participating counties under the local agency share and division of cost provisions under section 254B.03, subdivisions 3 and 4, as necessary to facilitate the operation of the navigator pilot projects.

~~(d) To the extent that state fiscal year expenditures within a pilot project are less than the expected share of forecasted expenditures in the absence of the pilot projects, the commissioner shall deposit the unexpended funds in a separate account within the consolidated chemical dependency treatment fund, and make these funds available for expenditure by the pilot projects the following year. To the extent that treatment and nontreatment pilot services expenditures within the pilot project exceed the amount expected in the absence of the pilot projects, the pilot project county or counties are responsible for the portion of nontreatment pilot services expenditures in excess of the otherwise expected share of forecasted expenditures.~~

~~(e)~~ (d) The commissioner may waive administrative rule requirements that are incompatible with the implementation of the navigator pilot project, except that any

chemical dependency treatment funded under this section must continue to be provided by a licensed treatment provider.

~~(f)~~ (e) The commissioner shall not approve or enter into any agreement related to navigator pilot projects authorized under this section that puts current or future federal funding at risk.

(f) The commissioner shall provide participating navigator pilot projects with transactional data, reports, provider data, and other data generated by county activity to assess and measure outcomes. This information must be transmitted or made available in an acceptable form to participating navigator pilot projects at least once every six months or within a reasonable time following the commissioner's receipt of information from the counties needed to comply with this paragraph.

Subd. 6. **Duties of county board.** The county board, or other county entity that is approved to administer a navigator pilot project, shall:

(1) administer the navigator pilot project in a manner consistent with the objectives described in subdivision 2 and the planning process in subdivision 5;

(2) ensure that no one is denied chemical dependency treatment services for which they would otherwise be eligible under section 254A.03, subdivision 3; and

(3) provide the commissioner with timely and pertinent information as negotiated in agreements governing operation of the navigator pilot projects.

Subd. 7. **Managed care.** An individual who is eligible for the navigator pilot program under subdivision 2a is excluded from mandatory enrollment in managed care until these services are included in the health plan's benefit set.

Subd. 8. **Authorization for continuation of navigator pilots.** The navigator pilot projects implemented pursuant to subdivision 1 are authorized to continue operation after July 1, 2013, under existing agreements governing operation of the pilot projects.

EFFECTIVE DATE. The amendments to subdivisions 1 to 6 and 8 are effective August 1, 2013. Subdivision 7 is effective July 1, 2013.

Sec. 7. **[254B.14] CONTINUUM OF CARE PILOT PROJECTS; CHEMICAL HEALTH CARE.**

Subdivision 1. **Authorization for continuum of care pilot projects.** The commissioner shall establish chemical dependency continuum of care pilot projects to begin implementing the measures developed with stakeholder input and identified in the report completed pursuant to Laws 2012, chapter 247, article 5, section 8. The pilot projects are intended to improve the effectiveness and efficiency of the service continuum

for chemically dependent individuals in Minnesota while reducing duplication of efforts and promoting scientifically supported practices.

Subd. 2. **Program implementation.** (a) The commissioner, in coordination with representatives of the Minnesota Association of County Social Service Administrators and the Minnesota Inter-County Association, shall develop a process for identifying and selecting interested counties and providers for participation in the continuum of care pilot projects. There will be three pilot projects; one representing the northern region, one for the metro region, and one for the southern region. The selection process of counties and providers must include consideration of population size, geographic distribution, cultural and racial demographics, and provider accessibility. The commissioner shall identify counties and providers that are selected for participation in the continuum of care pilot projects no later than September 30, 2013.

(b) The commissioner and entities participating in the continuum of care pilot projects shall enter into agreements governing the operation of the continuum of care pilot projects. The agreements shall identify pilot project outcomes and include timelines for implementation and beginning operation of the pilot projects.

(c) Entities that are currently participating in the navigator pilot project are eligible to participate in the continuum of care pilot project subsequent to or instead of participating in the navigator pilot project.

(d) The commissioner may waive administrative rule requirements that are incompatible with implementation of the continuum of care pilot projects.

(e) Notwithstanding section 254A.19, the commissioner may designate noncounty entities to complete chemical use assessments and placement authorizations required under section 254A.19 and Minnesota Rules, parts 9530.6600 to 9530.6655. Section 254A.19, subdivision 3, is applicable to the continuum of care pilot projects at the discretion of the commissioner.

Subd. 3. **Program design.** (a) The operation of the pilot projects shall include:

(1) new services that are responsive to the chronic nature of substance use disorder;

(2) telehealth services, when appropriate to address barriers to services;

(3) services that assure integration with the mental health delivery system when appropriate;

(4) services that address the needs of diverse populations; and

(5) an assessment and access process that permits clients to present directly to a service provider for a substance use disorder assessment and authorization of services.

(b) Prior to implementation of the continuum of care pilot projects, a utilization review process must be developed and agreed to by the commissioner, participating

counties, and providers. The utilization review process shall be described in the agreements governing operation of the continuum of care pilot projects.

Subd. 4. **Notice of project discontinuation.** Each entity's participation in the continuum of care pilot project may be discontinued for any reason by the county or the commissioner after 30 days' written notice to the entity.

Subd. 5. **Duties of commissioner.** (a) Notwithstanding any other provisions in this chapter, the commissioner may authorize chemical dependency treatment funds to pay for nontreatment services arranged by continuum of care pilot projects. Individuals who are currently accessing Rule 31 treatment services are eligible for concurrent participation in the continuum of care pilot projects.

(b) County expenditures for continuum of care pilot project services shall not be greater than their expected share of forecasted expenditures in the absence of the continuum of care pilot projects.

EFFECTIVE DATE. This section is effective August 1, 2013.

Sec. 8. **[256.478] HOME AND COMMUNITY-BASED SERVICES TRANSITIONS GRANTS.**

(a) The commissioner shall make available home and community-based services transition grants to serve individuals who do not meet eligibility criteria for the medical assistance program under section 256B.056 or 256B.057, but who otherwise meet the criteria under section 256B.092, subdivision 13, or 256B.49, subdivision 24.

(b) For the purposes of this section, the commissioner has the authority to transfer funds between the medical assistance account and the home and community-based services transitions grants account.

EFFECTIVE DATE. This section is effective July 1, 2015.

Sec. 9. Minnesota Statutes 2012, section 256B.0623, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Adult rehabilitative mental health services" means mental health services which are rehabilitative and enable the recipient to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, ~~and~~ independent living, parenting skills, and community skills, when these abilities are impaired by the symptoms of mental illness. Adult rehabilitative mental health services are also appropriate when provided to enable a recipient to retain stability and functioning, if the recipient would

be at risk of significant functional decompensation or more restrictive service settings without these services.

(1) Adult rehabilitative mental health services instruct, assist, and support the recipient in areas such as: interpersonal communication skills, community resource utilization and integration skills, crisis assistance, relapse prevention skills, health care directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom management skills, household management skills, employment-related skills, parenting skills, and transition to community living services.

(2) These services shall be provided to the recipient on a one-to-one basis in the recipient's home or another community setting or in groups.

(b) "Medication education services" means services provided individually or in groups which focus on educating the recipient about mental illness and symptoms; the role and effects of medications in treating symptoms of mental illness; and the side effects of medications. Medication education is coordinated with medication management services and does not duplicate it. Medication education services are provided by physicians, pharmacists, physician's assistants, or registered nurses.

(c) "Transition to community living services" means services which maintain continuity of contact between the rehabilitation services provider and the recipient and which facilitate discharge from a hospital, residential treatment program under Minnesota Rules, chapter 9505, board and lodging facility, or nursing home. Transition to community living services are not intended to provide other areas of adult rehabilitative mental health services.

Sec. 10. Minnesota Statutes 2012, section 256B.0625, is amended by adding a subdivision to read:

Subd. 35c. **School-linked mental health services.** Medical assistance covers mental health services provided in a school as part of a school-linked mental health program by an individual who is licensed by the Board of Behavioral Health and Therapy, Board of Marriage and Family Therapy, Board of Psychology, or Board of Social Work, and who also meets the definition of a mental health practitioner under section 245.462, subdivision 17, or 245.4871, subdivision 26. For purposes of this subdivision, an individual who meets the definition of mental health practitioner under section 245.462, subdivision 17, or 245.4871, subdivision 26, is not limited to having less than 4,000 hours of post-master's experience. The mental health practitioner must be supervised by a licensed mental health professional.

Sec. 11. Minnesota Statutes 2012, section 256B.0625, subdivision 48, is amended to read:

Subd. 48. **Psychiatric consultation to primary care practitioners.** ~~Effective January 1, 2006,~~ Medical assistance covers consultation provided by a psychiatrist or psychologist via telephone, e-mail, facsimile, or other means of communication to primary care practitioners, including pediatricians. The need for consultation and the receipt of the consultation must be documented in the patient record maintained by the primary care practitioner. If the patient consents, and subject to federal limitations and data privacy provisions, the consultation may be provided without the patient present.

Sec. 12. Minnesota Statutes 2012, section 256B.0625, is amended by adding a subdivision to read:

Subd. 61. **Family psychoeducation services.** Effective July 1, 2013, or upon federal approval, whichever is later, medical assistance covers family psychoeducation services provided to a child up to age 21 with a diagnosed mental health condition when identified in the child's individual treatment plan and provided by a licensed mental health professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C, who has determined it medically necessary to involve family members in the child's care. For the purposes of this subdivision, "family psychoeducation services" means information or demonstration provided to an individual or family as part of an individual, family, multifamily group, or peer group session to explain, educate, and support the child and family in understanding a child's symptoms of mental illness, the impact on the child's development, and needed components of treatment and skill development so that the individual, family, or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders, and to achieve optimal mental health and long-term resilience.

Sec. 13. Minnesota Statutes 2012, section 256B.0625, is amended by adding a subdivision to read:

Subd. 62. **Mental health clinical care consultation.** Effective July 1, 2013, or upon federal approval, whichever is later, medical assistance covers clinical care consultation for a person up to age 21 who is diagnosed with a complex mental health condition or a mental health condition that co-occurs with other complex and chronic conditions, when described in the person's individual treatment plan and provided by a licensed mental health professional, as defined in Minnesota Rules, part 9505.0371, subpart 5, item A. For the purposes of this subdivision, "clinical care consultation" means communication from a

treating mental health professional to other providers not under the clinical supervision of the treating mental health professional who are working with the same client to inform, inquire, and instruct regarding the client's symptoms; strategies for effective engagement, care, and intervention needs; and treatment expectations across service settings; and to direct and coordinate clinical service components provided to the client and family.

Sec. 14. Minnesota Statutes 2012, section 256B.092, is amended by adding a subdivision to read:

Subd. 13. **Waiver allocations for transition populations.** (a) The commissioner shall make available additional waiver allocations and additional necessary resources to assure timely discharges from the Anoka Metro Regional Treatment Center and the Minnesota Security Hospital in St. Peter for individuals who meet the following criteria:

(1) are otherwise eligible for the developmental disabilities waiver under this section;

(2) who would otherwise remain at the Anoka Metro Regional Treatment Center or the Minnesota Security Hospital;

(3) whose discharge would be significantly delayed without the available waiver allocation; and

(4) who have met treatment objectives and no longer meet hospital level of care.

(b) Additional waiver allocations under this subdivision must meet cost-effectiveness requirements of the federal approved waiver plan.

(c) Any corporate foster care home developed under this subdivision must be considered an exception under section 245A.03, subdivision 7, paragraph (a).

EFFECTIVE DATE. This section is effective July 1, 2015.

Sec. 15. Minnesota Statutes 2012, section 256B.0946, is amended to read:

256B.0946 INTENSIVE TREATMENT IN FOSTER CARE.

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

(b) Intensive treatment services to children with ~~severe emotional disturbance~~ mental illness residing in ~~treatment~~ foster ~~care~~ family settings ~~must meet the relevant standards for mental health services under sections 245.487 to 245.4889. In addition,~~ that comprise

specific required service components provided in clauses (1) to (5), are reimbursed by medical assistance ~~must~~ when they meet the following standards:

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

(1) psychotherapy provided by a mental health professional as defined in Minnesota Rules, part 9505.0371, subpart 5, item A, or a clinical trainee, as defined in Minnesota Rules, part 9505.0371, subpart 5, item C;

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

(3) individual family, and group psychoeducation services ~~under supervision of~~, defined in subdivision 1a, paragraph (q), provided by a mental health professional~~.~~ or a clinical trainee;

(4) clinical care consultation, as defined in subdivision 1a, and provided by a mental health professional or a clinical trainee; and

(5) service delivery payment requirements as provided under subdivision 4.

Subd. 1a. **Definitions.** For the purposes of this section, the following terms have the meanings given them.

(a) "Clinical care consultation" means communication from a treating clinician to other providers working with the same client to inform, inquire, and instruct regarding the client's symptoms, strategies for effective engagement, care and intervention needs, and treatment expectations across service settings, including but not limited to the client's school, social services, day care, probation, home, primary care, medication prescribers, disabilities services, and other mental health providers and to direct and coordinate clinical service components provided to the client and family.

(b) "Clinical supervision" means the documented time a clinical supervisor and supervisee spend together to discuss the supervisee's work, to review individual client cases, and for the supervisee's professional development. It includes the documented oversight and supervision responsibility for planning, implementation, and evaluation of services for a client's mental health treatment.

(c) "Clinical supervisor" means the mental health professional who is responsible for clinical supervision.

(d) "Clinical trainee" has the meaning given in Minnesota Rules, part 9505.0371, subpart 5, item C;

(e) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a, including the development of a plan that addresses prevention and intervention strategies to be used in a potential crisis, but does not include actual crisis intervention.

(f) "Culturally appropriate" means providing mental health services in a manner that incorporates the child's cultural influences, as defined in Minnesota Rules, part 9505.0370, subpart 9, into interventions as a way to maximize resiliency factors and utilize cultural strengths and resources to promote overall wellness.

(g) "Culture" means the distinct ways of living and understanding the world that are used by a group of people and are transmitted from one generation to another or adopted by an individual.

(h) "Diagnostic assessment" has the meaning given in Minnesota Rules, part 9505.0370, subpart 11.

(i) "Family" means a person who is identified by the client or the client's parent or guardian as being important to the client's mental health treatment. Family may include, but is not limited to, parents, foster parents, children, spouse, committed partners, former spouses, persons related by blood or adoption, persons who are a part of the client's permanency plan, or persons who are presently residing together as a family unit.

(j) "Foster care" has the meaning given in section 260C.007, subdivision 18.

(k) "Foster family setting" means the foster home in which the license holder resides.

(l) "Individual treatment plan" has the meaning given in Minnesota Rules, part 9505.0370, subpart 15.

(m) "Mental health practitioner" has the meaning given in Minnesota Rules, part 9505.0370, subpart 17.

(n) "Mental health professional" has the meaning given in Minnesota Rules, part 9505.0370, subpart 18.

(o) "Mental illness" has the meaning given in Minnesota Rules, part 9505.0370, subpart 20.

(p) "Parent" has the meaning given in section 260C.007, subdivision 25.

(q) "Psychoeducation services" means information or demonstration provided to an individual, family, or group to explain, educate, and support the individual, family, or group in understanding a child's symptoms of mental illness, the impact on the child's development, and needed components of treatment and skill development so that the individual, family, or group can help the child to prevent relapse, prevent the acquisition of comorbid disorders, and to achieve optimal mental health and long-term resilience.

(r) "Psychotherapy" has the meaning given in Minnesota Rules, part 9505.0370, subpart 27.

(s) "Team consultation and treatment planning" means the coordination of treatment plans and consultation among providers in a group concerning the treatment needs of the child, including disseminating the child's treatment service schedule to all members of the service team. Team members must include all mental health professionals working with the child, a parent, the child unless the team lead or parent deem it clinically inappropriate, and at least two of the following: an individualized education program case manager; probation agent; children's mental health case manager; child welfare worker, including adoption or guardianship worker; primary care provider; foster parent; and any other member of the child's service team.

Subd. 2. **Determination of client eligibility.** ~~A client's eligibility to receive treatment foster care under this section shall be determined by~~ An eligible recipient is an individual, from birth through age 20, who is currently placed in a foster home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, and has received a diagnostic assessment~~,~~ and an evaluation of level of care needed, ~~and development of an individual treatment plan,~~ as defined in paragraphs (a) ~~to (c)~~ and (b).

(a) The diagnostic assessment must:

(1) meet criteria described in Minnesota Rules, part 9505.0372, subpart 1, and be conducted by a ~~psychiatrist, licensed psychologist, or licensed independent clinical social worker that is~~ mental health professional or a clinical trainee;

(2) determine whether or not a child meets the criteria for mental illness, as defined in Minnesota Rules, part 9505.0370, subpart 20;

(3) document that intensive treatment services are medically necessary within a foster family setting to ameliorate identified symptoms and functional impairments;

(4) be performed within 180 days ~~prior to~~ before the start of service; and

~~(2) include current diagnoses on all five axes of the client's current mental health status;~~

~~(3) determine whether or not a child meets the criteria for severe emotional disturbance in section 245.4871, subdivision 6, or for serious and persistent mental illness in section 245.462, subdivision 20; and~~

~~(4) be completed annually until age 18. For individuals between age 18 and 21, unless a client's mental health condition has changed markedly since the client's most recent diagnostic assessment, annual updating is necessary. For the purpose of this section, "updating" means a written summary, including current diagnoses on all five axes, by a mental health professional of the client's current mental status and service needs.~~

(5) be completed as either a standard or extended diagnostic assessment annually to determine continued eligibility for the service.

(b) The evaluation of level of care must be conducted by the placing county ~~with an instrument~~, tribe, or case manager in conjunction with the diagnostic assessment as described by Minnesota Rules, part 9505.0372, subpart 1, item B, using a validated tool approved by the commissioner of human services and not subject to the rulemaking process, consistent with section 245.4885, subdivision 1, paragraph (d), the result of which evaluation demonstrates that the child requires intensive intervention without 24-hour medical monitoring. The commissioner shall update the list of approved level of care ~~instruments~~ tools annually and publish on the department's Web site.

~~(c) The individual treatment plan must be:~~

~~(1) based on the information in the client's diagnostic assessment;~~

~~(2) developed through a child-centered, family driven planning process that identifies service needs and individualized, planned, and culturally appropriate interventions that contain specific measurable treatment goals and objectives for the client and treatment strategies for the client's family and foster family;~~

~~(3) reviewed at least once every 90 days and revised; and~~

~~(4) signed by the client or, if appropriate, by the client's parent or other person authorized by statute to consent to mental health services for the client.~~

Subd. 3. **Eligible mental health services providers.** (a) Eligible providers for intensive children's mental health services in a foster family setting must be certified by the state and have a service provision contract with a county board or a reservation tribal council and must be able to demonstrate the ability to provide all of the services required in this section.

(b) For purposes of this section, a provider agency must ~~have an individual placement agreement for each recipient and must be a licensed child placing agency, under Minnesota Rules, parts 9543.0010 to 9543.0150, and either~~ be:

(1) a ~~county~~ county-operated entity certified by the state;

(2) an Indian Health Services facility operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title 3 of the Indian Self-Determination Act, Public Law 93-638, section 638 (facilities or providers); or

(3) a noncounty entity ~~under contract with a county board~~.

(c) Certified providers that do not meet the service delivery standards required in this section shall be subject to a decertification process.

(d) For the purposes of this section, all services delivered to a client must be provided by a mental health professional or a clinical trainee.

Subd. 4. ~~**Eligible provider responsibilities**~~ **Service delivery payment requirements.** (a) To be ~~an~~ eligible ~~provider~~ for payment under this section, a provider

must develop and practice written policies and procedures for ~~treatment foster care services~~ intensive treatment in foster care, consistent with subdivision 1, paragraph (b), ~~clauses (1), (2), and (3)~~ and comply with the following requirements in paragraphs (b) to (n).

~~(b) In delivering services under this section, a treatment foster care provider must ensure that staff caseload size reasonably enables the provider to play an active role in service planning, monitoring, delivering, and reviewing for discharge planning to meet the needs of the client, the client's foster family, and the birth family, as specified in each client's individual treatment plan.~~

(b) A qualified clinical supervisor, as defined in and performing in compliance with Minnesota Rules, part 9505.0371, subpart 5, item D, must supervise the treatment and provision of services described in this section.

(c) Each client receiving treatment services must receive an extended diagnostic assessment, as described in Minnesota Rules, part 9505.0372, subpart 1, item C, within 30 days of enrollment in this service unless the client has a previous extended diagnostic assessment that the client, parent, and mental health professional agree still accurately describes the client's current mental health functioning.

(d) Each previous and current mental health, school, and physical health treatment provider must be contacted to request documentation of treatment and assessments that the eligible client has received and this information must be reviewed and incorporated into the diagnostic assessment and team consultation and treatment planning review process.

(e) Each client receiving treatment must be assessed for a trauma history and the client's treatment plan must document how the results of the assessment will be incorporated into treatment.

(f) Each client receiving treatment services must have an individual treatment plan that is reviewed, evaluated, and signed every 90 days using the team consultation and treatment planning process, as defined in subdivision 1a, paragraph (s).

(g) Care consultation, as defined in subdivision 1a, paragraph (a), must be provided in accordance with the client's individual treatment plan.

(h) Each client must have a crisis assistance plan within ten days of initiating services and must have access to clinical phone support 24 hours per day, seven days per week, during the course of treatment, and the crisis plan must demonstrate coordination with the local or regional mobile crisis intervention team.

(i) Services must be delivered and documented at least three days per week, equaling at least six hours of treatment per week, unless reduced units of service are specified on the treatment plan as part of transition or on a discharge plan to another service or level of care. Documentation must comply with Minnesota Rules, parts 9505.2175 and 9505.2197.

(j) Location of service delivery must be in the client's home, day care setting, school, or other community-based setting that is specified on the client's individualized treatment plan.

(k) Treatment must be developmentally and culturally appropriate for the client.

(l) Services must be delivered in continual collaboration and consultation with the client's medical providers and, in particular, with prescribers of psychotropic medications, including those prescribed on an off-label basis, and members of the service team must be aware of the medication regimen and potential side effects.

(m) Parents, siblings, foster parents, and members of the child's permanency plan must be involved in treatment and service delivery unless otherwise noted in the treatment plan.

(n) Transition planning for the child must be conducted starting with the first treatment plan and must be addressed throughout treatment to support the child's permanency plan and postdischarge mental health service needs.

Subd. 5. **Service authorization.** The commissioner will administer authorizations for services under this section in compliance with section 256B.0625, subdivision 25.

Subd. 6. **Excluded services.** (a) Services in clauses (1) to ~~(4)~~ (7) are not covered under this section and are not eligible for medical assistance payment as components of intensive treatment in foster care services, but may be billed separately:

~~(1) treatment foster care services provided in violation of medical assistance policy in Minnesota Rules, part 9505.0220;~~

~~(2) service components of children's therapeutic services and supports simultaneously provided by more than one treatment foster care provider;~~

~~(3) home and community-based waiver services; and~~

~~(4) treatment foster care services provided to a child without a level of care determination according to section 245.4885, subdivision 1.~~

(1) inpatient psychiatric hospital treatment;

(2) mental health targeted case management;

(3) partial hospitalization;

(4) medication management;

(5) children's mental health day treatment services;

(6) crisis response services under section 256B.0944; and

(7) transportation.

(b) Children receiving intensive treatment in foster care services are not eligible for medical assistance reimbursement for the following services while receiving intensive treatment in foster care:

~~(1) mental health case management services under section 256B.0625, subdivision 20; and~~

~~(2)~~ (1) psychotherapy and ~~skill~~ skills training components of children's therapeutic services and supports under section 256B.0625, subdivision 35b~~.~~;

(2) mental health behavioral aide services as defined in section 256B.0943, subdivision 1, paragraph (m);

(3) home and community-based waiver services;

(4) mental health residential treatment; and

(5) room and board costs as defined in section 256I.03, subdivision 6.

Subd. 7. **Medical assistance payment and rate setting.** The commissioner shall establish a single daily per-client encounter rate for intensive treatment in foster care services. The rate must be constructed to cover only eligible services delivered to an eligible recipient by an eligible provider, as prescribed in subdivision 1, paragraph (b).

Sec. 16. Minnesota Statutes 2012, section 256B.49, is amended by adding a subdivision to read:

Subd. 24. **Waiver allocations for transition populations.** (a) The commissioner shall make available additional waiver allocations and additional necessary resources to assure timely discharges from the Anoka Metro Regional Treatment Center and the Minnesota Security Hospital in St. Peter for individuals who meet the following criteria:

(1) are otherwise eligible for the brain injury, community alternatives for disabled individuals, or community alternative care waivers under this section;

(2) who would otherwise remain at the Anoka Metro Regional Treatment Center or the Minnesota Security Hospital;

(3) whose discharge would be significantly delayed without the available waiver allocation; and

(4) who have met treatment objectives and no longer meet hospital level of care.

(b) Additional waiver allocations under this subdivision must meet cost-effectiveness requirements of the federal approved waiver plan.

(c) Any corporate foster care home developed under this subdivision must be considered an exception under section 245A.03, subdivision 7, paragraph (a).

EFFECTIVE DATE. This section is effective July 1, 2015.

Sec. 17. Minnesota Statutes 2012, section 256B.761, is amended to read:

256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.

(a) Effective for services rendered on or after July 1, 2001, payment for medication management provided to psychiatric patients, outpatient mental health services, day treatment services, home-based mental health services, and family community support services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of 1999 charges.

(b) Effective July 1, 2001, the medical assistance rates for outpatient mental health services provided by an entity that operates: (1) a Medicare-certified comprehensive outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1, 1993, with at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year who are medical assistance recipients, will be increased by 38 percent, when those services are provided within the comprehensive outpatient rehabilitation facility and provided to residents of nursing facilities owned by the entity.

(c) The commissioner shall establish three levels of payment for mental health diagnostic assessment, based on three levels of complexity. The aggregate payment under the tiered rates must not exceed the projected aggregate payments for mental health diagnostic assessment under the previous single rate. The new rate structure is effective January 1, 2011, or upon federal approval, whichever is later.

(d) In addition to rate increases otherwise provided, the commissioner may restructure coverage policy and rates to improve access to adult rehabilitative mental health services under section 256B.0623 and related mental health support services under section 256B.021, subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and 2016, the projected state share of increased costs due to this paragraph is transferred from adult mental health grants under sections 245.4661 and 256E.12. The transfer for fiscal year 2016 is a permanent base adjustment for subsequent fiscal years. Payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the rate changes described in this paragraph.

Sec. 18. **STATE ASSISTANCE TO COUNTIES; TRANSITIONS FOR HIGH NEEDS POPULATIONS.**

(a) Effective immediately, the commissioner of human services shall work with counties that request assistance to assure timely discharge from Anoka Metro Regional Treatment Center and the Minnesota Security Hospital for individuals who are ready for discharge but for whom the county may not have provider resources or appropriate placement available. Special consideration must be given to uninsured individuals who are not eligible for medical assistance and who may need continued treatment, and individuals

with complex needs and other factors that hinder county efforts to place the individual in a safe, affordable setting.

(b) The commissioner shall assure that, given Olmstead court directives and the role family and friends play in treatment progress, metropolitan area residents are asked whether they wished to be placed in an Intensive Residential Treatment Service program at Willmar or Cambridge or to be placed in a location more accessible to family, friends, and health providers.

Sec. 19. **INSTRUCTIONS TO THE COMMISSIONER.**

In consultation with labor organizations, the commissioner of human services shall develop clear and consistent standards for state-operated services programs to:

(1) address direct service staffing shortages;

(2) identify and help resolve workplace safety issues; and

(3) elevate the use and visibility of performance measures and objectives related to overtime use.

ARTICLE 5

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.

Sec. 4. Minnesota Statutes 2012, section 256B.04, subdivision 21, is amended to read:

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

(b) An enrolled provider that is also licensed by the commissioner under chapter 245A must designate an individual as the entity's compliance officer. The compliance officer must:

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

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

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

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

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

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

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

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

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

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

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

(g) As a condition of enrollment, all durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers operating in Minnesota are required to name the Department of Human Services, in addition to the Centers for Medicare and Medicaid Services, as an obligee on all surety performance bonds required pursuant to section

4312(a) of the Balanced Budget Act of 1997, Public Law 105-33, amending Social Security Act, section 1834(a). The performance bond must also allow for recovery of costs and fees in pursuing a claim on the bond.

(h) The Department of Human Services may require a provider to purchase a performance surety bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment if: (1) the provider fails to demonstrate financial viability, (2) the department determines there is significant evidence of or potential for fraud and abuse by the provider, or (3) the provider or category of providers is designated high-risk pursuant to paragraph (a) and as per Code of Federal Regulations, title 42, section 455.450, or the department otherwise finds it is in the best interest of the Medicaid program to do so. The performance bond must be in an amount of $100,000 or ten percent of the provider's payments from Medicaid during the immediately preceding 12 months, whichever is greater. The performance bond must name the Department of Human Services as an obligee and must allow for recovery of costs and fees in pursuing a claim on the bond.

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

Sec. 5. Minnesota Statutes 2012, section 256B.04, is amended by adding a subdivision to read:

Subd. 22. **Application fee.** (a) The commissioner must collect and retain federally required nonrefundable application fees to pay for provider screening activities in accordance with Code of Federal Regulations, title 42, section 455, subpart E. The enrollment application must be made under the procedures specified by the commissioner, in the form specified by the commissioner, and accompanied by an application fee described in paragraph (b), or a request for a hardship exception as described in the specified procedures. Application fees must be deposited in the provider screening account in the special revenue fund. Amounts in the provider screening account are appropriated to the commissioner for costs associated with the provider screening activities required in Code of Federal Regulations, title 42, section 455, subpart E. The commissioner shall conduct screening activities as required by Code of Federal Regulations, title 42, section 455, subpart E, and as otherwise provided by law, to include database checks, unannounced pre- and postenrollment site visits, fingerprinting, and criminal background studies. The commissioner must revalidate all providers under this subdivision at least once every five years.

(b) The application fee under this subdivision is $532 for the calendar year 2013. For calendar year 2014 and subsequent years, the fee:

(1) is adjusted by the percentage change to the consumer price index for all urban consumers, United States city average, for the 12-month period ending with June of the previous year. The resulting fee must be announced in the Federal Register;

(2) is effective from January 1 to December 31 of a calendar year;

(3) is required on the submission of an initial application, an application to establish a new practice location, an application for re-enrollment when the provider is not enrolled at the time of application of re-enrollment, or at revalidation when required by federal regulation; and

(4) must be in the amount in effect for the calendar year during which the application for enrollment, new practice location, or re-enrollment is being submitted.

(c) The application fee under this subdivision cannot be charged to:

(1) providers who are enrolled in Medicare or who provide documentation of payment of the fee to, and enrollment with, another state;

(2) providers who are enrolled but are required to submit new applications for purposes of re-enrollment; or

(3) a provider who enrolls as an individual.

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

Sec. 6. Minnesota Statutes 2012, section 256B.064, subdivision 1a, is amended to read:

Subd. 1a. **Grounds for sanctions against vendors.** The commissioner may impose sanctions against a vendor of medical care for any of the following: (1) fraud, theft, or abuse in connection with the provision of medical care to recipients of public assistance; (2) a pattern of presentment of false or duplicate claims or claims for services not medically necessary; (3) a pattern of making false statements of material facts for the purpose of obtaining greater compensation than that to which the vendor is legally entitled; (4) suspension or termination as a Medicare vendor; (5) refusal to grant the state agency access during regular business hours to examine all records necessary to disclose the extent of services provided to program recipients and appropriateness of claims for payment; (6) failure to repay an overpayment or a fine finally established under this section; ~~and~~ (7) failure to correct errors in the maintenance of health service or financial records for which a fine was imposed or after issuance of a warning by the commissioner; and (8) any reason for which a vendor could be excluded from participation in the Medicare program under section 1128, 1128A, or 1866(b)(2) of the Social Security Act. The determination of services not medically necessary may be made by the commissioner in consultation with a peer advisory task force appointed by the commissioner on the

recommendation of appropriate professional organizations. The task force expires as provided in section 15.059, subdivision 5.

Sec. 7. Minnesota Statutes 2012, section 256B.064, subdivision 1b, is amended to read:

Subd. 1b. **Sanctions available.** The commissioner may impose the following sanctions for the conduct described in subdivision 1a: suspension or withholding of payments to a vendor and suspending or terminating participation in the program, or imposition of a fine under subdivision 2, paragraph (f). When imposing sanctions under this section, the commissioner shall consider the nature, chronicity, or severity of the conduct and the effect of the conduct on the health and safety of persons served by the vendor. Regardless of imposition of sanctions, the commissioner may make a referral to the appropriate state licensing board.

Sec. 8. Minnesota Statutes 2012, section 256B.064, subdivision 2, is amended to read:

Subd. 2. **Imposition of monetary recovery and sanctions.** (a) The commissioner shall determine any monetary amounts to be recovered and sanctions to be imposed upon a vendor of medical care under this section. Except as provided in paragraphs (b) and (d), neither a monetary recovery nor a sanction will be imposed by the commissioner without prior notice and an opportunity for a hearing, according to chapter 14, on the commissioner's proposed action, provided that the commissioner may suspend or reduce payment to a vendor of medical care, except a nursing home or convalescent care facility, after notice and prior to the hearing if in the commissioner's opinion that action is necessary to protect the public welfare and the interests of the program.

(b) Except when the commissioner finds good cause not to suspend payments under Code of Federal Regulations, title 42, section 455.23 (e) or (f), the commissioner shall withhold or reduce payments to a vendor of medical care without providing advance notice of such withholding or reduction if either of the following occurs:

(1) the vendor is convicted of a crime involving the conduct described in subdivision 1a; or

(2) the commissioner determines there is a credible allegation of fraud for which an investigation is pending under the program. A credible allegation of fraud is an allegation which has been verified by the state, from any source, including but not limited to:

(i) fraud hotline complaints;

(ii) claims data mining; and

(iii) patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

Allegations are considered to be credible when they have an indicia of reliability and the state agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

(c) The commissioner must send notice of the withholding or reduction of payments under paragraph (b) within five days of taking such action unless requested in writing by a law enforcement agency to temporarily withhold the notice. The notice must:

(1) state that payments are being withheld according to paragraph (b);

(2) set forth the general allegations as to the nature of the withholding action, but need not disclose any specific information concerning an ongoing investigation;

(3) except in the case of a conviction for conduct described in subdivision 1a, state that the withholding is for a temporary period and cite the circumstances under which withholding will be terminated;

(4) identify the types of claims to which the withholding applies; and

(5) inform the vendor of the right to submit written evidence for consideration by the commissioner.

The withholding or reduction of payments will not continue after the commissioner determines there is insufficient evidence of fraud by the vendor, or after legal proceedings relating to the alleged fraud are completed, unless the commissioner has sent notice of intention to impose monetary recovery or sanctions under paragraph (a).

(d) The commissioner shall suspend or terminate a vendor's participation in the program without providing advance notice and an opportunity for a hearing when the suspension or termination is required because of the vendor's exclusion from participation in Medicare. Within five days of taking such action, the commissioner must send notice of the suspension or termination. The notice must:

(1) state that suspension or termination is the result of the vendor's exclusion from Medicare;

(2) identify the effective date of the suspension or termination; and

(3) inform the vendor of the need to be reinstated to Medicare before reapplying for participation in the program.

(e) Upon receipt of a notice under paragraph (a) that a monetary recovery or sanction is to be imposed, a vendor may request a contested case, as defined in section 14.02, subdivision 3, by filing with the commissioner a written request of appeal. The appeal request must be received by the commissioner no later than 30 days after the date the notification of monetary recovery or sanction was mailed to the vendor. The appeal request must specify:

(1) each disputed item, the reason for the dispute, and an estimate of the dollar amount involved for each disputed item;

(2) the computation that the vendor believes is correct;

(3) the authority in statute or rule upon which the vendor relies for each disputed item;

(4) the name and address of the person or entity with whom contacts may be made regarding the appeal; and

(5) other information required by the commissioner.

(f) The commissioner may order a vendor to forfeit a fine for failure to fully document services according to standards in this chapter and Minnesota Rules, chapter 9505. Fines may be assessed when the commissioner has no evidence that services were not provided and services are partially documented in the health service or financial record, but specific required components of documentation are missing. The fine for incomplete documentation shall equal 20 percent of the amount paid on the claims for reimbursement submitted by the vendor, or up to $5,000, whichever is less.

(g) The vendor shall pay the fine assessed on or before the payment date specified. If the vendor fails to pay the fine, the commissioner may withhold or reduce payments and recover the amount of the fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

Sec. 9. Minnesota Statutes 2012, section 256B.0659, subdivision 21, is amended to read:

Subd. 21. **Requirements for initial enrollment of personal care assistance provider agencies.** (a) All personal care assistance provider agencies must provide, at the time of enrollment as a personal care assistance provider agency in a format determined by the commissioner, information and documentation that includes, but is not limited to, the following:

(1) the personal care assistance 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~~ $100,000 or ten percent of the provider's payments from Medicaid in the previous year, whichever is ~~less~~ more. The performance bond must be in a form approved by the commissioner, must be renewed annually, and must allow for recovery of costs and fees in pursuing a claim on the bond;

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

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

(6) a description of the personal care assistance provider agency's organization identifying the names of 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 personal care assistance 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 personal care assistance provider agency uses in the course of daily business including, but not limited to:

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

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

(iii) the personal care assistance provider agency's template for the written agreement in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

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

(10) documentation that the personal care assistance 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 personal care assistance services for employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal care assistance choice option and 72.5 percent of revenue from other personal care assistance providers. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation; and

(14) effective May 15, 2010, 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 personal care

assistance recipient or for another personal care assistance 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) Personal care assistance provider agencies shall provide the information specified in paragraph (a) to the commissioner at the time the personal care assistance provider agency enrolls as a vendor or upon request from the commissioner. The commissioner shall collect the information specified in paragraph (a) from all personal care assistance providers beginning July 1, 2009.

(c) All personal care assistance 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 before enrollment of the agency as a provider. 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 personal care assistance 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. By September 1, 2010, the required training must be available with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online or by electronic remote connection. The required training must provide for competency testing. Personal care assistance provider agency billing staff shall complete training about personal care assistance program financial management. This training is effective July 1, 2009. Any personal care assistance provider agency enrolled before that date shall, if it has not already, complete the provider training within 18 months of July 1, 2009. 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. Personal care assistance provider agencies certified for participation in Medicare as home health agencies are exempt from the training required in this subdivision. When available, Medicare-certified home health agency owners, supervisors, or managers must successfully complete the competency test.

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

ARTICLE 6

HEALTH CARE

Section 1. Minnesota Statutes 2012, section 256.9657, subdivision 2, is amended to read:

Subd. 2. **Hospital surcharge.** (a) Effective October 1, 1992, each Minnesota hospital except facilities of the federal Indian Health Service and regional treatment centers shall pay to the medical assistance account a surcharge equal to 1.4 percent of net patient revenues excluding net Medicare revenues reported by that provider to the health care cost information system according to the schedule in subdivision 4.

(b) Effective July 1, 1994, the surcharge under paragraph (a) is increased to 1.56 percent.

(c) Effective July 1, 2013, the surcharge under paragraph (b) is increased to 2.68 percent for all nongovernment-owned hospitals.

(d) Notwithstanding the Medicare cost finding and allowable cost principles, the hospital surcharge is not an allowable cost for purposes of rate setting under sections 256.9685 to 256.9695.

EFFECTIVE DATE. This section is effective July 1, 2013.

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

Subd. 2. **Federal requirements.** (a) If it is determined that a provision of this section or section 256.9686, 256.969, or 256.9695 conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, ~~in the aggregate,~~ prospectively and retrospectively, reduce payment rates and payments to avoid reduced federal financial participation resulting from rates and payments determined by the commissioner that are in excess of the Medicare upper payment limitations.

(b) For rates and payments determined by the commissioner to be in excess of the Medicare upper payment limits for the nongovernment-owned limit category, rates and payments shall be reduced to the limits according to clauses (1) to (4):

(1) rates and payments under section 256.969, subdivision 3a, paragraph (j), shall be reduced proportionately;

(2) if rates and payments remain above the limit, medical education payments under section 62J.692, subdivision 8, shall be the first reduction for the government-owned limit category;

(3) if rates and payments remain above the limit, rates and payments not included under clause (1) shall be reduced in total; and

(4) the state share of payments under clauses (1) and (2) shall be returned to the hospital.

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

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

services rendered during the rate year in effect and established based on the date of admission shall be adjusted to the rate year in effect by the hospital cost index.

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

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

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

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

(f) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2009, through June 30, 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.9 percent from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after July 1, 2009, through June 30, 2011, to reflect this reduction.

(g) In addition to the reductions in paragraphs (b), (c), and (d), the total payment for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.79 percent

from the current statutory rates. Mental health services with diagnosis related groups 424 to 432 and facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after July 1, 2011, to reflect this reduction.

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

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

(j) In order to offset the rateable reductions provided for in this subdivision, the total payment rate for medical assistance admissions for nongovernment-owned hospitals occurring on or after July 1, 2013, made to Minnesota hospitals for inpatient services before third-party liability and spenddown, shall be increased by 30 percent from the current statutory rates. The commissioner shall not adjust rates paid to a prepaid health plan under contract with the commissioner to reflect payments provided in this paragraph. The commissioner shall adjust rates and payments in excess of the Medicare upper limits on payments according to section 256.9685, subdivision 2.

EFFECTIVE DATE. This section is effective July 1, 2013.

Sec. 4. Minnesota Statutes 2012, section 256.969, subdivision 29, is amended to read:

Subd. 29. **Reimbursement for the fee increase for the early hearing detection and intervention program.** (a) For admissions occurring on or after July 1, 2010, payment rates shall be adjusted to include the increase to the fee that is effective on July 1, 2010, for the early hearing detection and intervention program recipients under section 144.125, subdivision 1, that is paid by the hospital for public program recipients. This payment increase shall be in effect until the increase is fully recognized in the base year cost under subdivision 2b. This payment shall be included in payments to contracted managed care organizations.

(b) For admissions occurring on or after July 1, 2013, payment rates shall be adjusted to include the increase to the fee that is effective July 1, 2013, for the early hearing detection and intervention program recipients under section 144.125, subdivision 1, that is paid by the hospital for public program recipients. This payment increase shall be in effect until the increase is fully recognized in the base year cost under subdivision 2b. This payment shall be included in payments to contracted managed care organizations.

Sec. 5. Minnesota Statutes 2012, section 256B.055, subdivision 14, is amended to read:

Subd. 14. **Persons detained by law.** (a) Medical assistance may be paid for an inmate of a correctional facility who is conditionally released as authorized under section 241.26, 244.065, or 631.425, if the individual does not require the security of a public detention facility and is housed in a halfway house or community correction center, or under house arrest and monitored by electronic surveillance in a residence approved by the commissioner of corrections, and if the individual meets the other eligibility requirements of this chapter.

(b) An individual who is enrolled in medical assistance, and who is charged with a crime and incarcerated for less than 12 months shall be suspended from eligibility at the time of incarceration until the individual is released. Upon release, medical assistance eligibility is reinstated without reapplication using a reinstatement process and form, if the individual is otherwise eligible.

(c) An individual, regardless of age, who is considered an inmate of a public institution as defined in Code of Federal Regulations, title 42, section 435.1010, and who meets the eligibility requirements in section 256B.056, is not eligible for medical assistance, except for covered services received while an inpatient in a medical institution as defined in the Code of Federal Regulations, title 42, section 435.1010. Security issues related to the inpatient treatment of an inmate are the responsibility of the entity with jurisdiction over the inmate.

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

Sec. 6. Minnesota Statutes 2012, section 256B.06, subdivision 4, is amended to read:

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

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

(1) admitted for lawful permanent residence according to United States Code, title 8;

(2) admitted to the United States as a refugee according to United States Code, title 8, section 1157;

(3) granted asylum according to United States Code, title 8, section 1158;

(4) granted withholding of deportation according to United States Code, title 8, section 1253(h);

(5) paroled for a period of at least one year according to United States Code, title 8, section 1182(d)(5);

(6) granted conditional entrant status according to United States Code, title 8, section 1153(a)(7);

(7) determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;

(8) is a child of a noncitizen determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill, Public Law 104-200; or

(9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public Law 96-422, the Refugee Education Assistance Act of 1980.

(c) All qualified noncitizens who were residing in the United States before August 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance with federal financial participation.

(d) Beginning December 1, 1996, qualified noncitizens who entered the United States on or after August 22, 1996, and who otherwise meet the eligibility requirements of this chapter are eligible for medical assistance with federal participation for five years if they meet one of the following criteria:

(1) refugees admitted to the United States according to United States Code, title 8, section 1157;

(2) persons granted asylum according to United States Code, title 8, section 1158;

(3) persons granted withholding of deportation according to United States Code, title 8, section 1253(h);

(4) veterans of the United States armed forces with an honorable discharge for a reason other than noncitizen status, their spouses and unmarried minor dependent children; or

(5) persons on active duty in the United States armed forces, other than for training, their spouses and unmarried minor dependent children.

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

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

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

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

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

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

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

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

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

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

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

(iii) services for routine prenatal care;

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

(v) elective surgery;

(vi) outpatient prescription drugs, unless the drugs are administered or dispensed as part of an emergency room visit;

(vii) preventative health care and family planning services;

~~(viii) dialysis;~~

~~(ix) chemotherapy or therapeutic radiation services;~~

~~(x)~~ (viii) rehabilitation services;

~~(xi)~~ (ix) physical, occupational, or speech therapy;

~~(xii)~~ (x) transportation services;

~~(xiii)~~ (xi) case management;

~~(xiv)~~ (xii) prosthetics, orthotics, durable medical equipment, or medical supplies;

~~(xv)~~ (xiii) dental services;

~~(xvi)~~ (xiv) hospice care;

~~(xvii)~~ (xv) audiology services and hearing aids;

~~(xviii)~~ (xvi) podiatry services;

~~(xix)~~ (xvii) chiropractic services;

~~(xx)~~ (xviii) immunizations;

~~(xxi)~~ (xix) vision services and eyeglasses;

~~(xxii)~~ (xx) waiver services;

~~(xxiii)~~ (xxi) individualized education programs; or

~~(xxiv)~~ (xxii) chemical dependency treatment.

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

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

(k) Notwithstanding paragraph (h), clause (2), the following services are covered as emergency medical conditions under paragraph (f) except where coverage is prohibited under federal law:

(1) dialysis services provided in a hospital or freestanding dialysis facility; and

(2) surgery and the administration of chemotherapy, radiation, and related services necessary to treat cancer if the recipient has a cancer diagnosis that is not in remission and requires surgery, chemotherapy, or radiation treatment.

EFFECTIVE DATE. This section is effective July 1, 2013.

Sec. 7. Minnesota Statutes 2012, section 256B.0625, subdivision 9, is amended to read:

Subd. 9. **Dental services.** (a) Medical assistance covers dental services.

(b) Medical assistance dental coverage for nonpregnant adults is limited to the following services:

(1) comprehensive exams, limited to once every five years;

(2) periodic exams, limited to one per year;

(3) limited exams;

(4) bitewing x-rays, limited to one per year;

(5) periapical x-rays;

(6) panoramic x-rays, limited to one every five years except (1) when medically necessary for the diagnosis and follow-up of oral and maxillofacial pathology and trauma or (2) once every two years for patients who cannot cooperate for intraoral film due to a developmental disability or medical condition that does not allow for intraoral film placement;

(7) prophylaxis, limited to one per year;

(8) application of fluoride varnish, limited to one per year;

(9) posterior fillings, all at the amalgam rate;

(10) anterior fillings;

(11) endodontics, limited to root canals on the anterior and premolars only;

(12) removable prostheses, each dental arch limited to one every six years;

(13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;

(14) palliative treatment and sedative fillings for relief of pain; and

(15) full-mouth debridement, limited to one every five years.

(c) In addition to the services specified in paragraph (b), medical assistance covers the following services for adults, if provided in an outpatient hospital setting or freestanding ambulatory surgical center as part of outpatient dental surgery:

(1) periodontics, limited to periodontal scaling and root planing once every two years;

(2) general anesthesia; and

(3) full-mouth survey once every five years.

(d) Medical assistance covers medically necessary dental services for children and pregnant women. The following guidelines apply:

(1) posterior fillings are paid at the amalgam rate;

(2) application of sealants are covered once every five years per permanent molar for children only;

(3) application of fluoride varnish is covered once every six months; and

(4) orthodontia is eligible for coverage for children only.

(e) In addition to the services specified in paragraphs (b) and (c), medical assistance covers the following services for adults:

(1) house calls or extended care facility calls for on-site delivery of covered services;

(2) behavioral management when additional staff time is required to accommodate behavioral challenges and sedation is not used;

(3) oral or IV sedation, if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center; and

(4) prophylaxis, in accordance with an appropriate individualized treatment plan, but no more than four times per year.

Sec. 8. Minnesota Statutes 2012, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs or the maximum allowable cost by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be $3.65, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated

by the commissioner at wholesale acquisition cost plus four percent for independently owned pharmacies located in a designated rural area within Minnesota, and at wholesale acquisition cost plus two percent for all other pharmacies. A pharmacy is "independently owned" if it is one of four or fewer pharmacies under the same ownership nationally. A "designated rural area" means an area defined as a small rural area or isolated rural area according to the four-category classification of the Rural Urban Commuting Area system developed for the United States Health Resources and Services Administration. The actual acquisition cost of a drug acquired through the federal 340B Drug Pricing Program shall be estimated by the commissioner at wholesale acquisition cost minus 44 percent. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(c) Whenever a maximum allowable cost has been set for a multisource drug, payment shall be the lower of the usual and customary price charged to the public or the maximum allowable cost established by the commissioner unless prior authorization for the brand name product has been granted according to the criteria established by the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in a manner consistent with section 151.21, subdivision 2.

(d) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider ~~or~~, 106 percent of the average sales price as determined by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. If average sales price is unavailable, the amount of payment must be lower of the usual and customary cost submitted by the provider ~~or~~, the wholesale acquisition cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. The commissioner shall discount the payment rate for drugs obtained through the federal 340B Drug Pricing Program by 33 percent. The payment for drugs administered in an outpatient setting shall be made to the administering facility or practitioner. A retail or specialty pharmacy dispensing a drug for administration in an outpatient setting is not eligible for direct reimbursement.

(e) The commissioner may negotiate lower reimbursement rates for specialty pharmacy products than the rates specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the formulary committee to develop a list of specialty pharmacy products subject to this paragraph. In consulting with the formulary committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the reimbursement rate to prevent access to care issues.

(f) Home infusion therapy services provided by home infusion therapy pharmacies must be paid at rates according to subdivision 8d.

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

Sec. 9. Minnesota Statutes 2012, section 256B.0625, subdivision 31, is amended to read:

Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical supplies and equipment. Separate payment outside of the facility's payment rate shall be made for wheelchairs and wheelchair accessories for recipients who are residents of intermediate care facilities for the developmentally disabled. Reimbursement for wheelchairs and wheelchair accessories for ICF/MR recipients shall be subject to the same conditions and limitations as coverage for recipients who do not reside in institutions. A wheelchair purchased outside of the facility's payment rate is the property of the recipient. The commissioner may set reimbursement rates for specified categories of medical supplies at levels below the Medicare payment rate.

(b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies must enroll as a Medicare provider.

(c) When necessary to ensure access to durable medical equipment, prosthetics, orthotics, or medical supplies, the commissioner may exempt a vendor from the Medicare enrollment requirement if:

(1) the vendor supplies only one type of durable medical equipment, prosthetic, orthotic, or medical supply;

(2) the vendor serves ten or fewer medical assistance recipients per year;

(3) the commissioner finds that other vendors are not available to provide same or similar durable medical equipment, prosthetics, orthotics, or medical supplies; and

(4) the vendor complies with all screening requirements in this chapter and Code of Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare and Medicaid Services approved national accreditation organization as complying with the Medicare program's supplier and quality standards and the vendor serves primarily pediatric patients.

(d) Durable medical equipment means a device or equipment that:

(1) can withstand repeated use;

(2) is generally not useful in the absence of an illness, injury, or disability; and

(3) is provided to correct or accommodate a physiological disorder or physical condition or is generally used primarily for a medical purpose.

(e) Electronic tablets may be considered durable medical equipment if the electronic tablet will be used as an augmentative and alternative communication system as defined under subdivision 31a, paragraph (a). To be covered by medical assistance, the device must be locked in order to prevent use not related to communication.

Sec. 10. Minnesota Statutes 2012, section 256B.0625, is amended by adding a subdivision to read:

Subd. 31b. **Preferred diabetic testing supply program.** (a) The commissioner shall adopt and implement a point of sale preferred diabetic testing supply program by January 1, 2014. Medical assistance coverage for diabetic testing supplies shall conform to the limitations established under the program. The commissioner may enter into a contract with a vendor for the purpose of participating in a preferred diabetic testing supply list and supplemental rebate program. The commissioner shall ensure that any contract meets all federal requirements and maximizes federal financial participation. The commissioner shall maintain an accurate and up-to-date list on the agency Web site.

(b) The commissioner may add to, delete from, and otherwise modify the preferred diabetic testing supply program drug list after consulting with the Drug Formulary Committee and appropriate medial specialists and providing public notice and the opportunity for public comment.

(c) The commissioner shall adopt and administer the preferred diabetic testing supply program as part of the administration of the diabetic testing supply rebate program. Reimbursement for diabetic testing supplies not on the preferred diabetic testing supply list may be subject to prior authorization.

(d) All claims for diabetic testing supplies in categories on the preferred diabetic testing supply list must be submitted by enrolled pharmacy providers using the most current National Council of Prescription Drug Providers electronic claims standard.

(e) For purposes of this subdivision, "preferred diabetic testing supply list" means a list of diabetic testing supplies selected by the commissioner, for which prior authorization is not required.

(f) The commissioner shall seek any federal waivers or approvals necessary to implement this subdivision.

Sec. 11. Minnesota Statutes 2012, section 256B.0625, subdivision 39, is amended to read:

Subd. 39. **Childhood immunizations.** Providers who administer pediatric vaccines within the scope of their licensure, and who are enrolled as a medical assistance provider, must enroll in the pediatric vaccine administration program established by section 13631 of the Omnibus Budget Reconciliation Act of 1993. Medical assistance shall pay ~~an $8.50 fee per dose~~ for administration of the vaccine to children eligible for medical assistance. Medical assistance does not pay for vaccines that are available at no cost from the pediatric vaccine administration program.

Sec. 12. Minnesota Statutes 2012, section 256B.0625, subdivision 58, is amended to read:

Subd. 58. **Early and periodic screening, diagnosis, and treatment services.** Medical assistance covers early and periodic screening, diagnosis, and treatment services (EPSDT). The payment amount for a complete EPSDT screening shall not include charges for vaccines that are available at no cost to the provider and shall not exceed the rate established per Minnesota Rules, part 9505.0445, item M, effective October 1, 2010.

Sec. 13. Minnesota Statutes 2012, section 256B.0631, subdivision 1, is amended to read:

Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following cost-sharing for all recipients, effective for services provided on or after September 1, 2011:

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

(2) $3.50 for nonemergency visits to a hospital-based emergency room, except that this co-payment shall be increased to $20 upon federal approval;

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

(4) effective January 1, 2012, a family deductible equal to the maximum amount allowed under Code of Federal Regulations, title 42, part 447.54; and

(5) for individuals identified by the commissioner with income at or below 100 percent of the federal poverty guidelines, total monthly cost-sharing must not exceed five percent of family income. For purposes of this paragraph, family income is the total earned and unearned income of the individual and the individual's spouse, if the spouse is enrolled in medical assistance and also subject to the five percent limit on cost-sharing.

(b) Recipients of medical assistance are responsible for all co-payments and deductibles in this subdivision.

(c) Notwithstanding paragraph (b), the commissioner, through the contracting process under sections 256B.69 and 256B.692, may allow managed care plans and county-based purchasing plans to waive the family deductible under paragraph (a), clause (4). The value of the family deductible shall not be included in the capitation payment to managed care plans and county-based purchasing plans. Managed care plans

and county-based purchasing plans shall certify annually to the commissioner the dollar value of the family deductible.

(d) Notwithstanding paragraph (b), the commissioner may waive the collection of the family deductible described under paragraph (a), clause (4), from individuals and allow long-term care and waivered service providers to assume responsibility for payment.

(e) Notwithstanding paragraph (b), the commissioner, through the contracting process under section 256B.0756 shall allow the pilot program in Hennepin County to waive co-payments. The value of the co-payments shall not be included in the capitation amount to the managed care organization.

Sec. 14. Minnesota Statutes 2012, section 256B.0756, is amended to read:

256B.0756 HENNEPIN AND RAMSEY COUNTIES PILOT PROGRAM.

(a) The commissioner, upon federal approval of a new waiver request or amendment of an existing demonstration, may establish a pilot program in Hennepin County or Ramsey County, or both, to test alternative and innovative integrated health care delivery networks.

(b) Individuals eligible for the pilot program shall be individuals who are eligible for medical assistance under section 256B.055~~, subdivision 15,~~ and who reside in Hennepin County or Ramsey County. The commissioner may identify individuals to be enrolled in the Hennepin County pilot program based on zip code in Hennepin County or whether the individuals would benefit from an integrated health care delivery network.

(c) Individuals enrolled in the pilot program shall be enrolled in an integrated health care delivery network in their county of residence. The integrated health care delivery network in Hennepin County shall be a network, such as an accountable care organization or a community-based collaborative care network, created by or including Hennepin County Medical Center. The integrated health care delivery network in Ramsey County shall be a network, such as an accountable care organization or community-based collaborative care network, created by or including Regions Hospital.

~~(d) The commissioner shall cap pilot program enrollment at 7,000 enrollees for Hennepin County and 3,500 enrollees for Ramsey County.~~

~~(e)~~ (d) In developing a payment system for the pilot programs, the commissioner shall establish a total cost of care for the recipients enrolled in the pilot programs that equals the cost of care that would otherwise be spent for these enrollees in the prepaid medical assistance program.

~~(f) Counties may transfer funds necessary to support the nonfederal share of payments for integrated health care delivery networks in their county. Such transfers per county shall not exceed 15 percent of the expected expenses for county enrollees.~~

~~(g)~~ (e) The commissioner shall apply to the federal government for, or as appropriate, cooperate with counties, providers, or other entities that are applying for any applicable grant or demonstration under the Patient Protection and Affordable Health Care Act, Public Law 111-148, or the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, that would further the purposes of or assist in the creation of an integrated health care delivery network for the purposes of this subdivision, including, but not limited to, a global payment demonstration or the community-based collaborative care network grants.

Sec. 15. Minnesota Statutes 2012, section 256B.69, subdivision 5c, is amended to read:

Subd. 5c. **Medical education and research fund.** (a) The commissioner of human services shall transfer each year to the medical education and research fund established under section 62J.692, an amount specified in this subdivision. The commissioner shall calculate the following:

(1) an amount equal to the reduction in the prepaid medical assistance payments as specified in this clause. Until January 1, 2002, the county medical assistance capitation base rate prior to plan specific adjustments and after the regional rate adjustments under subdivision 5b is reduced 6.3 percent for Hennepin County, two percent for the remaining metropolitan counties, and no reduction for nonmetropolitan Minnesota counties; and after January 1, 2002, the county medical assistance capitation base rate prior to plan specific adjustments is reduced 6.3 percent for Hennepin County, two percent for the remaining metropolitan counties, and 1.6 percent for nonmetropolitan Minnesota counties. Nursing facility and elderly waiver payments and demonstration project payments operating under subdivision 23 are excluded from this reduction. The amount calculated under this clause shall not be adjusted for periods already paid due to subsequent changes to the capitation payments;

(2) beginning July 1, 2003, $4,314,000 from the capitation rates paid under this section;

(3) beginning July 1, 2002, an additional $12,700,000 from the capitation rates paid under this section; and

(4) beginning July 1, 2003, an additional $4,700,000 from the capitation rates paid under this section.

(b) This subdivision shall be effective upon approval of a federal waiver which allows federal financial participation in the medical education and research fund. The amount specified under paragraph (a), clauses (1) to (4), shall not exceed the total amount transferred for fiscal year 2009. Any excess shall first reduce the amounts specified under

paragraph (a), clauses (2) to (4). Any excess following this reduction shall proportionally reduce the amount specified under paragraph (a), clause (1).

(c) Beginning September 1, 2011, of the amount in paragraph (a), the commissioner shall transfer $21,714,000 each fiscal year to the medical education and research fund.

(d) Beginning September 1, 2011, of the amount in paragraph (a), following the transfer under paragraph (c), the commissioner shall transfer to the medical education research fund $23,936,000 in fiscal years 2012 and 2013 and ~~$36,744,000~~ $49,552,000 in fiscal year 2014 and thereafter.

Sec. 16. Minnesota Statutes 2012, section 256B.69, subdivision 31, is amended to read:

Subd. 31. **Payment reduction.** (a) Beginning September 1, 2011, the commissioner shall reduce payments and limit future rate increases paid to managed care plans and county-based purchasing plans. The limits in paragraphs (a) to (f) shall be achieved on a statewide aggregate basis by program. The commissioner may use competitive bidding, payment reductions, or other reductions to achieve the reductions and limits in this subdivision.

(b) Beginning September 1, 2011, the commissioner shall reduce payments to managed care plans and county-based purchasing plans as follows:

(1) 2.0 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 2.82 percent for medical assistance families and children;

(3) 10.1 percent for medical assistance adults without children; and

(4) 6.0 percent for MinnesotaCare families and children.

(c) Beginning January 1, 2012, the commissioner shall limit rates paid to managed care plans and county-based purchasing plans for calendar year 2012 to a percentage of the rates in effect on August 31, 2011, as follows:

(1) 98 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 97.18 percent for medical assistance families and children;

(3) 89.9 percent for medical assistance adults without children; and

(4) 94 percent for MinnesotaCare families and children.

(d) Beginning January 1, 2013, to December 31, 2013, the commissioner shall limit the maximum annual trend increases to rates paid to managed care plans and county-based purchasing plans as follows:

(1) 7.5 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) 5.0 percent for medical assistance special needs basic care;

(3) 2.0 percent for medical assistance families and children;

(4) 3.0 percent for medical assistance adults without children;

(5) 3.0 percent for MinnesotaCare families and children; and

(6) 3.0 percent for MinnesotaCare adults without children.

(e) The commissioner may limit trend increases to less than the maximum. Beginning ~~July~~ January 1, 2014, the commissioner shall limit the maximum annual trend increases to rates paid to managed care plans and county-based purchasing plans as follows for calendar years 2014 and 2015:

(1) ~~7.5~~ 3.25 percent for medical assistance elderly basic care. This shall not apply to Medicare cost-sharing, nursing facility, personal care assistance, and elderly waiver services;

(2) ~~5.0~~ 2.5 percent for medical assistance special needs basic care;

(3) 2.0 percent for medical assistance families and children;

(4) 3.0 percent for medical assistance adults without children;

(5) 3.0 percent for MinnesotaCare families and children; and

(6) ~~4.0~~ 3.0 percent for MinnesotaCare adults without children.

The commissioner may limit trend increases to less than the maximum.

Sec. 17. Minnesota Statutes 2012, section 256B.76, subdivision 2, is amended to read:

Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992; and

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases.

(b) Beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

(c) Effective for services rendered on or after January 1, 2000, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999.

(d) Effective for services provided on or after January 1, 2002, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (1) the submitted charge, or (2) 85 percent of median 1999 charges.

(e) The increases listed in paragraphs (b) and (c) shall be implemented January 1, 2000, for managed care.

(f) Effective for dental services rendered on or after October 1, 2010, by a state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based on the Medicare principles of reimbursement. This payment shall be effective for services rendered on or after January 1, 2011, to recipients enrolled in managed care plans or county-based purchasing plans.

(g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics in paragraph (f), including state and federal shares, are less than $1,850,000 per fiscal year, a supplemental state payment equal to the difference between the total payments in paragraph (f) and $1,850,000 shall be paid from the general fund to state-operated services for the operation of the dental clinics.

(h) If the cost-based payment system for state-operated dental clinics described in paragraph (f) does not receive federal approval, then state-operated dental clinics shall be designated as critical access dental providers under subdivision 4, paragraph (b), and shall receive the critical access dental reimbursement rate as described under subdivision 4, paragraph (a).

(i) Effective for services rendered on or after September 1, 2011, through June 30, 2013, payment rates for dental services shall be reduced by three percent. This reduction does not apply to state-operated dental clinics in paragraph (f).

(j) Effective for services rendered on or after January 1, 2014, payment rates for dental services shall be increased by five percent from the rates in effect on December 31, 2013. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services. Effective January 1, 2014, payments made to managed care plans and county-based purchasing plans under sections 256B.69, 256B.692, and 256L.12 shall reflect the payment increase described in this paragraph.

Sec. 18. Minnesota Statutes 2012, section 256B.76, subdivision 4, is amended to read:

Subd. 4. **Critical access dental providers.** (a) Effective for dental services rendered on or after January 1, 2002, the commissioner shall increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. For dental services rendered on or after July 1, 2007, the commissioner shall

increase reimbursement by 30 percent above the reimbursement rate that would otherwise be paid to the critical access dental provider. The commissioner shall pay the managed care plans and county-based purchasing plans in amounts sufficient to reflect increased reimbursements to critical access dental providers as approved by the commissioner.

(b) The commissioner shall designate the following dentists and dental clinics as critical access dental providers:

(1) nonprofit community clinics that:

(i) have nonprofit status in accordance with chapter 317A;

(ii) have tax exempt status in accordance with the Internal Revenue Code, section 501(c)(3);

(iii) are established to provide oral health services to patients who are low income, uninsured, have special needs, and are underserved;

(iv) have professional staff familiar with the cultural background of the clinic's patients;

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

(vi) do not restrict access or services because of a patient's financial limitations or public assistance status; and

(vii) have free care available as needed;

(2) federally qualified health centers, rural health clinics, and public health clinics;

(3) city or county owned and operated hospital-based dental clinics;

(4) a dental clinic ~~or dental group~~ owned and operated by a nonprofit corporation in accordance with chapter 317A with more than 10,000 patient encounters per year with patients who are uninsured or covered by medical assistance~~, general assistance medical care,~~ or MinnesotaCare, if more than 50 percent of the dental clinic's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare; ~~and~~

(5) a dental clinic owned and operated by the University of Minnesota or the Minnesota State Colleges and Universities system~~.~~; and

(6) private practicing dentists if:

(i) the dentist's office is located within a health professional shortage area as defined under Code of Federal Regulations, title 42, part 5, and United States Code, title 42, section 254E;

(ii) more than 50 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare;

(iii) the dentist does not restrict access or services because of a patient's financial limitations or public assistance status; and

(iv) the level of service provided by the dentist is critical to maintaining adequate levels of patient access within the service area in which the dentist operates.

(c) The commissioner may designate a dentist or dental clinic as a critical access dental provider if the dentist or dental clinic is willing to provide care to patients covered by medical assistance, general assistance medical care, or MinnesotaCare at a level which significantly increases access to dental care in the service area.

(d) A designated critical access clinic shall receive the reimbursement rate specified in paragraph (a) for dental services provided off site at a private dental office if the following requirements are met:

(1) the designated critical access dental clinic is located within a health professional shortage area as defined under Code of Federal Regulations, title 42, part 5, and United States Code, title 42, section 254E, and is located outside the seven-county metropolitan area;

(2) the designated critical access dental clinic is not able to provide the service and refers the patient to the off-site dentist;

(3) the service, if provided at the critical access dental clinic, would be reimbursed at the critical access reimbursement rate;

(4) the dentist and allied dental professionals providing the services off site are licensed and in good standing under chapter 150A;

(5) the dentist providing the services is enrolled as a medical assistance provider;

(6) the critical access dental clinic submits the claim for services provided off site and receives the payment for the services; and

(7) the critical access dental clinic maintains dental records for each claim submitted under this paragraph, including the name of the dentist, the off-site location, and the license number of the dentist and allied dental professionals providing the services.

Sec. 19. Minnesota Statutes 2012, section 256B.76, is amended by adding a subdivision to read:

Subd. 7. **Payment for certain primary care services and immunization administration.** Payment for certain primary care services and immunization administration services rendered on or after January 1, 2013, through December 31, 2014, shall be made in accordance with section 1902(a)(13) of the Social Security Act.

Sec. 20. Minnesota Statutes 2012, section 256B.764, is amended to read:

256B.764 REIMBURSEMENT FOR FAMILY PLANNING SERVICES.

(a) Effective for services rendered on or after July 1, 2007, payment rates for family planning services shall be increased by 25 percent over the rates in effect June 30, 2007, when these services are provided by a community clinic as defined in section 145.9268, subdivision 1.

(b) Effective for services rendered on or after July 1, 2013, payment rates for family planning services shall be increased by 20 percent over the rates in effect June 30, 2013, when these services are provided by a community clinic as defined in section 145.9268, subdivision 1. The commissioner shall adjust capitation rates to managed care and county-based purchasing plans to reflect this increase, and shall require plans to pass on the full amount of the rate increase to eligible community clinics, in the form of higher payment rates for family planning services.

EFFECTIVE DATE. This section is effective July 1, 2013.

Sec. 21. Minnesota Statutes 2012, section 256B.766, is amended to read:

256B.766 REIMBURSEMENT FOR BASIC CARE SERVICES.

(a) Effective for services provided on or after July 1, 2009, total payments for basic care services, shall be reduced by three percent, except that for the period July 1, 2009, through June 30, 2011, total payments shall be reduced by 4.5 percent for the medical assistance and general assistance medical care programs, prior to third-party liability and spenddown calculation. Effective July 1, 2010, the commissioner shall classify physical therapy services, occupational therapy services, and speech-language pathology and related services as basic care services. The reduction in this paragraph shall apply to physical therapy services, occupational therapy services, and speech-language pathology and related services provided on or after July 1, 2010.

(b) Payments made to managed care plans and county-based purchasing plans shall be reduced for services provided on or after October 1, 2009, to reflect the reduction effective July 1, 2009, and payments made to the plans shall be reduced effective October 1, 2010, to reflect the reduction effective July 1, 2010.

(c) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for outpatient hospital facility fees shall be reduced by five percent from the rates in effect on August 31, 2011.

(d) Effective for services provided on or after September 1, 2011, through June 30, 2013, total payments for ambulatory surgery centers facility fees, medical supplies

and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, renal dialysis services, laboratory services, public health nursing services, physical therapy services, occupational therapy services, speech therapy services, eyeglasses not subject to a volume purchase contract, hearing aids not subject to a volume purchase contract, anesthesia services, and hospice services shall be reduced by three percent from the rates in effect on August 31, 2011.

(e) This section does not apply to physician and professional services, inpatient hospital services, family planning services, mental health services, dental services, prescription drugs, medical transportation, federally qualified health centers, rural health centers, Indian health services, and Medicare cost-sharing.

(f) For services provided on or after July 1, 2013, fee-for-service payments made to pediatric hospitals as referenced in the Social Security Act, section 1886(d)(1)(B)(iii) and nonstate government hospitals located in cities of the first class for the provision of outpatient basic care services to persons under age 21 shall be increased by ... percent, subject to an aggregate spending limit under this paragraph of $500,000 for the biennium ending June 30, 2015.

Sec. 22. **PAYMENT FOR MULTIPLE SERVICES PROVIDED ON THE SAME DAY.**

The commissioner of human services shall report by December 15, 2013, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance on the costs and savings to the medical assistance program of allowing medical assistance payment, including supplemental payments, for mental health services or dental services provided to a patient by a federally qualified health center, federally qualified health care center look-alike, or a rural health clinic on the same day as other covered health services furnished by the same provider.

Sec. 23. **DENTAL ADMINISTRATION AND REIMBURSEMENT REPORT.**

(a) The commissioner of human services shall study the feasibility of a single administrator for all dental services provided under medical assistance and MinnesotaCare. Dental services shall include services provided through the prepaid medical assistance program and the fee-for-service system administered by the Department of Human Services. The commissioner's study shall address and include recommendations on:

(1) possible administrative savings under a single administrator;

(2) current reimbursement levels and alternative reimbursement that could target funding to assure greater access to dental services;

(3) flexible scheduling and the coordination of referrals to encourage greater participation from private dental practitioners and clinics;

(4) approaches to reduce emergency room visits; and

(5) the use of a streamlined information system to provide information on patient eligibility and restrictions on benefits.

(b) The commissioner shall also make recommendations on service delivery and reimbursement methods, including the continuation or modification of critical access dental provider payments under sections 256B.76, subdivision 4, and 256L.11, subdivision 7.

(c) In conducting the study, the commissioner shall consult with dental providers currently providing services to enrollees of Minnesota health care programs, including those receiving enhanced payments through critical access dental provider payments, private practice dentists, safety net clinics, and the University of Minnesota Dental School.

(d) The commissioner shall submit a report and recommendations relating to dental administration and reimbursement to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by December 15, 2013.

Sec. 24. **EMERGENCY MEDICAL ASSISTANCE DEMONSTRATION PROJECT.**

(a) The commissioner of human services shall implement, beginning January 1, 2014, a pilot program to provide alternative services to high-risk individuals with complex and chronic conditions eligible for emergency medical assistance under Minnesota Statutes, section 256B.06, subdivision 4. The program must be offered to eligible persons with two or more chronic conditions who have had two or more acute care admissions in the past 12 months.

(b) The pilot program must be designed to provide health care services to eligible persons in their own environment, to significantly reduce nonemergency inpatient hospital admissions and long-term nursing facility stays. The program must include visits by health care professionals to the residences of eligible persons, regardless of whether the residence is a home, shelter, long-term care facility, residential program, or other location. The program may include features such as patient education, assistance with treatment plan compliance, medication management, and coordination of care with other health care and social service providers.

(c) The commissioner shall select, by September 1, 2013, one or more vendors: (1) experienced with providing in-home primary and acute care to a population similar to persons receiving emergency medical assistance services; and (2) that have data analysis

skills and modeling capability to identify the target population and evaluate the quality and cost-effectiveness of the intervention. The vendor contract must guarantee a savings to the state through operation of the pilot program. Savings generated through this pilot project must be shared with the vendor. Prior to entering into a final contract, the commissioner shall require prospective vendors to conduct preliminary analysis and test model feasibility and effectiveness for the population to be served.

ARTICLE 7

CONTINUING CARE

Section 1. Minnesota Statutes 2012, section 16A.152, subdivision 2, is amended to read:

Subd. 2. **Additional revenues; priority.** (a) If on the basis of a forecast of general fund revenues and expenditures, the commissioner of management and budget determines that there will be a positive unrestricted budgetary general fund balance at the close of the biennium, the commissioner of management and budget must allocate money to the following accounts and purposes in priority order:

(1) the cash flow account established in subdivision 1 until that account reaches $350,000,000;

(2) the budget reserve account established in subdivision 1a until that account reaches $653,000,000;

(3) the amount necessary to increase the aid payment schedule for school district aids and credits payments in section 127A.45 to not more than 90 percent rounded to the nearest tenth of a percent without exceeding the amount available and with any remaining funds deposited in the budget reserve;

(4) the amount necessary to restore all or a portion of the net aid reductions under section 127A.441 and to reduce the property tax revenue recognition shift under section 123B.75, subdivision 5, by the same amount; ~~and~~

(5) to the extent the balance is due to a reduction in the nursing facility and elderly waiver forecast, an equal amount shall be used to increase nursing facility operating payment rates and elderly waiver rates, including all components and limits, but that amount is not less than zero; and

~~(5)~~ (6) to the state airports fund, the amount necessary to restore the amount transferred from the state airports fund under Laws 2008, chapter 363, article 11, section 3, subdivision 5.

(b) The amounts necessary to meet the requirements of this section are appropriated from the general fund within two weeks after the forecast is released or, in the case of

transfers under paragraph (a), clauses (3) and (4), as necessary to meet the appropriations schedules otherwise established in statute.

(c) The commissioner of management and budget shall certify the total dollar amount of the reductions under paragraph (a), clauses (3) and (4), to the commissioner of education. The commissioner of education shall increase the aid payment percentage and reduce the property tax shift percentage by these amounts and apply those reductions to the current fiscal year and thereafter.

Sec. 2. Minnesota Statutes 2012, section 245A.03, subdivision 7, is amended to read:

Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter for a physical location that will not be the primary residence of the license holder for the entire period of licensure. If a license is issued during this moratorium, and the license holder changes the license holder's primary residence away from the physical location of the foster care license, the commissioner shall revoke the license according to section 245A.07. Exceptions to the moratorium include:

(1) foster care settings that are required to be registered under chapter 144D;

(2) foster care licenses replacing foster care licenses in existence on May 15, 2009, and determined to be needed by the commissioner under paragraph (b);

(3) new foster care licenses determined to be needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/MR, or regional treatment center, or restructuring of state-operated services that limits the capacity of state-operated facilities;

(4) new foster care licenses determined to be needed by the commissioner under paragraph (b) for persons requiring hospital level care; or

(5) new foster care licenses determined to be needed by the commissioner for the transition of people from personal care assistance to the home and community-based services.

(b) The commissioner shall determine the need for newly licensed foster care homes as defined under this subdivision. As part of the determination, the commissioner shall consider the availability of foster care capacity in the area in which the licensee seeks to operate, and the recommendation of the local county board. The determination by the commissioner must be final. A determination of need is not required for a change in ownership at the same address.

~~(e) The commissioner shall study the effects of the license moratorium under this subdivision and shall report back to the legislature by January 15, 2011. This study shall include, but is not limited to the following:~~

~~(1) the overall capacity and utilization of foster care beds where the physical location is not the primary residence of the license holder prior to and after implementation of the moratorium;~~

~~(2) the overall capacity and utilization of foster care beds where the physical location is the primary residence of the license holder prior to and after implementation of the moratorium; and~~

~~(3) the number of licensed and occupied ICF/MR beds prior to and after implementation of the moratorium.~~

~~(d)~~ (c) When a foster care recipient moves out of a foster home that is not the primary residence of the license holder according to section 256B.49, subdivision 15, paragraph (f), the county shall immediately inform the Department of Human Services Licensing Division. The department shall decrease the statewide licensed capacity for foster care settings where the physical location is not the primary residence of the license holder, if the voluntary changes described in paragraph ~~(f)~~ (e) are not sufficient to meet the savings required by reductions in licensed bed capacity under Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40, paragraph (f), and maintain statewide long-term care residential services capacity within budgetary limits. Implementation of the statewide licensed capacity reduction shall begin on July 1, 2013. The commissioner shall delicense up to 128 beds by June 30, 2014, using the needs determination process. Under this paragraph, the commissioner has the authority to reduce unused licensed capacity of a current foster care program to accomplish the consolidation or closure of settings. A decreased licensed capacity according to this paragraph is not subject to appeal under this chapter.

~~(e)~~ (d) Residential settings that would otherwise be subject to the decreased license capacity established in paragraph ~~(d)~~ (c) shall be exempt under the following circumstances:

(1) until August 1, 2013, the license holder's beds occupied by residents whose primary diagnosis is mental illness and the license holder is:

(i) a provider of assertive community treatment (ACT) or adult rehabilitative mental health services (ARMHS) as defined in section 256B.0623;

(ii) a mental health center certified under Minnesota Rules, parts 9520.0750 to 9520.0870;

(iii) a mental health clinic certified under Minnesota Rules, parts 9520.0750 to 9520.0870; or

(iv) a provider of intensive residential treatment services (IRTS) licensed under Minnesota Rules, parts 9520.0500 to 9520.0670; or

(2) the license holder is certified under the requirements in subdivision 6a.

~~(f)~~ (e) A resource need determination process, managed at the state level, using the available reports required by section 144A.351, and other data and information shall be used to determine where the reduced capacity required under paragraph ~~(d)~~ (c) will be implemented. The commissioner shall consult with the stakeholders described in section 144A.351, and employ a variety of methods to improve the state's capacity to meet long-term care service needs within budgetary limits, including seeking proposals from service providers or lead agencies to change service type, capacity, or location to improve services, increase the independence of residents, and better meet needs identified by the long-term care services reports and statewide data and information. By February 1 of ~~each~~ 2013 and August 1 of 2014 and each following year, the commissioner shall provide information and data on the overall capacity of licensed long-term care services, actions taken under this subdivision to manage statewide long-term care services and supports resources, and any recommendations for change to the legislative committees with jurisdiction over health and human services budget.

~~(g)~~ (f) At the time of application and reapplication for licensure, the applicant and the license holder that are subject to the moratorium or an exclusion established in paragraph (a) are required to inform the commissioner whether the physical location where the foster care will be provided is or will be the primary residence of the license holder for the entire period of licensure. If the primary residence of the applicant or license holder changes, the applicant or license holder must notify the commissioner immediately. The commissioner shall print on the foster care license certificate whether or not the physical location is the primary residence of the license holder.

~~(h)~~ (g) License holders of foster care homes identified under paragraph ~~(g)~~ (f) that are not the primary residence of the license holder and that also provide services in the foster care home that are covered by a federally approved home and community-based services waiver, as authorized under section 256B.0915, 256B.092, or 256B.49, must inform the human services licensing division that the license holder provides or intends to provide these waiver-funded services. These license holders must be considered registered under section 256B.092, subdivision 11, paragraph (c), and this registration status must be identified on their license certificates.

Sec. 3. 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 commissioner of human services and the commissioner of 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 systems 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 public Web site by September 30 each year.

Sec. 4. Minnesota Statutes 2012, section 256.9657, subdivision 3a, is amended to read:

Subd. 3a. **~~ICF/MR~~ ICF/DD license surcharge.** (a) Effective July 1, 2003, each non-state-operated facility as defined under section 256B.501, subdivision 1, shall pay to the commissioner an annual surcharge according to the schedule in subdivision 4, paragraph (d). The annual surcharge shall be $1,040 per licensed bed. If the number of licensed beds is reduced, the surcharge shall be based on the number of remaining licensed beds the second month following the receipt of timely notice by the commissioner of human services that beds have been delicensed. The facility must notify the commissioner of health in writing when beds are delicensed. The commissioner of health must notify the commissioner of human services within ten working days after receiving written

notification. If the notification is received by the commissioner of human services by the 15th of the month, the invoice for the second following month must be reduced to recognize the delicensing of beds. The commissioner may reduce, and may subsequently restore, the surcharge under this subdivision based on the commissioner's determination of a permissible surcharge.

(b) Effective July 1, 2013, the surcharge under paragraph (a) is increased to $3,717 per licensed bed.

EFFECTIVE DATE. This section is effective July 1, 2013.

Sec. 5. Minnesota Statutes 2012, section 256B.0911, subdivision 4d, is amended to read:

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

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

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

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

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

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

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

(h) At the face-to-face assessment, the long-term care consultation team member or the case manager must present information about home and community-based options,

including consumer-directed options, so the individual can make informed choices. If the individual chooses home and community-based services, the long-term care consultation team member or case manager must complete a written relocation plan within 20 working days of the visit. The plan shall describe the services needed to move out of the facility and a time line for the move which is designed to ensure a smooth transition to the individual's home and community.

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

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

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

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

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

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

~~(c)~~ (d) In the event of the layaway, delicensure and decertification, or removal from layaway of 25 percent or more of the beds in a facility, the commissioner may adjust the per diem payment amount in paragraph ~~(b)~~ (c) and may adjust the monthly payment amount in paragraph (a). The effective date of an adjustment made under this paragraph

shall be on or after the first day of the month following the effective date of the layaway, delicensure and decertification, or removal from layaway.

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

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

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

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

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

Sec. 7. Minnesota Statutes 2012, section 256B.0916, is amended by adding a subdivision to read:

Subd. 11. **Excess spending.** County and tribal agencies are responsible for spending in excess of the allocation made by the commissioner. In the event a county or tribal agency spends in excess of the allocation made by the commissioner for a given allocation period, they must submit a corrective action plan to the commissioner. The plan must state

the actions the agency will take to correct their overspending for the year following the period when the overspending occurred. Failure to correct overspending shall result in recoupment of spending in excess of the allocation. Nothing in this subdivision shall be construed as reducing the county's responsibility to offer and make available feasible home and community-based options to eligible waiver recipients within the resources allocated to them for that purpose.

Sec. 8. Minnesota Statutes 2012, section 256B.092, subdivision 11, is amended to read:

Subd. 11. **Residential support services.** (a) Upon federal approval, there is established a new service called residential support that is available on the community alternative care, community alternatives for disabled individuals, developmental disabilities, and brain injury waivers. Existing waiver service descriptions must be modified to the extent necessary to ensure there is no duplication between other services. Residential support services must be provided by vendors licensed as a community residential setting as defined in section 245A.11, subdivision 8.

(b) Residential support services must meet the following criteria:

(1) providers of residential support services must own or control the residential site;

(2) the residential site must not be the primary residence of the license holder;

(3) the residential site must have a designated program supervisor responsible for program oversight, development, and implementation of policies and procedures;

(4) the provider of residential support services must provide supervision, training, and assistance as described in the person's coordinated service and support plan; and

(5) the provider of residential support services must meet the requirements of licensure and additional requirements of the person's coordinated service and support plan.

(c) Providers of residential support services that meet the definition in paragraph (a) must be registered using a process determined by the commissioner beginning July 1, 2009. Providers licensed to provide child foster care under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, and that meet the requirements in section 245A.03, subdivision 7, paragraph ~~(g)~~ (f), are considered registered under this section.

Sec. 9. Minnesota Statutes 2012, section 256B.092, subdivision 12, is amended to read:

Subd. 12. **Waivered services statewide priorities.** (a) The commissioner shall establish statewide priorities for individuals on the waiting list for developmental disabilities (DD) waiver services, as of January 1, 2010. The statewide priorities must include, but are not limited to, individuals who continue to have a need for waiver services

after they have maximized the use of state plan services and other funding resources, including natural supports, prior to accessing waiver services, and who meet at least one of the following criteria:

(1) have unstable living situations due to the age, incapacity, or sudden loss of the primary caregivers;

(2) are moving from an institution due to bed closures;

(3) experience a sudden closure of their current living arrangement;

(4) require protection from confirmed abuse, neglect, or exploitation;

(5) experience a sudden change in need that can no longer be met through state plan services or other funding resources alone; or

(6) meet other priorities established by the department.

(b) When allocating resources to lead agencies, the commissioner must take into consideration the number of individuals waiting who meet statewide priorities and the lead agencies' current use of waiver funds and existing service options. The commissioner has the authority to transfer funds between counties, groups of counties, and tribes to accommodate statewide priorities and resource needs while accounting for a necessary base level reserve amount for each county, group of counties, and tribe.

~~(c) The commissioner shall evaluate the impact of the use of statewide priorities and provide recommendations to the legislature on whether to continue the use of statewide priorities in the November 1, 2011, annual report required by the commissioner in sections 256B.0916, subdivision 7, and 256B.49, subdivision 21.~~

Sec. 10. **[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, which 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 upon 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 a 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 which 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 which 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 for this purpose.

(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 which 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 for this purpose.

(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 have been requested pursuant to section 256.045, subdivision 10.

Subd. 8. **Refining the 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 change, 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 the 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 which 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 this treatment as part of the special education services offered to all students in the district diagnosed with an 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. 11. Minnesota Statutes 2012, section 256B.095, is amended to read:

256B.095 QUALITY ASSURANCE SYSTEM ESTABLISHED.

(a) Effective July 1, 1998, a quality assurance system for persons with developmental disabilities, which includes an alternative quality assurance licensing system for programs, is established in Dodge, Fillmore, Freeborn, Goodhue, Houston, Mower, Olmsted, Rice, Steele, Wabasha, and Winona Counties for the purpose of improving the quality of services provided to persons with developmental disabilities. A county, at its option, may choose to have all programs for persons with developmental disabilities located within the county licensed under chapter 245A using standards determined under the alternative quality assurance licensing system or may continue regulation of these programs under the licensing system operated by the commissioner. ~~The project expires on June 30, 2014.~~

(b) Effective July 1, 2003, a county not listed in paragraph (a) may apply to participate in the quality assurance system established under paragraph (a). The commission established under section 256B.0951 may, at its option, allow additional counties to participate in the system.

(c) Effective July 1, 2003, any county or group of counties not listed in paragraph (a) may establish a quality assurance system under this section. A new system established under this section shall have the same rights and duties as the system established under paragraph (a). A new system shall be governed by a commission under section 256B.0951. The commissioner shall appoint the initial commission members based on recommendations from advocates, families, service providers, and counties in the geographic area included in the new system. Counties that choose to participate in a new system shall have the duties assigned under section 256B.0952. The new system shall establish a quality assurance process under section 256B.0953. The provisions of section 256B.0954 shall apply to a new system established under this paragraph. The commissioner shall delegate authority to a new system established under this paragraph according to section 256B.0955.

(d) Effective July 1, 2007, the quality assurance system may be expanded to include programs for persons with disabilities and older adults.

(e) Effective July 1, 2013, a provider of service located in a county listed in paragraph (a) that is a non-opted-in county may opt-in to the quality assurance system provided the county where services are provided indicates its agreement with a county with a delegation agreement with the Department of Human Services.

EFFECTIVE DATE. This section is effective July 1, 2013.

Sec. 12. Minnesota Statutes 2012, section 256B.0951, subdivision 1, is amended to read:

Subdivision 1. **Membership.** The Quality Assurance Commission is established. The commission consists of at least 14 but not more than 21 members as follows: at least three but not more than five members representing advocacy organizations; at least three but not more than five members representing consumers, families, and their legal representatives; at least three but not more than five members representing service providers; at least three but not more than five members representing counties; and the commissioner of human services or the commissioner's designee. The first commission shall establish membership guidelines for the transition and recruitment of membership for the commission's ongoing existence. Members of the commission who do not receive a salary or wages from an employer for time spent on commission duties may receive a per diem payment when performing commission duties and functions. All members may be reimbursed for expenses related to commission activities. ~~Notwithstanding the provisions of section 15.059, subdivision 5, the commission expires on June 30, 2014.~~

Sec. 13. Minnesota Statutes 2012, section 256B.0951, subdivision 4, is amended to read:

Subd. 4. **Commission's authority to recommend variances of licensing standards.** The commission may recommend to the commissioners of human services and health variances from the standards governing licensure of programs for persons with ~~developmental~~ disabilities in order to improve the quality of services by implementing an alternative ~~developmental~~ disabilities licensing system if the commission determines that the alternative licensing system does not adversely affect the health or safety of persons being served by the licensed program nor compromise the qualifications of staff to provide services.

Sec. 14. Minnesota Statutes 2012, section 256B.0952, subdivision 1, is amended to read:

Subdivision 1. **Notification.** Counties or providers shall give notice to the commission and commissioners of human services and health of intent to join the

alternative quality assurance licensing system. A county or provider choosing to participate in the alternative quality assurance licensing system commits to participate for three years.

Sec. 15. Minnesota Statutes 2012, section 256B.0952, subdivision 5, is amended to read:

Subd. 5. **Quality assurance teams.** Quality assurance teams shall be comprised of county staff; providers; consumers, families, and their legal representatives; members of advocacy organizations; and other involved community members. Team members must satisfactorily complete the training program approved by the commission and must demonstrate performance-based competency. Team members are not considered to be county employees for purposes of workers' compensation, unemployment insurance, or state retirement laws solely on the basis of participation on a quality assurance team. ~~The county may pay~~ A per diem may be paid to team members for time spent on alternative quality assurance process matters. All team members may be reimbursed for expenses related to their participation in the alternative process.

Sec. 16. Minnesota Statutes 2012, section 256B.097, subdivision 1, is amended to read:

Subdivision 1. **Scope.** (a) In order to improve the quality of services provided to Minnesotans with disabilities and to meet the requirements of the federally approved home and community-based waivers under section 1915c of the Social Security Act, a State Quality Assurance, Quality Improvement, and Licensing System for Minnesotans receiving disability services is enacted. This system is a partnership between the Department of Human Services and the State Quality Council established under subdivision 3.

(b) This system is a result of the recommendations from the Department of Human Services' licensing and alternative quality assurance study mandated under Laws 2005, First Special Session chapter 4, article 7, section 57, and presented to the legislature in February 2007.

(c) The disability services eligible under this section include:

(1) the home and community-based services waiver programs for persons with developmental disabilities under section 256B.092, subdivision 4, or section 256B.49, including brain injuries and services for those who qualify for nursing facility level of care or hospital facility level of care and any other services licensed under chapter 245D;

(2) home care services under section 256B.0651;

(3) family support grants under section 252.32;

(4) consumer support grants under section 256.476;

(5) semi-independent living services under section 252.275; and

(6) services provided through an intermediate care facility for the developmentally disabled.

(d) For purposes of this section, the following definitions apply:

(1) "commissioner" means the commissioner of human services;

(2) "council" means the State Quality Council under subdivision 3;

(3) "Quality Assurance Commission" means the commission under section 256B.0951; and

(4) "system" means the State Quality Assurance, Quality Improvement and Licensing System under this section.

Sec. 17. Minnesota Statutes 2012, section 256B.097, subdivision 3, is amended to read:

Subd. 3. **State Quality Council.** (a) There is hereby created a State Quality Council which must define regional quality councils, and carry out a community-based, person-directed quality review component, and a comprehensive system for effective incident reporting, investigation, analysis, and follow-up.

(b) By August 1, 2011, the commissioner of human services shall appoint the members of the initial State Quality Council. Members shall include representatives from the following groups:

(1) disability service recipients and their family members;

(2) during the first ~~two~~ four years of the State Quality Council, there must be at least three members from the Region 10 stakeholders. As regional quality councils are formed under subdivision 4, each regional quality council shall appoint one member;

(3) disability service providers;

(4) disability advocacy groups; and

(5) county human services agencies and staff from the Department of Human Services and Ombudsman for Mental Health and Developmental Disabilities.

(c) Members of the council who do not receive a salary or wages from an employer for time spent on council duties may receive a per diem payment when performing council duties and functions.

(d) The State Quality Council shall:

(1) assist the Department of Human Services in fulfilling federally mandated obligations by monitoring disability service quality and quality assurance and improvement practices in Minnesota;

(2) establish state quality improvement priorities with methods for achieving results and provide an annual report to the legislative committees with jurisdiction over policy

and funding of disability services on the outcomes, improvement priorities, and activities undertaken by the commission during the previous state fiscal year;

(3) identify issues pertaining to financial and personal risk that impede Minnesotans with disabilities from optimizing choice of community-based services; and

(4) recommend to the chairs and ranking minority members of the legislative committees with jurisdiction over human services and civil law by January 15, ~~2013~~ 2014, statutory and rule changes related to the findings under clause (3) that promote individualized service and housing choices balanced with appropriate individualized protection.

(e) The State Quality Council, in partnership with the commissioner, shall:

(1) approve and direct implementation of the community-based, person-directed system established in this section;

(2) recommend an appropriate method of funding this system, and determine the feasibility of the use of Medicaid, licensing fees, as well as other possible funding options;

(3) approve measurable outcomes in the areas of health and safety, consumer evaluation, education and training, providers, and systems;

(4) establish variable licensure periods not to exceed three years based on outcomes achieved; and

(5) in cooperation with the Quality Assurance Commission, design a transition plan for licensed providers from Region 10 into the alternative licensing system ~~by July 1, 2013~~.

(f) The State Quality Council shall notify the commissioner of human services that a facility, program, or service has been reviewed by quality assurance team members under subdivision 4, paragraph (b), clause (13), and qualifies for a license.

(g) The State Quality Council, in partnership with the commissioner, shall establish an ongoing review process for the system. The review shall take into account the comprehensive nature of the system which is designed to evaluate the broad spectrum of licensed and unlicensed entities that provide services to persons with disabilities. The review shall address efficiencies and effectiveness of the system.

(h) The State Quality Council may recommend to the commissioner certain variances from the standards governing licensure of programs for persons with disabilities in order to improve the quality of services so long as the recommended variances do not adversely affect the health or safety of persons being served or compromise the qualifications of staff to provide services.

(i) The safety standards, rights, or procedural protections referenced under subdivision 2, paragraph (c), shall not be varied. The State Quality Council may make recommendations to the commissioner or to the legislature in the report required under

paragraph (c) regarding alternatives or modifications to the safety standards, rights, or procedural protections referenced under subdivision 2, paragraph (c).

(j) The State Quality Council may hire staff to perform the duties assigned in this subdivision.

Sec. 18. Minnesota Statutes 2012, section 256B.431, subdivision 44, is amended to read:

Subd. 44. **Property rate ~~increase~~ increases for ~~a facility in Bloomington effective November 1, 2010~~ certain nursing facilities.** (a) Notwithstanding any other law to the contrary, money available for moratorium projects under section 144A.073, subdivision 11, shall be used, effective November 1, 2010, to fund an approved moratorium exception project for a nursing facility in Bloomington licensed for 137 beds as of November 1, 2010, up to a total property rate adjustment of $19.33.

(b) Effective June 1, 2012, any nursing facility in McLeod County licensed for 110 beds shall have its replacement-cost-new limit under subdivision 17e adjusted to allow $1,129,463 of a completed construction project to increase the property payment rate. Notwithstanding any other law to the contrary, money available under section 144A.073, subdivision 11, after the completion of the moratorium exception approval process in 2013 under section 144A.073, subdivision 3, shall be used to reduce the fiscal impact to the medical assistance budget for the increase in the replacement-cost-new limit.

EFFECTIVE DATE. This section is effective retroactively from June 1, 2012.

Sec. 19. Minnesota Statutes 2012, section 256B.434, subdivision 4, is amended to read:

Subd. 4. **Alternate rates for nursing facilities.** (a) For nursing facilities which have their payment rates determined under this section rather than section 256B.431, the commissioner shall establish a rate under this subdivision. The nursing facility must enter into a written contract with the commissioner.

(b) A nursing facility's case mix payment rate for the first rate year of a facility's contract under this section is the payment rate the facility would have received under section 256B.431.

(c) A nursing facility's case mix payment rates for the second and subsequent years of a facility's contract under this section are the previous rate year's contract payment rates plus an inflation adjustment and, for facilities reimbursed under this section or section 256B.431, an adjustment to include the cost of any increase in Health Department licensing fees for the facility taking effect on or after July 1, 2001. The index for the inflation adjustment must be based on the change in the Consumer Price Index-All Items (United States City average) (CPI-U) forecasted by the commissioner of management and

budget's national economic consultant, as forecasted in the fourth quarter of the calendar year preceding the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined. For the rate years beginning on July 1, 1999, July 1, 2000, July 1, 2001, July 1, 2002, July 1, 2003, July 1, 2004, July 1, 2005, July 1, 2006, July 1, 2007, July 1, 2008, October 1, 2009, and October 1, 2010, this paragraph shall apply only to the property-related payment rate. For the rate years beginning on October 1, 2011, ~~and~~ October 1, 2012, October 1, 2013, October 1, 2014, October 1, 2015, and October 1, 2016, the rate adjustment under this paragraph shall be suspended. Beginning in 2005, adjustment to the property payment rate under this section and section 256B.431 shall be effective on October 1. In determining the amount of the property-related payment rate adjustment under this paragraph, the commissioner shall determine the proportion of the facility's rates that are property-related based on the facility's most recent cost report.

(d) The commissioner shall develop additional incentive-based payments of up to five percent above a facility's operating payment rate for achieving outcomes specified in a contract. The commissioner may solicit contract amendments and implement those which, on a competitive basis, best meet the state's policy objectives. The commissioner shall limit the amount of any incentive payment and the number of contract amendments under this paragraph to operate the incentive payments within funds appropriated for this purpose. The contract amendments may specify various levels of payment for various levels of performance. Incentive payments to facilities under this paragraph may be in the form of time-limited rate adjustments or onetime supplemental payments. In establishing the specified outcomes and related criteria, the commissioner shall consider the following state policy objectives:

(1) successful diversion or discharge of residents to the residents' prior home or other community-based alternatives;

(2) adoption of new technology to improve quality or efficiency;

(3) improved quality as measured in the Nursing Home Report Card;

(4) reduced acute care costs; and

(5) any additional outcomes proposed by a nursing facility that the commissioner finds desirable.

(e) Notwithstanding the threshold in section 256B.431, subdivision 16, facilities that take action to come into compliance with existing or pending requirements of the life safety code provisions or federal regulations governing sprinkler systems must receive reimbursement for the costs associated with compliance if all of the following conditions are met:

(1) the expenses associated with compliance occurred on or after January 1, 2005, and before December 31, 2008;

(2) the costs were not otherwise reimbursed under subdivision 4f or section 144A.071 or 144A.073; and

(3) the total allowable costs reported under this paragraph are less than the minimum threshold established under section 256B.431, subdivision 15, paragraph (e), and subdivision 16.

The commissioner shall use money appropriated for this purpose to provide to qualifying nursing facilities a rate adjustment beginning October 1, 2007, and ending September 30, 2008. Nursing facilities that have spent money or anticipate the need to spend money to satisfy the most recent life safety code requirements by (1) installing a sprinkler system or (2) replacing all or portions of an existing sprinkler system may submit to the commissioner by June 30, 2007, on a form provided by the commissioner the actual costs of a completed project or the estimated costs, based on a project bid, of a planned project. The commissioner shall calculate a rate adjustment equal to the allowable costs of the project divided by the resident days reported for the report year ending September 30, 2006. If the costs from all projects exceed the appropriation for this purpose, the commissioner shall allocate the money appropriated on a pro rata basis to the qualifying facilities by reducing the rate adjustment determined for each facility by an equal percentage. Facilities that used estimated costs when requesting the rate adjustment shall report to the commissioner by January 31, 2009, on the use of this money on a form provided by the commissioner. If the nursing facility fails to provide the report, the commissioner shall recoup the money paid to the facility for this purpose. If the facility reports expenditures allowable under this subdivision that are less than the amount received in the facility's annualized rate adjustment, the commissioner shall recoup the difference.

Sec. 20. Minnesota Statutes 2012, section 256B.434, is amended by adding a subdivision to read:

Subd. 19a. **Nursing facility rate adjustments beginning October 1, 2013.** (a) For the rate year beginning October 1, 2013, the commissioner shall make available to each nursing facility reimbursed under this section a two percent operating payment rate increase.

(b) Seventy-five percent of the money resulting from the rate adjustment under paragraph (a) must be used for increases in compensation-related costs for employees directly employed by the nursing facility on or after the effective date of the rate adjustment, except:

(1) the administrator;

(2) persons employed in the central office of a corporation that has an ownership interest in the nursing facility or exercises control over the nursing facility; and

(3) persons paid by the nursing facility under a management contract.

(c) The commissioner shall allow as compensation-related costs all costs for:

(1) wages and salaries;

(2) FICA taxes, Medicare taxes, state and federal unemployment taxes, and workers' compensation;

(3) the employer's share of health and dental insurance, life insurance, disability insurance, long-term care insurance, uniform allowance, and pensions; and

(4) other benefits provided and workforce needs including the recruiting and training of employees, subject to the approval of the commissioner.

(d) The portion of the rate adjustment under paragraph (a) that is not subject to the requirements of paragraph (b) shall be provided to nursing facilities effective October 1. Nursing facilities may apply for the portion of the rate adjustment under paragraph (a) that is subject to the requirements in paragraph (b). The application must be submitted to the commissioner within six months of the effective date of the rate adjustment, and the nursing facility must provide additional information required by the commissioner within nine months of the effective date of the rate adjustment. The commissioner must respond to all applications within three weeks of receipt. The commissioner may waive the deadlines in this paragraph under extraordinary circumstances, to be determined at the sole discretion of the commissioner. The application must contain:

(1) an estimate of the amounts of money that must be used as specified in paragraph (b);

(2) a detailed distribution plan specifying the allowable compensation-related and wage increases the nursing facility will implement to use the funds available in clause (1);

(3) a description of how the nursing facility will notify eligible employees of the contents of the approved application, which must provide for giving each eligible employee a copy of the approved application, excluding the information required in clause (1), or posting a copy of the approved application, excluding the information required in clause (1), for a period of at least six weeks in an area of the nursing facility to which all eligible employees have access; and

(4) instructions for employees who believe they have not received the compensation-related or wage increases specified in clause (2), as approved by the commissioner, and which must include a mailing address, e-mail address, and the

telephone number that may be used by the employee to contact the commissioner or the commissioner's representative.

(e) For the October 1, 2013, rate increase, the commissioner shall ensure that cost increases in distribution plans under paragraph (d), clause (2), that may be included in approved applications, comply with the following requirements:

(1) a portion of the costs resulting from tenure-related wage or salary increases may be considered to be allowable wage increases, according to formulas that the commissioner shall provide, where employee retention is above the average statewide rate of retention of direct care employees;

(2) the annualized amount of increases in costs for the employer's share of health and dental insurance, life insurance, disability insurance, and workers' compensation shall be allowable compensation-related increases if they are effective on or after April 1, 2013, and prior to April 1, 2014; and

(3) for nursing facilities in which employees are represented by an exclusive bargaining representative, the commissioner shall approve the application only upon receipt of a letter of acceptance of the distribution plan, in regard to members of the bargaining unit, signed by the exclusive bargaining agent and dated after May 25, 2013. Upon receipt of the letter of acceptance, the commissioner shall deem all requirements of this provision as having been met in regard to the members of the bargaining unit.

(f) The commissioner shall review applications received under paragraph (e) and shall provide the portion of the rate adjustment under paragraph (b) if the requirements of this statute have been met. The rate adjustment shall be effective October 1. Notwithstanding paragraph (a), if the approved application distributes less money than is available, the amount of the rate adjustment shall be reduced so that the amount of money made available is equal to the amount to be distributed.

(g) The increase in this subdivision shall be applied as a total percentage to operating rates effective September 30, 2013, except that they shall not increase any performance-based incentive payments under section 256B.434, subdivision 4, paragraph (d), awarded prior to the effective date of the rate adjustment. Facilities receiving equitable cost-sharing for publicly owned nursing facilities program rate adjustments under section 256B.441, subdivision 55a, must have rate increases under this paragraph computed based on rates in effect before the increases given under section 256B.441, subdivision 55a.

Sec. 21. Minnesota Statutes 2012, section 256B.437, subdivision 6, is amended to read:

Subd. 6. **Planned closure rate adjustment.** (a) The commissioner of human services shall calculate the amount of the planned closure rate adjustment available under subdivision 3, paragraph (b), for up to 5,140 beds according to clauses (1) to (4):

(1) the amount available is the net reduction of nursing facility beds multiplied by $2,080;

(2) the total number of beds in the nursing facility or facilities receiving the planned closure rate adjustment must be identified;

(3) capacity days are determined by multiplying the number determined under clause (2) by 365; and

(4) the planned closure rate adjustment is the amount available in clause (1), divided by capacity days determined under clause (3).

(b) A planned closure rate adjustment under this section is effective on the first day of the month following completion of closure of the facility designated for closure in the application and becomes part of the nursing facility's ~~total operating~~ external fixed payment rate.

(c) Applicants may use the planned closure rate adjustment to allow for a property payment for a new nursing facility or an addition to an existing nursing facility or as an ~~operating payment~~ external fixed rate adjustment. Applications approved under this subdivision are exempt from other requirements for moratorium exceptions under section 144A.073, subdivisions 2 and 3.

(d) Upon the request of a closing facility, the commissioner must allow the facility a closure rate adjustment as provided under section 144A.161, subdivision 10.

(e) A facility that has received a planned closure rate adjustment may reassign it to another facility that is under the same ownership at any time within three years of its effective date. The amount of the adjustment shall be computed according to paragraph (a).

(f) If the per bed dollar amount specified in paragraph (a), clause (1), is increased, the commissioner shall recalculate planned closure rate adjustments for facilities that delicense beds under this section on or after July 1, 2001, to reflect the increase in the per bed dollar amount. The recalculated planned closure rate adjustment shall be effective from the date the per bed dollar amount is increased.

(g) For planned closures approved after June 30, 2009, the commissioner of human services shall calculate the amount of the planned closure rate adjustment available under subdivision 3, paragraph (b), according to paragraph (a), clauses (1) to (4).

(h) ~~Beginning~~ Between July 16, 2011, and June 30, 2013, the commissioner shall ~~no longer~~ not accept applications for planned closure rate adjustments under subdivision 3.

Sec. 22. Minnesota Statutes 2012, section 256B.441, subdivision 13, is amended to read:

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

Sec. 23. Minnesota Statutes 2012, section 256B.441, subdivision 53, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

Sec. 24. Minnesota Statutes 2012, section 256B.49, subdivision 11a, is amended to read:

Subd. 11a. **Waivered services statewide priorities.** (a) The commissioner shall establish statewide priorities for individuals on the waiting list for community alternative care, community alternatives for disabled individuals, and brain injury waiver services, as of January 1, 2010. The statewide priorities must include, but are not limited to, individuals who continue to have a need for waiver services after they have maximized the use of state plan services and other funding resources, including natural supports, prior to accessing waiver services, and who meet at least one of the following criteria:

(1) have unstable living situations due to the age, incapacity, or sudden loss of the primary caregivers;

(2) are moving from an institution due to bed closures;

(3) experience a sudden closure of their current living arrangement;

(4) require protection from confirmed abuse, neglect, or exploitation;

(5) experience a sudden change in need that can no longer be met through state plan services or other funding resources alone; or

(6) meet other priorities established by the department.

(b) When allocating resources to lead agencies, the commissioner must take into consideration the number of individuals waiting who meet statewide priorities and the lead agencies' current use of waiver funds and existing service options. The commissioner has the authority to transfer funds between counties, groups of counties, and tribes to accommodate statewide priorities and resource needs while accounting for a necessary base level reserve amount for each county, group of counties, and tribe.

~~(c) The commissioner shall evaluate the impact of the use of statewide priorities and provide recommendations to the legislature on whether to continue the use of statewide priorities in the November 1, 2011, annual report required by the commissioner in sections 256B.0916, subdivision 7, and 256B.49, subdivision 21.~~

Sec. 25. Minnesota Statutes 2012, section 256B.49, subdivision 14, is amended to read:

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

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

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

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

(e) The commissioner shall develop criteria to identify recipients whose level of functioning is reasonably expected to improve and reassess these recipients to establish a baseline assessment. Recipients who meet these criteria must have a comprehensive transitional service plan developed under subdivision 15, paragraphs (b) and (c), and be reassessed every six months until there has been no significant change in the recipient's functioning for at least 12 months. Upon federal approval, if the recipient is able to have the recipient's needs met through alternative services in a less restrictive setting, the case manager shall help the recipient develop a plan to transition to an appropriate less restrictive setting. After there has been no significant change in the recipient's functioning for at least 12 months, reassessments of the recipient's strengths, informal support systems, and need for services shall be conducted at least every 12 months and at other times when there has been a significant change in the recipient's functioning. Counties, case

managers, and service providers are responsible for conducting these reassessments and shall complete the reassessments out of existing funds.

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

Sec. 26. Minnesota Statutes 2012, section 256B.49, subdivision 15, is amended to read:

Subd. 15. **Coordinated service and support plan; comprehensive transitional service plan; maintenance service plan.** (a) Each recipient of home and community-based waivered services shall be provided a copy of the written coordinated service and support plan which meets the requirements in section 256B.092, subdivision 1b.

(b) In developing the comprehensive transitional service plan, the individual receiving services, the case manager, and the guardian, if applicable, will identify the transitional service plan fundamental service outcome and anticipated timeline to achieve this outcome. Within the first 20 days following a recipient's request for an assessment or reassessment, the transitional service planning team must be identified. A team leader must be identified who will be responsible for assigning responsibility and communicating with team members to ensure implementation of the transition plan and ongoing assessment and communication process. The team leader should be an individual, such as the case manager or guardian, who has the opportunity to follow the recipient to the next level of service.

Within ten days following an assessment, a comprehensive transitional service plan must be developed incorporating elements of a comprehensive functional assessment and including short-term measurable outcomes and timelines for achievement of and reporting on these outcomes. Functional milestones must also be identified and reported according to the timelines agreed upon by the transitional service planning team. In addition, the comprehensive transitional service plan must identify additional supports that may assist in the achievement of the fundamental service outcome such as the development of greater natural community support, increased collaboration among agencies, and technological supports.

The timelines for reporting on functional milestones will prompt a reassessment of services provided, the units of services, rates, and appropriate service providers. It is the responsibility of the transitional service planning team leader to review functional milestone reporting to determine if the milestones are consistent with observable skills and that milestone achievement prompts any needed changes to the comprehensive transitional service plan.

For those whose fundamental transitional service outcome involves the need to procure housing, a plan for the recipient to seek the resources necessary to secure the least

restrictive housing possible should be incorporated into the plan, including employment and public supports such as housing access and shelter needy funding.

(c) Counties and other agencies responsible for funding community placement and ongoing community supportive services are responsible for the implementation of the comprehensive transitional service plans. Oversight responsibilities include both ensuring effective transitional service delivery and efficient utilization of funding resources.

(d) Following one year of transitional services, the transitional services planning team will make a determination as to whether or not the individual receiving services requires the current level of continuous and consistent support in order to maintain the recipient's current level of functioning. Recipients who are determined to have not had a significant change in functioning for 12 months must move from a transitional to a maintenance service plan. Recipients on a maintenance service plan must be reassessed to determine if the recipient would benefit from a transitional service plan at least every 12 months and at other times when there has been a significant change in the recipient's functioning. This assessment should consider any changes to technological or natural community supports.

(e) When a county is evaluating denials, reductions, or terminations of home and community-based services under section 256B.49 for an individual, the case manager shall offer to meet with the individual or the individual's guardian in order to discuss the prioritization of service needs within the coordinated service and support plan, comprehensive transitional service plan, or maintenance service plan. The reduction in the authorized services for an individual due to changes in funding for waivered services may not exceed the amount needed to ensure medically necessary services to meet the individual's health, safety, and welfare.

(f) At the time of reassessment, local agency case managers shall assess each recipient of community alternatives for disabled individuals or brain injury waivered services currently residing in a licensed adult foster home that is not the primary residence of the license holder, or in which the license holder is not the primary caregiver, to determine if that recipient could appropriately be served in a community-living setting. If appropriate for the recipient, the case manager shall offer the recipient, through a person-centered planning process, the option to receive alternative housing and service options. In the event that the recipient chooses to transfer from the adult foster home, the vacated bed shall not be filled with another recipient of waiver services and group residential housing and the licensed capacity shall be reduced accordingly, unless the savings required by the licensed bed closure reductions under Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40, paragraph (f), for foster care settings where the physical location is not the primary residence of the license holder are met through voluntary changes described

in section 245A.03, subdivision 7, paragraph ~~(f)~~ (e), or as provided under paragraph (a), clauses (3) and (4). If the adult foster home becomes no longer viable due to these transfers, the county agency, with the assistance of the department, shall facilitate a consolidation of settings or closure. This reassessment process shall be completed by July 1, 2013.

Sec. 27. Minnesota Statutes 2012, section 256B.49, is amended by adding a subdivision to read:

Subd. 25. **Excess allocations.** County and tribal agencies will be responsible for authorizations in excess of the allocation made by the commissioner. In the event a county or tribal agency authorizes in excess of the allocation made by the commissioner for a given allocation period, they must submit a corrective action plan to the commissioner. The plan must state the actions the agency will take to correct their over-authorization for the year following the period when the over-authorization occurred. Failure to correct over-authorizations shall result in recoupment of authorizations in excess of the allocation. Nothing in this subdivision shall be construed as reducing the county's responsibility to offer and make available feasible home and community-based options to eligible waiver recipients within the resources allocated to them for that purpose.

Sec. 28. Minnesota Statutes 2012, section 256B.492, is amended to read:

256B.492 HOME AND COMMUNITY-BASED SETTINGS FOR PEOPLE WITH DISABILITIES.

(a) Individuals receiving services under a home and community-based waiver under section 256B.092 or 256B.49 may receive services in the following settings:

(1) an individual's own home or family home;

(2) a licensed adult foster care setting of up to five people; and

(3) community living settings as defined in section 256B.49, subdivision 23, where individuals with disabilities may reside in all of the units in a building of four or fewer units, and no more than the greater of four or 25 percent of the units in a multifamily building of more than four units, unless required by the Housing Opportunities for Persons with AIDS program.

(b) The settings in paragraph (a) must not:

(1) be located in a building that is a publicly or privately operated facility that provides institutional treatment or custodial care;

(2) be located in a building on the grounds of or adjacent to a public or private institution;

(3) be a housing complex designed expressly around an individual's diagnosis or disability, unless required by the Housing Opportunities for Persons with AIDS program;

(4) be segregated based on a disability, either physically or because of setting characteristics, from the larger community; and

(5) have the qualities of an institution which include, but are not limited to: regimented meal and sleep times, limitations on visitors, and lack of privacy. Restrictions agreed to and documented in the person's individual service plan shall not result in a residence having the qualities of an institution as long as the restrictions for the person are not imposed upon others in the same residence and are the least restrictive alternative, imposed for the shortest possible time to meet the person's needs.

(c) The provisions of paragraphs (a) and (b) do not apply to any setting in which individuals receive services under a home and community-based waiver as of July 1, 2012, and the setting does not meet the criteria of this section.

(d) Notwithstanding paragraph (c), a program in Hennepin County established as part of a Hennepin County demonstration project is qualified for the exception allowed under paragraph (c).

(e) The commissioner shall submit an amendment to the waiver plan no later than December 31, 2012.

Sec. 29. Minnesota Statutes 2012, section 256B.493, subdivision 2, is amended to read:

Subd. 2. **Planned closure process needs determination.** The commissioner shall announce and implement a program for planned closure of adult foster care homes. Planned closure shall be the preferred method for achieving necessary budgetary savings required by the licensed bed closure budget reduction in section 245A.03, subdivision 7, paragraph ~~(d)~~ (c). If additional closures are required to achieve the necessary savings, the commissioner shall use the process and priorities in section 245A.03, subdivision 7, paragraph ~~(d)~~ (c).

Sec. 30. Minnesota Statutes 2012, section 256B.5012, is amended by adding a subdivision to read:

Subd. 14. **Rate increase effective June 1, 2013.** For rate periods beginning on or after June 1, 2013, the commissioner shall increase the total operating payment rate for each facility reimbursed under this section by $7.81 per day. The increase shall not be subject to any annual percentage increase.

EFFECTIVE DATE. This section is effective June 1, 2013.

Sec. 31. Minnesota Statutes 2012, section 256B.5012, is amended by adding a subdivision to read:

Subd. 15. **ICF/DD rate increases effective July 1, 2013.** (a) Notwithstanding subdivision 12, for each facility reimbursed under this section, for the rate period beginning July 1, 2013, the commissioner shall increase operating payments equal to two percent of the operating payment rates in effect on June 30, 2013.

(b) For each facility, the commissioner shall apply the rate increase based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate, but excluding the property-related payment rate in effect on the preceding date. The total rate increase shall include the adjustment provided in section 256B.501, subdivision 12.

Sec. 32. 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. 33. Laws 2011, First Special Session chapter 9, article 10, section 3, subdivision 3, as amended by Laws 2012, chapter 247, article 4, section 43, is amended to read:

Subd. 3. **Forecasted Programs**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) **MFIP/DWP Grants**

	Appropriations by Fund	
General	84,680,000	91,978,000
Federal TANF	84,425,000	75,417,000

(b) **MFIP Child Care Assistance Grants** 55,456,000 30,923,000

(c) **General Assistance Grants** 49,192,000 46,938,000

General Assistance Standard. The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from parents or a legal guardian at $203. The commissioner may reduce this amount according to Laws 1997, chapter 85, article 3, section 54.

Emergency General Assistance. The amount appropriated for emergency general assistance funds is limited to no more than $6,689,812 in fiscal year 2012 and $6,729,812 in fiscal year 2013. Funds to counties shall be allocated by the commissioner using the allocation method specified in Minnesota Statutes, section 256D.06.

(d) **Minnesota Supplemental Aid Grants** 38,095,000 39,120,000

(e) **Group Residential Housing Grants** 121,080,000 129,238,000

(f) **MinnesotaCare Grants** 295,046,000 317,272,000

This appropriation is from the health care access fund.

(g) **Medical Assistance Grants** 4,501,582,000 4,437,282,000

Managed Care Incentive Payments. The commissioner shall not make managed care incentive payments for expanding preventive services during fiscal years beginning July 1, 2011, and July 1, 2012.

Reduction of Rates for Congregate Living for Individuals with Lower Needs. Beginning October 1, 2011, lead agencies must reduce rates in effect on January 1, 2011, by ten percent for individuals with lower needs living in foster care settings where the license holder does not share the residence with recipients on the CADI and DD waivers and customized living settings for CADI. Lead agencies shall consult with providers to review individual service plans and identify changes or modifications to reduce the utilization of services while maintaining the health and safety of the individual receiving services. Lead agencies must adjust contracts within 60 days of the effective date. If federal waiver approval is obtained under the long-term care realignment waiver application submitted on February 13, 2012, and federal financial participation is authorized for the alternative care program, the commissioner shall adjust this payment rate reduction from ten to five percent for services rendered on or after July 1, 2012, or the first day of the month following federal approval, whichever is later. Effective

August 1, 2013, this provision does not apply to individuals whose primary diagnosis is mental illness and who are living in foster care settings where the license holder is also (1) a provider of assertive community treatment (ACT) or adult rehabilitative mental health services (ARMHS) as defined in Minnesota Statutes, section 256B.0623; (2) a mental health center or mental health clinic certified under Minnesota Rules, parts 9520.0750 to 9520.0870; or (3) a provider of intensive residential treatment services (IRTS) licensed under Minnesota Rules, parts 9520.0500 to 9520.0670.

Reduction of Lead Agency Waiver Allocations to Implement Rate Reductions for Congregate Living for Individuals with Lower Needs. Beginning October 1, 2011, the commissioner shall reduce lead agency waiver allocations to implement the reduction of rates for individuals with lower needs living in foster care settings where the license holder does not share the residence with recipients on the CADI and DD waivers and customized living settings for CADI.

Reduce customized living and 24-hour customized living component rates. Effective July 1, 2011, the commissioner shall reduce elderly waiver customized living and 24-hour customized living component service spending by five percent through reductions in component rates and service rate limits. The commissioner shall adjust the elderly waiver capitation payment rates for managed care organizations paid under Minnesota Statutes, section 256B.69,

subdivisions 6a and 23, to reflect reductions in component spending for customized living services and 24-hour customized living services under Minnesota Statutes, section 256B.0915, subdivisions 3e and 3h, for the contract period beginning January 1, 2012. To implement the reduction specified in this provision, capitation rates paid by the commissioner to managed care organizations under Minnesota Statutes, section 256B.69, shall reflect a ten percent reduction for the specified services for the period January 1, 2012, to June 30, 2012, and a five percent reduction for those services on or after July 1, 2012.

Limit Growth in the Developmental Disability Waiver. The commissioner shall limit growth in the developmental disability waiver to six diversion allocations per month beginning July 1, 2011, through June 30, 2013, and 15 diversion allocations per month beginning July 1, 2013, through June 30, 2015. Waiver allocations shall be targeted to individuals who meet the priorities for accessing waiver services identified in Minnesota Statutes, 256B.092, subdivision 12. The limits do not include conversions from intermediate care facilities for persons with developmental disabilities. Notwithstanding any contrary provisions in this article, this paragraph expires June 30, 2015.

Limit Growth in the Community Alternatives for Disabled Individuals Waiver. The commissioner shall limit growth in the community alternatives for

disabled individuals waiver to 60 allocations per month beginning July 1, 2011, through June 30, 2013, and 85 allocations per month beginning July 1, 2013, through June 30, 2015. Waiver allocations must be targeted to individuals who meet the priorities for accessing waiver services identified in Minnesota Statutes, section 256B.49, subdivision 11a. The limits include conversions and diversions, unless the commissioner has approved a plan to convert funding due to the closure or downsizing of a residential facility or nursing facility to serve directly affected individuals on the community alternatives for disabled individuals waiver. Notwithstanding any contrary provisions in this article, this paragraph expires June 30, 2015.

Personal Care Assistance Relative Care. The commissioner shall adjust the capitation payment rates for managed care organizations paid under Minnesota Statutes, section 256B.69, to reflect the rate reductions for personal care assistance provided by a relative pursuant to Minnesota Statutes, section 256B.0659, subdivision 11. This rate reduction is effective July 1, 2013.

(h) **Alternative Care Grants**	46,421,000	46,035,000

Alternative Care Transfer. Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but shall be transferred to the medical assistance account.

(i) **Chemical Dependency Entitlement Grants**	94,675,000	93,298,000

EFFECTIVE DATE. This section is effective August 1, 2013.

Sec. 34. **RECOMMENDATIONS FOR CONCENTRATION LIMITS ON HOME AND COMMUNITY-BASED SETTINGS.**

The commissioner of human services shall consult with the Minnesota Olmstead subcabinet, advocates, providers, and city representatives to develop recommendations on concentration limits on home and community-based settings, as defined in Minnesota Statutes, section 256B.492, as well as any other exceptions to the definition. The recommendations must be consistent with Minnesota's Olmstead plan. The recommendations and proposed legislation must be submitted to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 1, 2014.

Sec. 35. **PROVIDER RATE AND GRANT INCREASES EFFECTIVE JULY 1, 2013.**

(a) The commissioner of human services shall increase reimbursement rates, grants, allocations, individual limits, and rate limits, as applicable, by two percent for the rate period beginning July 1, 2013, for services rendered on or after those dates. County or tribal contracts for services specified in this section must be amended to pass through these rate increases within 60 days of the effective date.

(b) The rate changes described in this section must be provided to:

(1) home and community-based waivered services for persons with developmental disabilities or related conditions, including consumer-directed community supports, under Minnesota Statutes, section 256B.501;

(2) waivered services under community alternatives for disabled individuals, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(3) community alternative care waivered services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(4) traumatic brain injury waivered services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(5) home and community-based waivered services for the elderly under Minnesota Statutes, section 256B.0915;

(6) nursing services and home health services under Minnesota Statutes, section 256B.0625, subdivision 6a;

(7) personal care services and qualified professional supervision of personal care services under Minnesota Statutes, section 256B.0625, subdivisions 6a and 19a;

(8) private duty nursing services under Minnesota Statutes, section 256B.0625, subdivision 7;

(9) day training and habilitation services for adults with developmental disabilities or related conditions under Minnesota Statutes, sections 252.40 to 252.46, including the additional cost of rate adjustments on day training and habilitation services, provided as a social service, under Minnesota Statutes, section 256M.60;

(10) alternative care services under Minnesota Statutes, section 256B.0913;

(11) living skills training programs for persons with intractable epilepsy who need assistance in the transition to independent living under Laws 1988, chapter 689;

(12) semi-independent living services (SILS) under Minnesota Statutes, section 252.275, including SILS funding under county social services grants formerly funded under Minnesota Statutes, chapter 256I;

(13) consumer support grants under Minnesota Statutes, section 256.476;

(14) family support grants under Minnesota Statutes, section 252.32;

(15) housing access grants under Minnesota Statutes, section 256B.0658;

(16) self-advocacy grants under Laws 2009, chapter 101; and

(17) technology grants under Laws 2009, chapter 79.

(c) A managed care plan receiving state payments for the services in this section must include these increases in their payments to providers. To implement the rate increase in this section, capitation rates paid by the commissioner to managed care organizations under Minnesota Statutes, section 256B.69, shall reflect a two percent increase for the specified services for the period beginning July 1, 2013.

(d) Counties shall increase the budget for each recipient of consumer-directed community supports by the amounts in paragraph (a) on the effective dates in paragraph (a).

Sec. 36. **TRAINING OF AUTISM SERVICE PROVIDERS.**

The commissioners of health and human services shall ensure that the departments' autism-related service providers receive training in culturally appropriate approaches to serving the Somali, Latino, Hmong, and Indigenous American Indian communities, and other cultural groups experiencing a disproportionate incidence of autism.

Sec. 37. **DIRECTION TO COMMISSIONER.**

By January 1, 2014, the commissioner of human services shall apply to the federal Centers for Medicare and Medicaid Services for a waiver or other authority to provide applied behavioral analysis services to children with autism spectrum disorder and related conditions under the medical assistance program.

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

Sec. 38. **RECOMMENDATIONS ON RAISING THE ASSET LIMITS FOR SENIORS AND PERSONS WITH DISABILITIES.**

The commissioner of human services shall consult with interested stakeholders to develop recommendations to increase the asset limit a reasonable amount considering changes since the limit was established for (1) individuals who are not homeowners and (2) homeowners eligible for medical assistance due to disability or age who are not residing in a nursing facility, intermediate care facility for persons with developmental disabilities, or other institution whose costs for room and board are covered by medical assistance or state funds. The recommendations must be provided to the legislative committees with jurisdiction over health and human services policy and finance by February 1, 2014.

Sec. 39. **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.

Sec. 40. **REPEALER.**

(a) Minnesota Statutes 2012, sections 256B.14, subdivision 3a; and 256B.5012, subdivision 13; and Laws 2011, First Special Session chapter 9, article 7, section 54, as amended by Laws 2012, chapter 247, article 4, section 42, and Laws 2012, chapter 298, section 3, are repealed.

(b) Minnesota Statutes 2012, section 256B.096, subdivisions 1, 2, 3, and 4, are repealed.

ARTICLE 8

WAIVER PROVIDER STANDARDS

Section 1. Minnesota Statutes 2012, section 145C.01, subdivision 7, is amended to read:

Subd. 7. **Health care facility.** "Health care facility" means a hospital or other entity licensed under sections 144.50 to 144.58, a nursing home licensed to serve adults under section 144A.02, a home care provider licensed under sections 144A.43 to 144A.47, an adult foster care provider licensed under chapter 245A and Minnesota Rules, parts 9555.5105 to 9555.6265, a community residential setting licensed under chapter 245D, or a hospice provider licensed under sections 144A.75 to 144A.755.

Sec. 2. Minnesota Statutes 2012, section 243.166, subdivision 4b, is amended to read:

Subd. 4b. **Health care facility; notice of status.** (a) For the purposes of this subdivision, "health care facility" means a facility:

(1) licensed by the commissioner of health as a hospital, boarding care home or supervised living facility under sections 144.50 to 144.58, or a nursing home under chapter 144A;

(2) registered by the commissioner of health as a housing with services establishment as defined in section 144D.01; or

(3) licensed by the commissioner of human services as a residential facility under chapter 245A to provide adult foster care, adult mental health treatment, chemical dependency treatment to adults, or residential services to persons with ~~developmental~~ disabilities.

(b) Prior to admission to a health care facility, a person required to register under this section shall disclose to:

(1) the health care facility employee processing the admission the person's status as a registered predatory offender under this section; and

(2) the person's corrections agent, or if the person does not have an assigned corrections agent, the law enforcement authority with whom the person is currently required to register, that inpatient admission will occur.

(c) A law enforcement authority or corrections agent who receives notice under paragraph (b) or who knows that a person required to register under this section is planning to be admitted and receive, or has been admitted and is receiving health care at a health care facility shall notify the administrator of the facility and deliver a fact sheet to the administrator containing the following information: (1) name and physical description of the offender; (2) the offender's conviction history, including the dates of

conviction; (3) the risk level classification assigned to the offender under section 244.052, if any; and (4) the profile of likely victims.

(d) Except for a hospital licensed under sections 144.50 to 144.58, if a health care facility receives a fact sheet under paragraph (c) that includes a risk level classification for the offender, and if the facility admits the offender, the facility shall distribute the fact sheet to all residents at the facility. If the facility determines that distribution to a resident is not appropriate given the resident's medical, emotional, or mental status, the facility shall distribute the fact sheet to the patient's next of kin or emergency contact.

Sec. 3. **[245.8251] POSITIVE SUPPORT STRATEGIES AND EMERGENCY MANUAL RESTRAINT; LICENSED FACILITIES AND PROGRAMS.**

Subdivision 1. **Rules.** The commissioner of human services shall, within 24 months of enactment of this section, adopt rules governing the use of positive support strategies, safety interventions, and emergency use of manual restraint in facilities and services licensed under chapter 245D.

Subd. 2. **Data collection.** (a) The commissioner shall, with stakeholder input, develop data collection elements specific to incidents on the use of controlled procedures with persons receiving services from providers regulated under Minnesota Rules, parts 9525.2700 to 9525.2810, and incidents involving persons receiving services from providers identified to be licensed under chapter 245D effective January 1, 2014. Providers shall report the data in a format and at a frequency provided by the commissioner of human services.

(b) Beginning July 1, 2013, providers regulated under Minnesota Rules, parts 9525.2700 to 9525.2810, shall submit data regarding the use of all controlled procedures in a format and at a frequency provided by the commissioner.

Sec. 4. Minnesota Statutes 2012, section 245A.02, subdivision 10, is amended to read:

Subd. 10. **Nonresidential program.** "Nonresidential program" means care, supervision, rehabilitation, training or habilitation of a person provided outside the person's own home and provided for fewer than 24 hours a day, including adult day care programs; and chemical dependency or chemical abuse programs that are located in a nursing home or hospital and receive public funds for providing chemical abuse or chemical dependency treatment services under chapter 254B. Nonresidential programs include home and community-based services ~~and semi-independent living services~~ for persons with ~~developmental~~ disabilities or persons age 65 and older that are provided in or outside of a person's own home under chapter 245D.

Sec. 5. Minnesota Statutes 2012, section 245A.02, subdivision 14, is amended to read:

Subd. 14. **Residential program.** "Residential program" means a program that provides 24-hour-a-day care, supervision, food, lodging, rehabilitation, training, education, habilitation, or treatment outside a person's own home, including a program in an intermediate care facility for four or more persons with developmental disabilities; and chemical dependency or chemical abuse programs that are located in a hospital or nursing home and receive public funds for providing chemical abuse or chemical dependency treatment services under chapter 254B. Residential programs include home and community-based services for persons with ~~developmental~~ disabilities or persons age 65 and older that are provided in or outside of a person's own home under chapter 245D.

Sec. 6. Minnesota Statutes 2012, section 245A.03, subdivision 7, is amended to read:

Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, under this chapter for a physical location that will not be the primary residence of the license holder for the entire period of licensure. If a license is issued during this moratorium, and the license holder changes the license holder's primary residence away from the physical location of the foster care license, the commissioner shall revoke the license according to section 245A.07. The commissioner shall not issue an initial license for a community residential setting licensed under chapter 245D. Exceptions to the moratorium include:

(1) foster care settings that are required to be registered under chapter 144D;

(2) foster care licenses replacing foster care licenses in existence on May 15, 2009, or community residential setting licenses replacing adult foster care licenses in existence on December 31, 2013, and determined to be needed by the commissioner under paragraph (b);

(3) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/MR, or regional treatment center, or restructuring of state-operated services that limits the capacity of state-operated facilities;

(4) new foster care licenses or community residential setting licenses determined to be needed by the commissioner under paragraph (b) for persons requiring hospital level care; or

(5) new foster care licenses or community residential setting licenses determined to be needed by the commissioner for the transition of people from personal care assistance to the home and community-based services.

(b) The commissioner shall determine the need for newly licensed foster care homes or community residential settings as defined under this subdivision. As part of the determination, the commissioner shall consider the availability of foster care capacity in the area in which the licensee seeks to operate, and the recommendation of the local county board. The determination by the commissioner must be final. A determination of need is not required for a change in ownership at the same address.

(c) The commissioner shall study the effects of the license moratorium under this subdivision and shall report back to the legislature by January 15, 2011. This study shall include, but is not limited to the following:

(1) the overall capacity and utilization of foster care beds where the physical location is not the primary residence of the license holder prior to and after implementation of the moratorium;

(2) the overall capacity and utilization of foster care beds where the physical location is the primary residence of the license holder prior to and after implementation of the moratorium; and

(3) the number of licensed and occupied ICF/MR beds prior to and after implementation of the moratorium.

(d) When a ~~foster care recipient~~ resident served by the program moves out of a foster home that is not the primary residence of the license holder according to section 256B.49, subdivision 15, paragraph (f), or the community residential setting, the county shall immediately inform the Department of Human Services Licensing Division. The department shall decrease the statewide licensed capacity for foster care settings where the physical location is not the primary residence of the license holder, or for community residential settings, if the voluntary changes described in paragraph (f) are not sufficient to meet the savings required by reductions in licensed bed capacity under Laws 2011, First Special Session chapter 9, article 7, sections 1 and 40, paragraph (f), and maintain statewide long-term care residential services capacity within budgetary limits. Implementation of the statewide licensed capacity reduction shall begin on July 1, 2013. The commissioner shall delicense up to 128 beds by June 30, 2014, using the needs determination process. Under this paragraph, the commissioner has the authority to reduce unused licensed capacity of a current foster care program, or the community residential settings, to accomplish the consolidation or closure of settings. A decreased licensed capacity according to this paragraph is not subject to appeal under this chapter.

(e) Residential settings that would otherwise be subject to the decreased license capacity established in paragraph (d) shall be exempt under the following circumstances:

(1) until August 1, 2013, the license holder's beds occupied by residents whose primary diagnosis is mental illness and the license holder is:

(i) a provider of assertive community treatment (ACT) or adult rehabilitative mental health services (ARMHS) as defined in section 256B.0623;

(ii) a mental health center certified under Minnesota Rules, parts 9520.0750 to 9520.0870;

(iii) a mental health clinic certified under Minnesota Rules, parts 9520.0750 to 9520.0870; or

(iv) a provider of intensive residential treatment services (IRTS) licensed under Minnesota Rules, parts 9520.0500 to 9520.0670; or

(2) the license holder is certified under the requirements in subdivision 6a or section 245D.33.

(f) A resource need determination process, managed at the state level, using the available reports required by section 144A.351, and other data and information shall be used to determine where the reduced capacity required under paragraph (d) will be implemented. The commissioner shall consult with the stakeholders described in section 144A.351, and employ a variety of methods to improve the state's capacity to meet long-term care service needs within budgetary limits, including seeking proposals from service providers or lead agencies to change service type, capacity, or location to improve services, increase the independence of residents, and better meet needs identified by the long-term care services reports and statewide data and information. By February 1 of each year, the commissioner shall provide information and data on the overall capacity of licensed long-term care services, actions taken under this subdivision to manage statewide long-term care services and supports resources, and any recommendations for change to the legislative committees with jurisdiction over health and human services budget.

(g) At the time of application and reapplication for licensure, the applicant and the license holder that are subject to the moratorium or an exclusion established in paragraph (a) are required to inform the commissioner whether the physical location where the foster care will be provided is or will be the primary residence of the license holder for the entire period of licensure. If the primary residence of the applicant or license holder changes, the applicant or license holder must notify the commissioner immediately. The commissioner shall print on the foster care license certificate whether or not the physical location is the primary residence of the license holder.

(h) License holders of foster care homes identified under paragraph (g) that are not the primary residence of the license holder and that also provide services in the foster care home that are covered by a federally approved home and community-based services

waiver, as authorized under section 256B.0915, 256B.092, or 256B.49, must inform the human services licensing division that the license holder provides or intends to provide these waiver-funded services. ~~These license holders must be considered registered under section 256B.092, subdivision 11, paragraph (c), and this registration status must be identified on their license certificates.~~

Sec. 7. Minnesota Statutes 2012, section 245A.03, subdivision 8, is amended to read:

Subd. 8. **Excluded providers seeking licensure.** Nothing in this section shall prohibit a program that is excluded from licensure under subdivision 2, paragraph (a), clause ~~(28)~~ (26), from seeking licensure. The commissioner shall ensure that any application received from such an excluded provider is processed in the same manner as all other applications for child care center licensure.

Sec. 8. Minnesota Statutes 2012, section 245A.042, subdivision 3, is amended to read:

Subd. 3. **Implementation.** (a) The commissioner shall implement the responsibilities of this chapter according to the timelines in paragraphs (b) and (c) only within the limits of available appropriations or other administrative cost recovery methodology.

(b) The licensure of home and community-based services according to this section shall be implemented January 1, 2014. License applications shall be received and processed on a phased-in schedule as determined by the commissioner beginning July 1, 2013. Licenses will be issued thereafter upon the commissioner's determination that the application is complete according to section 245A.04.

(c) Within the limits of available appropriations or other administrative cost recovery methodology, implementation of compliance monitoring must be phased in after January 1, 2014.

(1) Applicants who do not currently hold a license issued under ~~this~~ chapter 245B must receive an initial compliance monitoring visit after 12 months of the effective date of the initial license for the purpose of providing technical assistance on how to achieve and maintain compliance with the applicable law or rules governing the provision of home and community-based services under chapter 245D. If during the review the commissioner finds that the license holder has failed to achieve compliance with an applicable law or rule and this failure does not imminently endanger the health, safety, or rights of the persons served by the program, the commissioner may issue a licensing review report with recommendations for achieving and maintaining compliance.

(2) Applicants who do currently hold a license issued under this chapter must receive a compliance monitoring visit after 24 months of the effective date of the initial license.

(d) Nothing in this subdivision shall be construed to limit the commissioner's authority to suspend or revoke a license or issue a fine at any time under section 245A.07, or ~~make~~ issue correction orders and make a license conditional for failure to comply with applicable laws or rules under section 245A.06, based on the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of persons served by the program.

Sec. 9. Minnesota Statutes 2012, section 245A.08, subdivision 2a, is amended to read:

Subd. 2a. **Consolidated contested case hearings.** (a) When a denial of a license under section 245A.05 or a licensing sanction under section 245A.07, subdivision 3, is based on a disqualification for which reconsideration was requested and which was not set aside under section 245C.22, the scope of the contested case hearing shall include the disqualification and the licensing sanction or denial of a license, unless otherwise specified in this subdivision. When the licensing sanction or denial of a license is based on a determination of maltreatment under section 626.556 or 626.557, or a disqualification for serious or recurring maltreatment which was not set aside, the scope of the contested case hearing shall include the maltreatment determination, disqualification, and the licensing sanction or denial of a license, unless otherwise specified in this subdivision. In such cases, a fair hearing under section 256.045 shall not be conducted as provided for in sections 245C.27, 626.556, subdivision 10i, and 626.557, subdivision 9d.

(b) Except for family child care and child foster care, reconsideration of a maltreatment determination under sections 626.556, subdivision 10i, and 626.557, subdivision 9d, and reconsideration of a disqualification under section 245C.22, shall not be conducted when:

(1) a denial of a license under section 245A.05, or a licensing sanction under section 245A.07, is based on a determination that the license holder is responsible for maltreatment or the disqualification of a license holder is based on serious or recurring maltreatment;

(2) the denial of a license or licensing sanction is issued at the same time as the maltreatment determination or disqualification; and

(3) the license holder appeals the maltreatment determination or disqualification, and denial of a license or licensing sanction. In these cases, a fair hearing shall not be conducted under sections 245C.27, 626.556, subdivision 10i, and 626.557, subdivision 9d. The scope of the contested case hearing must include the maltreatment determination, disqualification, and denial of a license or licensing sanction.

Notwithstanding clauses (1) to (3), if the license holder appeals the maltreatment determination or disqualification, but does not appeal the denial of a license or a licensing sanction, reconsideration of the maltreatment determination shall be conducted under sections 626.556, subdivision 10i, and 626.557, subdivision 9d, and reconsideration of the disqualification shall be conducted under section 245C.22. In such cases, a fair hearing shall also be conducted as provided under sections 245C.27, 626.556, subdivision 10i, and 626.557, subdivision 9d.

(c) In consolidated contested case hearings regarding sanctions issued in family child care, child foster care, family adult day services, ~~and~~ adult foster care, and community residential settings, the county attorney shall defend the commissioner's orders in accordance with section 245A.16, subdivision 4.

(d) The commissioner's final order under subdivision 5 is the final agency action on the issue of maltreatment and disqualification, including for purposes of subsequent background studies under chapter 245C and is the only administrative appeal of the final agency determination, specifically, including a challenge to the accuracy and completeness of data under section 13.04.

(e) When consolidated hearings under this subdivision involve a licensing sanction based on a previous maltreatment determination for which the commissioner has issued a final order in an appeal of that determination under section 256.045, or the individual failed to exercise the right to appeal the previous maltreatment determination under section 626.556, subdivision 10i, or 626.557, subdivision 9d, the commissioner's order is conclusive on the issue of maltreatment. In such cases, the scope of the administrative law judge's review shall be limited to the disqualification and the licensing sanction or denial of a license. In the case of a denial of a license or a licensing sanction issued to a facility based on a maltreatment determination regarding an individual who is not the license holder or a household member, the scope of the administrative law judge's review includes the maltreatment determination.

(f) The hearings of all parties may be consolidated into a single contested case hearing upon consent of all parties and the administrative law judge, if:

(1) a maltreatment determination or disqualification, which was not set aside under section 245C.22, is the basis for a denial of a license under section 245A.05 or a licensing sanction under section 245A.07;

(2) the disqualified subject is an individual other than the license holder and upon whom a background study must be conducted under section 245C.03; and

(3) the individual has a hearing right under section 245C.27.

(g) When a denial of a license under section 245A.05 or a licensing sanction under section 245A.07 is based on a disqualification for which reconsideration was requested and was not set aside under section 245C.22, and the individual otherwise has no hearing right under section 245C.27, the scope of the administrative law judge's review shall include the denial or sanction and a determination whether the disqualification should be set aside, unless section 245C.24 prohibits the set-aside of the disqualification. In determining whether the disqualification should be set aside, the administrative law judge shall consider the factors under section 245C.22, subdivision 4, to determine whether the individual poses a risk of harm to any person receiving services from the license holder.

(h) Notwithstanding section 245C.30, subdivision 5, when a licensing sanction under section 245A.07 is based on the termination of a variance under section 245C.30, subdivision 4, the scope of the administrative law judge's review shall include the sanction and a determination whether the disqualification should be set aside, unless section 245C.24 prohibits the set-aside of the disqualification. In determining whether the disqualification should be set aside, the administrative law judge shall consider the factors under section 245C.22, subdivision 4, to determine whether the individual poses a risk of harm to any person receiving services from the license holder.

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

245A.10 FEES.

Subdivision 1. **Application or license fee required, programs exempt from fee.** (a) Unless exempt under paragraph (b), the commissioner shall charge a fee for evaluation of applications and inspection of programs which are licensed under this chapter.

(b) Except as provided under subdivision 2, no application or license fee shall be charged for child foster care, adult foster care, ~~or~~ family and group family child care, or a community residential setting.

Subd. 2. **County fees for background studies and licensing inspections.** (a) For purposes of family and group family child care licensing under this chapter, a county agency may charge a fee to an applicant or license holder to recover the actual cost of background studies, but in any case not to exceed $100 annually. A county agency may also charge a license fee to an applicant or license holder not to exceed $50 for a one-year license or $100 for a two-year license.

(b) A county agency may charge a fee to a legal nonlicensed child care provider or applicant for authorization to recover the actual cost of background studies completed under section 119B.125, but in any case not to exceed $100 annually.

(c) Counties may elect to reduce or waive the fees in paragraph (a) or (b):

(1) in cases of financial hardship;

(2) if the county has a shortage of providers in the county's area;

(3) for new providers; or

(4) for providers who have attained at least 16 hours of training before seeking initial licensure.

(d) Counties may allow providers to pay the applicant fees in paragraph (a) or (b) on an installment basis for up to one year. If the provider is receiving child care assistance payments from the state, the provider may have the fees under paragraph (a) or (b) deducted from the child care assistance payments for up to one year and the state shall reimburse the county for the county fees collected in this manner.

(e) For purposes of adult foster care and child foster care licensing, and licensing the physical plant of a community residential setting, under this chapter, a county agency may charge a fee to a corporate applicant or corporate license holder to recover the actual cost of licensing inspections, not to exceed $500 annually.

(f) Counties may elect to reduce or waive the fees in paragraph (e) under the following circumstances:

(1) in cases of financial hardship;

(2) if the county has a shortage of providers in the county's area; or

(3) for new providers.

Subd. 3. **Application fee for initial license or certification.** (a) For fees required under subdivision 1, an applicant for an initial license or certification issued by the commissioner shall submit a $500 application fee with each new application required under this subdivision. An applicant for an initial day services facility license under chapter 245D shall submit a $250 application fee with each new application. The application fee shall not be prorated, is nonrefundable, and is in lieu of the annual license or certification fee that expires on December 31. The commissioner shall not process an application until the application fee is paid.

(b) Except as provided in clauses (1) to ~~(4)~~ (3), an applicant shall apply for a license to provide services at a specific location.

(1) ~~For a license to provide residential-based habilitation services to persons with developmental disabilities under chapter 245B, an applicant shall submit an application for each county in which the services will be provided. Upon licensure, the license holder may provide services to persons in that county plus no more than three persons at any one time in each of up to ten additional counties. A license holder in one county may not provide services under the home and community-based waiver for persons with developmental disabilities to more than three people in a second county without holding~~

~~a separate license for that second county. Applicants or licensees providing services under this clause to not more than three persons remain subject to the inspection fees established in section 245A.10, subdivision 2, for each location. The license issued by the commissioner must state the name of each additional county where services are being provided to persons with developmental disabilities. A license holder must notify the commissioner before making any changes that would alter the license information listed under section 245A.04, subdivision 7, paragraph (a), including any additional counties where persons with developmental disabilities are being served.~~ For a license to provide home and community-based services to persons with disabilities or age 65 and older under chapter 245D, an applicant shall submit an application to provide services statewide.

(2) ~~For a license to provide supported employment, crisis respite, or semi-independent living services to persons with developmental disabilities under chapter 245B, an applicant shall submit a single application to provide services statewide.~~

~~(3)~~ For a license to provide independent living assistance for youth under section 245A.22, an applicant shall submit a single application to provide services statewide.

~~(4)~~ (3) For a license for a private agency to provide foster care or adoption services under Minnesota Rules, parts 9545.0755 to 9545.0845, an applicant shall submit a single application to provide services statewide.

(c) The initial application fee charged under this subdivision does not include the temporary license surcharge under section 16E.22.

Subd. 4. **License or certification fee for certain programs.** (a) Child care centers shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	Child Care CenterLicense Fee
1 to 24 persons	$200
25 to 49 persons	$300
50 to 74 persons	$400
75 to 99 persons	$500
100 to 124 persons	$600
125 to 149 persons	$700
150 to 174 persons	$800
175 to 199 persons	$900
200 to 224 persons	$1,000
225 or more persons	$1,100

~~(b) A day training and habilitation program serving persons with developmental disabilities or related conditions shall pay an annual nonrefundable license fee based on the following schedule:~~

~~Licensed Capacity~~	~~License Fee~~
~~1 to 24 persons~~	~~$800~~

~~25 to 49 persons~~	~~$1,000~~
~~50 to 74 persons~~	~~$1,200~~
~~75 to 99 persons~~	~~$1,400~~
~~100 to 124 persons~~	~~$1,600~~
~~125 to 149 persons~~	~~$1,800~~
~~150 or more persons~~	~~$2,000~~

~~Except as provided in paragraph (c), when a day training and habilitation program serves more than 50 percent of the same persons in two or more locations in a community, the day training and habilitation program shall pay a license fee based on the licensed capacity of the largest facility and the other facility or facilities shall be charged a license fee based on a licensed capacity of a residential program serving one to 24 persons.~~

~~(c) When a day training and habilitation program serving persons with developmental disabilities or related conditions seeks a single license allowed under section 245B.07, subdivision 12, clause (2) or (3), the licensing fee must be based on the combined licensed capacity for each location.~~

~~(d) A program licensed to provide supported employment services to persons with developmental disabilities under chapter 245B shall pay an annual nonrefundable license fee of $650.~~

~~(e) A program licensed to provide crisis respite services to persons with developmental disabilities under chapter 245B shall pay an annual nonrefundable license fee of $700.~~

~~(f) A program licensed to provide semi-independent living services to persons with developmental disabilities under chapter 245B shall pay an annual nonrefundable license fee of $700.~~

~~(g) A program licensed to provide residential-based habilitation services under the home and community-based waiver for persons with developmental disabilities shall pay an annual license fee that includes a base rate of $690 plus $60 times the number of clients served on the first day of July of the current license year.~~

~~(h) A residential program certified by the Department of Health as an intermediate care facility for persons with developmental disabilities (ICF/MR) and a noncertified residential program licensed to provide health or rehabilitative services for persons with developmental disabilities shall pay an annual nonrefundable license fee based on the following schedule:~~

~~Licensed Capacity~~	~~License Fee~~
~~1 to 24 persons~~	~~$535~~
~~25 to 49 persons~~	~~$735~~
~~50 or more persons~~	~~$935~~

(b) A program licensed to provide one or more of the home and community-based services and supports identified under chapter 245D to persons with disabilities or age 65 and older, shall pay an annual nonrefundable license fee that includes a base rate of $2,250, plus $92 times the number of persons served, on average, greater than 40 hours per week for the month of June of the current license year for programs serving ten or more persons. The fee is limited to a maximum of 200 persons, regardless of the actual number of persons served. Programs serving nine or fewer persons pay only half of the base rate.

(c) A facility licensed under chapter 245D to provide day services shall pay an annual nonrefundable license fee of $100.

~~(i)~~ (d) A chemical dependency treatment program licensed under Minnesota Rules, parts 9530.6405 to 9530.6505, to provide chemical dependency treatment shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$600
25 to 49 persons	$800
50 to 74 persons	$1,000
75 to 99 persons	$1,200
100 or more persons	$1,400

~~(j)~~ (e) A chemical dependency program licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, to provide detoxification services shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$760
25 to 49 persons	$960
50 or more persons	$1,160

~~(k)~~ (f) Except for child foster care, a residential facility licensed under Minnesota Rules, chapter 2960, to serve children shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$1,000
25 to 49 persons	$1,100
50 to 74 persons	$1,200
75 to 99 persons	$1,300
100 or more persons	$1,400

~~(l)~~ (g) A residential facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670, to serve persons with mental illness shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$2,525
25 or more persons	$2,725

~~(m)~~ (h) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400, to serve persons with physical disabilities shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$450
25 to 49 persons	$650
50 to 74 persons	$850
75 to 99 persons	$1,050
100 or more persons	$1,250

~~(n)~~ (i) A program licensed to provide independent living assistance for youth under section 245A.22 shall pay an annual nonrefundable license fee of $1,500.

~~(o)~~ (j) A private agency licensed to provide foster care and adoption services under Minnesota Rules, parts 9545.0755 to 9545.0845, shall pay an annual nonrefundable license fee of $875.

~~(p)~~ (k) A program licensed as an adult day care center licensed under Minnesota Rules, parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$500
25 to 49 persons	$700
50 to 74 persons	$900
75 to 99 persons	$1,100
100 or more persons	$1,300

~~(q)~~ (l) A program licensed to provide treatment services to persons with sexual psychopathic personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to 9515.3110, shall pay an annual nonrefundable license fee of $20,000.

~~(r)~~ (m) A mental health center or mental health clinic requesting certification for purposes of insurance and subscriber contract reimbursement under Minnesota Rules, parts 9520.0750 to 9520.0870, shall pay a certification fee of $1,550 per year. If the mental health center or mental health clinic provides services at a primary location with satellite facilities, the satellite facilities shall be certified with the primary location without an additional charge.

Subd. 6. **License not issued until license or certification fee is paid.** The commissioner shall not issue a license or certification until the license or certification fee

is paid. The commissioner shall send a bill for the license or certification fee to the billing address identified by the license holder. If the license holder does not submit the license or certification fee payment by the due date, the commissioner shall send the license holder a past due notice. If the license holder fails to pay the license or certification fee by the due date on the past due notice, the commissioner shall send a final notice to the license holder informing the license holder that the program license will expire on December 31 unless the license fee is paid before December 31. If a license expires, the program is no longer licensed and, unless exempt from licensure under section 245A.03, subdivision 2, must not operate after the expiration date. After a license expires, if the former license holder wishes to provide licensed services, the former license holder must submit a new license application and application fee under subdivision 3.

Subd. 7. **Human services licensing fees to recover expenditures.** Notwithstanding section 16A.1285, subdivision 2, related to activities for which the commissioner charges a fee, the commissioner must plan to fully recover direct expenditures for licensing activities under this chapter over a five-year period. The commissioner may have anticipated expenditures in excess of anticipated revenues in a biennium by using surplus revenues accumulated in previous bienniums.

Subd. 8. **Deposit of license fees.** A human services licensing account is created in the state government special revenue fund. Fees collected under subdivisions 3 and 4 must be deposited in the human services licensing account and are annually appropriated to the commissioner for licensing activities authorized under this chapter.

EFFECTIVE DATE. This section is effective July 1, 2013.

Sec. 11. Minnesota Statutes 2012, section 245A.11, subdivision 2a, is amended to read:

Subd. 2a. **Adult foster care and community residential setting license capacity.** (a) The commissioner shall issue adult foster care and community residential setting licenses with a maximum licensed capacity of four beds, including nonstaff roomers and boarders, except that the commissioner may issue a license with a capacity of five beds, including roomers and boarders, according to paragraphs (b) to (f).

(b) ~~An adult foster care~~ The license holder may have a maximum license capacity of five if all persons in care are age 55 or over and do not have a serious and persistent mental illness or a developmental disability.

(c) The commissioner may grant variances to paragraph (b) to allow a ~~foster care provider~~ facility with a licensed capacity of five persons to admit an individual under the age of 55 if the variance complies with section 245A.04, subdivision 9, and approval of

the variance is recommended by the county in which the licensed ~~foster care provider~~ facility is located.

(d) The commissioner may grant variances to paragraph (b) to allow the use of a fifth bed for emergency crisis services for a person with serious and persistent mental illness or a developmental disability, regardless of age, if the variance complies with section 245A.04, subdivision 9, and approval of the variance is recommended by the county in which the licensed ~~foster care provider~~ facility is located.

(e) The commissioner may grant a variance to paragraph (b) to allow for the use of a fifth bed for respite services, as defined in section 245A.02, for persons with disabilities, regardless of age, if the variance complies with sections 245A.03, subdivision 7, and 245A.04, subdivision 9, and approval of the variance is recommended by the county in which the licensed ~~foster care provider~~ facility is ~~licensed~~ located. Respite care may be provided under the following conditions:

(1) staffing ratios cannot be reduced below the approved level for the individuals being served in the home on a permanent basis;

(2) no more than two different individuals can be accepted for respite services in any calendar month and the total respite days may not exceed 120 days per program in any calendar year;

(3) the person receiving respite services must have his or her own bedroom, which could be used for alternative purposes when not used as a respite bedroom, and cannot be the room of another person who lives in the ~~foster care home~~ facility; and

(4) individuals living in the ~~foster care home~~ facility must be notified when the variance is approved. The provider must give 60 days' notice in writing to the residents and their legal representatives prior to accepting the first respite placement. Notice must be given to residents at least two days prior to service initiation, or as soon as the license holder is able if they receive notice of the need for respite less than two days prior to initiation, each time a respite client will be served, unless the requirement for this notice is waived by the resident or legal guardian.

(f) The commissioner may issue an adult foster care or community residential setting license with a capacity of five adults if the fifth bed does not increase the overall statewide capacity of licensed adult foster care or community residential setting beds in homes that are not the primary residence of the license holder, as identified in a plan submitted to the commissioner by the county, when the capacity is recommended by the county licensing agency of the county in which the facility is located and if the recommendation verifies that:

(1) the facility meets the physical environment requirements in the adult foster care licensing rule;

(2) the five-bed living arrangement is specified for each resident in the resident's:

(i) individualized plan of care;

(ii) individual service plan under section 256B.092, subdivision 1b, if required; or

(iii) individual resident placement agreement under Minnesota Rules, part 9555.5105, subpart 19, if required;

(3) the license holder obtains written and signed informed consent from each resident or resident's legal representative documenting the resident's informed choice to remain living in the home and that the resident's refusal to consent would not have resulted in service termination; and

(4) the facility was licensed for adult foster care before March 1, 2011.

(g) The commissioner shall not issue a new adult foster care license under paragraph (f) after June 30, 2016. The commissioner shall allow a facility with an adult foster care license issued under paragraph (f) before June 30, 2016, to continue with a capacity of five adults if the license holder continues to comply with the requirements in paragraph (f).

Sec. 12. Minnesota Statutes 2012, section 245A.11, subdivision 7, is amended to read:

Subd. 7. **Adult foster care; variance for alternate overnight supervision.** (a) The commissioner may grant a variance under section 245A.04, subdivision 9, to rule parts requiring a caregiver to be present in an adult foster care home during normal sleeping hours to allow for alternative methods of overnight supervision. The commissioner may grant the variance if the local county licensing agency recommends the variance and the county recommendation includes documentation verifying that:

(1) the county has approved the license holder's plan for alternative methods of providing overnight supervision and determined the plan protects the residents' health, safety, and rights;

(2) the license holder has obtained written and signed informed consent from each resident or each resident's legal representative documenting the resident's or legal representative's agreement with the alternative method of overnight supervision; and

(3) the alternative method of providing overnight supervision, which may include the use of technology, is specified for each resident in the resident's: (i) individualized plan of care; (ii) individual service plan under section 256B.092, subdivision 1b, if required; or (iii) individual resident placement agreement under Minnesota Rules, part 9555.5105, subpart 19, if required.

(b) To be eligible for a variance under paragraph (a), the adult foster care license holder must not have had a conditional license issued under section 245A.06, or any other licensing sanction issued under section 245A.07 during the prior 24 months based

on failure to provide adequate supervision, health care services, or resident safety in the adult foster care home.

(c) A license holder requesting a variance under this subdivision to utilize technology as a component of a plan for alternative overnight supervision may request the commissioner's review in the absence of a county recommendation. Upon receipt of such a request from a license holder, the commissioner shall review the variance request with the county.

(d) A variance granted by the commissioner according to this subdivision before January 1, 2014, to a license holder for an adult foster care home must transfer with the license when the license converts to a community residential setting license under chapter 245D. The terms and conditions of the variance remain in effect as approved at the time the variance was granted.

Sec. 13. Minnesota Statutes 2012, section 245A.11, subdivision 7a, is amended to read:

Subd. 7a. **Alternate overnight supervision technology; adult foster care ~~license~~ and community residential setting licenses.** (a) The commissioner may grant an applicant or license holder an adult foster care or community residential setting license for a residence that does not have a caregiver in the residence during normal sleeping hours as required under Minnesota Rules, part 9555.5105, subpart 37, item B, or section 245D.02, subdivision 33b, but uses monitoring technology to alert the license holder when an incident occurs that may jeopardize the health, safety, or rights of a foster care recipient. The applicant or license holder must comply with all other requirements under Minnesota Rules, parts 9555.5105 to 9555.6265, or applicable requirements under chapter 245D, and the requirements under this subdivision. The license printed by the commissioner must state in bold and large font:

(1) that the facility is under electronic monitoring; and

(2) the telephone number of the county's common entry point for making reports of suspected maltreatment of vulnerable adults under section 626.557, subdivision 9.

(b) Applications for a license under this section must be submitted directly to the Department of Human Services licensing division. The licensing division must immediately notify the ~~host county and lead county contract agency and the host~~ county licensing agency. The licensing division must collaborate with the county licensing agency in the review of the application and the licensing of the program.

(c) Before a license is issued by the commissioner, and for the duration of the license, the applicant or license holder must establish, maintain, and document the

implementation of written policies and procedures addressing the requirements in paragraphs (d) through (f).

(d) The applicant or license holder must have policies and procedures that:

(1) establish characteristics of target populations that will be admitted into the home, and characteristics of populations that will not be accepted into the home;

(2) explain the discharge process when a ~~foster care recipient~~ resident served by the program requires overnight supervision or other services that cannot be provided by the license holder due to the limited hours that the license holder is on site;

(3) describe the types of events to which the program will respond with a physical presence when those events occur in the home during time when staff are not on site, and how the license holder's response plan meets the requirements in paragraph (e), clause (1) or (2);

(4) establish a process for documenting a review of the implementation and effectiveness of the response protocol for the response required under paragraph (e), clause (1) or (2). The documentation must include:

(i) a description of the triggering incident;

(ii) the date and time of the triggering incident;

(iii) the time of the response or responses under paragraph (e), clause (1) or (2);

(iv) whether the response met the resident's needs;

(v) whether the existing policies and response protocols were followed; and

(vi) whether the existing policies and protocols are adequate or need modification.

When no physical presence response is completed for a three-month period, the license holder's written policies and procedures must require a physical presence response drill to be conducted for which the effectiveness of the response protocol under paragraph (e), clause (1) or (2), will be reviewed and documented as required under this clause; and

(5) establish that emergency and nonemergency phone numbers are posted in a prominent location in a common area of the home where they can be easily observed by a person responding to an incident who is not otherwise affiliated with the home.

(e) The license holder must document and include in the license application which response alternative under clause (1) or (2) is in place for responding to situations that present a serious risk to the health, safety, or rights of ~~people receiving foster care services in the home~~ residents served by the program:

(1) response alternative (1) requires only the technology to provide an electronic notification or alert to the license holder that an event is underway that requires a response. Under this alternative, no more than ten minutes will pass before the license holder will be physically present on site to respond to the situation; or

(2) response alternative (2) requires the electronic notification and alert system under alternative (1), but more than ten minutes may pass before the license holder is present on site to respond to the situation. Under alternative (2), all of the following conditions are met:

(i) the license holder has a written description of the interactive technological applications that will assist the license holder in communicating with and assessing the needs related to the care, health, and safety of the foster care recipients. This interactive technology must permit the license holder to remotely assess the well being of the ~~foster care recipient~~ resident served by the program without requiring the initiation of the foster care recipient. Requiring the foster care recipient to initiate a telephone call does not meet this requirement;

(ii) the license holder documents how the remote license holder is qualified and capable of meeting the needs of the foster care recipients and assessing foster care recipients' needs under item (i) during the absence of the license holder on site;

(iii) the license holder maintains written procedures to dispatch emergency response personnel to the site in the event of an identified emergency; and

(iv) each ~~foster care recipient's~~ resident's individualized plan of care, ~~individual service plan~~ coordinated service and support plan under ~~section~~ sections 256B.0913, subdivision 8; 256B.0915, subdivision 6; 256B.092, subdivision 1b; and 256B.49, subdivision 15, if required, or individual resident placement agreement under Minnesota Rules, part 9555.5105, subpart 19, if required, identifies the maximum response time, which may be greater than ten minutes, for the license holder to be on site for that ~~foster care recipient~~ resident.

(f) Each ~~foster care recipient's~~ resident's placement agreement, individual service agreement, and plan must clearly state that the adult foster care or community residential setting license category is a program without the presence of a caregiver in the residence during normal sleeping hours; the protocols in place for responding to situations that present a serious risk to the health, safety, or rights of ~~foster care recipients~~ residents served by the program under paragraph (e), clause (1) or (2); and a signed informed consent from each ~~foster care recipient~~ resident served by the program or the person's legal representative documenting the person's or legal representative's agreement with placement in the program. If electronic monitoring technology is used in the home, the informed consent form must also explain the following:

(1) how any electronic monitoring is incorporated into the alternative supervision system;

(2) the backup system for any electronic monitoring in times of electrical outages or other equipment malfunctions;

(3) how the caregivers or direct support staff are trained on the use of the technology;

(4) the event types and license holder response times established under paragraph (e);

(5) how the license holder protects ~~the foster care recipient's~~ each resident's privacy related to electronic monitoring and related to any electronically recorded data generated by the monitoring system. A ~~foster care recipient~~ resident served by the program may not be removed from a program under this subdivision for failure to consent to electronic monitoring. The consent form must explain where and how the electronically recorded data is stored, with whom it will be shared, and how long it is retained; and

(6) the risks and benefits of the alternative overnight supervision system.

The written explanations under clauses (1) to (6) may be accomplished through cross-references to other policies and procedures as long as they are explained to the person giving consent, and the person giving consent is offered a copy.

(g) Nothing in this section requires the applicant or license holder to develop or maintain separate or duplicative policies, procedures, documentation, consent forms, or individual plans that may be required for other licensing standards, if the requirements of this section are incorporated into those documents.

(h) The commissioner may grant variances to the requirements of this section according to section 245A.04, subdivision 9.

(i) For the purposes of paragraphs (d) through (h), "license holder" has the meaning under section 245A.2, subdivision 9, and additionally includes all staff, volunteers, and contractors affiliated with the license holder.

(j) For the purposes of paragraph (e), the terms "assess" and "assessing" mean to remotely determine what action the license holder needs to take to protect the well-being of the foster care recipient.

(k) The commissioner shall evaluate license applications using the requirements in paragraphs (d) to (f). The commissioner shall provide detailed application forms, including a checklist of criteria needed for approval.

(l) To be eligible for a license under paragraph (a), the adult foster care or community residential setting license holder must not have had a conditional license issued under section 245A.06 or any licensing sanction under section 245A.07 during the prior 24 months based on failure to provide adequate supervision, health care services, or resident safety in the adult foster care home or community residential setting.

(m) The commissioner shall review an application for an alternative overnight supervision license within 60 days of receipt of the application. When the commissioner receives an application that is incomplete because the applicant failed to submit required documents or that is substantially deficient because the documents submitted do not meet

licensing requirements, the commissioner shall provide the applicant written notice that the application is incomplete or substantially deficient. In the written notice to the applicant, the commissioner shall identify documents that are missing or deficient and give the applicant 45 days to resubmit a second application that is substantially complete. An applicant's failure to submit a substantially complete application after receiving notice from the commissioner is a basis for license denial under section 245A.05. The commissioner shall complete subsequent review within 30 days.

(n) Once the application is considered complete under paragraph (m), the commissioner will approve or deny an application for an alternative overnight supervision license within 60 days.

(o) For the purposes of this subdivision, "supervision" means:

(1) oversight by a caregiver or direct support staff as specified in the individual resident's place agreement or coordinated service and support plan and awareness of the resident's needs and activities; and

(2) the presence of a caregiver or direct support staff in a residence during normal sleeping hours, unless a determination has been made and documented in the individual's coordinated service and support plan that the individual does not require the presence of a caregiver or direct support staff during normal sleeping hours.

Sec. 14. 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. 15. Minnesota Statutes 2012, section 245A.11, subdivision 8, is amended to read:

Subd. 8. **Community residential setting license.** (a) The commissioner shall establish provider standards for residential support services that integrate service standards and the residential setting under one license. The commissioner shall propose statutory language and an implementation plan for licensing requirements for residential support services to the legislature by January 15, 2012, as a component of the quality outcome standards recommendations required by Laws 2010, chapter 352, article 1, section 24.

(b) Providers licensed under chapter 245B, and providing, contracting, or arranging for services in settings licensed as adult foster care under Minnesota Rules, parts 9555.5105

to 9555.6265~~, or child foster care under Minnesota Rules, parts 2960.3000 to 2960.3340~~; and meeting the provisions of ~~section 256B.092, subdivision 11, paragraph (b)~~ section 245D.02, subdivision 4a, must be required to obtain a community residential setting license.

Sec. 16. Minnesota Statutes 2012, section 245A.16, subdivision 1, is amended to read:

Subdivision 1. **Delegation of authority to agencies.** (a) County agencies and private agencies that have been designated or licensed by the commissioner to perform licensing functions and activities under section 245A.04 and background studies for family child care under chapter 245C; to recommend denial of applicants under section 245A.05; to issue correction orders, to issue variances, and recommend a conditional license under section 245A.06, or to recommend suspending or revoking a license or issuing a fine under section 245A.07, shall comply with rules and directives of the commissioner governing those functions and with this section. The following variances are excluded from the delegation of variance authority and may be issued only by the commissioner:

(1) dual licensure of family child care and child foster care, dual licensure of child and adult foster care, and adult foster care and family child care;

(2) adult foster care maximum capacity;

(3) adult foster care minimum age requirement;

(4) child foster care maximum age requirement;

(5) variances regarding disqualified individuals except that county agencies may issue variances under section 245C.30 regarding disqualified individuals when the county is responsible for conducting a consolidated reconsideration according to sections 245C.25 and 245C.27, subdivision 2, clauses (a) and (b), of a county maltreatment determination and a disqualification based on serious or recurring maltreatment; ~~and~~

(6) the required presence of a caregiver in the adult foster care residence during normal sleeping hours; and

(7) variances for community residential setting licenses under chapter 245D.

Except as provided in section 245A.14, subdivision 4, paragraph (e), a county agency must not grant a license holder a variance to exceed the maximum allowable family child care license capacity of 14 children.

(b) County agencies must report information about disqualification reconsiderations under sections 245C.25 and 245C.27, subdivision 2, paragraphs (a) and (b), and variances granted under paragraph (a), clause (5), to the commissioner at least monthly in a format prescribed by the commissioner.

(c) For family day care programs, the commissioner may authorize licensing reviews every two years after a licensee has had at least one annual review.

(d) For family adult day services programs, the commissioner may authorize licensing reviews every two years after a licensee has had at least one annual review.

(e) A license issued under this section may be issued for up to two years.

Sec. 17. Minnesota Statutes 2012, section 245D.02, is amended to read:

245D.02 DEFINITIONS.

Subdivision 1. **Scope.** The terms used in this chapter have the meanings given them in this section.

Subd. 2. **Annual and annually.** "Annual" and "annually" have the meaning given in section 245A.02, subdivision 2b.

Subd. 2a. **Authorized representative.** "Authorized representative" means a parent, family member, advocate, or other adult authorized by the person or the person's legal representative, to serve as a representative in connection with the provision of services licensed under this chapter. This authorization must be in writing or by another method that clearly indicates the person's free choice. The authorized representative must have no financial interest in the provision of any services included in the person's service delivery plan and must be capable of providing the support necessary to assist the person in the use of home and community-based services licensed under this chapter.

Subd. 3. **Case manager.** "Case manager" means the individual designated to provide waiver case management services, care coordination, or long-term care consultation, as specified in sections 256B.0913, 256B.0915, 256B.092, and 256B.49, or successor provisions.

Subd. 3a. **Certification.** "Certification" means the commissioner's written authorization for a license holder to provide specialized services based on certification standards in section 245D.33. The term certification and its derivatives have the same meaning and may be substituted for the term licensure and its derivatives in this chapter and chapter 245A.

Subd. 4. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or the commissioner's designated representative.

Subd. 4a. **Community residential setting.** "Community residential setting" means a residential program as identified in section 245A.11, subdivision 8, where residential supports and services identified in section 245D.03, subdivision 1, paragraph (c), clause (3), items (i) and (ii), are provided and the license holder is the owner, lessor, or tenant of the facility licensed according to this chapter, and the license holder does not reside in the facility.

Subd. 4b. **Coordinated service and support plan.** "Coordinated service and support plan" has the meaning given in sections 256B.0913, subdivision 8; 256B.0915, subdivision 6; 256B.092, subdivision 1b; and 256B.49, subdivision 15, or successor provisions.

Subd. 4c. **Coordinated service and support plan addendum.** "Coordinated service and support plan addendum" means the documentation that this chapter requires of the license holder for each person receiving services.

Subd. 4d. **Corporate foster care.** "Corporate foster care" means a child foster residence setting licensed according to Minnesota Rules, parts 2960.0010 to 2960.3340, or an adult foster care home licensed according to Minnesota Rules, parts 9555.5105 to 9555.6265, where the license holder does not live in the home.

Subd. 4e. **Cultural competence or culturally competent.** "Cultural competence" or "culturally competent" means the ability and the will to respond to the unique needs of a person that arise from the person's culture and the ability to use the person's culture as a resource or tool to assist with the intervention and help meet the person's needs.

Subd. 4f. **Day services facility.** "Day services facility" means a facility licensed according to this chapter at which persons receive day services licensed under this chapter from the license holder's direct support staff for a cumulative total of more than 30 days within any 12-month period and the license holder is the owner, lessor, or tenant of the facility.

Subd. 5. **Department.** "Department" means the Department of Human Services.

Subd. 6. **Direct contact.** "Direct contact" has the meaning given in section 245C.02, subdivision 11, and is used interchangeably with the term "direct support service."

Subd. 6a. **Direct support staff or staff.** "Direct support staff" or "staff" means employees of the license holder who have direct contact with persons served by the program and includes temporary staff or subcontractors, regardless of employer, providing program services for hire under the control of the license holder who have direct contact with persons served by the program.

Subd. 7. **Drug.** "Drug" has the meaning given in section 151.01, subdivision 5.

Subd. 8. **Emergency.** "Emergency" means any event that affects the ordinary daily operation of the program including, but not limited to, fires, severe weather, natural disasters, power failures, or other events that threaten the immediate health and safety of a person receiving services and that require calling 911, emergency evacuation, moving to an emergency shelter, or temporary closure or relocation of the program to another facility or service site for more than 24 hours.

Subd. 8a. **Emergency use of manual restraint.** "Emergency use of manual restraint" means using a manual restraint when a person poses an imminent risk of

physical harm to self or others and is the least restrictive intervention that would achieve safety. Property damage, verbal aggression, or a person's refusal to receive or participate in treatment or programming on their own, do not constitute an emergency.

Subd. 8b. **Expanded support team.** "Expanded support team" means the members of the support team defined in subdivision 46, and a licensed health or mental health professional or other licensed, certified, or qualified professionals or consultants working with the person and included in the team at the request of the person or the person's legal representative.

Subd. 8c. **Family foster care.** "Family foster care" means a child foster family setting licensed according to Minnesota Rules, parts 2960.0010 to 2960.3340, or an adult foster care home licensed according to Minnesota Rules, parts 9555.5105 to 9555.6265, where the license holder lives in the home.

Subd. 9. **Health services.** "Health services" means any service or treatment consistent with the physical and mental health needs of the person, such as medication administration and monitoring, medical, dental, nutritional, health monitoring, wellness education, and exercise.

Subd. 10. **Home and community-based services.** "Home and community-based services" means the services ~~subject to the provisions of this chapter~~ identified in section 245D.03, subdivision 1, and as defined in:

(1) the ~~federal~~ federally approved waiver plans governed by United States Code, title 42, sections 1396 et seq., ~~or the state's alternative care program according to section 256B.0913,~~ including the waivers for persons with disabilities under section 256B.49, subdivision 11, including the brain injury (BI) waiver~~;~~ plan; the community alternative care (CAC) waiver~~;~~ plan; the community alternatives for disabled individuals (CADI) waiver~~;~~ plan; the developmental disability (DD) waiver~~;~~ plan under section 256B.092, subdivision 5; the elderly waiver (EW)~~, and~~ plan under section 256B.0915, subdivision 1; or successor plans respective to each waiver; or

(2) the alternative care (AC) program under section 256B.0913.

Subd. 11. **Incident.** "Incident" means an occurrence ~~that affects the~~ which involves a person and requires the program to make a response that is not a part of the program's ordinary provision of services to ~~a~~ that person, and includes ~~any of the following~~:

(1) serious injury of a person as determined by section 245.91, subdivision 6;

(2) a person's death;

(3) any medical emergency, unexpected serious illness, or significant unexpected change in an illness or medical condition~~, or the mental health status~~ of a person that

requires ~~calling~~ the program to call 911 ~~or a mental health crisis intervention team~~, physician treatment, or hospitalization;

(4) any mental health crisis that requires the program to call 911 or a mental health crisis intervention team;

(5) an act or situation involving a person that requires the program to call 911, law enforcement, or the fire department;

~~(4)~~ (6) a person's unauthorized or unexplained absence from a program;

~~(5)~~ (7) ~~physical aggression~~ conduct by a person receiving services against another person receiving services that ~~causes physical pain, injury, or persistent emotional distress, including, but not limited to, hitting, slapping, kicking, scratching, pinching, biting, pushing, and spitting;~~:

(i) is so severe, pervasive, or objectively offensive that it substantially interferes with a person's opportunities to participate in or receive service or support;

(ii) places the person in actual and reasonable fear of harm;

(iii) places the person in actual and reasonable fear of damage to property of the person; or

(iv) substantially disrupts the orderly operation of the program;

~~(6)~~ (8) any sexual activity between persons receiving services involving force or coercion as defined under section 609.341, subdivisions 3 and 14; ~~or~~

(9) any emergency use of manual restraint as identified in section 245D.061; or

~~(7)~~ (10) a report of alleged or suspected child or vulnerable adult maltreatment under section 626.556 or 626.557.

Subd. 11a. **Intermediate care facility for persons with developmental disabilities or ICF/DD.** "Intermediate care facility for persons with developmental disabilities" or "ICF/DD" means a residential program licensed to serve four or more persons with developmental disabilities under section 252.28 and chapter 245A and licensed as a supervised living facility under chapter 144, which together are certified by the Department of Health as an intermediate care facility for persons with developmental disabilities.

Subd. 11b. **Least restrictive alternative.** "Least restrictive alternative" means the alternative method for providing supports and services that is the least intrusive and most normalized given the level of supervision and protection required for the person. This level of supervision and protection allows risk taking to the extent that there is no reasonable likelihood that serious harm will happen to the person or others.

Subd. 12. **Legal representative.** "Legal representative" means the parent of a person who is under 18 years of age, a court-appointed guardian, or other representative with legal authority to make decisions about services for a person. 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.

Subd. 13. **License.** "License" has the meaning given in section 245A.02, subdivision 8.

Subd. 14. **Licensed health professional.** "Licensed health professional" means a person licensed in Minnesota to practice those professions described in section 214.01, subdivision 2.

Subd. 15. **License holder.** "License holder" has the meaning given in section 245A.02, subdivision 9.

Subd. 16. **Medication.** "Medication" means a prescription drug or over-the-counter drug. For purposes of this chapter, "medication" includes dietary supplements.

~~Subd. 17. **Medication administration.** "Medication administration" means performing the following set of tasks to ensure a person takes both prescription and over-the-counter medications and treatments according to orders issued by appropriately licensed professionals, and includes the following:~~

~~(1) checking the person's medication record;~~

~~(2) preparing the medication for administration;~~

~~(3) administering the medication to the person;~~

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

~~(5) reporting to the prescriber or a nurse any concerns about the medication, including side effects, adverse reactions, effectiveness, or the person's refusal to take the medication or the person's self-administration of the medication.~~

~~Subd. 18. **Medication assistance.** "Medication assistance" means providing verbal or visual reminders to take regularly scheduled medication, which includes either of the following:~~

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

~~(2) providing verbal or visual reminders to perform regularly scheduled treatments and exercises.~~

~~Subd. 19. **Medication management.** "Medication management" means the provision of any of the following:~~

~~(1) medication-related services to a person;~~

~~(2) medication setup;~~

~~(3) medication administration;~~

~~(4) medication storage and security;~~

~~(5) medication documentation and charting;~~

~~(6) verification and monitoring of effectiveness of systems to ensure safe medication handling and administration;~~

~~(7) coordination of medication refills;~~

~~(8) handling changes to prescriptions and implementation of those changes;~~

~~(9) communicating with the pharmacy; or~~

~~(10) coordination and communication with prescriber.~~

~~For the purposes of this chapter, medication management does not mean "medication therapy management services" as identified in section 256B.0625, subdivision 13h.~~

Subd. 20. **Mental health crisis intervention team.** "Mental health crisis intervention team" means a mental health crisis response ~~providers~~ provider as identified in section 256B.0624, subdivision 2, paragraph (d), for adults, and in section 256B.0944, subdivision 1, paragraph (d), for children.

Subd. 20a. **Most integrated setting.** "Most integrated setting" means a setting that enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible.

Subd. 21. **Over-the-counter drug.** "Over-the-counter drug" means a drug that is not required by federal law to bear the statement "Caution: Federal law prohibits dispensing without prescription."

Subd. 21a. **Outcome.** "Outcome" means the behavior, action, or status attained by the person that can be observed, measured, and determined reliable and valid.

Subd. 22. **Person.** "Person" has the meaning given in section 245A.02, subdivision 11.

Subd. 23. **Person with a disability.** "Person with a disability" means a person determined to have a disability by the commissioner's state medical review team as identified in section 256B.055, subdivision 7, the Social Security Administration, or the person is determined to have a developmental disability as defined in Minnesota Rules, part 9525.0016, subpart 2, item B, or a related condition as defined in section 252.27, subdivision 1a.

Subd. 23a. **Physician.** "Physician" means a person who is licensed under chapter 147.

Subd. 24. **Prescriber.** "Prescriber" means a ~~licensed practitioner as defined in section 151.01, subdivision 23,~~ person who is authorized under ~~section~~ sections 148.235;

151.01, subdivision 23; or 151.37 to prescribe drugs. ~~For the purposes of this chapter, the term "prescriber" is used interchangeably with "physician."~~

Subd. 25. **Prescription drug.** "Prescription drug" has the meaning given in section 151.01, subdivision ~~17~~ 16.

Subd. 26. **Program.** "Program" means either the nonresidential or residential program as defined in section 245A.02, subdivisions 10 and 14.

Subd. 27. **Psychotropic medication.** "Psychotropic medication" means any medication prescribed to treat the symptoms of mental illness that affect thought processes, mood, sleep, or behavior. The major classes of psychotropic medication are antipsychotic (neuroleptic), antidepressant, antianxiety, mood stabilizers, anticonvulsants, and stimulants and nonstimulants for the treatment of attention deficit/hyperactivity disorder. Other miscellaneous medications are considered to be a psychotropic medication when they are specifically prescribed to treat a mental illness or to control or alter behavior.

Subd. 28. **Restraint.** "Restraint" means physical or mechanical limiting of the free and normal movement of body or limbs.

Subd. 29. **Seclusion.** "Seclusion" means ~~separating a person from others in a way that prevents social contact and prevents the person from leaving the situation if he or she chooses~~ the placement of a person alone in a room from which exit is prohibited by a staff person or a mechanism such as a lock, a device, or an object positioned to hold the door closed or otherwise prevent the person from leaving the room.

Subd. 29a. **Self-determination.** "Self-determination" means the person makes decisions independently, plans for the person's own future, determines how money is spent for the person's supports, and takes responsibility for making these decisions. If a person has a legal representative, the legal representative's decision-making authority is limited to the scope of authority granted by the court or allowed in the document authorizing the legal representative to act.

Subd. 29b. **Semi-independent living services.** "Semi-independent living services" has the meaning given in section 252.275.

Subd. 30. **Service.** "Service" means care, training, supervision, counseling, consultation, or medication assistance assigned to the license holder in the coordinated service and support plan.

~~Subd. 31. **Service plan.** "Service plan" means the individual service plan or individual care plan identified in sections 256B.0913, 256B.0915, 256B.092, and 256B.49, or successor provisions, and includes any support plans or service needs identified as a result of long-term care consultation, or a support team meeting that includes the~~

~~participation of the person, the person's legal representative, and case manager, or assigned to a license holder through an authorized service agreement.~~

Subd. 32. **Service site.** "Service site" means the location where the service is provided to the person, including, but not limited to, a facility licensed according to chapter 245A; a location where the license holder is the owner, lessor, or tenant; a person's own home; or a community-based location.

~~Subd. 33. **Staff.** "Staff" means an employee who will have direct contact with a person served by the facility, agency, or program.~~

Subd. 33a. **Supervised living facility.** "Supervised living facility" has the meaning given in Minnesota Rules, part 4665.0100, subpart 10.

Subd. 33b. **Supervision.** (a) "Supervision" means:

(1) oversight by direct support staff as specified in the person's coordinated service and support plan or coordinated service and support plan addendum and awareness of the person's needs and activities;

(2) responding to situations that present a serious risk to the health, safety, or rights of the person while services are being provided; and

(3) the presence of direct support staff at a service site while services are being provided, unless a determination has been made and documented in the person's coordinated service and support plan or coordinated service and support plan addendum that the person does not require the presence of direct support staff while services are being provided.

(b) For the purposes of this definition, "while services are being provided," means any period of time during which the license holder will seek reimbursement for services.

Subd. 34. **Support team.** "Support team" means the service planning team identified in section 256B.49, subdivision 15, or the interdisciplinary team identified in Minnesota Rules, part 9525.0004, subpart 14.

Subd. 34a. **Time out.** "Time out" means removing a person involuntarily from an ongoing activity to a room, either locked or unlocked, or otherwise separating a person from others in a way that prevents social contact and prevents the person from leaving the situation if the person chooses. For the purpose of chapter 245D, "time out" does not mean voluntary removal or self-removal for the purpose of calming, prevention of escalation, or de-escalation of behavior for a period of up to 15 minutes. "Time out" does not include a person voluntarily moving from an ongoing activity to an unlocked room or otherwise separating from a situation or social contact with others if the person chooses. For the purposes of this definition, "voluntarily" means without being forced, compelled, or coerced.

~~Subd. 35. **Unit of government.** "Unit of government" means every city, county, town, school district, other political subdivisions of the state, and any agency of the state or the United States, and includes any instrumentality of a unit of government.~~

Subd. 35a. **Treatment.** "Treatment" means the provision of care, other than medications, ordered or prescribed by a licensed health or mental health professional, provided to a person to cure, rehabilitate, or ease symptoms.

Subd. 36. **Volunteer.** "Volunteer" means an individual who, under the direction of the license holder, provides direct services without pay to a person served by the license holder.

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

Sec. 18. Minnesota Statutes 2012, section 245D.03, is amended to read:

245D.03 APPLICABILITY AND EFFECT.

Subdivision 1. **Applicability.** (a) The commissioner shall regulate the provision of home and community-based services to persons with disabilities and persons age 65 and older pursuant to this chapter. The licensing standards in this chapter govern the provision of ~~the following~~ basic support services: and intensive support services.

~~(1) housing access coordination as defined under the current BI, CADI, and DD waiver plans or successor plans;~~

~~(2) respite services as defined under the current CADI, BI, CAC, DD, and EW waiver plans or successor plans when the provider is an individual who is not an employee of a residential or nonresidential program licensed by the Department of Human Services or the Department of Health that is otherwise providing the respite service;~~

~~(3) behavioral programming as defined under the current BI and CADI waiver plans or successor plans;~~

~~(4) specialist services as defined under the current DD waiver plan or successor plans;~~

~~(5) companion services as defined under the current BI, CADI, and EW waiver plans or successor plans, excluding companion services provided under the Corporation for National and Community Services Senior Companion Program established under the Domestic Volunteer Service Act of 1973, Public Law 98-288;~~

~~(6) personal support as defined under the current DD waiver plan or successor plans;~~

~~(7) 24-hour emergency assistance, on-call and personal emergency response as defined under the current CADI and DD waiver plans or successor plans;~~

~~(8) night supervision services as defined under the current BI waiver plan or successor plans;~~

~~(9) homemaker services as defined under the current CADI, BI, CAC, DD, and EW waiver plans or successor plans, excluding providers licensed by the Department of Health under chapter 144A and those providers providing cleaning services only;~~

~~(10) independent living skills training as defined under the current BI and CADI waiver plans or successor plans;~~

~~(11) prevocational services as defined under the current BI and CADI waiver plans or successor plans;~~

~~(12) structured day services as defined under the current BI waiver plan or successor plans; or~~

~~(13) supported employment as defined under the current BI and CADI waiver plans or successor plans.~~

(b) Basic support services provide the level of assistance, supervision, and care that is necessary to ensure the health and safety of the person and do not include services that are specifically directed toward the training, treatment, habilitation, or rehabilitation of the person. Basic support services include:

(1) in-home and out-of-home respite care services as defined in section 245A.02, subdivision 15, and under the brain injury, community alternative care, community alternatives for disabled individuals, developmental disability, and elderly waiver plans;

(2) companion services as defined under the brain injury, community alternatives for disabled individuals, and elderly waiver plans, excluding companion services provided under the Corporation for National and Community Services Senior Companion Program established under the Domestic Volunteer Service Act of 1973, Public Law 98-288;

(3) personal support as defined under the developmental disability waiver plan;

(4) 24-hour emergency assistance, personal emergency response as defined under the community alternatives for disabled individuals and developmental disability waiver plans;

(5) night supervision services as defined under the brain injury waiver plan; and

(6) homemaker services as defined under the community alternatives for disabled individuals, brain injury, community alternative care, developmental disability, and elderly waiver plans, excluding providers licensed by the Department of Health under chapter 144A and those providers providing cleaning services only.

(c) Intensive support services provide assistance, supervision, and care that is necessary to ensure the health and safety of the person and services specifically directed toward the training, habilitation, or rehabilitation of the person. Intensive support services include:

(1) intervention services, including:

(i) behavioral support services as defined under the brain injury and community alternatives for disabled individuals waiver plans;

(ii) in-home or out-of-home crisis respite services as defined under the developmental disability waiver plan; and

(iii) specialist services as defined under the current developmental disability waiver plan;

(2) in-home support services, including:

(i) in-home family support and supported living services as defined under the developmental disability waiver plan;

(ii) independent living services training as defined under the brain injury and community alternatives for disabled individuals waiver plans; and

(iii) semi-independent living services;

(3) residential supports and services, including:

(i) supported living services as defined under the developmental disability waiver plan provided in a family or corporate child foster care residence, a family adult foster care residence, a community residential setting, or a supervised living facility;

(ii) foster care services as defined in the brain injury, community alternative care, and community alternatives for disabled individuals waiver plans provided in a family or corporate child foster care residence, a family adult foster care residence, or a community residential setting; and

(iii) residential services provided in a supervised living facility that is certified by the Department of Health as an ICF/DD;

(4) day services, including:

(i) structured day services as defined under the brain injury waiver plan;

(ii) day training and habilitation services under sections 252.40 to 252.46, and as defined under the developmental disability waiver plan; and

(iii) prevocational services as defined under the brain injury and community alternatives for disabled individuals waiver plans; and

(5) supported employment as defined under the brain injury, developmental disability, and community alternatives for disabled individuals waiver plans.

Subd. 2. **Relationship to other standards governing home and community-based services.** (a) A license holder governed by this chapter is also subject to the licensure requirements under chapter 245A.

(b) ~~A license holder concurrently providing child foster care services licensed according to Minnesota Rules, chapter 2960, to the same person receiving a service licensed under this chapter is exempt from section 245D.04 as it applies to the person.~~ A corporate

or family child foster care site controlled by a license holder and providing services governed by this chapter is exempt from compliance with section 245D.04. This exemption applies to foster care homes where at least one resident is receiving residential supports and services licensed according to this chapter. This chapter does not apply to corporate or family child foster care homes that do not provide services licensed under this chapter.

(c) A family adult foster care site controlled by a license holder and providing services governed by this chapter is exempt from compliance with Minnesota Rules, parts 9555.6185; 9555.6225, subpart 8; 9555.6235, item C; 9555.6245; 9555.6255, subpart 2; and 9555.6265. These exemptions apply to family adult foster care homes where at least one resident is receiving residential supports and services licensed according to this chapter. This chapter does not apply to family adult foster care homes that do not provide services licensed under this chapter.

(d) A license holder providing services licensed according to this chapter in a supervised living facility is exempt from compliance with sections 245D.04; 245D.05, subdivision 2; and 245D.06, subdivision 2, clauses (1), (4), and (5).

(e) A license holder providing residential services to persons in an ICF/DD is exempt from compliance with sections 245D.04; 245D.05, subdivision 1b; 245D.06, subdivision 2, clauses (4) and (5); 245D.071, subdivisions 4 and 5; 245D.081, subdivision 2; 245D.09, subdivision 7; 245D.095, subdivision 2; and 245D.11, subdivision 3.

~~(e)~~ (f) A license holder ~~concurrently~~ providing ~~home care~~ homemaker services ~~registered~~ licensed according to ~~sections 144A.43 to 144A.49 to the same person receiving home management services licensed under~~ this chapter and registered according to chapter 144A is exempt from compliance with section 245D.04 ~~as it applies to the person~~.

~~(d) A license holder identified in subdivision 1, clauses (1), (5), and (9), is exempt from compliance with sections 245A.65, subdivision 2, paragraph (a), and 626.557, subdivision 14, paragraph (b).~~

~~(e) Notwithstanding section 245D.06, subdivision 5, a license holder providing structured day, prevocational, or supported employment services under this chapter and day training and habilitation or supported employment services licensed under chapter 245B within the same program is exempt from compliance with this chapter when the license holder notifies the commissioner in writing that the requirements under chapter 245B will be met for all persons receiving these services from the program. For the purposes of this paragraph, if the license holder has obtained approval from the commissioner for an alternative inspection status according to section 245B.031, that approval will apply to all persons receiving services in the program.~~

(g) Nothing in this chapter prohibits a license holder from concurrently serving persons without disabilities or people who are or are not age 65 and older, provided this chapter's standards are met as well as other relevant standards.

(h) The documentation required under sections 245D.07 and 245D.071 must meet the individual program plan requirements identified in section 256B.092 or successor provisions.

Subd. 3. **Variance.** If the conditions in section 245A.04, subdivision 9, are met, the commissioner may grant a variance to any of the requirements in this chapter, except sections 245D.04, ~~and 245D.10, subdivision 4, paragraph (b)~~ 245D.06, subdivision 4, paragraph (b), and 245D.061, subdivision 3, or provisions governing data practices and information rights of persons.

~~Subd. 4. **License holders with multiple 245D licenses.** (a) When a person changes service from one license to a different license held by the same license holder, the license holder is exempt from the requirements in section 245D.10, subdivision 4, paragraph (b).~~

~~(b) When a staff person begins providing direct service under one or more licenses held by the same license holder, other than the license for which staff orientation was initially provided according to section 245D.09, subdivision 4, the license holder is exempt from those staff orientation requirements, except the staff person must review each person's service plan and medication administration procedures in accordance with section 245D.09, subdivision 4, paragraph (c), if not previously reviewed by the staff person.~~

Subd. 5. **Program certification.** An applicant or a license holder may apply for program certification as identified in section 245D.33.

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

Sec. 19. Minnesota Statutes 2012, section 245D.04, is amended to read:

245D.04 SERVICE RECIPIENT RIGHTS.

Subdivision 1. **License holder responsibility for individual rights of persons served by the program.** The license holder must:

(1) provide each person or each person's legal representative with a written notice that identifies the service recipient rights in subdivisions 2 and 3, and an explanation of those rights within five working days of service initiation and annually thereafter;

(2) make reasonable accommodations to provide this information in other formats or languages as needed to facilitate understanding of the rights by the person and the person's legal representative, if any;

(3) maintain documentation of the person's or the person's legal representative's receipt of a copy and an explanation of the rights; and

(4) ensure the exercise and protection of the person's rights in the services provided by the license holder and as authorized in the coordinated service and support plan.

Subd. 2. **Service-related rights.** A person's service-related rights include the right to:

(1) participate in the development and evaluation of the services provided to the person;

(2) have services and supports identified in the coordinated service and support plan and the coordinated service and support plan addendum provided in a manner that respects and takes into consideration the person's preferences according to the requirements in sections 245D.07 and 245D.071;

(3) refuse or terminate services and be informed of the consequences of refusing or terminating services;

(4) know, in advance, limits to the services available from the license holder, including the license holder's knowledge, skill, and ability to meet the person's service and support needs based on the information required in section 245D.031, subdivision 2;

(5) know conditions and terms governing the provision of services, including the license holder's admission criteria and policies and procedures related to temporary service suspension and service termination;

(6) a coordinated transfer to ensure continuity of care when there will be a change in the provider;

(7) know what the charges are for services, regardless of who will be paying for the services, and be notified of changes in those charges;

~~(7)~~ (8) know, in advance, whether services are covered by insurance, government funding, or other sources, and be told of any charges the person or other private party may have to pay; and

~~(8)~~ (9) receive services from an individual who is competent and trained, who has professional certification or licensure, as required, and who meets additional qualifications identified in the person's coordinated service and support plan~~.~~ or coordinated service and support plan addendum.

Subd. 3. **Protection-related rights.** (a) A person's protection-related rights include the right to:

(1) have personal, financial, service, health, and medical information kept private, and be advised of disclosure of this information by the license holder;

(2) access records and recorded information about the person in accordance with applicable state and federal law, regulation, or rule;

(3) be free from maltreatment;

(4) be free from restraint, time out, or seclusion ~~used for a purpose other than~~ except for emergency use of manual restraint to protect the person from imminent danger to self or others according to the requirements in section 245D.06;

(5) receive services in a clean and safe environment when the license holder is the owner, lessor, or tenant of the service site;

(6) be treated with courtesy and respect and receive respectful treatment of the person's property;

(7) reasonable observance of cultural and ethnic practice and religion;

(8) be free from bias and harassment regarding race, gender, age, disability, spirituality, and sexual orientation;

(9) be informed of and use the license holder's grievance policy and procedures, including knowing how to contact persons responsible for addressing problems and to appeal under section 256.045;

(10) know the name, telephone number, and the Web site, e-mail, and street addresses of protection and advocacy services, including the appropriate state-appointed ombudsman, and a brief description of how to file a complaint with these offices;

(11) assert these rights personally, or have them asserted by the person's family, authorized representative, or legal representative, without retaliation;

(12) give or withhold written informed consent to participate in any research or experimental treatment;

(13) associate with other persons of the person's choice;

(14) personal privacy; and

(15) engage in chosen activities.

(b) For a person residing in a residential site licensed according to chapter 245A, or where the license holder is the owner, lessor, or tenant of the residential service site, protection-related rights also include the right to:

(1) have daily, private access to and use of a non-coin-operated telephone for local calls and long-distance calls made collect or paid for by the person;

(2) receive and send, without interference, uncensored, unopened mail or electronic correspondence or communication; ~~and~~

(3) have use of and free access to common areas in the residence; and

(4) privacy for visits with the person's spouse, next of kin, legal counsel, religious advisor, or others, in accordance with section 363A.09 of the Human Rights Act, including privacy in the person's bedroom.

(c) Restriction of a person's rights under subdivision 2, clause (10), or paragraph (a), clauses (13) to (15), or paragraph (b) is allowed only if determined necessary to ensure the health, safety, and well-being of the person. Any restriction of those rights must be documented in the person's coordinated service and support plan ~~for the person and~~ or coordinated service and support plan addendum. The restriction must be implemented in the least restrictive alternative manner necessary to protect the person and provide support to reduce or eliminate the need for the restriction in the most integrated setting and inclusive manner. The documentation must include the following information:

(1) the justification for the restriction based on an assessment of the person's vulnerability related to exercising the right without restriction;

(2) the objective measures set as conditions for ending the restriction;

(3) a schedule for reviewing the need for the restriction based on the conditions for ending the restriction to occur~~, at a minimum, every three months for persons who do not have a legal representative and annually for persons who do have a legal representative~~ semiannually from the date of initial approval, at a minimum, or more frequently if requested by the person, the person's legal representative, if any, and case manager; and

(4) signed and dated approval for the restriction from the person, or the person's legal representative, if any. A restriction may be implemented only when the required approval has been obtained. Approval may be withdrawn at any time. If approval is withdrawn, the right must be immediately and fully restored.

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

Sec. 20. 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. 21. **[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. 22. 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. 23. **[245D.061] EMERGENCY USE OF MANUAL RESTRAINTS.**

Subdivision 1. **Standards for emergency use of manual restraints.** Except for the emergency use of controlled procedures with a person with a developmental disability as governed by Minnesota Rules, part 9525.2770, or its successor provisions, the license holder must ensure that emergency use of manual restraints complies with the requirements of this chapter and the license holder's policy and procedures as required under subdivision 10.

Subd. 2. **Definitions.** (a) The terms used in this section have the meaning given them in this subdivision.

(b) "Manual restraint" means physical intervention intended to hold a person immobile or limit a person's voluntary movement by using body contact as the only source of physical restraint.

(c) "Mechanical restraint" means the use of devices, materials, or equipment attached or adjacent to the person's body, or the use of practices which restrict freedom of movement or normal access to one's body or body parts, or limits a person's voluntary movement or holds a person immobile as an intervention precipitated by a person's behavior. The term does apply to mechanical restraint used to prevent injury with persons who engage in self-injurious behaviors, such as head-banging, gouging, or other actions resulting in tissue damage that have caused or could cause medical problems resulting from the self-injury.

Subd. 3. **Conditions for emergency use of manual restraint.** Emergency use of manual restraint must meet the following conditions:

(1) immediate intervention must be needed to protect the person or others from imminent risk of physical harm; and

(2) the type of manual restraint used must be the least restrictive intervention to eliminate the immediate risk of harm and effectively achieve safety. The manual restraint must end when the threat of harm ends.

Subd. 4. **Permitted instructional techniques and therapeutic conduct.** (a) Use of physical contact as therapeutic conduct or as an instructional technique as identified in paragraphs (b) and (c), is permitted and is not subject to the requirements of this section when such use is addressed in a person's coordinated service and support plan addendum and the required conditions have been met. For the purposes of this subdivision, "therapeutic conduct" has the meaning given in section 626.5572, subdivision 20.

(b) Physical contact or instructional techniques must use the least restrictive alternative possible to meet the needs of the person and may be used:

(1) to calm or comfort a person by holding that person with no resistance from that person;

(2) to protect a person known to be at risk of injury due to frequent falls as a result of a medical condition; or

(3) to position a person with physical disabilities in a manner specified in the person's coordinated service and support plan addendum.

(c) Restraint may be used as therapeutic conduct:

(1) to allow a licensed health care professional to safely conduct a medical examination or to provide medical treatment ordered by a licensed health care professional to a person necessary to promote healing or recovery from an acute, meaning short-term, medical condition;

(2) to facilitate the person's completion of a task or response when the person does not resist or the person's resistance is minimal in intensity and duration;

(3) to briefly block or redirect a person's limbs or body without holding the person or limiting the person's movement to interrupt the person's behavior that may result in injury to self or others; or

(4) to assist in the safe evacuation of a person in the event of an emergency or to redirect a person who is at imminent risk of harm in a dangerous situation.

(d) A plan for using restraint as therapeutic conduct must be developed according to the requirements in sections 245D.07 and 245D.071, and must include methods to reduce or eliminate the use of and need for restraint.

Subd. 5. **Restrictions when implementing emergency use of manual restraint.** (a) Emergency use of manual restraint procedures must not:

(1) be implemented with a child in a manner that constitutes sexual abuse, neglect, physical abuse, or mental injury, as defined in section 626.556, subdivision 2;

(2) be implemented with an adult in a manner that constitutes abuse or neglect as defined in section 626.5572, subdivisions 2 and 17;

(3) be implemented in a manner that violates a person's rights and protections identified in section 245D.04;

(4) restrict a person's normal access to a nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, or necessary clothing, or to any protection required by state licensing standards and federal regulations governing the program;

(5) deny the person visitation or ordinary contact with legal counsel, a legal representative, or next of kin;

(6) be used as a substitute for adequate staffing, for the convenience of staff, as punishment, or as a consequence if the person refuses to participate in the treatment or services provided by the program; or

(7) use prone restraint. For the purposes of this section, "prone restraint" means use of manual restraint that places a person in a face-down position. This does not include brief physical holding of a person who, during an emergency use of manual restraint, rolls into a prone position, and the person is restored to a standing, sitting, or side-lying position as quickly as possible. Applying back or chest pressure while a person is in the prone or supine position or face-up is prohibited.

Subd. 6. **Monitoring emergency use of manual restraint.** The license holder shall monitor a person's health and safety during an emergency use of a manual restraint. Staff monitoring the procedure must not be the staff implementing the procedure when possible. The license holder shall complete a monitoring form, approved by the commissioner, for each incident involving the emergency use of a manual restraint.

Subd. 7. **Reporting emergency use of manual restraint incident.** (a) Within three calendar days after an emergency use of a manual restraint, the staff person who implemented the emergency use must report in writing to the designated coordinator the following information about the emergency use:

(1) the staff and persons receiving services who were involved in the incident leading up to the emergency use of manual restraint;

(2) a description of the physical and social environment, including who was present before and during the incident leading up to the emergency use of manual restraint;

(3) a description of what less restrictive alternative measures were attempted to de-escalate the incident and maintain safety before the manual restraint was implemented that identifies when, how, and how long the alternative measures were attempted before manual restraint was implemented;

(4) a description of the mental, physical, and emotional condition of the person who was restrained, and other persons involved in the incident leading up to, during, and following the manual restraint;

(5) whether there was any injury to the person who was restrained or other persons involved in the incident, including staff, before or as a result of the use of manual restraint; and

(6) whether there was an attempt to debrief with the staff, and, if not contraindicated, with the person who was restrained and other persons who were involved in or who witnessed the restraint, following the incident and the outcome of the debriefing. If the debriefing was not conducted at the time the incident report was made, the report should identify whether a debriefing is planned.

(b) Each single incident of emergency use of manual restraint must be reported separately. For the purposes of this subdivision, an incident of emergency use of manual restraint is a single incident when the following conditions have been met:

(1) after implementing the manual restraint, staff attempt to release the person at the moment staff believe the person's conduct no longer poses an imminent risk of physical harm to self or others and less restrictive strategies can be implemented to maintain safety;

(2) upon the attempt to release the restraint, the person's behavior immediately re-escalates; and

(3) staff must immediately reimplement the restraint in order to maintain safety.

Subd. 8. **Internal review of emergency use of manual restraint.** (a) Within five working days of the emergency use of manual restraint, the license holder must complete an internal review of each report of emergency use of manual restraint. The review must include an evaluation of whether:

(1) the person's service and support strategies developed according to sections 245D.07 and 245D.071 need to be revised;

(2) related policies and procedures were followed;

(3) the policies and procedures were adequate;

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

(5) the reported event is similar to past events with the persons, staff, or the services involved; and

(6) there is a need for corrective action by the license holder to protect the health and safety of persons.

(b) Based on the results of the internal review, the license holder must develop, document, and implement a corrective action plan for the program designed to correct current lapses and prevent future lapses in performance by individuals or the license holder, if any. The corrective action plan, if any, must be implemented within 30 days of the internal review being completed.

Subd. 9. **Expanded support team review.** (a) Within five working days after the completion of the internal review required in subdivision 8, the license holder must consult with the expanded support team following the emergency use of manual restraint to:

(1) discuss the incident reported in subdivision 7, to define the antecedent or event that gave rise to the behavior resulting in the manual restraint and identify the perceived function the behavior served; and

(2) determine whether the person's coordinated service and support plan addendum needs to be revised according to sections 245D.07 and 245D.071 to positively and effectively help the person maintain stability and to reduce or eliminate future occurrences requiring emergency use of manual restraint.

Subd. 10. **Emergency use of manual restraints policy and procedures.** The license holder must develop, document, and implement a policy and procedures that promote service recipient rights and protect health and safety during the emergency use of manual restraints. The policy and procedures must comply with the requirements of this section and must specify the following:

(1) a description of the positive support strategies and techniques staff must use to attempt to de-escalate a person's behavior before it poses an imminent risk of physical harm to self or others;

(2) a description of the types of manual restraints the license holder allows staff to use on an emergency basis, if any. If the license holder will not allow the emergency use of manual restraint, the policy and procedure must identify the alternative measures the

license holder will require staff to use when a person's conduct poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety;

(3) instructions for safe and correct implementation of the allowed manual restraint procedures;

(4) the training that staff must complete and the timelines for completion, before they may implement an emergency use of manual restraint. In addition to the training on this policy and procedure and the orientation and annual training required in section 245D.09, subdivision 4, the training for emergency use of manual restraint must incorporate the following subjects:

(i) alternatives to manual restraint procedures, including techniques to identify events and environmental factors that may escalate conduct that poses an imminent risk of physical harm to self or others;

(ii) de-escalation methods, positive support strategies, and how to avoid power struggles;

(iii) simulated experiences of administering and receiving manual restraint procedures allowed by the license holder on an emergency basis;

(iv) how to properly identify thresholds for implementing and ceasing restrictive procedures;

(v) how to recognize, monitor, and respond to the person's physical signs of distress, including positional asphyxia;

(vi) the physiological and psychological impact on the person and the staff when restrictive procedures are used;

(vii) the communicative intent of behaviors; and

(viii) relationship building;

(5) the procedures and forms to be used to monitor the emergency use of manual restraints, including what must be monitored and the frequency of monitoring per each incident of emergency use of manual restraint, and the person or position who is responsible for monitoring the use;

(6) the instructions, forms, and timelines required for completing and submitting an incident report by the person or persons who implemented the manual restraint; and

(7) the procedures and timelines for conducting the internal review and the expanded support team review, and the person or position responsible for completing the reviews and who is responsible for ensuring that corrective action is taken or the person's coordinated service and support plan addendum is revised, when determined necessary.

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

Sec. 24. Minnesota Statutes 2012, section 245D.07, is amended to read:

245D.07 SERVICE ~~NEEDS~~ PLANNING AND DELIVERY.

Subdivision 1. **Provision of services.** The license holder must provide services as ~~specified~~ assigned in the coordinated service and support plan ~~and assigned to the license holder~~. The provision of services must comply with the requirements of this chapter and the federal waiver plans.

Subd. 1a. **Person-centered planning and service delivery.** (a) The license holder must provide services in response to the person's identified needs, interests, preferences, and desired outcomes as specified in the coordinated service and support plan, the coordinated service and support plan addendum, and in compliance with the requirements of this chapter. License holders providing intensive support services must also provide outcome-based services according to the requirements in section 245D.071.

(b) Services must be provided in a manner that supports the person's preferences, daily needs, and activities and accomplishment of the person's personal goals and service outcomes, consistent with the principles of:

(1) person-centered service planning and delivery that:

(i) identifies and supports what is important to the person as well as what is important for the person, including preferences for when, how, and by whom direct support service is provided;

(ii) uses that information to identify outcomes the person desires; and

(iii) respects each person's history, dignity, and cultural background;

(2) self-determination that supports and provides:

(i) opportunities for the development and exercise of functional and age-appropriate skills, decision making and choice, personal advocacy, and communication; and

(ii) the affirmation and protection of each person's civil and legal rights;

(3) providing the most integrated setting and inclusive service delivery that supports, promotes, and allows:

(i) inclusion and participation in the person's community as desired by the person in a manner that enables the person to interact with nondisabled persons to the fullest extent possible and supports the person in developing and maintaining a role as a valued community member;

(ii) opportunities for self-sufficiency as well as developing and maintaining social relationships and natural supports; and

(iii) a balance between risk and opportunity, meaning the least restrictive supports or interventions necessary are provided in the most integrated settings in the most inclusive

manner possible to support the person to engage in activities of the person's own choosing that may otherwise present a risk to the person's health, safety, or rights.

Subd. 2. **Service planning requirements for basic support services.** (a) License holders providing basic support services must meet the requirements of this subdivision.

(b) Within 15 days of service initiation the license holder must complete a preliminary coordinated service and support plan addendum based on the coordinated service and support plan.

(c) Within 60 days of service initiation the license holder must review and revise as needed the preliminary coordinated service and support plan addendum to document the services that will be provided including how, when, and by whom services will be provided, and the person responsible for overseeing the delivery and coordination of services.

(d) The license holder must participate in service planning and support team meetings ~~related to~~ for the person following stated timelines established in the person's coordinated service and support plan or as requested by ~~the support team,~~ the person~~,~~ or the person's legal representative, the support team or the expanded support team.

Subd. 3. **Reports.** The license holder must provide written reports regarding the person's progress or status as requested by the person, the person's legal representative, the case manager, or the team.

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

Sec. 25. **[245D.071] SERVICE PLANNING AND DELIVERY; INTENSIVE SUPPORT SERVICES.**

Subdivision 1. **Requirements for intensive support services.** A license holder providing intensive support services identified in section 245D.03, subdivision 1, paragraph (c), must comply with the requirements in section 245D.07, subdivisions 1 and 3, and this section.

Subd. 2. **Abuse prevention.** Prior to or upon initiating services, the license holder must develop, document, and implement an abuse prevention plan according to section 245A.65, subdivision 2.

Subd. 3. **Assessment and initial service planning.** (a) Within 15 days of service initiation the license holder must complete a preliminary coordinated service and support plan addendum based on the coordinated service and support plan.

(b) Within 45 days of service initiation the license holder must meet with the person, the person's legal representative, the case manager, and other members of the support team or expanded support team to assess and determine the following based on the person's

coordinated service and support plan and the requirements in subdivision 4 and section 245D.07, subdivision 1a:

(1) the scope of the services to be provided to support the person's daily needs and activities;

(2) the person's desired outcomes and the supports necessary to accomplish the person's desired outcomes;

(3) the person's preferences for how services and supports are provided;

(4) whether the current service setting is the most integrated setting available and appropriate for the person; and

(5) how services must be coordinated across other providers licensed under this chapter serving the same person to ensure continuity of care for the person.

(c) Within the scope of services, the license holder must, at a minimum, assess the following areas:

(1) the person's ability to self-manage health and medical needs to maintain or improve physical, mental, and emotional well-being, including, when applicable, allergies, seizures, choking, special dietary needs, chronic medical conditions, self-administration of medication or treatment orders, preventative screening, and medical and dental appointments;

(2) the person's ability to self-manage personal safety to avoid injury or accident in the service setting, including, when applicable, risk of falling, mobility, regulating water temperature, community survival skills, water safety skills, and sensory disabilities; and

(3) the person's ability to self-manage symptoms or behavior that may otherwise result in an incident as defined in section 245D.02, subdivision 11, clauses (4) to (7), suspension or termination of services by the license holder, or other symptoms or behaviors that may jeopardize the health and safety of the person or others. The assessments must produce information about the person that is descriptive of the person's overall strengths, functional skills and abilities, and behaviors or symptoms.

Subd. 4. **Service outcomes and supports.** (a) Within ten working days of the 45-day meeting, the license holder must develop and document the service outcomes and supports based on the assessments completed under subdivision 3 and the requirements in section 245D.07, subdivision 1a. The outcomes and supports must be included in the coordinated service and support plan addendum.

(b) The license holder must document the supports and methods to be implemented to support the accomplishment of outcomes related to acquiring, retaining, or improving skills. The documentation must include:

(1) the methods or actions that will be used to support the person and to accomplish the service outcomes, including information about:

(i) any changes or modifications to the physical and social environments necessary when the service supports are provided;

(ii) any equipment and materials required; and

(iii) techniques that are consistent with the person's communication mode and learning style;

(2) the measurable and observable criteria for identifying when the desired outcome has been achieved and how data will be collected;

(3) the projected starting date for implementing the supports and methods and the date by which progress towards accomplishing the outcomes will be reviewed and evaluated; and

(4) the names of the staff or position responsible for implementing the supports and methods.

(c) Within 20 working days of the 45-day meeting, the license holder must obtain dated signatures from the person or the person's legal representative and case manager to document completion and approval of the assessment and coordinated service and support plan addendum.

Subd. 5. **Progress reviews.** (a) The license holder must give the person or the person's legal representative and case manager an opportunity to participate in the ongoing review and development of the methods used to support the person and accomplish outcomes identified in subdivisions 3 and 4. The license holder, in coordination with the person's support team or expanded support team, must meet with the person, the person's legal representative, and the case manager, and participate in progress review meetings following stated timelines established in the person's coordinated service and support plan or coordinated service and support plan addendum or within 30 days of a written request by the person, the person's legal representative, or the case manager, at a minimum of once per year.

(b) The license holder must summarize the person's progress toward achieving the identified outcomes and make recommendations and identify the rationale for changing, continuing, or discontinuing implementation of supports and methods identified in subdivision 4 in a written report sent to the person or the person's legal representative and case manager five working days prior to the review meeting, unless the person, the person's legal representative, or the case manager request to receive the report at the time of the meeting.

(c) Within ten working days of the progress review meeting, the license holder must obtain dated signatures from the person or the person's legal representative and the case manager to document approval of any changes to the coordinated service and support plan addendum.

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

Sec. 26. **[245D.081] PROGRAM COORDINATION, EVALUATION, AND OVERSIGHT.**

Subdivision 1. **Program coordination and evaluation.** (a) The license holder is responsible for:

(1) coordination of service delivery and evaluation for each person served by the program as identified in subdivision 2; and

(2) program management and oversight that includes evaluation of the program quality and program improvement for services provided by the license holder as identified in subdivision 3.

(b) The same person may perform the functions in paragraph (a) if the work and education qualifications are met in subdivisions 2 and 3.

Subd. 2. **Coordination and evaluation of individual service delivery.** (a) Delivery and evaluation of services provided by the license holder must be coordinated by a designated staff person. The designated coordinator must provide supervision, support, and evaluation of activities that include:

(1) oversight of the license holder's responsibilities assigned in the person's coordinated service and support plan and the coordinated service and support plan addendum;

(2) taking the action necessary to facilitate the accomplishment of the outcomes according to the requirements in section 245D.07;

(3) instruction and assistance to direct support staff implementing the coordinated service and support plan and the service outcomes, including direct observation of service delivery sufficient to assess staff competency; and

(4) evaluation of the effectiveness of service delivery, methodologies, and progress on the person's outcomes based on the measurable and observable criteria for identifying when the desired outcome has been achieved according to the requirements in section 245D.07.

(b) The license holder must ensure that the designated coordinator is competent to perform the required duties identified in paragraph (a) through education and training in human services and disability-related fields, and work experience in providing direct care services and supports to persons with disabilities. The designated coordinator must have

the skills and ability necessary to develop effective plans and to design and use data systems to measure effectiveness of services and supports. The license holder must verify and document competence according to the requirements in section 245D.09, subdivision 3. The designated coordinator must minimally have:

(1) a baccalaureate degree in a field related to human services, and one year of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older;

(2) an associate degree in a field related to human services, and two years of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older;

(3) a diploma in a field related to human services from an accredited postsecondary institution and three years of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older; or

(4) a minimum of 50 hours of education and training related to human services and disabilities; and

(5) four years of full-time work experience providing direct care services to persons with disabilities or persons age 65 and older under the supervision of a staff person who meets the qualifications identified in clauses (1) to (3).

Subd. 3. **Program management and oversight.** (a) The license holder must designate a managerial staff person or persons to provide program management and oversight of the services provided by the license holder. The designated manager is responsible for the following:

(1) maintaining a current understanding of the licensing requirements sufficient to ensure compliance throughout the program as identified in section 245A.04, subdivision 1, paragraph (e), and when applicable, as identified in section 256B.04, subdivision 21, paragraph (b);

(2) ensuring the duties of the designated coordinator are fulfilled according to the requirements in subdivision 2;

(3) ensuring the program implements corrective action identified as necessary by the program following review of incident and emergency reports according to the requirements in section 245D.11, subdivision 2, clause (7). An internal review of incident reports of alleged or suspected maltreatment must be conducted according to the requirements in section 245A.65, subdivision 1, paragraph (b);

(4) evaluation of satisfaction of persons served by the program, the person's legal representative, if any, and the case manager, with the service delivery and progress

towards accomplishing outcomes identified in sections 245D.07 and 245D.071, and ensuring and protecting each person's rights as identified in section 245D.04;

(5) ensuring staff competency requirements are met according to the requirements in section 245D.09, subdivision 3, and ensuring staff orientation and training is provided according to the requirements in section 245D.09, subdivisions 4, 4a, and 5;

(6) ensuring corrective action is taken when ordered by the commissioner and that the terms and condition of the license and any variances are met; and

(7) evaluating the information identified in clauses (1) to (6) to develop, document, and implement ongoing program improvements.

(b) The designated manager must be competent to perform the duties as required and must minimally meet the education and training requirements identified in subdivision 2, paragraph (b), and have a minimum of three years of supervisory level experience in a program providing direct support services to persons with disabilities or persons age 65 and older.

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

Sec. 27. Minnesota Statutes 2012, section 245D.09, is amended to read:

245D.09 STAFFING STANDARDS.

Subdivision 1. **Staffing requirements.** The license holder must provide the level of direct service support staff ~~sufficient~~ supervision, assistance, and training necessary:

(1) to ensure the health, safety, and protection of rights of each person; and

(2) to be able to implement the responsibilities assigned to the license holder in each person's coordinated service and support plan or identified in the coordinated service and support plan addendum, according to the requirements of this chapter.

Subd. 2. **Supervision of staff having direct contact.** Except for a license holder who is the sole direct ~~service~~ support staff, the license holder must provide adequate supervision of staff providing direct ~~service~~ support to ensure the health, safety, and protection of rights of each person and implementation of the responsibilities assigned to the license holder in each person's ~~service plan~~ coordinated service and support plan or coordinated service and support plan addendum.

Subd. 3. **Staff qualifications.** (a) The license holder must ensure that staff providing direct support, or staff who have responsibilities related to supervising or managing the provision of direct support service, is competent as demonstrated through skills and knowledge training, experience, and education to meet the person's needs and additional requirements as written in the coordinated service and support plan or coordinated

service and support plan addendum, or when otherwise required by the case manager or the federal waiver plan. The license holder must verify and maintain evidence of staff competency, including documentation of:

(1) education and experience qualifications relevant to the job responsibilities assigned to the staff and the needs of the general population of persons served by the program, including a valid degree and transcript, or a current license, registration, or certification, when a degree or licensure, registration, or certification is required by this chapter or in the coordinated service and support plan or coordinated service and support plan addendum;

(2) ~~completion of required~~ demonstrated competency in the orientation and training areas required under this chapter, ~~including~~ and when applicable, completion of continuing education required to maintain professional licensure, registration, or certification requirements. Competency in these areas is determined by the license holder through knowledge testing and observed skill assessment conducted by the trainer or instructor; and

(3) except for a license holder who is the sole direct ~~service~~ support staff, periodic performance evaluations completed by the license holder of the direct ~~service~~ support staff person's ability to perform the job functions based on direct observation.

(b) Staff under 18 years of age may not perform overnight duties or administer medication.

Subd. 4. **Orientation to program requirements.** ~~(a)~~ Except for a license holder who does not supervise any direct ~~service~~ support staff, within ~~90 days of hiring direct service staff~~ 60 days of hire, unless stated otherwise, the license holder must provide and ensure completion of orientation for direct support staff that combines supervised on-the-job training with review of and instruction ~~on~~ in the following areas:

(1) the job description and how to complete specific job functions, including:

(i) responding to and reporting incidents as required under section 245D.06, subdivision 1; and

(ii) following safety practices established by the license holder and as required in section 245D.06, subdivision 2;

(2) the license holder's current policies and procedures required under this chapter, including their location and access, and staff responsibilities related to implementation of those policies and procedures;

(3) data privacy requirements according to sections 13.01 to 13.10 and 13.46, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), and staff responsibilities related to complying with data privacy practices;

(4) the service recipient rights ~~under section 245D.04~~, and staff responsibilities related to ensuring the exercise and protection of those rights according to the requirements in section 245D.04;

(5) sections 245A.65, 245A.66, 626.556, and 626.557, governing maltreatment reporting and service planning for children and vulnerable adults, and staff responsibilities related to protecting persons from maltreatment and reporting maltreatment. This orientation must be provided within 72 hours of first providing direct contact services and annually thereafter according to section 245A.65, subdivision 3;

(6) ~~what constitutes use of restraints, seclusion, and psychotropic medications, and staff responsibilities related to the prohibitions of their use~~ the principles of person-centered service planning and delivery as identified in section 245D.07, subdivision 1a, and how they apply to direct support service provided by the staff person; and

(7) other topics as determined necessary in the person's coordinated service and support plan by the case manager or other areas identified by the license holder.

~~(b) License holders who provide direct service themselves must complete the orientation required in paragraph (a), clauses (3) to (7).~~

Subd. 4a. **Orientation to individual service recipient needs.** ~~(c)~~ (a) Before ~~providing~~ having unsupervised direct ~~service to~~ contact with a person served by the program, or for whom the staff person has not previously provided direct ~~service~~ support, or any time the plans or procedures identified in ~~clauses (1) and (2)~~ paragraphs (b) to (f) are revised, the staff person must review and receive instruction on the ~~following as it relates~~ requirements in paragraphs (b) to (f) as they relate to the staff person's job functions for that person~~:~~.

(b) Orientation training and competency evaluation of direct care staff in a program providing 24-hour care for a client with corporate supervision must be provided under the direction of a registered nurse. Training and competency evaluations 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 hair care; bathing; care of teeth, gums, and oral prosthetic devices; and other activities of daily living (ADLs);

(6) an understanding of what constitutes a healthy diet according to data from the Centers for Disease Control and the skills necessary to prepare that diet;

(7) skills necessary to provide appropriate support in instrumental activities of daily living (IADLs); and

(8) demonstrated competence in providing first aid.

~~(1)~~ (c) The staff person must review and receive instruction on the person's coordinated service and support plan or coordinated service and support plan addendum as it relates to the responsibilities assigned to the license holder, and when applicable, the person's individual abuse prevention plan ~~according to section 245A.65~~, to achieve and demonstrate an understanding of the person as a unique individual, and how to implement those plans~~; and~~.

~~(2)~~ (d) The staff person must review and receive instruction on medication administration procedures established for the person when medication administration is assigned to the license holder according to section 245D.05, subdivision 1, paragraph (b). Unlicensed staff may administer medications only after successful completion of a medication administration training, from a training curriculum developed by a registered nurse, clinical nurse specialist in psychiatric and mental health nursing, certified nurse practitioner, physician's assistant, or physician ~~incorporating~~. The training curriculum must incorporate an observed skill assessment conducted by the trainer to ensure staff demonstrate the ability to safely and correctly follow medication procedures.

Medication administration must be taught by a registered nurse, clinical nurse specialist, certified nurse practitioner, physician's assistant, or physician if, at the time of service initiation or any time thereafter, the person has or develops a health care condition that affects the service options available to the person because the condition requires:

~~(i)~~ (1) specialized or intensive medical or nursing supervision; and

~~(ii)~~ (2) nonmedical service providers to adapt their services to accommodate the health and safety needs of the person~~; and~~.

~~(iii) necessary training in order to meet the health service needs of the person as determined by the person's physician.~~

(e) The staff person must review and receive instruction on the safe and correct operation of medical equipment used by the person to sustain life, including but not limited to ventilators, feeding tubes, or endotracheal tubes. The training must be provided by a licensed health care professional or a manufacturer's representative and incorporate an observed skill assessment to ensure staff demonstrate the ability to safely and correctly operate the equipment according to the treatment orders and the manufacturer's instructions.

(f) The staff person must review and receive instruction on what constitutes use of restraints, time out, and seclusion, including chemical restraint, and staff responsibilities related to the prohibitions of their use according to the requirements in section 245D.06, subdivision 5, why such procedures are not effective for reducing or eliminating symptoms or undesired behavior and why they are not safe, and the safe and correct use of manual restraint on an emergency basis according to the requirements in section 245D.061.

(g) In the event of an emergency service initiation, the license holder must ensure the training required in this subdivision occurs within 72 hours of the direct support staff person first having unsupervised contact with the person receiving services. The license holder must document the reason for the unplanned or emergency service initiation and maintain the documentation in the person's service recipient record.

(h) License holders who provide direct support services themselves must complete the orientation required in subdivision 4, clauses (3) to (7).

Subd. 5. **Annual training.** ~~(a)~~ A license holder must provide annual training to direct ~~service~~ support staff on the topics identified in subdivision 4, ~~paragraph (a),~~ clauses (3) to ~~(6)~~ (7), and subdivision 4a, paragraphs (a) to (h). A license holder providing 24-hour care with corporate supervision must provide a minimum of 24 hours of annual training to direct service staff in topics described in subdivisions 4, clauses (1) to (7), and 4a, paragraphs (a) to (h). Training on relevant topics received from sources other than the license holder may count toward training requirements.

~~(b) A license holder providing behavioral programming, specialist services, personal support, 24-hour emergency assistance, night supervision, independent living skills, structured day, prevocational, or supported employment services must provide a minimum of eight hours of annual training to direct service staff that addresses:~~

~~(1) topics related to the general health, safety, and service needs of the population served by the license holder; and~~

~~(2) other areas identified by the license holder or in the person's current service plan.~~

~~Training on relevant topics received from sources other than the license holder may count toward training requirements.~~

~~(c) When the license holder is the owner, lessor, or tenant of the service site and whenever a person receiving services is present at the site, the license holder must have a staff person available on site who is trained in basic first aid and, when required in a person's service plan, cardiopulmonary resuscitation.~~

Subd. 5a. **Alternative sources of training.** Orientation or training received by the staff person from sources other than the license holder in the same subjects as identified in subdivision 4 may count toward the orientation and annual training requirements if

received in the 12-month period before the staff person's date of hire. The license holder must maintain documentation of the training received from other sources and of each staff person's competency in the required area according to the requirements in subdivision 3.

Subd. 6. **Subcontractors and temporary staff.** If the license holder uses a subcontractor or temporary staff to perform services licensed under this chapter on the license holder's behalf, the license holder must ensure that the subcontractor or temporary staff meets and maintains compliance with all requirements under this chapter that apply to the services to be provided, including training, orientation, and supervision necessary to fulfill their responsibilities. The license holder must ensure that a background study has been completed according to the requirements in sections 245C.03, subdivision 1, and 245C.04. Subcontractors and temporary staff hired by the license holder must meet the Minnesota licensing requirements applicable to the disciplines in which they are providing services. The license holder must maintain documentation that the applicable requirements have been met.

Subd. 7. **Volunteers.** The license holder must ensure that volunteers who provide direct support services to persons served by the program receive the training, orientation, and supervision necessary to fulfill their responsibilities. The license holder must ensure that a background study has been completed according to the requirements in sections 245C.03, subdivision 1, and 245C.04. The license holder must maintain documentation that the applicable requirements have been met.

Subd. 8. **Staff orientation and training plan.** The license holder must develop a staff orientation and training plan documenting when and how compliance with subdivisions 4, 4a, and 5 will be met.

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

Sec. 28. **[245D.091] INTERVENTION SERVICES.**

Subdivision 1. **Licensure requirements.** An individual meeting the staff qualification requirements of this section who is an employee of a program licensed according to this chapter and providing behavioral support services, specialist services, or crisis respite services is not required to hold a separate license under this chapter. An individual meeting the staff qualifications of this section who is not providing these services as an employee of a program licensed according to this chapter must obtain a license according to this chapter.

Subd. 2. **Behavior professional qualifications.** A behavior professional, as defined in the brain injury and community alternatives for disabled individuals waiver plans or successor plans, must have competencies in areas related to:

(1) ethical considerations;

(2) functional assessment;

(3) functional analysis;

(4) measurement of behavior and interpretation of data;

(5) selecting intervention outcomes and strategies;

(6) behavior reduction and elimination strategies that promote least restrictive approved alternatives;

(7) data collection;

(8) staff and caregiver training;

(9) support plan monitoring;

(10) co-occurring mental disorders or neuro-cognitive disorder;

(11) demonstrated expertise with populations being served; and

(12) must be a:

(i) psychologist licensed under sections 148.88 to 148.98, who has stated to the Board of Psychology competencies in the above identified areas;

(ii) clinical social worker licensed as an independent clinical social worker under chapter 148D, or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the areas identified in clauses (1) to (11);

(iii) physician licensed under chapter 147 and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry with competencies in the areas identified in clauses (1) to (11);

(iv) licensed professional clinical counselor licensed under sections 148B.29 to 148B.39 with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services who has demonstrated competencies in the areas identified in clauses (1) to (11);

(v) person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services with demonstrated competencies in the areas identified in clauses (1) to (11); or

(vi) registered nurse who is licensed under sections 148.171 to 148.285, and who is certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization, or who has a master's degree in nursing or one of the behavioral sciences or related fields from an accredited college or university or its equivalent, with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services.

Subd. 3. **Behavior analyst qualifications.** (a) A behavior analyst, as defined in the brain injury and community alternatives for disabled individuals waiver plans or successor plans, must:

(1) have obtained a baccalaureate degree, master's degree, or a PhD in a social services discipline; or

(2) meet the qualifications of a mental health practitioner as defined in section 245.462, subdivision 17.

(b) In addition, a behavior analyst must:

(1) have four years of supervised experience working with individuals who exhibit challenging behaviors as well as co-occurring mental disorders or neuro-cognitive disorder;

(2) have received ten hours of instruction in functional assessment and functional analysis;

(3) have received 20 hours of instruction in the understanding of the function of behavior;

(4) have received ten hours of instruction on design of positive practices behavior support strategies;

(5) have received 20 hours of instruction on the use of behavior reduction approved strategies used only in combination with behavior positive practices strategies;

(6) be determined by a behavior professional to have the training and prerequisite skills required to provide positive practice strategies as well as behavior reduction approved and permitted intervention to the person who receives behavioral support; and

(7) be under the direct supervision of a behavior professional.

Subd. 4. **Behavior specialist qualifications.** (a) A behavior specialist, as defined in the brain injury and community alternatives for disabled individuals waiver plans or successor plans, must meet the following qualifications:

(1) have an associate's degree in a social services discipline; or

(2) have two years of supervised experience working with individuals who exhibit challenging behaviors as well as co-occurring mental disorders or neuro-cognitive disorder.

(b) In addition, a behavior specialist must:

(1) have received a minimum of four hours of training in functional assessment;

(2) have received 20 hours of instruction in the understanding of the function of behavior;

(3) have received ten hours of instruction on design of positive practices behavioral support strategies;

(4) be determined by a behavior professional to have the training and prerequisite skills required to provide positive practices strategies as well as behavior reduction approved intervention to the person who receives behavioral support; and

(5) be under the direct supervision of a behavior professional.

Subd. 5. **Specialist services qualifications.** An individual providing specialist services, as defined in the developmental disabilities waiver plan or successor plan, must have:

(1) the specific experience and skills required of the specialist to meet the needs of the person identified by the person's service planning team; and

(2) the qualifications of the specialist identified in the person's coordinated service and support plan.

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

Sec. 29. **[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. 30. 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. 31. **[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.

Sec. 32. **[245D.21] FACILITY LICENSURE REQUIREMENTS AND APPLICATION PROCESS.**

Subdivision 1. **Community residential settings and day service facilities.** For purposes of this section, "facility" means both a community residential setting and day service facility and the physical plant.

Subd. 2. **Inspections and code compliance.** (a) Physical plants must comply with applicable state and local fire, health, building, and zoning codes.

(b)(1) The facility must be inspected by a fire marshal or their delegate within 12 months before initial licensure to verify that it meets the applicable occupancy requirements as defined in the State Fire Code and that the facility complies with the fire safety standards for that occupancy code contained in the State Fire Code.

(2) The fire marshal inspection of a community residential setting must verify the residence is a dwelling unit within a residential occupancy as defined in section 9.117 of the State Fire Code. A home safety checklist, approved by the commissioner, must be completed for a community residential setting by the license holder and the commissioner before the satellite license is reissued.

(3) The facility shall be inspected according to the facility capacity specified on the initial application form.

(4) If the commissioner has reasonable cause to believe that a potentially hazardous condition may be present or the licensed capacity is increased, the commissioner shall request a subsequent inspection and written report by a fire marshal to verify the absence of hazard.

(5) Any condition cited by a fire marshal, building official, or health authority as hazardous or creating an immediate danger of fire or threat to health and safety must be corrected before a license is issued by the department, and for community residential settings, before a license is reissued.

(c) The facility must maintain in a permanent file the reports of health, fire, and other safety inspections.

(d) The facility's plumbing, ventilation, heating, cooling, lighting, and other fixtures and equipment, including elevators or food service, if provided, must conform to applicable health, sanitation, and safety codes and regulations.

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

Sec. 33. **[245D.22] FACILITY SANITATION AND HEALTH.**

Subdivision 1. **General maintenance.** The license holder must maintain the interior and exterior of buildings, structures, or enclosures used by the facility, including walls, floors, ceilings, registers, fixtures, equipment, and furnishings in good repair and in a sanitary and safe condition. The facility must be clean and free from accumulations of dirt, grease, garbage, peeling paint, mold, vermin, and insects. The license holder must correct building and equipment deterioration, safety hazards, and unsanitary conditions.

Subd. 2. **Hazards and toxic substances.** (a) The license holder must ensure that service sites owned or leased by the license holder are free from hazards that would

threaten the health or safety of a person receiving services by ensuring the requirements in paragraphs (b) to (h) are met.

(b) Chemicals, detergents, and other hazardous or toxic substances must not be stored with food products or in any way that poses a hazard to persons receiving services.

(c) The license holder must install handrails and nonslip surfaces on interior and exterior runways, stairways, and ramps according to the applicable building code.

(d) If there are elevators in the facility, the license holder must have elevators inspected each year. The date of the inspection, any repairs needed, and the date the necessary repairs were made must be documented.

(e) The license holder must keep stairways, ramps, and corridors free of obstructions.

(f) Outside property must be free from debris and safety hazards. Exterior stairs and walkways must be kept free of ice and snow.

(g) Heating, ventilation, air conditioning units, and other hot surfaces and moving parts of machinery must be shielded or enclosed.

(h) Use of dangerous items or equipment by persons served by the program must be allowed in accordance with the person's coordinated service and support plan addendum or the program abuse prevention plan, if not addressed in the coordinated service and support plan addendum.

Subd. 3. **Storage and disposal of medication.** Schedule II controlled substances in the facility that are named in section 152.02, subdivision 3, must be stored in a locked storage area permitting access only by persons and staff authorized to administer the medication. This must be incorporated into the license holder's medication administration policy and procedures required under section 245D.11, subdivision 2, clause (3). Medications must be disposed of according to the Environmental Protection Agency recommendations.

Subd. 4. **First aid must be available on site.** (a) A staff person trained in first aid must be available on site 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.

(b) A facility must have first aid kits readily available for use by, and that meets the needs of, persons receiving services and staff. At a minimum, the first aid kit must be equipped with accessible first aid supplies including bandages, sterile compresses, scissors, an ice bag or cold pack, an oral or surface thermometer, mild liquid soap, adhesive tape, and first aid manual.

Subd. 5. **Emergencies.** (a) The license holder must have a written plan for responding to emergencies as defined in section 245D.02, subdivision 8, to ensure the safety of persons served in the facility. The plan must include:

(1) procedures for emergency evacuation and emergency sheltering, including:

(i) how to report a fire or other emergency;

(ii) procedures to notify, relocate, and evacuate occupants, including use of adaptive procedures or equipment to assist with the safe evacuation of persons with physical or sensory disabilities; and

(iii) instructions on closing off the fire area, using fire extinguishers, and activating and responding to alarm systems;

(2) a floor plan that identifies:

(i) the location of fire extinguishers;

(ii) the location of audible or visual alarm systems, including but not limited to manual fire alarm boxes, smoke detectors, fire alarm enunciators and controls, and sprinkler systems;

(iii) the location of exits, primary and secondary evacuation routes, and accessible egress routes, if any; and

(iv) the location of emergency shelter within the facility;

(3) a site plan that identifies:

(i) designated assembly points outside the facility;

(ii) the locations of fire hydrants; and

(iii) the routes of fire department access;

(4) the responsibilities each staff person must assume in case of emergency;

(5) procedures for conducting quarterly drills each year and recording the date of each drill in the file of emergency plans;

(6) procedures for relocation or service suspension when services are interrupted for more than 24 hours;

(7) for a community residential setting with three or more dwelling units, a floor plan that identifies the location of enclosed exit stairs; and

(8) an emergency escape plan for each resident.

(b) The license holder must:

(1) maintain a log of quarterly fire drills on file in the facility;

(2) provide an emergency response plan that is readily available to staff and persons receiving services;

(3) inform each person of a designated area within the facility where the person should go to for emergency shelter during severe weather and the designated assembly points outside the facility; and

(4) maintain emergency contact information for persons served at the facility that can be readily accessed in an emergency.

Subd. 6. **Emergency equipment.** The facility must have a flashlight and a portable radio or television set that do not require electricity and can be used if a power failure occurs.

Subd. 7. **Telephone and posted numbers.** A facility must have a non-coin operated telephone that is readily accessible. A list of emergency numbers must be posted in a prominent location. When an area has a 911 number or a mental health crisis intervention team number, both numbers must be posted and the emergency number listed must be 911. In areas of the state without a 911 number, the numbers listed must be those of the local fire department, police department, emergency transportation, and poison control center. The names and telephone numbers of each person's representative, physician, and dentist must be readily available.

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

Sec. 34. **[245D.23] COMMUNITY RESIDENTIAL SETTINGS; SATELLITE LICENSURE REQUIREMENTS AND APPLICATION PROCESS.**

Subdivision 1. **Separate satellite license required for separate sites.** (a) A license holder providing residential support services must obtain a separate satellite license for each community residential setting located at separate addresses when the community residential settings are to be operated by the same license holder. For purposes of this chapter, a community residential setting is a satellite of the home and community-based services license.

(b) Community residential settings are permitted single-family use homes. After a license has been issued, the commissioner shall notify the local municipality where the residence is located of the approved license.

Subd. 2. **Notification to local agency.** The license holder must notify the local agency within 24 hours of the onset of changes in a residence resulting from construction, remodeling, or damages requiring repairs that require a building permit or may affect a licensing requirement in this chapter.

Subd. 3. **Alternate overnight supervision.** A license holder granted an alternate overnight supervision technology adult foster care license according to section 245A.11,

subdivision 7a, that converts to a community residential setting satellite license according to this chapter must retain that designation.

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

Sec. 35. **[245D.24] COMMUNITY RESIDENTIAL SETTINGS; PHYSICAL PLANT AND ENVIRONMENT.**

Subdivision 1. **Occupancy.** The residence must meet the definition of a dwelling unit in a residential occupancy.

Subd. 2. **Common area requirements.** The living area must be provided with an adequate number of furnishings for the usual functions of daily living and social activities. The dining area must be furnished to accommodate meals shared by all persons living in the residence. These furnishings must be in good repair and functional to meet the daily needs of the persons living in the residence.

Subd. 3. **Bedrooms.** (a) People receiving services must mutually consent, in writing, to sharing a bedroom with one another. No more than two people receiving services may share one bedroom.

(b) A single occupancy bedroom must have at least 80 square feet of floor space with a 7-1/2 foot ceiling. A double occupancy room must have at least 120 square feet of floor space with a 7-1/2 foot ceiling. Bedrooms must be separated from halls, corridors, and other habitable rooms by floor to ceiling walls containing no openings except doorways and must not serve as a corridor to another room used in daily living.

(c) A person's personal possessions and items for the person's own use are the only items permitted to be stored in a person's bedroom.

(d) Unless otherwise documented through assessment as a safety concern for the person, each person must be provided with the following furnishings:

(1) a separate bed of proper size and height for the convenience and comfort of the person, with a clean mattress in good repair;

(2) clean bedding appropriate for the season for each person;

(3) an individual cabinet, or dresser, shelves, and a closet, for storage of personal possessions and clothing; and

(4) a mirror for grooming.

(e) When possible, a person must be allowed to have items of furniture that the person personally owns in the bedroom, unless doing so would interfere with safety precautions, violate a building or fire code, or interfere with another person's use of the bedroom. A person may choose to not have a cabinet, dresser, shelves, or a mirror in the bedroom, as otherwise required under paragraph (d), clause (3) or (4). A person may

choose to use a mattress other than an innerspring mattress and may choose to not have the mattress on a mattress frame or support. If a person chooses not to have a piece of required furniture, the license holder must document this choice and is not required to provide the item. If a person chooses to use a mattress other than an innerspring mattress or chooses to not have a mattress frame or support, the license holder must document this choice and allow the alternative desired by the person.

(f) A person must be allowed to bring personal possessions into the bedroom and other designated storage space, if such space is available, in the residence. The person must be allowed to accumulate possessions to the extent the residence is able to accommodate them, unless doing so is contraindicated for the person's physical or mental health, would interfere with safety precautions or another person's use of the bedroom, or would violate a building or fire code. The license holder must allow for locked storage of personal items. Any restriction on the possession or locked storage of personal items, including requiring a person to use a lock provided by the license holder, must comply with section 245D.04, subdivision 3, paragraph (c), and allow the person to be present if and when the license holder opens the lock.

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

Sec. 36. **[245D.25] COMMUNITY RESIDENTIAL SETTINGS; FOOD AND WATER.**

Subdivision 1. **Water.** Potable water from privately owned wells must be tested annually by a Department of Health-certified laboratory for coliform bacteria and nitrate nitrogens to verify safety. The health authority may require retesting and corrective measures if results exceed state water standards in Minnesota Rules, chapter 4720, or in the event of a flooding or incident which may put the well at risk of contamination. To prevent scalding, the water temperature of faucets must not exceed 120 degrees Fahrenheit.

Subd. 2. **Food.** Food served must meet any special dietary needs of a person as prescribed by the person's physician or dietitian. Three nutritionally balanced meals a day must be served or made available to persons, and nutritious snacks must be available between meals.

Subd. 3. **Food safety.** Food must be obtained, handled, and properly stored to prevent contamination, spoilage, or a threat to the health of a person.

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

Sec. 37. **[245D.26] COMMUNITY RESIDENTIAL SETTINGS; SANITATION AND HEALTH.**

Subdivision 1. **Goods provided by the license holder.** Individual clean bed linens appropriate for the season and the person's comfort, including towels and wash cloths, must be available for each person. Usual or customary goods for the operation of a residence which are communally used by all persons receiving services living in the residence must be provided by the license holder, including household items for meal preparation, cleaning supplies to maintain the cleanliness of the residence, window coverings on windows for privacy, toilet paper, and hand soap.

Subd. 2. **Personal items.** Personal health and hygiene items must be stored in a safe and sanitary manner.

Subd. 3. **Pets and service animals.** Pets and service animals housed within the residence must be immunized and maintained in good health as required by local ordinances and state law. The license holder must ensure that the person and the person's representative is notified before admission of the presence of pets in the residence.

Subd. 4. **Smoking in the residence.** License holders must comply with the requirements of the Minnesota Clean Indoor Air Act, sections 144.411 to 144.417, when smoking is permitted in the residence.

Subd. 5. **Weapons.** Weapons and ammunition must be stored separately in locked areas that are inaccessible to a person receiving services. For purposes of this subdivision, "weapons" means firearms and other instruments or devices designed for and capable of producing bodily harm.

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

Sec. 38. **[245D.27] DAY SERVICES FACILITIES; SATELLITE LICENSURE REQUIREMENTS AND APPLICATION PROCESS.**

Except for day service facilities on the same or adjoining lot, the license holder providing day services must apply for a separate license for each facility-based service site when the license holder is the owner, lessor, or tenant of the service site at which persons receive day services and the license holder's employees who provide day services are present for a cumulative total of more than 30 days within any 12-month period. For purposes of this chapter, a day services facility license is a satellite license of the day services program. A day services program may operate multiple licensed day service facilities in one or more counties in the state. For the purposes of this section, "adjoining lot" means day services facilities that are next door to or across the street from one another.

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

Sec. 39. **[245D.28] DAY SERVICES FACILITIES; PHYSICAL PLANT AND SPACE REQUIREMENTS.**

Subdivision 1. **Facility capacity and useable space requirements.** (a) The facility capacity of each day service facility must be determined by the amount of primary space available, the scheduling of activities at other service sites, and the space requirements of all persons receiving services at the facility, not just the licensed services. The facility capacity must specify the maximum number of persons that may receive services on site at any one time.

(b) When a facility is located in a multifunctional organization, the facility may share common space with the multifunctional organization if the required available primary space for use by persons receiving day services is maintained while the facility is operating. The license holder must comply at all times with all applicable fire and safety codes under section 245A.04, subdivision 2a, and adequate supervision requirements under section 245D.31 for all persons receiving day services.

(c) A day services facility must have a minimum of 40 square feet of primary space available for each consumer who is present at the site at any one time. Primary space does not include:

(1) common areas, such as hallways, stairways, closets, utility areas, bathrooms, and kitchens;

(2) floor areas beneath stationary equipment; or

(3) any space occupied by persons associated with the multifunctional organization while persons receiving day services are using common space.

Subd. 2. **Individual personal articles.** Each person must be provided space in a closet, cabinet, on a shelf, or a coat hook for storage of personal items for the person's own use while receiving services at the facility, unless doing so would interfere with safety precautions, another person's work space, or violate a building or fire code.

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

Sec. 40. **[245D.29] DAY SERVICES FACILITIES; HEALTH AND SAFETY REQUIREMENTS.**

Subdivision 1. **Refrigeration.** If the license holder provides refrigeration at service sites owned or leased by the license holder for storing perishable foods and perishable portions of bag lunches, whether the foods are supplied by the license holder or the

persons receiving services, the refrigeration must have a temperature of 40 degrees Fahrenheit or less.

Subd. 2. **Drinking water.** Drinking water must be available to all persons receiving services. If a person is unable to request or obtain drinking water, it must be provided according to that person's individual needs. Drinking water must be provided in single-service containers or from drinking fountains accessible to all persons.

Subd. 3. **Individuals who become ill during the day.** There must be an area in which a person receiving services can rest if:

(1) the person becomes ill during the day;

(2) the person does not live in a licensed residential site;

(3) the person requires supervision; and

(4) there is not a caretaker immediately available. Supervision must be provided until the caretaker arrives to bring the person home.

Subd. 4. **Safety procedures.** The license holder must establish general written safety procedures that include criteria for selecting, training, and supervising persons who work with hazardous machinery, tools, or substances. Safety procedures specific to each person's activities must be explained and be available in writing to all staff members and persons receiving services.

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

Sec. 41. **[245D.31] DAY SERVICES FACILITIES; STAFF RATIO AND FACILITY COVERAGE.**

Subdivision 1. **Scope.** This section applies only to facility-based day services.

Subd. 2. **Factors.** (a) The number of direct support service staff members that a license holder must have on duty at the facility at a given time to meet the minimum staffing requirements established in this section varies according to:

(1) the number of persons who are enrolled and receiving direct support services at that given time;

(2) the staff ratio requirement established under subdivision 3 for each person who is present; and

(3) whether the conditions described in subdivision 8 exist and warrant additional staffing beyond the number determined to be needed under subdivision 7.

(b) The commissioner must consider the factors in paragraph (a) in determining a license holder's compliance with the staffing requirements and must further consider whether the staff ratio requirement established under subdivision 3 for each person receiving services accurately reflects the person's need for staff time.

Subd. 3. **Staff ratio requirement for each person receiving services.** The case manager, in consultation with the interdisciplinary team, must determine at least once each year which of the ratios in subdivisions 4, 5, and 6 is appropriate for each person receiving services on the basis of the characteristics described in subdivisions 4, 5, and 6. The ratio assigned each person and the documentation of how the ratio was arrived at must be kept in each person's individual service plan. Documentation must include an assessment of the person with respect to the characteristics in subdivisions 4, 5, and 6 recorded on a standard assessment form required by the commissioner.

Subd. 4. **Person requiring staff ratio of one to four.** A person must be assigned a staff ratio requirement of one to four if:

(1) on a daily basis the person requires total care and monitoring or constant hand-over-hand physical guidance to successfully complete at least three of the following activities: toileting, communicating basic needs, eating, ambulating; or is not capable of taking appropriate action for self-preservation under emergency conditions; or

(2) the person engages in conduct that poses an imminent risk of physical harm to self or others at a documented level of frequency, intensity, or duration requiring frequent daily ongoing intervention and monitoring as established in the person's coordinated service and support plan or coordinated service and support plan addendum.

Subd. 5. **Person requiring staff ratio of one to eight.** A person must be assigned a staff ratio requirement of one to eight if:

(1) the person does not meet the requirements in subdivision 4; and

(2) on a daily basis the person requires verbal prompts or spot checks and minimal or no physical assistance to successfully complete at least four of the following activities: toileting, communicating basic needs, eating, ambulating, or taking appropriate action for self-preservation under emergency conditions.

Subd. 6. **Person requiring staff ratio of one to six.** A person who does not have any of the characteristics described in subdivision 4 or 5 must be assigned a staff ratio requirement of one to six.

Subd. 7. **Determining number of direct support service staff required.** The minimum number of direct support service staff members required at any one time to meet the combined staff ratio requirements of the persons present at that time can be determined by the following steps:

(1) assign each person in attendance the three-digit decimal below that corresponds to the staff ratio requirement assigned to that person. A staff ratio requirement of one to four equals 0.250. A staff ratio requirement of one to eight equals 0.125. A staff ratio requirement of one to six equals 0.166. A staff ratio requirement of one to ten equals 0.100;

(2) add all of the three-digit decimals (one three-digit decimal for every person in attendance) assigned in clause (1);

(3) when the sum in clause (2) falls between two whole numbers, round off the sum to the larger of the two whole numbers; and

(4) the larger of the two whole numbers in clause (3) equals the number of direct support service staff members needed to meet the staff ratio requirements of the persons in attendance.

Subd. 8. **Staff to be included in calculating minimum staffing requirement.** Only staff providing direct support must be counted as staff members in calculating the staff-to-participant ratio. A volunteer may be counted as a staff providing direct support in calculating the staff-to-participant ratio if the volunteer meets the same standards and requirements as paid staff. No person receiving services must be counted as or be substituted for a staff member in calculating the staff-to-participant ratio.

Subd. 9. **Conditions requiring additional direct support staff.** The license holder must increase the number of direct support staff members present at any one time beyond the number arrived at in subdivision 4 if necessary when any one or combination of the following circumstances can be documented by the commissioner as existing:

(1) the health and safety needs of the persons receiving services cannot be met by the number of staff members available under the staffing pattern in effect even though the number has been accurately calculated under subdivision 7; or

(2) the person's conduct frequently presents an imminent risk of physical harm to self or others.

Subd. 10. **Supervision requirements.** (a) At no time must one direct support staff member be assigned responsibility for supervision and training of more than ten persons receiving supervision and training, except as otherwise stated in each person's risk management plan.

(b) In the temporary absence of the director or a supervisor, a direct support staff member must be designated to supervise the center.

Subd. 11. **Multifunctional programs.** A multifunctional program may count other employees of the organization besides direct support staff of the day service facility in calculating the staff to participant ratio if the employee is assigned to the day services facility for a specified amount of time, during which the employee is not assigned to another organization or program.

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

Sec. 42. **[245D.32] ALTERNATIVE LICENSING INSPECTIONS.**

Subdivision 1. **Eligibility for an alternative licensing inspection.** (a) A license holder providing services licensed under this chapter, with a qualifying accreditation and meeting the eligibility criteria in paragraphs (b) and (c) may request approval for an alternative licensing inspection when all services provided under the license holder's license are accredited. A license holder with a qualifying accreditation and meeting the eligibility criteria in paragraphs (b) and (c) may request approval for an alternative licensing inspection for individual community residential settings or day services facilities licensed under this chapter.

(b) In order to be eligible for an alternative licensing inspection, the program must have had at least one inspection by the commissioner following issuance of the initial license. For programs operating a day services facility, each facility must have had at least one on-site inspection by the commissioner following issuance of the initial license.

(c) In order to be eligible for an alternative licensing inspection, the program must have been in "substantial and consistent compliance" at the time of the last licensing inspection and during the current licensing period. For purposes of this section, substantial and consistent compliance means:

(1) the license holder's license was not made conditional, suspended, or revoked;

(2) there have been no substantiated allegations of maltreatment against the license holder;

(3) there were no program deficiencies identified that would jeopardize the health, safety, or rights of persons being served; and

(4) the license holder maintained substantial compliance with the other requirements of chapters 245A and 245C and other applicable laws and rules.

(d) For the purposes of this section, the license holder's license includes services licensed under this chapter that were previously licensed under chapter 245B until December 31, 2013.

Subd. 2. **Qualifying accreditation.** The commissioner must accept a three-year accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) as a qualifying accreditation.

Subd. 3. **Request for approval of an alternative inspection status.** (a) A request for an alternative inspection must be made on the forms and in the manner prescribed by the commissioner. When submitting the request, the license holder must submit all documentation issued by the accrediting body verifying that the license holder has obtained and maintained the qualifying accreditation and has complied with recommendations or requirements from the accrediting body during the period of accreditation. Based

on the request and the additional required materials, the commissioner may approve an alternative inspection status.

(b) The commissioner must notify the license holder in writing that the request for an alternative inspection status has been approved. Approval must be granted until the end of the qualifying accreditation period.

(c) The license holder must submit a written request for approval to be renewed one month before the end of the current approval period according to the requirements in paragraph (a). If the license holder does not submit a request to renew approval as required, the commissioner must conduct a licensing inspection.

Subd. 4. **Programs approved for alternative licensing inspection; deemed compliance licensing requirements.** (a) A license holder approved for alternative licensing inspection under this section is required to maintain compliance with all licensing standards according to this chapter.

(b) A license holder approved for alternative licensing inspection under this section must be deemed to be in compliance with all the requirements of this chapter, and the commissioner must not perform routine licensing inspections.

(c) Upon receipt of a complaint regarding the services of a license holder approved for alternative licensing inspection under this section, the commissioner must investigate the complaint and may take any action as provided under section 245A.06 or 245A.07.

Subd. 5. **Investigations of alleged or suspected maltreatment.** Nothing in this section changes the commissioner's responsibilities to investigate alleged or suspected maltreatment of a minor under section 626.556 or a vulnerable adult under section 626.557.

Subd. 6. **Termination or denial of subsequent approval.** Following approval of an alternative licensing inspection, the commissioner may terminate or deny subsequent approval of an alternative licensing inspection if the commissioner determines that:

(1) the license holder has not maintained the qualifying accreditation;

(2) the commissioner has substantiated maltreatment for which the license holder or facility is determined to be responsible during the qualifying accreditation period; or

(3) during the qualifying accreditation period, the license holder has been issued an order for conditional license, fine, suspension, or license revocation that has not been reversed upon appeal.

Subd. 7. **Appeals.** The commissioner's decision that the conditions for approval for an alternative licensing inspection have not been met is final and not subject to appeal under the provisions of chapter 14.

Subd. 8. **Commissioner's programs.** Home and community-based services licensed under this chapter for which the commissioner is the license holder with a qualifying accreditation are excluded from being approved for an alternative licensing inspection.

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

Sec. 43. **[245D.33] ADULT MENTAL HEALTH CERTIFICATION STANDARDS.**

(a) The commissioner of human services shall issue a mental health certification for services licensed under this chapter, when a license holder is determined to have met the requirements under paragraph (b). This certification is voluntary for license holders. The certification shall be printed on the license and identified on the commissioner's public Web site.

(b) The requirements for certification are:

(1) all staff have received at least seven hours of annual training covering all of the following topics:

(i) mental health diagnoses;

(ii) mental health crisis response and de-escalation techniques;

(iii) recovery from mental illness;

(iv) treatment options, including evidence-based practices;

(v) medications and their side effects;

(vi) co-occurring substance abuse and health conditions; and

(vii) community resources;

(2) a mental health professional, as defined in section 245.462, subdivision 18, or a mental health practitioner as defined in section 245.462, subdivision 17, is available for consultation and assistance;

(3) there is a plan and protocol in place to address a mental health crisis; and

(4) each person's individual service and support plan identifies who is providing clinical services and their contact information, and includes an individual crisis prevention and management plan developed with the person.

(c) License holders seeking certification under this section must request this certification on forms and in the manner prescribed by the commissioner.

(d) If the commissioner finds that the license holder has failed to comply with the certification requirements under paragraph (b), the commissioner may issue a correction order and an order of conditional license in accordance with section 245A.06 or may issue a sanction in accordance with section 245A.07, including and up to removal of the certification.

(e) A denial of the certification or the removal of the certification based on a determination that the requirements under paragraph (b) have not been met is not subject to appeal. A license holder that has been denied a certification or that has had a certification removed may again request certification when the license holder is in compliance with the requirements of paragraph (b).

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

Sec. 44. Minnesota Statutes 2012, section 256B.092, subdivision 11, is amended to read:

Subd. 11. **Residential support services.** (a) Upon federal approval, there is established a new service called residential support that is available on the community alternative care, community alternatives for disabled individuals, developmental disabilities, and brain injury waivers. Existing waiver service descriptions must be modified to the extent necessary to ensure there is no duplication between other services. Residential support services must be provided by vendors licensed as a community residential setting as defined in section 245A.11, subdivision 8, a foster care setting licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or an adult foster care setting licensed under Minnesota Rules, parts 9555.5105 to 9555.6265.

(b) Residential support services must meet the following criteria:

~~(1) providers of residential support services must own or control the residential site;~~

~~(2) the residential site must not be the primary residence of the license holder;~~

~~(3)~~ (1) the residential site must have a designated ~~program supervisor~~ person responsible for program management, oversight, development, and implementation of policies and procedures;

~~(4)~~ (2) the provider of residential support services must provide supervision, training, and assistance as described in the person's coordinated service and support plan; and

~~(5)~~ (3) the provider of residential support services must meet the requirements of licensure and additional requirements of the person's coordinated service and support plan.

(c) Providers of residential support services that meet the definition in paragraph (a) ~~must be registered using a process determined by the commissioner beginning July 1, 2009~~ must be licensed according to chapter 245D. Providers licensed to provide child foster care under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, and that meet the requirements in section 245A.03, subdivision 7, paragraph (g), are considered registered under this section.

Sec. 45. Minnesota Statutes 2012, section 256B.4912, subdivision 1, is amended to read:

Subdivision 1. **Provider qualifications.** (a) For the home and community-based waivers providing services to seniors and individuals with disabilities under sections 256B.0913, 256B.0915, 256B.092, and 256B.49, the commissioner shall establish:

(1) agreements with enrolled waiver service providers to ensure providers meet Minnesota health care program requirements;

(2) regular reviews of provider qualifications, and including requests of proof of documentation; and

(3) processes to gather the necessary information to determine provider qualifications.

(b) Beginning July 1, 2012, staff that provide direct contact, as defined in section 245C.02, subdivision 11, for services specified in the federally approved waiver plans must meet the requirements of chapter 245C prior to providing waiver services and as part of ongoing enrollment. Upon federal approval, this requirement must also apply to consumer-directed community supports.

(c) Beginning January 1, 2014, service owners and managerial officials overseeing the management or policies of services that provide direct contact as specified in the federally approved waiver plans must meet the requirements of chapter 245C prior to reenrollment or, for new providers, prior to initial enrollment if they have not already done so as a part of service licensure requirements.

Sec. 46. Minnesota Statutes 2012, section 256B.4912, subdivision 7, is amended to read:

Subd. 7. **Applicant and license holder training.** An applicant or license holder for the home and community-based waivers providing services to seniors and individuals with disabilities under sections 256B.0913, 256B.0915, 256B.092, and 256B.49 that is not enrolled as a Minnesota health care program home and community-based services waiver provider at the time of application must ensure that at least one controlling individual completes a onetime training on the requirements for providing home and community-based services ~~from a qualified source~~ as determined by the commissioner, before a provider is enrolled or license is issued. Within six months of enrollment, a newly enrolled home and community-based waiver service provider must ensure that at least one controlling individual has completed training on waiver and related program billing.

Sec. 47. Minnesota Statutes 2012, section 256B.4912, is amended by adding a subdivision to read:

Subd. 8. **Data on use of emergency use of manual restraint.** Beginning July 1, 2013, facilities and services to be licensed under chapter 245D shall submit data regarding

the use of emergency use of manual restraint as identified in section 245D.061 in a format and at a frequency identified by the commissioner.

Sec. 48. Minnesota Statutes 2012, section 256B.4912, is amended by adding a subdivision to read:

Subd. 9. **Definitions.** (a) For the purposes of this section the following terms have the meanings given them.

(b) "Controlling individual" means a public body, governmental agency, business entity, officer, owner, or managerial official whose responsibilities include the direction of the management or policies of a program.

(c) "Managerial official" means an individual who has decision-making authority related to the operation of the program and responsibility for the ongoing management of or direction of the policies, services, or employees of the program.

(d) "Owner" means an individual who has direct or indirect ownership interest in a corporation or partnership, or business association enrolling with the Department of Human Services as a provider of waiver services.

Sec. 49. Minnesota Statutes 2012, section 256B.4912, is amended by adding a subdivision to read:

Subd. 10. **Enrollment requirements.** All home and community-based waiver providers must provide, at the time of enrollment and within 30 days of a request, in a format determined by the commissioner, information and documentation that includes, but is not limited to, the following:

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

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

(3) proof of liability insurance.

Sec. 50. Minnesota Statutes 2012, section 626.557, subdivision 9a, is amended to read:

Subd. 9a. **Evaluation and referral of reports made to common entry point unit.** The common entry point must screen the reports of alleged or suspected maltreatment for immediate risk and make all necessary referrals as follows:

(1) if the common entry point determines that there is an immediate need for adult protective services, the common entry point agency shall immediately notify the appropriate county agency;

(2) if the report contains suspected criminal activity against a vulnerable adult, the common entry point shall immediately notify the appropriate law enforcement agency;

(3) the common entry point shall refer all reports of alleged or suspected maltreatment to the appropriate lead investigative agency as soon as possible, but in any event no longer than two working days; and

~~(4) if the report involves services licensed by the Department of Human Services and subject to chapter 245D, the common entry point shall refer the report to the county as the lead agency according to clause (3), but shall also notify the Department of Human Services of the report; and~~

~~(5)~~ (4) if the report contains information about a suspicious death, the common entry point shall immediately notify the appropriate law enforcement agencies, the local medical examiner, and the ombudsman for mental health and developmental disabilities established under section 245.92. Law enforcement agencies shall coordinate with the local medical examiner and the ombudsman as provided by law.

Sec. 51. Minnesota Statutes 2012, section 626.5572, subdivision 13, is amended to read:

Subd. 13. **Lead investigative agency.** "Lead investigative agency" is the primary administrative agency responsible for investigating reports made under section 626.557.

(a) The Department of Health is the lead investigative agency for facilities or services licensed or required to be licensed as hospitals, home care providers, nursing homes, boarding care homes, hospice providers, residential facilities that are also federally certified as intermediate care facilities that serve people with developmental disabilities, or any other facility or service not listed in this subdivision that is licensed or required to be licensed by the Department of Health for the care of vulnerable adults. "Home care provider" has the meaning provided in section 144A.43, subdivision 4, and applies when care or services are delivered in the vulnerable adult's home, whether a private home or a housing with services establishment registered under chapter 144D, including those that offer assisted living services under chapter 144G.

(b) ~~Except as provided under paragraph (c), for services licensed according to chapter 245D,~~ The Department of Human Services is the lead investigative agency for facilities or services licensed or required to be licensed as adult day care, adult foster care, programs for people with developmental disabilities, family adult day services, mental health programs, mental health clinics, chemical dependency programs, the Minnesota sex offender program, or any other facility or service not listed in this subdivision that is licensed or required to be licensed by the Department of Human Services.

(c) The county social service agency or its designee is the lead investigative agency for all other reports, including, but not limited to, reports involving vulnerable adults receiving services from a personal care provider organization under section 256B.0659~~, or receiving home and community-based services licensed by the Department of Human Services and subject to chapter 245D~~.

Sec. 52. **INTEGRATED LICENSING SYSTEM FOR HOME CARE AND HOME AND COMMUNITY-BASED SERVICES.**

(a) The Department of Health Compliance Monitoring Division and the Department of Human Services Licensing Division shall jointly develop an integrated licensing system for providers of both home care services subject to licensure under Minnesota Statutes, chapter 144A, and for home and community-based services subject to licensure under Minnesota Statutes, chapter 245D. The integrated licensing system shall:

(1) require only one license of any provider of services under Minnesota Statutes, sections 144A.43 to 144A.482, and 245D.03, subdivision 1;

(2) promote quality services that recognize a person's individual needs and protect the person's health, safety, rights, and well-being;

(3) promote provider accountability through application requirements, compliance inspections, investigations, and enforcement actions;

(4) reference other applicable requirements in existing state and federal laws, including the federal Affordable Care Act;

(5) establish internal procedures to facilitate ongoing communications between the agencies, and with providers and services recipients about the regulatory activities;

(6) create a link between the agency Web sites so that providers and the public can access the same information regardless of which Web site is accessed initially; and

(7) collect data on identified outcome measures as necessary for the agencies to report to the Centers for Medicare and Medicaid Services.

(b) The joint recommendations for legislative changes to implement the integrated licensing system are due to the legislature by February 15, 2014.

(c) Before implementation of the integrated licensing system, providers licensed as home care providers under Minnesota Statutes, chapter 144A, may also provide home and community-based services subject to licensure under Minnesota Statutes, chapter 245D, without obtaining a home and community-based services license under Minnesota Statutes, chapter 245D. During this time, the conditions under clauses (1) to (3) shall apply to these providers:

(1) the provider must comply with all requirements under Minnesota Statutes, chapter 245D, for services otherwise subject to licensure under Minnesota Statutes, chapter 245D;

(2) a violation of requirements under Minnesota Statutes, chapter 245D, may be enforced by the Department of Health under the enforcement authority set forth in Minnesota Statutes, section 144A.475; and

(3) the Department of Health will provide information to the Department of Human Services about each provider licensed under this section, including the provider's license application, licensing documents, inspections, information about complaints received, and investigations conducted for possible violations of Minnesota Statutes, chapter 245D.

Sec. 53. **REPEALER.**

(a) Minnesota Statutes 2012, sections 245B.01; 245B.02; 245B.03; 245B.031; 245B.04; 245B.05, subdivisions 1, 2, 3, 5, 6, and 7; 245B.055; 245B.06; 245B.07; and 245B.08, are repealed effective January 1, 2014.

(b) Minnesota Statutes 2012, section 245D.08, is repealed.

ARTICLE 9

WAIVER PROVIDER STANDARDS TECHNICAL CHANGES

Section 1. Minnesota Statutes 2012, section 16C.10, subdivision 5, is amended to read:

Subd. 5. **Specific purchases.** The solicitation process described in this chapter is not required for acquisition of the following:

(1) merchandise for resale purchased under policies determined by the commissioner;

(2) farm and garden products which, as determined by the commissioner, may be purchased at the prevailing market price on the date of sale;

(3) goods and services from the Minnesota correctional facilities;

(4) goods and services from rehabilitation facilities and extended employment providers that are certified by the commissioner of employment and economic development, and day ~~training and habilitation~~ services licensed under ~~sections 245B.01 to 245B.08~~ chapter 245D;

(5) goods and services for use by a community-based facility operated by the commissioner of human services;

(6) goods purchased at auction or when submitting a sealed bid at auction provided that before authorizing such an action, the commissioner consult with the requesting agency to determine a fair and reasonable value for the goods considering factors including, but not limited to, costs associated with submitting a bid, travel, transportation, and storage. This fair and reasonable value must represent the limit of the state's bid;

(7) utility services where no competition exists or where rates are fixed by law or ordinance; and

(8) goods and services from Minnesota sex offender program facilities.

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

Sec. 2. Minnesota Statutes 2012, section 16C.155, subdivision 1, is amended to read:

Subdivision 1. **Service contracts.** The commissioner of administration shall ensure that a portion of all contracts for janitorial services; document imaging; document shredding; and mailing, collating, and sorting services be awarded by the state to rehabilitation programs and extended employment providers that are certified by the commissioner of employment and economic development, and day ~~training and habilitation~~ services licensed under ~~sections 245B.01 to 245B.08~~ chapter 245D. The amount of each contract awarded under this section may exceed the estimated fair market price as determined by the commissioner for the same goods and services by up to six percent. The aggregate value of the contracts awarded to eligible providers under this section in any given year must exceed 19 percent of the total value of all contracts for janitorial services; document imaging; document shredding; and mailing, collating, and sorting services entered into in the same year. For the 19 percent requirement to be applicable in any given year, the contract amounts proposed by eligible providers must be within six percent of the estimated fair market price for at least 19 percent of the contracts awarded for the corresponding service area.

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

Sec. 3. Minnesota Statutes 2012, section 144D.01, subdivision 4, is amended to read:

Subd. 4. **Housing with services establishment or establishment.** (a) "Housing with services establishment" or "establishment" means:

(1) an establishment providing sleeping accommodations to one or more adult residents, at least 80 percent of which are 55 years of age or older, and offering or providing, for a fee, one or more regularly scheduled health-related services or two or more regularly scheduled supportive services, whether offered or provided directly by the establishment or by another entity arranged for by the establishment; or

(2) an establishment that registers under section 144D.025.

(b) Housing with services establishment does not include:

(1) a nursing home licensed under chapter 144A;

(2) a hospital, certified boarding care home, or supervised living facility licensed under sections 144.50 to 144.56;

(3) a board and lodging establishment licensed under chapter 157 and Minnesota Rules, parts 9520.0500 to 9520.0670, 9525.0215 to 9525.0355, 9525.0500 to 9525.0660, or 9530.4100 to 9530.4450, or under chapter ~~245B~~ 245D;

(4) a board and lodging establishment which serves as a shelter for battered women or other similar purpose;

(5) a family adult foster care home licensed by the Department of Human Services;

(6) private homes in which the residents are related by kinship, law, or affinity with the providers of services;

(7) residential settings for persons with developmental disabilities in which the services are licensed under Minnesota Rules, parts 9525.2100 to 9525.2140, or applicable successor rules or laws;

(8) a home-sharing arrangement such as when an elderly or disabled person or single-parent family makes lodging in a private residence available to another person in exchange for services or rent, or both;

(9) a duly organized condominium, cooperative, common interest community, or owners' association of the foregoing where at least 80 percent of the units that comprise the condominium, cooperative, or common interest community are occupied by individuals who are the owners, members, or shareholders of the units; or

(10) services for persons with developmental disabilities that are provided under a license according to Minnesota Rules, parts 9525.2000 to 9525.2140 in effect until January 1, 1998, or under chapter ~~245B~~ 245D.

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

Sec. 4. Minnesota Statutes 2012, section 174.30, subdivision 1, is amended to read:

Subdivision 1. **Applicability.** (a) The operating standards for special transportation service adopted under this section do not apply to special transportation provided by:

(1) a common carrier operating on fixed routes and schedules;

(2) a volunteer driver using a private automobile;

(3) a school bus as defined in section 169.011, subdivision 71; or

(4) an emergency ambulance regulated under chapter 144.

(b) The operating standards adopted under this section only apply to providers of special transportation service who receive grants or other financial assistance from either the state or the federal government, or both, to provide or assist in providing that service; except that the operating standards adopted under this section do not apply

to any nursing home licensed under section 144A.02, to any board and care facility licensed under section 144.50, or to any day training and habilitation services, day care, or group home facility licensed under sections 245A.01 to 245A.19 unless the facility or program provides transportation to nonresidents on a regular basis and the facility receives reimbursement, other than per diem payments, for that service under rules promulgated by the commissioner of human services.

(c) Notwithstanding paragraph (b), the operating standards adopted under this section do not apply to any vendor of services licensed under chapter ~~245B~~ 245D that provides transportation services to consumers or residents of other vendors licensed under chapter ~~245B~~ 245D and transports 15 or fewer persons, including consumers or residents and the driver.

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

Sec. 5. Minnesota Statutes 2012, section 245A.02, subdivision 1, is amended to read:

Subdivision 1. **Scope.** The terms used in this chapter ~~and chapter 245B~~ have the meanings given them in this section.

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

Sec. 6. Minnesota Statutes 2012, section 245A.02, subdivision 9, is amended to read:

Subd. 9. **License holder.** "License holder" means an individual, corporation, partnership, voluntary association, or other organization that is legally responsible for the operation of the program, has been granted a license by the commissioner under this chapter or chapter ~~245B~~ 245D and the rules of the commissioner, and is a controlling individual.

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

Sec. 7. Minnesota Statutes 2012, section 245A.03, subdivision 9, is amended to read:

Subd. 9. **Permitted services by an individual who is related.** Notwithstanding subdivision 2, paragraph (a), clause (1), and subdivision 7, an individual who is related to a person receiving supported living services may provide licensed services to that person if:

(1) the person who receives supported living services received these services in a residential site on July 1, 2005;

(2) the services under clause (1) were provided in a corporate foster care setting for adults and were funded by the developmental disabilities home and community-based services waiver defined in section 256B.092;

(3) the individual who is related obtains and maintains both a license under chapter ~~245B~~ 245D and an adult foster care license under Minnesota Rules, parts 9555.5105 to 9555.6265; and

(4) the individual who is related is not the guardian of the person receiving supported living services.

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

Sec. 8. Minnesota Statutes 2012, section 245A.04, subdivision 13, is amended to read:

Subd. 13. **Funds and property; other requirements.** (a) A license holder must ensure that persons served by the program retain the use and availability of personal funds or property unless restrictions are justified in the person's individual plan. ~~This subdivision does not apply to programs governed by the provisions in section 245B.07, subdivision 10.~~

(b) The license holder must ensure separation of funds of persons served by the program from funds of the license holder, the program, or program staff.

(c) Whenever the license holder assists a person served by the program with the safekeeping of funds or other property, the license holder must:

(1) immediately document receipt and disbursement of the person's funds or other property at the time of receipt or disbursement, including the person's signature, or the signature of the conservator or payee; and

(2) return to the person upon the person's request, funds and property in the license holder's possession subject to restrictions in the person's treatment plan, as soon as possible, but no later than three working days after the date of request.

(d) License holders and program staff must not:

(1) borrow money from a person served by the program;

(2) purchase personal items from a person served by the program;

(3) sell merchandise or personal services to a person served by the program;

(4) require a person served by the program to purchase items for which the license holder is eligible for reimbursement; or

(5) use funds of persons served by the program to purchase items for which the facility is already receiving public or private payments.

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

Sec. 9. Minnesota Statutes 2012, section 245A.07, subdivision 3, is amended to read:

Subd. 3. **License suspension, revocation, or fine.** (a) The commissioner may suspend or revoke a license, or impose a fine if:

(1) a license holder fails to comply fully with applicable laws or rules;

(2) a license holder, a controlling individual, or an individual living in the household where the licensed services are provided or is otherwise subject to a background study has a disqualification which has not been set aside under section 245C.22;

(3) a license holder knowingly withholds relevant information from or gives false or misleading information to the commissioner in connection with an application for a license, in connection with the background study status of an individual, during an investigation, or regarding compliance with applicable laws or rules; or

(4) after July 1, 2012, and upon request by the commissioner, a license holder fails to submit the information required of an applicant under section 245A.04, subdivision 1, paragraph (f) or (g).

A license holder who has had a license suspended, revoked, or has been ordered to pay a fine must be given notice of the action by certified mail or personal service. If mailed, the notice must be mailed to the address shown on the application or the last known address of the license holder. The notice must state the reasons the license was suspended, revoked, or a fine was ordered.

(b) If the license was suspended or revoked, the notice must inform the license holder of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking a license. The appeal of an order suspending or revoking a license must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar days after the license holder receives notice that the license has been suspended or revoked. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the license holder received the order. Except as provided in subdivision 2a, paragraph (c), if a license holder submits a timely appeal of an order suspending or revoking a license, the license holder may continue to operate the program as provided in section 245A.04, subdivision 7, paragraphs (g) and (h), until the commissioner issues a final order on the suspension or revocation.

(c)(1) If the license holder was ordered to pay a fine, the notice must inform the license holder of the responsibility for payment of fines and the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The appeal of an order to pay a fine must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar days after the license holder receives notice that the fine has been ordered. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the license holder received the order.

(2) The license holder shall 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. If the license holder receives state funds, the state, county, or municipal agencies or departments responsible for administering the funds shall withhold payments and recover any payments made while the license is suspended for failure to pay a fine. A timely appeal shall stay payment of the fine until the commissioner issues a final order.

(3) A license holder shall promptly notify the commissioner of human services, in writing, when a violation specified in the order to forfeit a fine is corrected. If upon reinspection the commissioner determines that a violation has not been corrected as indicated by the order to forfeit a fine, the commissioner may issue a second fine. The commissioner shall notify the license holder by certified mail or personal service that a second fine has been assessed. The license holder may appeal the second fine as provided under this subdivision.

(4) Fines shall be assessed as follows: the license holder shall forfeit $1,000 for each determination of maltreatment of a child under section 626.556 or the maltreatment of a vulnerable adult under section 626.557 for which the license holder is determined responsible for the maltreatment under section 626.556, subdivision 10e, paragraph (i), or 626.557, subdivision 9c, paragraph (c); the license holder shall forfeit $200 for each occurrence of a violation of law or rule governing matters of health, safety, or supervision, including but not limited to the provision of adequate staff-to-child or adult ratios, and failure to comply with background study requirements under chapter 245C; and the license holder shall forfeit $100 for each occurrence of a violation of law or rule other than those subject to a $1,000 or $200 fine above. For purposes of this section, "occurrence" means each violation identified in the commissioner's fine order. Fines assessed against a license holder that holds a license to provide ~~the residential-based habilitation~~ home and community-based services, as ~~defined under~~ identified in section ~~245B.02, subdivision 20~~ 245D.03, subdivision 1, and a community residential setting or day services facility license ~~to provide foster care~~ under chapter 245D where the services are provided, may be assessed against both licenses for the same occurrence, but the combined amount of the fines shall not exceed the amount specified in this clause for that occurrence.

(5) 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 will be personally liable for payment. In the case of a corporation, each controlling individual is personally and jointly liable for payment.

(d) Except for background study violations involving the failure to comply with an order to immediately remove an individual or an order to provide continuous, direct supervision, the commissioner shall not issue a fine under paragraph (c) relating to a background study violation to a license holder who self-corrects a background study violation before the commissioner discovers the violation. A license holder who has previously exercised the provisions of this paragraph to avoid a fine for a background study violation may not avoid a fine for a subsequent background study violation unless at least 365 days have passed since the license holder self-corrected the earlier background study violation.

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

Sec. 10. Minnesota Statutes 2012, section 256B.0625, subdivision 19c, is amended to read:

Subd. 19c. **Personal care.** Medical assistance covers personal care assistance services provided by an individual who is qualified to provide the services according to subdivision 19a and sections 256B.0651 to 256B.0656, provided in accordance with a plan, and supervised by a qualified professional.

"Qualified professional" means a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), or 245.4871, subdivision 27, clauses (1) to (6); ~~or~~ a registered nurse as defined in sections 148.171 to 148.285, a licensed social worker as defined in sections 148E.010 and 148E.055, or a qualified ~~developmental disabilities specialist under section 245B.07, subdivision 4~~ designated coordinator under section 245D.081, subdivision 2. The qualified professional shall perform the duties required in section 256B.0659.

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

Sec. 11. Minnesota Statutes 2012, section 256B.5011, subdivision 2, is amended to read:

Subd. 2. **Contract provisions.** (a) The service contract with each intermediate care facility must include provisions for:

(1) modifying payments when significant changes occur in the needs of the consumers;

(2) appropriate and necessary statistical information required by the commissioner;

(3) annual aggregate facility financial information; and

(4) additional requirements for intermediate care facilities not meeting the standards set forth in the service contract.

(b) The commissioner of human services and the commissioner of health, in consultation with representatives from counties, advocacy organizations, and the provider community, shall review ~~the consolidated standards under chapter 245B and~~ the home and community-based services standards under chapter 245D and the supervised living facility rule under Minnesota Rules, chapter 4665, to determine what provisions in Minnesota Rules, chapter 4665, may be waived by the commissioner of health for intermediate care facilities in order to enable facilities to implement the performance measures in their contract and provide quality services to residents without a duplication of or increase in regulatory requirements.

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

Sec. 12. Minnesota Statutes 2012, section 471.59, subdivision 1, is amended to read:

Subdivision 1. **Agreement.** Two or more governmental units, by agreement entered into through action of their governing bodies, may jointly or cooperatively exercise any power common to the contracting parties or any similar powers, including those which are the same except for the territorial limits within which they may be exercised. The agreement may provide for the exercise of such powers by one or more of the participating governmental units on behalf of the other participating units. The term "governmental unit" as used in this section includes every city, county, town, school district, independent nonprofit firefighting corporation, other political subdivision of this or another state, another state, federally recognized Indian tribe, the University of Minnesota, the Minnesota Historical Society, nonprofit hospitals licensed under sections 144.50 to 144.56, rehabilitation facilities and extended employment providers that are certified by the commissioner of employment and economic development, ~~day training and habilitation services licensed under sections 245B.01 to 245B.08,~~ day and supported employment services licensed under chapter 245D, and any agency of the state of Minnesota or the United States, and includes any instrumentality of a governmental unit. For the purpose of this section, an instrumentality of a governmental unit means an instrumentality having independent policy-making and appropriating authority.

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

Sec. 13. Minnesota Statutes 2012, section 626.556, subdivision 2, is amended to read:

Subd. 2. **Definitions.** As used in this section, the following terms have the meanings given them unless the specific content indicates otherwise:

(a) "Family assessment" means a comprehensive assessment of child safety, risk of subsequent child maltreatment, and family strengths and needs that is applied to a child maltreatment report that does not allege substantial child endangerment. Family assessment does not include a determination as to whether child maltreatment occurred but does determine the need for services to address the safety of family members and the risk of subsequent maltreatment.

(b) "Investigation" means fact gathering related to the current safety of a child and the risk of subsequent maltreatment that determines whether child maltreatment occurred and whether child protective services are needed. An investigation must be used when reports involve substantial child endangerment, and for reports of maltreatment in facilities required to be licensed under chapter 245A or 245B; under sections 144.50 to 144.58 and 241.021; in a school as defined in sections 120A.05, subdivisions 9, 11, and 13, and 124D.10; or in a nonlicensed personal care provider association as defined in sections 256B.04, subdivision 16, and 256B.0625, subdivision 19a.

(c) "Substantial child endangerment" means a person responsible for a child's care, and in the case of sexual abuse includes a person who has a significant relationship to the child as defined in section 609.341, or a person in a position of authority as defined in section 609.341, who by act or omission commits or attempts to commit an act against a child under their care that constitutes any of the following:

(1) egregious harm as defined in section 260C.007, subdivision 14;

(2) sexual abuse as defined in paragraph (d);

(3) abandonment under section 260C.301, subdivision 2;

(4) neglect as defined in paragraph (f), clause (2), that substantially endangers the child's physical or mental health, including a growth delay, which may be referred to as failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

(5) murder in the first, second, or third degree under section 609.185, 609.19, or 609.195;

(6) manslaughter in the first or second degree under section 609.20 or 609.205;

(7) assault in the first, second, or third degree under section 609.221, 609.222, or 609.223;

(8) solicitation, inducement, and promotion of prostitution under section 609.322;

(9) criminal sexual conduct under sections 609.342 to 609.3451;

(10) solicitation of children to engage in sexual conduct under section 609.352;

(11) malicious punishment or neglect or endangerment of a child under section 609.377 or 609.378;

(12) use of a minor in sexual performance under section 617.246; or

(13) parental behavior, status, or condition which mandates that the county attorney file a termination of parental rights petition under section 260C.301, subdivision 3, paragraph (a).

(d) "Sexual abuse" means the subjection of a child by a person responsible for the child's care, by a person who has a significant relationship to the child, as defined in section 609.341, or by a person in a position of authority, as defined in section 609.341, subdivision 10, to any act which constitutes a violation of section 609.342 (criminal sexual conduct in the first degree), 609.343 (criminal sexual conduct in the second degree), 609.344 (criminal sexual conduct in the third degree), 609.345 (criminal sexual conduct in the fourth degree), or 609.3451 (criminal sexual conduct in the fifth degree). Sexual abuse also includes any act which involves a minor which constitutes a violation of prostitution offenses under sections 609.321 to 609.324 or 617.246. Sexual abuse includes threatened sexual abuse which includes the status of a parent or household member who has committed a violation which requires registration as an offender under section 243.166, subdivision 1b, paragraph (a) or (b), or required registration under section 243.166, subdivision 1b, paragraph (a) or (b).

(e) "Person responsible for the child's care" means (1) an individual functioning within the family unit and having responsibilities for the care of the child such as a parent, guardian, or other person having similar care responsibilities, or (2) an individual functioning outside the family unit and having responsibilities for the care of the child such as a teacher, school administrator, other school employees or agents, or other lawful custodian of a child having either full-time or short-term care responsibilities including, but not limited to, day care, babysitting whether paid or unpaid, counseling, teaching, and coaching.

(f) "Neglect" means the commission or omission of any of the acts specified under clauses (1) to (9), other than by accidental means:

(1) failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child's physical or mental health when reasonably able to do so;

(2) failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so, including a growth delay, which may be referred to as a failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

(3) failure to provide for necessary supervision or child care arrangements appropriate for a child after considering factors as the child's age, mental ability, physical

condition, length of absence, or environment, when the child is unable to care for the child's own basic needs or safety, or the basic needs or safety of another child in their care;

(4) failure to ensure that the child is educated as defined in sections 120A.22 and 260C.163, subdivision 11, which does not include a parent's refusal to provide the parent's child with sympathomimetic medications, consistent with section 125A.091, subdivision 5;

(5) nothing in this section shall be construed to mean that a child is neglected solely because the child's parent, guardian, or other person responsible for the child's care in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the child in lieu of medical care; except that a parent, guardian, or caretaker, or a person mandated to report pursuant to subdivision 3, has a duty to report if a lack of medical care may cause serious danger to the child's health. This section does not impose upon persons, not otherwise legally responsible for providing a child with necessary food, clothing, shelter, education, or medical care, a duty to provide that care;

(6) prenatal exposure to a controlled substance, as defined in section 253B.02, subdivision 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery or the child at birth, medical effects or developmental delays during the child's first year of life that medically indicate prenatal exposure to a controlled substance, or the presence of a fetal alcohol spectrum disorder;

(7) "medical neglect" as defined in section 260C.007, subdivision 6, clause (5);

(8) chronic and severe use of alcohol or a controlled substance by a parent or person responsible for the care of the child that adversely affects the child's basic needs and safety; or

(9) emotional harm from a pattern of behavior which contributes to impaired emotional functioning of the child which may be demonstrated by a substantial and observable effect in the child's behavior, emotional response, or cognition that is not within the normal range for the child's age and stage of development, with due regard to the child's culture.

(g) "Physical abuse" means any physical injury, mental injury, or threatened injury, inflicted by a person responsible for the child's care on a child other than by accidental means, or any physical or mental injury that cannot reasonably be explained by the child's history of injuries, or any aversive or deprivation procedures, or regulated interventions, that have not been authorized under section 121A.67 or 245.825.

Abuse does not include reasonable and moderate physical discipline of a child administered by a parent or legal guardian which does not result in an injury. Abuse does not include the use of reasonable force by a teacher, principal, or school employee as

allowed by section 121A.582. Actions which are not reasonable and moderate include, but are not limited to, any of the following that are done in anger or without regard to the safety of the child:

(1) throwing, kicking, burning, biting, or cutting a child;

(2) striking a child with a closed fist;

(3) shaking a child under age three;

(4) striking or other actions which result in any nonaccidental injury to a child under 18 months of age;

(5) unreasonable interference with a child's breathing;

(6) threatening a child with a weapon, as defined in section 609.02, subdivision 6;

(7) striking a child under age one on the face or head;

(8) purposely giving a child poison, alcohol, or dangerous, harmful, or controlled substances which were not prescribed for the child by a practitioner, in order to control or punish the child; or other substances that substantially affect the child's behavior, motor coordination, or judgment or that results in sickness or internal injury, or subjects the child to medical procedures that would be unnecessary if the child were not exposed to the substances;

(9) unreasonable physical confinement or restraint not permitted under section 609.379, including but not limited to tying, caging, or chaining; or

(10) in a school facility or school zone, an act by a person responsible for the child's care that is a violation under section 121A.58.

(h) "Report" means any report received by the local welfare agency, police department, county sheriff, or agency responsible for assessing or investigating maltreatment pursuant to this section.

(i) "Facility" means:

(1) a licensed or unlicensed day care facility, residential facility, agency, hospital, sanitarium, or other facility or institution required to be licensed under sections 144.50 to 144.58, 241.021, or 245A.01 to 245A.16, or chapter ~~245B~~ 245D;

(2) a school as defined in sections 120A.05, subdivisions 9, 11, and 13; and 124D.10; or

(3) a nonlicensed personal care provider organization as defined in sections 256B.04, subdivision 16, and 256B.0625, subdivision 19a.

(j) "Operator" means an operator or agency as defined in section 245A.02.

(k) "Commissioner" means the commissioner of human services.

(l) "Practice of social services," for the purposes of subdivision 3, includes but is not limited to employee assistance counseling and the provision of guardian ad litem and parenting time expeditor services.

(m) "Mental injury" means an injury to the psychological capacity or emotional stability of a child as evidenced by an observable or substantial impairment in the child's ability to function within a normal range of performance and behavior with due regard to the child's culture.

(n) "Threatened injury" means a statement, overt act, condition, or status that represents a substantial risk of physical or sexual abuse or mental injury. Threatened injury includes, but is not limited to, exposing a child to a person responsible for the child's care, as defined in paragraph (e), clause (1), who has:

(1) subjected a child to, or failed to protect a child from, an overt act or condition that constitutes egregious harm, as defined in section 260C.007, subdivision 14, or a similar law of another jurisdiction;

(2) been found to be palpably unfit under section 260C.301, paragraph (b), clause (4), or a similar law of another jurisdiction;

(3) committed an act that has resulted in an involuntary termination of parental rights under section 260C.301, or a similar law of another jurisdiction; or

(4) committed an act that has resulted in the involuntary transfer of permanent legal and physical custody of a child to a relative under Minnesota Statutes 2010, section 260C.201, subdivision 11, paragraph (d), clause (1), section 260C.515, subdivision 4, or a similar law of another jurisdiction.

A child is the subject of a report of threatened injury when the responsible social services agency receives birth match data under paragraph (o) from the Department of Human Services.

(o) Upon receiving data under section 144.225, subdivision 2b, contained in a birth record or recognition of parentage identifying a child who is subject to threatened injury under paragraph (n), the Department of Human Services shall send the data to the responsible social services agency. The data is known as "birth match" data. Unless the responsible social services agency has already begun an investigation or assessment of the report due to the birth of the child or execution of the recognition of parentage and the parent's previous history with child protection, the agency shall accept the birth match data as a report under this section. The agency may use either a family assessment or investigation to determine whether the child is safe. All of the provisions of this section apply. If the child is determined to be safe, the agency shall consult with the county attorney to determine the appropriateness of filing a petition alleging the child is in need

of protection or services under section 260C.007, subdivision 6, clause (16), in order to deliver needed services. If the child is determined not to be safe, the agency and the county attorney shall take appropriate action as required under section 260C.301, subdivision 3.

(p) Persons who conduct assessments or investigations under this section shall take into account accepted child-rearing practices of the culture in which a child participates and accepted teacher discipline practices, which are not injurious to the child's health, welfare, and safety.

(q) "Accidental" means a sudden, not reasonably foreseeable, and unexpected occurrence or event which:

(1) is not likely to occur and could not have been prevented by exercise of due care; and

(2) if occurring while a child is receiving services from a facility, happens when the facility and the employee or person providing services in the facility are in compliance with the laws and rules relevant to the occurrence or event.

(r) "Nonmaltreatment mistake" means:

(1) at the time of the incident, the individual was performing duties identified in the center's child care program plan required under Minnesota Rules, part 9503.0045;

(2) the individual has not been determined responsible for a similar incident that resulted in a finding of maltreatment for at least seven years;

(3) the individual has not been determined to have committed a similar nonmaltreatment mistake under this paragraph for at least four years;

(4) any injury to a child resulting from the incident, if treated, is treated only with remedies that are available over the counter, whether ordered by a medical professional or not; and

(5) except for the period when the incident occurred, the facility and the individual providing services were both in compliance with all licensing requirements relevant to the incident.

This definition only applies to child care centers licensed under Minnesota Rules, chapter 9503. If clauses (1) to (5) apply, rather than making a determination of substantiated maltreatment by the individual, the commissioner of human services shall determine that a nonmaltreatment mistake was made by the individual.

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

Sec. 14. Minnesota Statutes 2012, section 626.556, subdivision 3, is amended to read:

Subd. 3. **Persons mandated to report.** (a) A person who knows or has reason to believe a child is being neglected or physically or sexually abused, as defined in

subdivision 2, or has been neglected or physically or sexually abused within the preceding three years, shall immediately report the information to the local welfare agency, agency responsible for assessing or investigating the report, police department, or the county sheriff if the person is:

(1) a professional or professional's delegate who is engaged in the practice of the healing arts, social services, hospital administration, psychological or psychiatric treatment, child care, education, correctional supervision, probation and correctional services, or law enforcement; or

(2) employed as a member of the clergy and received the information while engaged in ministerial duties, provided that a member of the clergy is not required by this subdivision to report information that is otherwise privileged under section 595.02, subdivision 1, paragraph (c).

The police department or the county sheriff, upon receiving a report, shall immediately notify the local welfare agency or agency responsible for assessing or investigating the report, orally and in writing. The local welfare agency, or agency responsible for assessing or investigating the report, upon receiving a report, shall immediately notify the local police department or the county sheriff orally and in writing. The county sheriff and the head of every local welfare agency, agency responsible for assessing or investigating reports, and police department shall each designate a person within their agency, department, or office who is responsible for ensuring that the notification duties of this paragraph and paragraph (b) are carried out. Nothing in this subdivision shall be construed to require more than one report from any institution, facility, school, or agency.

(b) Any person may voluntarily report to the local welfare agency, agency responsible for assessing or investigating the report, police department, or the county sheriff if the person knows, has reason to believe, or suspects a child is being or has been neglected or subjected to physical or sexual abuse. The police department or the county sheriff, upon receiving a report, shall immediately notify the local welfare agency or agency responsible for assessing or investigating the report, orally and in writing. The local welfare agency or agency responsible for assessing or investigating the report, upon receiving a report, shall immediately notify the local police department or the county sheriff orally and in writing.

(c) A person mandated to report physical or sexual child abuse or neglect occurring within a licensed facility shall report the information to the agency responsible for licensing the facility under sections 144.50 to 144.58; 241.021; 245A.01 to 245A.16; or chapter ~~245B~~ 245D; or a nonlicensed personal care provider organization as defined in sections 256B.04, subdivision 16; and 256B.0625, subdivision 19. A health or corrections

agency receiving a report may request the local welfare agency to provide assistance pursuant to subdivisions 10, 10a, and 10b. A board or other entity whose licensees perform work within a school facility, upon receiving a complaint of alleged maltreatment, shall provide information about the circumstances of the alleged maltreatment to the commissioner of education. Section 13.03, subdivision 4, applies to data received by the commissioner of education from a licensing entity.

(d) Any person mandated to report shall receive a summary of the disposition of any report made by that reporter, including whether the case has been opened for child protection or other services, or if a referral has been made to a community organization, unless release would be detrimental to the best interests of the child. Any person who is not mandated to report shall, upon request to the local welfare agency, receive a concise summary of the disposition of any report made by that reporter, unless release would be detrimental to the best interests of the child.

(e) For purposes of this section, "immediately" means as soon as possible but in no event longer than 24 hours.

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

Sec. 15. Minnesota Statutes 2012, section 626.556, subdivision 10d, is amended to read:

Subd. 10d. **Notification of neglect or abuse in facility.** (a) When a report is received that alleges neglect, physical abuse, sexual abuse, or maltreatment of a child while in the care of a licensed or unlicensed day care facility, residential facility, agency, hospital, sanitarium, or other facility or institution required to be licensed according to sections 144.50 to 144.58; 241.021; or 245A.01 to 245A.16; or chapter ~~245B~~ 245D, or a school as defined in sections 120A.05, subdivisions 9, 11, and 13; and 124D.10; or a nonlicensed personal care provider organization as defined in section 256B.04, subdivision 16, and 256B.0625, subdivision 19a, the commissioner of the agency responsible for assessing or investigating the report or local welfare agency investigating the report shall provide the following information to the parent, guardian, or legal custodian of a child alleged to have been neglected, physically abused, sexually abused, or the victim of maltreatment of a child in the facility: the name of the facility; the fact that a report alleging neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility has been received; the nature of the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility; that the agency is conducting an assessment or investigation; any protective or corrective measures being taken pending the outcome of the investigation; and that a written memorandum will be provided when the investigation is completed.

(b) The commissioner of the agency responsible for assessing or investigating the report or local welfare agency may also provide the information in paragraph (a) to the parent, guardian, or legal custodian of any other child in the facility if the investigative agency knows or has reason to believe the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility has occurred. In determining whether to exercise this authority, the commissioner of the agency responsible for assessing or investigating the report or local welfare agency shall consider the seriousness of the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility; the number of children allegedly neglected, physically abused, sexually abused, or victims of maltreatment of a child in the facility; the number of alleged perpetrators; and the length of the investigation. The facility shall be notified whenever this discretion is exercised.

(c) When the commissioner of the agency responsible for assessing or investigating the report or local welfare agency has completed its investigation, every parent, guardian, or legal custodian previously notified of the investigation by the commissioner or local welfare agency shall be provided with the following information in a written memorandum: the name of the facility investigated; the nature of the alleged neglect, physical abuse, sexual abuse, or maltreatment of a child in the facility; the investigator's name; a summary of the investigation findings; a statement whether maltreatment was found; and the protective or corrective measures that are being or will be taken. The memorandum shall be written in a manner that protects the identity of the reporter and the child and shall not contain the name, or to the extent possible, reveal the identity of the alleged perpetrator or of those interviewed during the investigation. If maltreatment is determined to exist, the commissioner or local welfare agency shall also provide the written memorandum to the parent, guardian, or legal custodian of each child in the facility who had contact with the individual responsible for the maltreatment. When the facility is the responsible party for maltreatment, the commissioner or local welfare agency shall also provide the written memorandum to the parent, guardian, or legal custodian of each child who received services in the population of the facility where the maltreatment occurred. This notification must be provided to the parent, guardian, or legal custodian of each child receiving services from the time the maltreatment occurred until either the individual responsible for maltreatment is no longer in contact with a child or children in the facility or the conclusion of the investigation. In the case of maltreatment within a school facility, as defined in sections 120A.05, subdivisions 9, 11, and 13, and 124D.10, the commissioner of education need not provide notification to parents, guardians, or legal custodians of each child in the facility, but shall, within ten days after the investigation is completed, provide written notification to the parent, guardian, or legal custodian of any student

alleged to have been maltreated. The commissioner of education may notify the parent, guardian, or legal custodian of any student involved as a witness to alleged maltreatment.

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

Sec. 16. **REPEALER.**

Minnesota Statutes 2012, section 256B.49, subdivision 16a, is repealed effective January 1, 2014.

ARTICLE 10

MISCELLANEOUS

Section 1. Minnesota Statutes 2012, section 119B.13, subdivision 7, is amended to read:

Subd. 7. **Absent days.** (a) Licensed child care providers and license-exempt centers must not be reimbursed for more than ~~ten~~ 25 full-day absent days per child, excluding holidays, in a fiscal year, or for more than ten consecutive full-day absent days. Legal nonlicensed family child care providers must not be reimbursed for absent days. If a child attends for part of the time authorized to be in care in a day, but is absent for part of the time authorized to be in care in that same day, the absent time must be reimbursed but the time must not count toward the ~~ten~~ absent ~~day~~ days limit. Child care providers must only be reimbursed for absent days if the provider has a written policy for child absences and charges all other families in care for similar absences.

(b) Notwithstanding paragraph (a), children with documented medical conditions that cause more frequent absences may exceed the 25 absent days limit, or ten consecutive full-day absent days limit. Absences due to a documented medical condition of a parent or sibling who lives in the same residence as the child receiving child care assistance do not count against the absent days limit in a fiscal year. Documentation of medical conditions must be on the forms and submitted according to the timelines established by the commissioner. A public health nurse or school nurse may verify the illness in lieu of a medical practitioner. If a provider sends a child home early due to a medical reason, including, but not limited to, fever or contagious illness, the child care center director or lead teacher may verify the illness in lieu of a medical practitioner.

~~(b)~~ (c) Notwithstanding paragraph (a), children in families may exceed the ~~ten~~ absent days limit if at least one parent: (1) is under the age of 21; (2) does not have a high school or general equivalency diploma; and (3) is a student in a school district or another similar program that provides or arranges for child care, parenting support, social services, career and employment supports, and academic support to achieve high school graduation, upon

request of the program and approval of the county. If a child attends part of an authorized day, payment to the provider must be for the full amount of care authorized for that day.

~~(c)~~ (d) Child care providers must be reimbursed for up to ten federal or state holidays or designated holidays per year when the provider charges all families for these days and the holiday or designated holiday falls on a day when the child is authorized to be in attendance. Parents may substitute other cultural or religious holidays for the ten recognized state and federal holidays. Holidays do not count toward the ~~ten~~ absent ~~day~~ days limit.

~~(d)~~ (e) A family or child care provider must not be assessed an overpayment for an absent day payment unless (1) there was an error in the amount of care authorized for the family, (2) all of the allowed full-day absent payments for the child have been paid, or (3) the family or provider did not timely report a change as required under law.

~~(e)~~ (f) The provider and family shall receive notification of the number of absent days used upon initial provider authorization for a family and ongoing notification of the number of absent days used as of the date of the notification.

(g) For purposes of this subdivision, "absent days limit" means 25 full-day absent days per child, excluding holidays, in a fiscal year; and ten consecutive full-day absent days.

Sec. 2. **[214.075] HEALTH-RELATED LICENSING BOARDS; CRIMINAL BACKGROUND CHECKS.**

Subdivision 1. **Applications.** (a) By January 1, 2018, each health-related licensing board, as defined in section 214.01, subdivision 2, shall require applicants for initial licensure, licensure by endorsement, or reinstatement or other relicensure after a lapse in licensure, as defined by the individual health-related licensing boards to submit to a criminal history records check of state data completed by the Bureau of Criminal Apprehension (BCA) and a national criminal history records check, including a search of the records of the Federal Bureau of Investigation (FBI).

(b) An applicant must complete a criminal background check if more than one year has elapsed since the applicant last submitted a background check to the board.

Subd. 2. **Investigations.** If a health-related licensing board has reasonable cause to believe a licensee has been charged with or convicted of a crime in this or any other jurisdiction, the health-related licensing board may require the licensee to submit to a criminal history records check of state data completed by the BCA and a national criminal history records check, including a search of the records of the FBI.

Subd. 3. **Consent form; fees; fingerprints.** In order to effectuate the federal and state level, fingerprint-based criminal background check, the applicant or licensee must submit a completed criminal history records check consent form and a full set of

fingerprints to the respective health-related licensing board or a designee in the manner and form specified by the board. The applicant or licensee is responsible for all fees associated with preparation of the fingerprints, the criminal records check consent form, and the criminal background check. The fees for the criminal records background check shall be set by the BCA and the FBI and are not refundable.

Subd. 4. **Refusal to consent.** (a) The health-related licensing boards shall not issue a license to any applicant who refuses to consent to a criminal background check or fails to submit fingerprints within 90 days after submission of an application for licensure. Any fees paid by the applicant to the board shall be forfeited if the applicant refuses to consent to the criminal background check or fails to submit the required fingerprints.

(b) The failure of a licensee to submit to a criminal background check as provided in subdivision 3 is grounds for disciplinary action by the respective health licensing board.

Subd. 5. **Submission of fingerprints to BCA.** The health-related licensing board or designee shall submit applicant or licensee fingerprints to the BCA. The BCA shall perform a check for state criminal justice information and shall forward the applicant's or licensee's fingerprints to the FBI to perform a check for national criminal justice information regarding the applicant or licensee. The BCA shall report to the board the results of the state and national criminal justice information checks.

Subd. 6. **Alternatives to fingerprint-based criminal background checks.** The health-related licensing board may require an alternative method of criminal history checks for an applicant or licensee who has submitted at least three sets of fingerprints in accordance with this section that have been unreadable by the BCA or FBI.

Subd. 7. **Opportunity to challenge accuracy of report.** Prior to taking disciplinary action against an applicant or a licensee based on a criminal conviction, the health-related licensing board shall provide the applicant or licensee an opportunity to complete or challenge the accuracy of the criminal history information reported to the board. The applicant or licensee shall have 30 calendar days following notice from the board of the intent to deny licensure or take disciplinary action to request an opportunity to correct or complete the record prior to the board taking disciplinary action based on the information reported to the board. The board shall provide the applicant up to 180 days to challenge the accuracy or completeness of the report with the agency responsible for the record. This subdivision does not affect the right of the subject of the data to contest the accuracy or completeness under section 13.04, subdivision 4.

Subd. 8. **Instructions to the board; plans.** The health-related licensing boards, in collaboration with the commissioner of human services and the BCA, shall establish a plan for completing criminal background checks of all licensees who were licensed before

the effective date requirement under subdivision 1. The plan must seek to minimize duplication of requirements for background checks of licensed health professionals. The plan for background checks of current licensees shall be developed no later than January 1, 2017, and may be contingent upon the implementation of a system by the BCA or FBI in which any new crimes that an applicant or licensee commits after an initial background check are flagged in the BCA's or FBI's database and reported back to the board. The plan shall include recommendations for any necessary statutory changes.

Sec. 3. Minnesota Statutes 2012, section 214.40, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Administrative services unit" means the administrative services unit for the health-related licensing boards.

(c) "Charitable organization" means a charitable organization within the meaning of section 501(c)(3) of the Internal Revenue Code that has as a purpose the sponsorship or support of programs designed to improve the quality, awareness, and availability of health care services and that serves as a funding mechanism for providing those services.

(d) "Health care facility or organization" means a health care facility licensed under chapter 144 or 144A, or a charitable organization.

(e) "Health care provider" means a physician licensed under chapter 147, physician assistant registered and practicing under chapter 147A, nurse licensed and registered to practice under chapter 148, or dentist ~~or~~, dental hygienist, dental therapist, or advanced dental therapist licensed under chapter 150A.

(f) "Health care services" means health promotion, health monitoring, health education, diagnosis, treatment, minor surgical procedures, the administration of local anesthesia for the stitching of wounds, and primary dental services, including preventive, diagnostic, restorative, and emergency treatment. Health care services do not include the administration of general anesthesia or surgical procedures other than minor surgical procedures.

(g) "Medical professional liability insurance" means medical malpractice insurance as defined in section 62F.03.

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

Sec. 4. Minnesota Statutes 2012, section 245A.1435, is amended to read:

245A.1435 REDUCTION OF RISK OF SUDDEN INFANT DEATH SYNDROME IN LICENSED PROGRAMS.

(a) When a license holder is placing an infant to sleep, the license holder must place the infant on the infant's back, unless the license holder has documentation from the infant's ~~parent~~ doctor directing an alternative sleeping position for the infant. The ~~parent~~ doctor directive must be on a form approved by the commissioner and must ~~include a statement that the parent or legal guardian has read the information provided by the Minnesota Sudden Infant Death Center, related to the risk of SIDS and the importance of placing an infant or child on its back to sleep to reduce the risk of SIDS~~ remain on file at the licensed location. An infant who independently rolls over onto its stomach after being placed to sleep on its back may be allowed to remain on its stomach.

(b) The license holder must place the infant in a crib directly on a firm mattress with a fitted crib sheet that fits tightly on the mattress and overlaps the underside of the mattress so it cannot be dislodged by pulling on the corner of the sheet with reasonable effort. The license holder must not place pillows, quilts, comforters, sheepskin, pillow-like stuffed toys, or other soft products in the crib with the infant. The requirements of this section apply to license holders serving infants ~~up to and including 12 months of age~~ younger than the age of one year. Licensed child care providers must meet the crib requirements under section 245A.146.

Sec. 5. Minnesota Statutes 2012, section 246.54, is amended to read:

246.54 LIABILITY OF COUNTY; REIMBURSEMENT.

Subdivision 1. **County portion for cost of care.** (a) Except for chemical dependency services provided under sections 254B.01 to 254B.09, the client's county shall pay to the state of Minnesota a portion of the cost of care provided in a regional treatment center or a state nursing facility to a client legally settled in that county. A county's payment shall be made from the county's own sources of revenue and payments shall equal a percentage of the cost of care, as determined by the commissioner, for each day, or the portion thereof, that the client spends at a regional treatment center or a state nursing facility according to the following schedule:

(1) zero percent for the first 30 days;

(2) 20 percent for days 31 to 60; and

(3) ~~50~~ 75 percent for any days over 60.

(b) The increase in the county portion for cost of care under paragraph (a), clause (3), shall be imposed when the treatment facility has determined that it is clinically appropriate for the client to be discharged.

(c) If payments received by the state under sections 246.50 to 246.53 exceed 80 percent of the cost of care for days 31 to 60, or ~~50~~ 25 percent for days over 60, the county shall be responsible for paying the state only the remaining amount. The county shall not be entitled to reimbursement from the client, the client's estate, or from the client's relatives, except as provided in section 246.53.

Subd. 2. **Exceptions.** (a) Subdivision 1 does not apply to services provided at the Minnesota Security Hospital ~~or the Minnesota extended treatment options program~~. For services at ~~these facilities~~ the Minnesota Security Hospital, a county's payment shall be made from the county's own sources of revenue and payments ~~shall be paid as follows:~~. Excluding the state-operated forensic transition service, payments to the state from the county shall equal ten percent of the cost of care, as determined by the commissioner, for each day, or the portion thereof, that the client spends at the facility. For the state-operated forensic transition service, payments to the state from the county shall equal 50 percent of the cost of care, as determined by the commissioner, for each day, or the portion thereof, that the client spends in the program. If payments received by the state under sections 246.50 to 246.53 for services provided at the Minnesota Security Hospital, excluding the state-operated forensic transition service, exceed 90 percent of the cost of care, the county shall be responsible for paying the state only the remaining amount. If payments received by the state under sections 246.50 to 246.53 for the state-operated forensic transition service exceed 50 percent of the cost of care, the county shall be responsible for paying the state only the remaining amount. The county shall not be entitled to reimbursement from the client, the client's estate, or from the client's relatives, except as provided in section 246.53.

(b) Regardless of the facility to which the client is committed, subdivision 1 does not apply to the following individuals:

~~(1) clients who are committed as mentally ill and dangerous under section 253B.02, subdivision 17;~~

~~(2)~~ (1) clients who are committed as sexual psychopathic personalities under section 253B.02, subdivision 18b; and

~~(3)~~ (2) clients who are committed as sexually dangerous persons under section 253B.02, subdivision 18c.

~~For each of the individuals in clauses (1) to (3), the payment by the county to the state shall equal ten percent of the cost of care for each day as determined by the commissioner.~~

Sec. 6. **[256.999] CULTURAL AND ETHNIC COMMUNITIES LEADERSHIP COUNCIL.**

Subdivision 1. **Establishment; purpose.** There is hereby established the Cultural and Ethnic Communities Leadership Council for the Department of Human Services. The purpose of the council is to advise the commissioner of human services on reducing disparities that affect racial and ethnic groups.

Subd. 2. **Members.** (a) The council must consist of no fewer than 15 and no more than 25 members appointed by the commissioner of human services, in consultation with county, tribal, cultural, and ethnic communities; diverse program participants; and parent representatives from these communities. The commissioner shall direct the development of guidelines defining the membership of the council; setting out definitions; and developing duties of the commissioner, the council, and council members regarding racial and ethnic disparities reduction. The guidelines must be developed in consultation with:

(1) the chairs of relevant committees; and

(2) county, tribal, and cultural communities and program participants from these communities.

(b) Members must be appointed to allow for representation of the following groups:

(1) racial and ethnic minority groups;

(2) tribal service providers;

(3) culturally and linguistically specific advocacy groups and service providers;

(4) human services program participants;

(5) public and private institutions;

(6) parents of human services program participants;

(7) members of the faith community;

(8) Department of Human Services employees;

(9) chairs of relevant legislative committees; and

(10) any other group the commissioner deems appropriate to facilitate the goals and duties of the council.

(c) Each member of the council must be appointed to either a one-year or two-year term. The commissioner shall appoint one member as chair.

(d) Notwithstanding section 15.059, members of the council shall receive no compensation for their services.

Subd. 3. **Duties of commissioner.** (a) The commissioner of human services or the commissioner's designee shall:

(1) maintain the council established in this section;

(2) supervise and coordinate policies for persons from racial, ethnic, cultural, linguistic, and tribal communities who experience disparities in access and outcomes;

(3) identify human services rules or statutes affecting persons from racial, ethnic, cultural, linguistic, and tribal communities that may need to be revised;

(4) investigate and implement cost-effective models of service delivery such as careful adaptation of clinically proven services that constitute one strategy for increasing the number of culturally relevant services available to currently underserved populations;

(5) based on recommendations of the council, review identified department policies that maintain racial, ethnic, cultural, linguistic, and tribal disparities, and make adjustments to ensure those disparities are not perpetuated; and

(6) based on recommendations of the council, submit legislation to reduce disparities affecting racial and ethnic groups, increase access to programs, and promote better outcomes.

(b) The commissioner of human services or the commissioner's designee shall consult with the council and receive recommendations from the council when meeting the requirements of this section.

Subd. 4. **Duties of council.** The Cultural and Ethnic Communities Leadership Council shall:

(1) recommend to the commissioner for review identified policies in the Department of Human Services that maintain racial, ethnic, cultural, linguistic, and tribal disparities;

(2) identify issues regarding disparities by engaging diverse populations in human services programs;

(3) engage in mutual learning essential for achieving human services parity and optimal wellness for service recipients;

(4) raise awareness about human services disparities to the legislature and media;

(5) provide technical assistance and consultation support to counties, private nonprofit agencies, and other service providers to build their capacity to provide equitable human services for persons from racial, ethnic, cultural, linguistic, and tribal communities who experience disparities in access and outcomes;

(6) provide technical assistance to promote statewide development of culturally and linguistically appropriate, accessible, and cost-effective human services and related policies;

(7) provide training and outreach to facilitate access to culturally and linguistically appropriate, accessible, and cost-effective human services to prevent disparities;

(8) facilitate culturally appropriate and culturally sensitive admissions, continued services, discharges, and utilization review for human services agencies and institutions;

(9) form work groups to help carry out the duties of the council that include, but are not limited to, persons who provide and receive services and representatives of advocacy groups, and provide the work groups with clear guidelines, standardized parameters, and tasks for the work groups to accomplish; and

(10) promote information-sharing in the human services community and statewide.

Subd. 5. **Duties of council members.** The members of the council shall:

(1) attend and participate in scheduled meetings and be prepared by reviewing meeting notes;

(2) maintain open communication channels with respective constituencies;

(3) identify and communicate issues and risks that could impact the timely completion of tasks;

(4) collaborate on disparity reduction efforts;

(5) communicate updates of the council's work progress and status on the Department of Human Services Web site; and

(6) participate in any activities the council or chair deem appropriate and necessary to facilitate the goals and duties of the council.

Subd. 6. **Expiration.** Notwithstanding section 15.059, the council does not expire unless directed by the commissioner.

Sec. 7. Minnesota Statutes 2012, section 256I.04, subdivision 3, is amended to read:

Subd. 3. **Moratorium on development of group residential housing beds.** (a) County agencies shall not enter into agreements for new group residential housing beds with total rates in excess of the MSA equivalent rate except:

(1) for group residential housing establishments licensed under Minnesota Rules, parts 9525.0215 to 9525.0355, provided the facility is needed to meet the census reduction targets for persons with developmental disabilities at regional treatment centers;

(2) to ensure compliance with the federal Omnibus Budget Reconciliation Act alternative disposition plan requirements for inappropriately placed persons with developmental disabilities or mental illness;

(3) up to 80 beds in a single, specialized facility located in Hennepin County that will provide housing for chronic inebriates who are repetitive users of detoxification centers and are refused placement in emergency shelters because of their state of intoxication, and planning for the specialized facility must have been initiated before July 1, 1991, in anticipation of receiving a grant from the Housing Finance Agency under section 462A.05, subdivision 20a, paragraph (b);

(4) notwithstanding the provisions of subdivision 2a, for up to 190 supportive housing units in Anoka, Dakota, Hennepin, or Ramsey County for homeless adults with a mental illness, a history of substance abuse, or human immunodeficiency virus or acquired immunodeficiency syndrome. For purposes of this section, "homeless adult" means a person who is living on the street or in a shelter or discharged from a regional treatment center, community hospital, or residential treatment program and has no appropriate housing available and lacks the resources and support necessary to access appropriate housing. At least 70 percent of the supportive housing units must serve homeless adults with mental illness, substance abuse problems, or human immunodeficiency virus or acquired immunodeficiency syndrome who are about to be or, within the previous six months, has been discharged from a regional treatment center, or a state-contracted psychiatric bed in a community hospital, or a residential mental health or chemical dependency treatment program. If a person meets the requirements of subdivision 1, paragraph (a), and receives a federal or state housing subsidy, the group residential housing rate for that person is limited to the supplementary rate under section 256I.05, subdivision 1a, and is determined by subtracting the amount of the person's countable income that exceeds the MSA equivalent rate from the group residential housing supplementary rate. A resident in a demonstration project site who no longer participates in the demonstration program shall retain eligibility for a group residential housing payment in an amount determined under section 256I.06, subdivision 8, using the MSA equivalent rate. Service funding under section 256I.05, subdivision 1a, will end June 30, 1997, if federal matching funds are available and the services can be provided through a managed care entity. If federal matching funds are not available, then service funding will continue under section 256I.05, subdivision 1a;

(5) for group residential housing beds in settings meeting the requirements of subdivision 2a, clauses (1) and (3), which are used exclusively for recipients receiving home and community-based waiver services under sections 256B.0915, 256B.092, subdivision 5, 256B.093, and 256B.49, and who resided in a nursing facility for the six months immediately prior to the month of entry into the group residential housing setting. The group residential housing rate for these beds must be set so that the monthly group residential housing payment for an individual occupying the bed when combined with the nonfederal share of services delivered under the waiver for that person does not exceed the nonfederal share of the monthly medical assistance payment made for the person to the nursing facility in which the person resided prior to entry into the group residential housing establishment. The rate may not exceed the MSA equivalent rate plus $426.37 for any case;

(6) for an additional two beds, resulting in a total of 32 beds, for a facility located in Hennepin County providing services for recovering and chemically dependent men that has had a group residential housing contract with the county and has been licensed as a board and lodge facility with special services since 1980;

(7) for a group residential housing provider located in the city of St. Cloud, or a county contiguous to the city of St. Cloud, that operates a 40-bed facility, that received financing through the Minnesota Housing Finance Agency Ending Long-Term Homelessness Initiative and serves chemically dependent clientele, providing 24-hour-a-day supervision;

(8) for a new 65-bed facility in Crow Wing County that will serve chemically dependent persons, operated by a group residential housing provider that currently operates a 304-bed facility in Minneapolis, and a 44-bed facility in Duluth;

(9) for a group residential housing provider that operates two ten-bed facilities, one located in Hennepin County and one located in Ramsey County, that provide community support and 24-hour-a-day supervision to serve the mental health needs of individuals who have chronically lived unsheltered; and

(10) for a group residential facility in Hennepin County with a capacity of up to 48 beds that has been licensed since 1978 as a board and lodging facility and that until August 1, 2007, operated as a licensed chemical dependency treatment program.

(b) A county agency may enter into a group residential housing agreement for beds with rates in excess of the MSA equivalent rate in addition to those currently covered under a group residential housing agreement if the additional beds are only a replacement of beds with rates in excess of the MSA equivalent rate which have been made available due to closure of a setting, a change of licensure or certification which removes the beds from group residential housing payment, or as a result of the downsizing of a group residential housing setting. The transfer of available beds from one county to another can only occur by the agreement of both counties.

(c) Effective July 1, 2013, 35 beds with rates in excess of the MSA-equivalent rate must be designated for youth victims of sex trafficking.

Sec. 8. Minnesota Statutes 2012, section 256I.05, subdivision 1e, is amended to read:

Subd. 1e. **Supplementary rate for certain facilities.** ~~(a)~~ Notwithstanding the provisions of subdivisions 1a and 1c, beginning July 1, 2005, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed $700 per month, including any legislatively authorized inflationary adjustments, for a group residential housing provider that:

(1) is located in Hennepin County and has had a group residential housing contract with the county since June 1996;

(2) operates in three separate locations a 75-bed facility, a 50-bed facility, and a 26-bed facility; and

(3) serves a chemically dependent clientele, providing 24 hours per day supervision and limiting a resident's maximum length of stay to 13 months out of a consecutive 24-month period.

~~(b) Notwithstanding subdivisions 1a and 1c, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed $700 per month, including any legislatively authorized inflationary adjustments, of a group residential provider that:~~

~~(1) is located in St. Louis County and has had a group residential housing contract with the county since 2006;~~

~~(2) operates a 62-bed facility; and~~

~~(3) serves a chemically dependent adult male clientele, providing 24 hours per day supervision and limiting a resident's maximum length of stay to 13 months out of a consecutive 24-month period.~~

~~(c) Notwithstanding subdivisions 1a and 1c, beginning July 1, 2013, a county agency shall negotiate a supplementary rate in addition to the rate specified in subdivision 1, not to exceed $700 per month, including any legislatively authorized inflationary adjustments, for the group residential provider described under paragraphs (a) and (b), not to exceed an additional 115 beds.~~

Sec. 9. Minnesota Statutes 2012, section 256J.35, is amended to read:

256J.35 AMOUNT OF ASSISTANCE PAYMENT.

Except as provided in paragraphs (a) to ~~(c)~~ (d), the amount of an assistance payment is equal to the difference between the MFIP standard of need or the Minnesota family wage level in section 256J.24 and countable income.

(a) When MFIP eligibility exists for the month of application, the amount of the assistance payment for the month of application must be prorated from the date of application or the date all other eligibility factors are met for that applicant, whichever is later. This provision applies when an applicant loses at least one day of MFIP eligibility.

(b) MFIP overpayments to an assistance unit must be recouped according to section 256J.38, subdivision 4.

(c) An initial assistance payment must not be made to an applicant who is not eligible on the date payment is made.

(d) MFIP assistance units whose housing costs exceed 50 percent of their monthly cash grant are eligible for an additional cash amount in the form of a housing assistance grant. The housing assistance grant must be equal to 50 percent of the difference between the assistance unit's cash grant and its housing costs, with a maximum housing assistance grant of $250 per month. MFIP assistance units must report their housing costs to the lead agency on the forms and according to the timelines established by the commissioner.

EFFECTIVE DATE. This section is effective December 1, 2013.

Sec. 10. Minnesota Statutes 2012, section 256K.45, is amended to read:

256K.45 ~~RUNAWAY AND~~ HOMELESS YOUTH ACT.

Subdivision 1. **Mission.** The mission of the Homeless Youth Act is to reduce the incidence of homelessness among youth by providing integrated and supportive services and housing to homeless youth, youth at risk of homelessness, and runaways. The commissioner shall establish a Homeless Youth Act fund and award grants to providers who are committed to serving homeless youth, to provide street and community outreach and drop-in programs, emergency shelter programs, and supportive housing and transitional living programs, consistent with the program descriptions in this act.

Subd. 1a. **Definitions.** (a) The definitions in this subdivision apply to this section.

(b) "Commissioner" means the commissioner of human services.

(c) "Homeless youth" means a person 21 years of age or younger who is unaccompanied by a parent or guardian and is without shelter where appropriate care and supervision are available, whose parent or legal guardian is unable or unwilling to provide shelter and care, or who lacks a fixed, regular, and adequate nighttime residence. The following are not fixed, regular, or adequate nighttime residences:

(1) a supervised publicly or privately operated shelter designed to provide temporary living accommodations;

(2) an institution or a publicly or privately operated shelter designed to provide temporary living accommodations;

(3) transitional housing;

(4) a temporary placement with a peer, friend, or family member that has not offered permanent residence, a residential lease, or temporary lodging for more than 30 days; or

(5) a public or private place not designed for, nor ordinarily used as, a regular sleeping accommodation for human beings.

Homeless youth does not include persons incarcerated or otherwise detained under federal or state law.

(d) "Youth at risk of homelessness" means a person 21 years of age or younger whose status or circumstances indicate a significant danger of experiencing homelessness in the near future. Status or circumstances that indicate a significant danger may include: (1) youth exiting out-of-home placements; (2) youth who previously were homeless; (3) youth whose parents or primary caregivers are or were previously homeless; (4) youth who are exposed to abuse and neglect in their homes; (5) youth who experience conflict with parents due to chemical or alcohol dependency, mental health disabilities, or other disabilities; and (6) runaways.

(e) "Runaway" means an unmarried child under the age of 18 years who is absent from the home of a parent or guardian or other lawful placement without the consent of the parent, guardian, or lawful custodian.

Subd. 2. **Homeless and runaway youth report.** The commissioner shall develop a report for homeless youth, youth at risk of homelessness, and runaways. The report shall include coordination of services as defined under subdivisions 3 to 5.

Subd. 3. **Street and community outreach and drop-in program.** Youth drop-in centers must provide walk-in access to crisis intervention and ongoing supportive services including one-to-one case management services on a self-referral basis. Street and community outreach programs must locate, contact, and provide information, referrals, and services to homeless youth, youth at risk of homelessness, and runaways. Information, referrals, and services provided may include, but are not limited to:

(1) family reunification services;

(2) conflict resolution or mediation counseling;

(3) assistance in obtaining temporary emergency shelter;

(4) assistance in obtaining food, clothing, medical care, or mental health counseling;

(5) counseling regarding violence, prostitution, substance abuse, sexually transmitted diseases, and pregnancy;

(6) referrals to other agencies that provide support services to homeless youth, youth at risk of homelessness, and runaways;

(7) assistance with education, employment, and independent living skills;

(8) aftercare services;

(9) specialized services for highly vulnerable runaways and homeless youth, including teen parents, emotionally disturbed and mentally ill youth, and sexually exploited youth; and

(10) homelessness prevention.

Subd. 4. **Emergency shelter program.** (a) Emergency shelter programs must provide homeless youth and runaways with referral and walk-in access to emergency,

short-term residential care. The program shall provide homeless youth and runaways with safe, dignified shelter, including private shower facilities, beds, and at least one meal each day; and shall assist a runaway and homeless youth with reunification with the family or legal guardian when required or appropriate.

(b) The services provided at emergency shelters may include, but are not limited to:

(1) family reunification services;

(2) individual, family, and group counseling;

(3) assistance obtaining clothing;

(4) access to medical and dental care and mental health counseling;

(5) education and employment services;

(6) recreational activities;

(7) advocacy and referral services;

(8) independent living skills training;

(9) aftercare and follow-up services;

(10) transportation; and

(11) homelessness prevention.

Subd. 5. **Supportive housing and transitional living programs.** Transitional living programs must help homeless youth and youth at risk of homelessness to find and maintain safe, dignified housing. The program may also provide rental assistance and related supportive services, or refer youth to other organizations or agencies that provide such services. Services provided may include, but are not limited to:

(1) educational assessment and referrals to educational programs;

(2) career planning, employment, work skill training, and independent living skills training;

(3) job placement;

(4) budgeting and money management;

(5) assistance in securing housing appropriate to needs and income;

(6) counseling regarding violence, prostitution, substance abuse, sexually transmitted diseases, and pregnancy;

(7) referral for medical services or chemical dependency treatment;

(8) parenting skills;

(9) self-sufficiency support services or life skill training;

(10) aftercare and follow-up services; and

(11) homelessness prevention.

Subd. 6. **Funding.** ~~Any~~ Funds appropriated for this section may be expended on programs described under subdivisions 3 to 5, technical assistance, and capacity building.

~~Up to four percent of funds appropriated may be used for the purpose of monitoring and evaluating runaway and homeless youth programs receiving funding under this section. Funding shall be directed to meet the greatest need, with a significant share of the funding focused on homeless youth providers in greater Minnesota~~ to meet the greatest need on a statewide basis.

Sec. 11. Minnesota Statutes 2012, section 257.0755, subdivision 1, is amended to read:

Subdivision 1. **Creation.** ~~One~~ Each ombudsperson shall operate independently from but in collaboration with ~~each of the following groups~~ the community-specific board that appointed the ombudsperson under section 257.0768: the Indian Affairs Council, the Council on Affairs of Chicano/Latino people, the Council on Black Minnesotans, and the Council on Asian-Pacific Minnesotans.

Sec. 12. Minnesota Statutes 2012, section 260B.007, subdivision 6, is amended to read:

Subd. 6. **Delinquent child.** (a) Except as otherwise provided in paragraphs (b) and (c), "delinquent child" means a child:

(1) who has violated any state or local law, except as provided in section 260B.225, subdivision 1, and except for juvenile offenders as described in subdivisions 16 to 18;

(2) who has violated a federal law or a law of another state and whose case has been referred to the juvenile court if the violation would be an act of delinquency if committed in this state or a crime or offense if committed by an adult;

(3) who has escaped from confinement to a state juvenile correctional facility after being committed to the custody of the commissioner of corrections; or

(4) who has escaped from confinement to a local juvenile correctional facility after being committed to the facility by the court.

(b) The term delinquent child does not include a child alleged to have committed murder in the first degree after becoming 16 years of age, but the term delinquent child does include a child alleged to have committed attempted murder in the first degree.

(c) The term delinquent child does not include a child ~~under the age of 16 years~~ alleged to have engaged in conduct which would, if committed by an adult, violate any federal, state, or local law relating to being hired, offering to be hired, or agreeing to be hired by another individual to engage in sexual penetration or sexual conduct.

EFFECTIVE DATE. This section is effective August 1, 2014, and applies to offenses committed on or after that date.

Sec. 13. Minnesota Statutes 2012, section 260B.007, subdivision 16, is amended to read:

Subd. 16. **Juvenile petty offender; juvenile petty offense.** (a) "Juvenile petty offense" includes a juvenile alcohol offense, a juvenile controlled substance offense, a violation of section 609.685, or a violation of a local ordinance, which by its terms prohibits conduct by a child under the age of 18 years which would be lawful conduct if committed by an adult.

(b) Except as otherwise provided in paragraph (c), "juvenile petty offense" also includes an offense that would be a misdemeanor if committed by an adult.

(c) "Juvenile petty offense" does not include any of the following:

(1) a misdemeanor-level violation of section 518B.01, 588.20, 609.224, 609.2242, 609.324, subdivision 2 or 3, 609.5632, 609.576, 609.66, 609.746, 609.748, 609.79, or 617.23;

(2) a major traffic offense or an adult court traffic offense, as described in section 260B.225;

(3) a misdemeanor-level offense committed by a child whom the juvenile court previously has found to have committed a misdemeanor, gross misdemeanor, or felony offense; or

(4) a misdemeanor-level offense committed by a child whom the juvenile court has found to have committed a misdemeanor-level juvenile petty offense on two or more prior occasions, unless the county attorney designates the child on the petition as a juvenile petty offender notwithstanding this prior record. As used in this clause, "misdemeanor-level juvenile petty offense" includes a misdemeanor-level offense that would have been a juvenile petty offense if it had been committed on or after July 1, 1995.

(d) A child who commits a juvenile petty offense is a "juvenile petty offender." The term juvenile petty offender does not include a child ~~under the age of 16 years~~ alleged to have violated any law relating to being hired, offering to be hired, or agreeing to be hired by another individual to engage in sexual penetration or sexual conduct which, if committed by an adult, would be a misdemeanor.

EFFECTIVE DATE. This section is effective August 1, 2014, and applies to offenses committed on or after that date.

Sec. 14. Minnesota Statutes 2012, section 260C.007, subdivision 6, is amended to read:

Subd. 6. **Child in need of protection or services.** "Child in need of protection or services" means a child who is in need of protection or services because the child:

(1) is abandoned or without parent, guardian, or custodian;

(2)(i) has been a victim of physical or sexual abuse as defined in section 626.556, subdivision 2, (ii) resides with or has resided with a victim of child abuse as defined in

subdivision 5 or domestic child abuse as defined in subdivision 13, (iii) resides with or would reside with a perpetrator of domestic child abuse as defined in subdivision 13 or child abuse as defined in subdivision 5 or 13, or (iv) is a victim of emotional maltreatment as defined in subdivision 15;

(3) is without necessary food, clothing, shelter, education, or other required care for the child's physical or mental health or morals because the child's parent, guardian, or custodian is unable or unwilling to provide that care;

(4) is without the special care made necessary by a physical, mental, or emotional condition because the child's parent, guardian, or custodian is unable or unwilling to provide that care;

(5) is medically neglected, which includes, but is not limited to, the withholding of medically indicated treatment from a disabled infant with a life-threatening condition. The term "withholding of medically indicated treatment" means the failure to respond to the infant's life-threatening conditions by providing treatment, including appropriate nutrition, hydration, and medication which, in the treating physician's or physicians' reasonable medical judgment, will be most likely to be effective in ameliorating or correcting all conditions, except that the term does not include the failure to provide treatment other than appropriate nutrition, hydration, or medication to an infant when, in the treating physician's or physicians' reasonable medical judgment:

(i) the infant is chronically and irreversibly comatose;

(ii) the provision of the treatment would merely prolong dying, not be effective in ameliorating or correcting all of the infant's life-threatening conditions, or otherwise be futile in terms of the survival of the infant; or

(iii) the provision of the treatment would be virtually futile in terms of the survival of the infant and the treatment itself under the circumstances would be inhumane;

(6) is one whose parent, guardian, or other custodian for good cause desires to be relieved of the child's care and custody, including a child who entered foster care under a voluntary placement agreement between the parent and the responsible social services agency under section 260C.227;

(7) has been placed for adoption or care in violation of law;

(8) is without proper parental care because of the emotional, mental, or physical disability, or state of immaturity of the child's parent, guardian, or other custodian;

(9) is one whose behavior, condition, or environment is such as to be injurious or dangerous to the child or others. An injurious or dangerous environment may include, but is not limited to, the exposure of a child to criminal activity in the child's home;

(10) is experiencing growth delays, which may be referred to as failure to thrive, that have been diagnosed by a physician and are due to parental neglect;

(11) ~~has engaged in prostitution as defined in section 609.321, subdivision 9~~ is a sexually exploited youth;

(12) has committed a delinquent act or a juvenile petty offense before becoming ten years old;

(13) is a runaway;

(14) is a habitual truant;

(15) has been found incompetent to proceed or has been found not guilty by reason of mental illness or mental deficiency in connection with a delinquency proceeding, a certification under section 260B.125, an extended jurisdiction juvenile prosecution, or a proceeding involving a juvenile petty offense; or

(16) has a parent whose parental rights to one or more other children were involuntarily terminated or whose custodial rights to another child have been involuntarily transferred to a relative and there is a case plan prepared by the responsible social services agency documenting a compelling reason why filing the termination of parental rights petition under section 260C.301, subdivision 3, is not in the best interests of the child~~; or~~.

~~(17) is a sexually exploited youth.~~

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

Sec. 15. Minnesota Statutes 2012, section 260C.007, subdivision 31, is amended to read:

Subd. 31. **Sexually exploited youth.** "Sexually exploited youth" means an individual who:

(1) is alleged to have engaged in conduct which would, if committed by an adult, violate any federal, state, or local law relating to being hired, offering to be hired, or agreeing to be hired by another individual to engage in sexual penetration or sexual conduct;

(2) is a victim of a crime described in section 609.342, 609.343, 609.344, 609.345, 609.3451, 609.3453, 609.352, 617.246, or 617.247;

(3) is a victim of a crime described in United States Code, title 18, section 2260; 2421; 2422; 2423; 2425; 2425A; or 2256; or

(4) is a sex trafficking victim as defined in section 609.321, subdivision 7b.

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

Sec. 16. Laws 1998, chapter 407, article 6, section 116, is amended to read:

Sec. 116. **EBT TRANSACTION COSTS~~; APPROVAL FROM LEGISLATURE~~.**

The commissioner of human services shall ~~request and receive approval from the legislature before adjusting the payment to~~ not subsidize retailers for electronic benefit transfer ~~transaction costs~~ Supplemental Nutrition Assistance Program transactions.

EFFECTIVE DATE. This section is effective 30 days after the commissioner notifies retailers of the termination of their agreement with the state. The commissioner of human services must notify the revisor of statutes of that date.

Sec. 17. **INCLUSION OF OTHER HEALTH-RELATED OCCUPATIONS TO CRIMINAL BACKGROUND CHECKS.**

(a) If the Department of Health is not reviewed by the Sunset Advisory Commission according to the schedule in Minnesota Statutes, section 3D.21, the commissioner of health, as the regulator for occupational therapy practitioners, speech-language pathologists, audiologists, and hearing instrument dispensers, shall require applicants for licensure or renewal to submit to a criminal history records check as required under Minnesota Statutes, section 214.075, for other health-related licensed occupations regulated by the health-related licensing boards.

(b) Any statutory changes necessary to include the commissioner of health to Minnesota Statutes, section 214.075, shall be included in the plan required in Minnesota Statutes, section 214.075, subdivision 8.

Sec. 18. **DIRECTION TO COMMISSIONERS; INCOME AND ASSET EXCLUSION.**

(a) The commissioner of human services shall not count conditional cash transfers made to families participating in a family independence demonstration as income or assets for purposes of determining or redetermining eligibility for child care assistance programs under Minnesota Statutes, chapter 119B; general assistance under Minnesota Statutes, chapter 256D; group residential housing under Minnesota Statutes, chapter 256I; the Minnesota family investment program, work benefit program, or diversionary work program under Minnesota Statutes, chapter 256J; or the MinnesotaCare program under Minnesota Statutes, chapter 256L, during the duration of the demonstration.

(b) The commissioner of human services shall not count conditional cash transfers made to families participating in a family independence demonstration as income or assets for purposes of determining or redetermining eligibility for medical assistance, except that for enrollees subject to a modified adjusted gross income calculation to determine eligibility, the conditional cash transfer payments shall be counted as income if they are

included on the enrollee's federal tax return as income or if the payments can be taken into account in the month of receipt as a lump sum payment.

(c) The commissioner of the Minnesota Housing Finance Agency shall not count conditional cash transfers made to families participating in a family independence demonstration as income or assets for purposes of determining or redetermining eligibility for housing assistance programs under Minnesota Statutes, section 462A.201, during the duration of the demonstration. For purposes of this section:

(1) "conditional cash transfer" means a payment made to a participant in a family independence demonstration by a sponsoring organization to incent, support, or facilitate participation; and

(2) "family independence demonstration" means an initiative sponsored or cosponsored by a governmental or nongovernmental organization, the goal of which is to facilitate individualized goal setting and peer support for cohorts of no more than 12 families each toward the development of financial and nonfinancial assets that enable the participating families to achieve financial independence.

Sec. 19. **REPEALER.**

(a) Minnesota Statutes 2012, sections 256J.24, subdivision 6; and 256K.45, subdivision 2, are repealed.

(b) Minnesota Statutes 2012, section 609.093, is repealed.

EFFECTIVE DATE. Paragraph (b) is effective the day following final enactment.

ARTICLE 11

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.43 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.43 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.43 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.43 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. Minnesota Statutes 2012, section 144A.43, is amended to read:

144A.43 DEFINITIONS.

Subdivision 1. **Applicability.** The definitions in this section apply to sections 144.699, subdivision 2, and 144A.43 to ~~144A.47~~ 144A.482.

Subd. 1a. **Agent.** "Agent" means the person upon whom all notices and orders shall be served and who is authorized to accept service of notices and orders on behalf of the home care provider.

Subd. 1b. **Applicant.** "Applicant" means an individual, organization, association, corporation, unit of government, or other entity that applies for a temporary license, license, or renewal of their home care provider license under section 144A.472.

Subd. 1c. **Client.** "Client" means a person to whom home care services are provided.

Subd. 1d. **Client record.** "Client record" means all records that document information about the home care services provided to the client by the home care provider.

Subd. 1e. **Client representative.** "Client representative" means a person who, because of the client's needs, makes decisions about the client's care on behalf of the client. A client representative may be a guardian, health care agent, family member, or other agent of the client. Nothing in this section expands or diminishes the rights of persons to act on behalf of clients under other law.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 2a. **Controlled substance.** "Controlled substance" has the meaning given in section 152.01, subdivision 4.

Subd. 2b. **Department.** "Department" means the Minnesota Department of Health.

Subd. 2c. **Dietary supplement.** "Dietary supplement" means a product taken by mouth that contains a "dietary ingredient" intended to supplement the diet. Dietary ingredients may include vitamins, minerals, herbs or other botanicals, amino acids, and substances such as enzymes, organ tissue, glandulars, or metabolites.

Subd. 2d. **Dietitian.** "Dietitian" is a person licensed under sections 148.621 to 148.633.

Subd. 2e. **Dietetics or nutrition practice.** "Dietetics or nutrition practice" is performed by a licensed dietician or licensed nutritionist and includes the activities of assessment, setting priorities and objectives, providing nutrition counseling, developing and implementing nutrition care services, and evaluating and maintaining appropriate standards of quality of nutrition care under sections 148.621 to 148.633.

Subd. 3. **Home care service.** "Home care service" means any of the following services ~~when~~ delivered in ~~a place of residence to~~ the home of a person whose illness, disability, or physical condition creates a need for the service:

~~(1) nursing services, including the services of a home health aide;~~

~~(2) personal care services not included under sections 148.171 to 148.285;~~

~~(3) physical therapy;~~

~~(4) speech therapy;~~

~~(5) respiratory therapy;~~

~~(6) occupational therapy;~~

~~(7) nutritional services;~~

~~(8) home management services when provided to a person who is unable to perform these activities due to illness, disability, or physical condition. Home management services include at least two of the following services: housekeeping, meal preparation, and shopping;~~

~~(9) medical social services;~~

~~(10) the provision of medical supplies and equipment when accompanied by the provision of a home care service; and~~

~~(11) other similar medical services and health-related support services identified by the commissioner in rule.~~

~~"Home care service" does not include the following activities conducted by the commissioner of health or a board of health as defined in section 145A.02, subdivision 2: communicable disease investigations or testing; 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.~~

(1) assistive tasks provided by unlicensed personnel;

(2) services provided by a registered nurse or licensed practical nurse, physical therapist, respiratory therapist, occupational therapist, speech-language pathologist, dietitian or nutritionist, or social worker;

(3) medication and treatment management services; or

(4) the provision of durable medical equipment services when provided with any of the home care services listed in clauses (1) to (3).

Subd. 3a. **Hands-on-assistance.** "Hands-on-assistance" means physical help by another person without which the client is not able to perform the activity.

Subd. 3b. **Home.** "Home" means the client's temporary or permanent place of residence.

Subd. 4. **Home care provider.** "Home care provider" means an individual, organization, association, corporation, unit of government, or other entity that is regularly engaged in the delivery of at least one home care service, directly ~~or by contractual arrangement, of home care services~~ in a client's home for a fee and who has a valid current temporary license or license issued under sections 144A.43 to 144A.482. ~~At least one home care service must be provided directly, although additional home care services may be provided by contractual arrangements. "Home care provider" does not include:~~

~~(1) any home care or nursing services conducted by and for the adherents of any recognized church or religious denomination for the purpose of providing care and services for those who depend upon spiritual means, through prayer alone, for healing;~~

~~(2) an individual who only provides services to a relative;~~

~~(3) an individual not connected with a home care provider who provides assistance with home management services or personal care needs if the assistance is provided primarily as a contribution and not as a business;~~

~~(4) an individual not connected with a home care provider who shares housing with and provides primarily housekeeping or homemaking services to an elderly or disabled person in return for free or reduced-cost housing;~~

~~(5) an individual or agency providing home-delivered meal services;~~

~~(6) an agency providing senior companion services and other older American volunteer programs established under the Domestic Volunteer Service Act of 1973, Public Law 98-288;~~

~~(7) 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;~~

~~(8) a member of a professional corporation organized under chapter 319B that does not regularly offer or provide home care services as defined in subdivision 3;~~

~~(9) the following organizations established to provide medical or surgical services that do not regularly offer or provide home care services as defined in 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;~~

~~(10) 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;~~

~~(11) an individual licensed under chapter 147; or~~

~~(12) 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.~~

~~Subd. 5. **Medication reminder.** "Medication reminder" means providing a verbal or visual reminder to a client to take medication. This includes bringing the medication to the client and providing liquids or nutrition to accompany medication that a client is self-administering.~~

Subd. 6. **License.** "License" means a basic or comprehensive home care license issued by the commissioner to a home care provider.

Subd. 7. **Licensed health professional.** "Licensed health professional" means a person, other than a registered nurse or licensed practical nurse, who provides home care services within the scope of practice of the person's health occupation license, registration, or certification as regulated and who is licensed by the appropriate Minnesota state board or agency.

Subd. 8. **Licensee.** "Licensee" means a home care provider that is licensed under this chapter.

Subd. 9. **Managerial official.** "Managerial official" means an administrator, director, officer, trustee, or employee of a home care provider, however designated, who has the authority to establish or control business policy.

Subd. 10. **Medication.** "Medication" means a prescription or over-the-counter drug. For purposes of this chapter only, medication includes dietary supplements.

Subd. 11. **Medication administration.** "Medication administration" means performing a set of tasks to ensure a client takes medications, and includes the following:

(1) checking the client's medication record;

(2) preparing the medication as necessary;

(3) administering the medication to the client;

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

(5) reporting to a nurse any concerns about the medication, the client, or the client's refusal to take the medication.

Subd. 12. **Medication management.** "Medication management" means the provision of any of the following medication-related services to a client:

(1) performing medication setup;

(2) administering medication;

(3) storing and securing medications;

(4) documenting medication activities;

(5) verifying and monitoring effectiveness of systems to ensure safe handling and administration;

(6) coordinating refills;

(7) handling and implementing changes to prescriptions;

(8) communicating with the pharmacy about the client's medications; and

(9) coordinating and communicating with the prescriber.

Subd. 13. **Medication setup.** "Medication setup" means arranging medications by a nurse, pharmacy, or authorized prescriber for later administration by the client or by comprehensive home care staff.

Subd. 14. **Nurse.** "Nurse" means a person who is licensed under sections 148.171 to 148.285.

Subd. 15. **Occupational therapist.** "Occupational therapist" means a person who is licensed under sections 148.6401 to 148.6450.

Subd. 16. **Over-the-counter drug.** "Over-the-counter drug" means a drug that is not required by federal law to bear the symbol "Rx only."

Subd. 17. **Owner.** "Owner" means a proprietor, general partner, limited partner who has five percent or more of equity interest in a limited partnership, a person who owns or controls voting stock in a corporation in an amount equal to or greater than five percent of the shares issued and outstanding, or a corporation that owns equity interest in a licensee or applicant for a license.

Subd. 18. **Pharmacist.** "Pharmacist" has the meaning given in section 151.01, subdivision 3.

Subd. 19. **Physical therapist.** "Physical therapist" means a person who is licensed under sections 148.65 to 148.78.

Subd. 20. **Physician.** "Physician" means a person who is licensed under chapter 147.

Subd. 21. **Prescriber.** "Prescriber" means a person who is authorized by sections 148.235; 151.01, subdivision 23; and 151.37, to prescribe prescription drugs.

Subd. 22. **Prescription.** "Prescription" has the meaning given in section 151.01, subdivision 16.

Subd. 23. **Regularly scheduled.** "Regularly scheduled" means ordered or planned to be completed at predetermined times or according to a predetermined routine.

Subd. 24. **Reminder.** "Reminder" means providing a verbal or visual reminder to a client.

Subd. 25. **Respiratory therapist.** "Respiratory therapist" means a person who is licensed under chapter 147C.

Subd. 26. **Revenues.** "Revenues" means all money received by a licensee derived from the provision of home care services, including fees for services and appropriations of public money for home care services.

Subd. 27. **Service plan.** "Service plan" means the written plan between the client or client's representative and the temporary licensee or licensee about the services that will be provided to the client.

Subd. 28. **Social worker.** "Social worker" means a person who is licensed under chapter 148D or 148E.

Subd. 29. **Speech language pathologist.** "Speech language pathologist" has the meaning given in section 148.512.

Subd. 30. **Standby assistance.** "Standby assistance" means the presence of another person within arm's reach to minimize the risk of injury while performing daily activities through physical intervention or cuing.

Subd. 31. **Substantial compliance.** "Substantial compliance" means complying with the requirements in this chapter sufficiently to prevent unacceptable health or safety risks to the home care client.

Subd. 32. **Survey.** "Survey" means an inspection of a licensee or applicant for licensure for compliance with this chapter.

Subd. 33. **Surveyor.** "Surveyor" means a staff person of the department authorized to conduct surveys of home care providers and applicants.

Subd. 34. **Temporary license.** "Temporary license" means the initial basic or comprehensive home care license the department issues after approval of a complete written application and before the department completes the temporary license survey and determines that the temporary licensee is in substantial compliance.

Subd. 35. **Treatment or therapy.** "Treatment" or "therapy" means the provision of care, other than medications, ordered or prescribed by a licensed health professional provided to a client to cure, rehabilitate, or ease symptoms.

Subd. 36. **Unit of government.** "Unit of government" means every city, county, town, school district, other political subdivisions of the state, and any agency of the state or federal government, which includes any instrumentality of a unit of government.

Subd. 37. **Unlicensed personnel.** "Unlicensed personnel" are individuals not otherwise licensed or certified by a governmental health board or agency who provide home care services in the client's home.

Subd. 38. **Verbal.** "Verbal" means oral and not in writing.

Sec. 6. Minnesota Statutes 2012, section 144A.44, is amended to read:

144A.44 HOME CARE BILL OF RIGHTS.

Subdivision 1. **Statement of rights.** A person who receives home care services has these rights:

(1) the right to receive written information about rights ~~in advance of~~ before receiving ~~care or during the initial evaluation visit before the initiation of treatment~~ services, including what to do if rights are violated;

(2) the right to receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards, to take an active part in ~~creating and changing the plan~~ developing, modifying, and evaluating ~~care~~ the plan and services;

(3) the right to be told ~~in advance of~~ before receiving ~~care about the~~ services ~~that will be provided, the disciplines that will furnish care~~ the type and disciplines of staff who will be providing the services, the frequency of visits proposed to be furnished, other choices that are available for addressing home care needs, and ~~the consequences of these choices including~~ the potential consequences of refusing these services;

(4) the right to be told in advance of any ~~change~~ recommended changes by the provider in the service plan ~~of care~~ and to take an active part in any ~~change~~ decisions about changes to the service plan;

(5) the right to refuse services or treatment;

(6) the right to know, ~~in advance~~ before receiving services or during the initial visit, any limits to the services available from a home care provider~~, and the provider's grounds for a termination of services~~;

~~(7) the right to know in advance of receiving care whether the services are covered by health insurance, medical assistance, or other health programs, the charges for services that will not be covered by Medicare, and the charges that the individual may have to pay;~~

~~(8)~~ (7) the right to ~~know~~ be told before services are initiated what the provider charges are for the services, ~~no matter who will be paying the bill~~ and if known to what extent payment may be expected from health insurance, public programs or other sources, and what charges the client may be responsible for paying;

~~(9)~~ (8) the right to know that there may be other services available in the community, including other home care services and providers, and to know where to ~~go for~~ find information about these services;

~~(10)~~ (9) the right to choose freely among available providers and to change providers after services have begun, within the limits of health insurance, long-term care insurance, medical assistance, or other health programs;

~~(11)~~ (10) the right to have personal, financial, and medical information kept private, and to be advised of the provider's policies and procedures regarding disclosure of such information;

~~(12)~~ (11) the right to ~~be allowed~~ access ~~to~~ the client's own records and written information from those records in accordance with sections 144.291 to 144.298;

~~(13)~~ (12) the right to be served by people who are properly trained and competent to perform their duties;

~~(14)~~ (13) the right to be treated with courtesy and respect, and to have the ~~patient's~~ client's property treated with respect;

~~(15)~~ (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act;

~~(16)~~ (15) the right to reasonable, advance notice of changes in services or charges~~, including~~;

(16) the right to know the provider's reason for termination of services;

(17) the right to at least ten days' advance notice of the termination of a service by a provider, except in cases where:

(i) the ~~recipient of services~~ client engages in conduct that significantly alters the ~~conditions of employment as specified in the employment contract between~~ terms of the service plan with the home care provider ~~and the individual providing home care services, or creates~~;

(ii) the client, person who lives with the client, or others create an abusive or unsafe work environment for the ~~individual~~ person providing home care services; or

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

~~(17)~~ (18) the right to a coordinated transfer when there will be a change in the provider of services;

~~(18)~~ (19) the right to ~~voice grievances regarding treatment or care that is~~ complain about services that are provided, or ~~fails to be, furnished, or regarding~~ fail to be provided, and the lack of courtesy or respect to the ~~patient~~ client or the ~~patient's~~ client's property;

~~(19)~~ (20) the right to know how to contact an individual associated with the home care provider who is responsible for handling problems and to have the home care provider investigate and attempt to resolve the grievance or complaint;

~~(20)~~ (21) the right to know the name and address of the state or county agency to contact for additional information or assistance; and

~~(21)~~ (22) the right to assert these rights personally, or have them asserted by the ~~patient's family or guardian when the patient has been judged incompetent,~~ client's representative or by anyone on behalf of the client, without retaliation.

Subd. 2. **Interpretation and enforcement of rights.** These rights are established for the benefit of ~~persons~~ clients who receive home care services. ~~"Home care services" means home care services as defined in section 144A.43, subdivision 3, and unlicensed personal care assistance services, including services covered by medical assistance under section 256B.0625, subdivision 19a.~~ All home care providers, including those exempted under section 144A.471, must comply with this section. The commissioner shall enforce this section and the home care bill of rights requirement against home care providers exempt from licensure in the same manner as for licensees. A home care provider may not request or require a ~~person~~ client to surrender any of these rights as a condition of receiving services. ~~A guardian or conservator or, when there is no guardian or conservator, a designated person, may seek to enforce these rights.~~ This statement of rights does not replace or diminish other rights and liberties that may exist relative to ~~persons~~ clients receiving home care services, persons providing home care services, or providers licensed under ~~Laws 1987, chapter 378. A copy of these rights must be provided to an individual at the time home care services, including personal care assistance services, are initiated. The copy shall also contain the address and phone number of the Office of Health Facility Complaints and the Office of Ombudsman for Long-Term Care and a brief statement describing how to file a complaint with these offices. Information about how to contact the Office of Ombudsman for Long-Term Care shall be included in notices of change in client fees and in notices where home care providers initiate transfer or discontinuation of services~~ sections 144A.43 to 144A.482.

Sec. 7. Minnesota Statutes 2012, section 144A.45, is amended to read:

144A.45 REGULATION OF HOME CARE SERVICES.

Subdivision 1. **~~Rules~~ Regulations.** The commissioner shall ~~adopt rules for the regulation of~~ regulate home care providers pursuant to sections 144A.43 to ~~144A.47~~ 144A.482. The ~~rules~~ regulations shall include the following:

(1) provisions to assure, to the extent possible, the health, safety and well-being, and appropriate treatment of persons who receive home care services while respecting clients' autonomy and choice;

(2) requirements that home care providers furnish the commissioner with specified information necessary to implement sections 144A.43 to ~~144A.47~~ 144A.482;

(3) standards of training of home care provider personnel~~, which may vary according to the nature of the services provided or the health status of the consumer~~;

(4) standards for provision of home care services;

~~(4)~~ (5) standards for medication management ~~which may vary according to the nature of the services provided, the setting in which the services are provided, or the status of the consumer. Medication management includes the central storage, handling, distribution, and administration of medications~~;

~~(5)~~ (6) standards for supervision of home care services ~~requiring supervision by a registered nurse or other appropriate health care professional which must occur on site at least every 62 days, or more frequently if indicated by a clinical assessment, and in accordance with sections 148.171 to 148.285 and rules adopted thereunder, except that a person performing home care aide tasks for a class B licensee providing paraprofessional services does not require nursing supervision~~;

~~(6)~~ (7) standards for client evaluation or assessment ~~which may vary according to the nature of the services provided or the status of the consumer~~;

~~(7)~~ (8) requirements for the involvement of a ~~consumer's physician~~ client's health care provider, the documentation of ~~physicians'~~ health care providers' orders, if required, and the ~~consumer's treatment~~ client's service plan~~, and~~;

(9) the maintenance of accurate, current ~~clinical~~ client records;

~~(8)~~ (10) the establishment of ~~different classes~~ basic and comprehensive levels of licenses ~~for different types of providers and different standards and requirements for different kinds of home care~~ based on services provided; and

~~(9) operating procedures required to implement~~ (11) provisions to enforce these regulations and the home care bill of rights.

~~Subd. 1a. **Home care aide tasks.** Notwithstanding the provisions of Minnesota Rules, part 4668.0110, subpart 1, item E, home care aide tasks also include assisting toileting, transfers, and ambulation if the client is ambulatory and if the client has no serious acute illness or infectious disease.~~

~~Subd. 1b. **Home health aide qualifications.** Notwithstanding the provisions of Minnesota Rules, part 4668.0100, subpart 5, a person may perform home health aide tasks if the person maintains current registration as a nursing assistant on the Minnesota nursing assistant registry. Maintaining current registration on the Minnesota nursing assistant registry satisfies the documentation requirements of Minnesota Rules, part 4668.0110, subpart 3.~~

Subd. 2. **Regulatory functions.** ~~(a)~~ The commissioner shall:

(1) ~~evaluate, monitor, and~~ license, survey, and monitor without advance notice, home care providers in accordance with sections ~~144A.45 to 144A.47~~ 144A.43 to 144A.482;

~~(2) inspect the office and records of a provider during regular business hours without advance notice to the home care provider;~~

(2) survey every temporary licensee within one year of the temporary license issuance date subject to the temporary licensee providing home care services to a client or clients;

(3) survey all licensed home care providers on an interval that will promote the health and safety of clients;

~~(3)~~ (4) with the consent of the ~~consumer~~ client, visit the home where services are being provided;

~~(4)~~ (5) issue correction orders and assess civil penalties in accordance with section 144.653, subdivisions 5 to 8, for violations of sections 144A.43 to ~~144A.47 or the rules adopted under those sections~~ 144A.482;

~~(5)~~ (6) take action as authorized in section ~~144A.46, subdivision 3~~ 144A.475; and

~~(6)~~ (7) take other action reasonably required to accomplish the purposes of sections 144A.43 to ~~144A.47~~ 144A.482.

~~(b) In the exercise of the authority granted in sections 144A.43 to 144A.47, the commissioner shall comply with the applicable requirements of section 144.122, the Government Data Practices Act, and the Administrative Procedure Act.~~

~~Subd. 4.~~ **~~Medicaid reimbursement.~~** ~~Notwithstanding the provisions of section 256B.37 or state plan requirements to the contrary, certification by the federal Medicare program must not be a requirement of Medicaid payment for services delivered under section 144A.4605.~~

~~Subd. 5.~~ **~~Home care providers; services for Alzheimer's disease or related disorder.~~** ~~(a) If a home care provider licensed under section 144A.46 or 144A.4605 markets or otherwise promotes services for persons with Alzheimer's disease or related disorders, the facility's direct care staff and their supervisors must be trained in dementia care.~~

~~(b) Areas of required training include:~~

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

~~(2) assistance with activities of daily living;~~

~~(3) problem solving with challenging behaviors; and~~

~~(4) communication skills.~~

~~(c) The licensee shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered.~~

Sec. 8. **[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. 9. **[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) e-mail address, physical address, mailing address, and telephone number of the principal administrative office;

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

(5) 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 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. 10. **[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. 11. **[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" is the survey conducted of a new temporary licensee 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 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 reviews 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 will 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 will 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" are 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, 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 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 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 as follows and fines will be assessed accordingly:

(1) Level of violation:

(i) Level 1. 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. A violation that did not harm the 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. 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.

(iv) Level 4. 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.

(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.** 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 9, and any fine assessed. During the correction order reconsideration request, the issuance for the correction orders under reconsideration are not stayed, but the department will post in formation on the Web site with the correction order that the licensee has requested a reconsideration required and that the review is pending.

(a) 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.

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 the fine assigned to the correction order was applied incorrectly.

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

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

Subd. 13. **Home care surveyor training.** 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.

Materials used for this training will 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. 12. **[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. 13. **[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 144.057 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. 14. **[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. 15. **[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. 16. **[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. 17. **[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. 18. **[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 mediation 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. **Medications 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 will 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 will 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 it will require a prescription for all medications it 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 will agree 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 drugs.** A comprehensive home care provider providing storage of medications outside of the client's private living space must store all prescription drugs 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 drugs.** (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 drugs and controlled substances.

(c) Upon disposition, the comprehensive home care provider must document in the client's record the disposition of the medications 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. 19. **[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 has demonstrated their 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. 20. **[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. 21. **[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:

(1) have 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;

(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) have, 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. 22. **[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 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. 23. **[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. 24. **[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. 25. **[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. 26. **[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 temporary licenses issued beginning January 1, 2014, will be issued according to the provisions in sections 144A.43 to 144A.4799 and fees in section 144A.472 and will be required to comply with this chapter.

(c) No temporary licenses or 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. 27. **[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 address, e-mail address, and telephone number of the individual or organization and a signed statement declaring that the individual 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. An individual or organization applying for a certificate must also provide the name, business address, and telephone number of each of the individuals responsible for the management or direction of the organization.

(c) The commissioner shall charge an annual registration fee of $20 for individuals 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.

Sec. 28. **AGENCY QUALITY IMPROVEMENT PROGRAM.**

Subdivision 1. **Annual legislative report on home care licensing.** The commissioner shall establish a quality improvement program for the home care survey and home care complaint investigation processes. The commissioner shall submit to the legislature an annual report, beginning October 1, 2015, and each October 1 thereafter. Each report will review the previous state fiscal year of home care licensing and regulatory activities. The report must include, but is not limited to, an analysis of:

(1) the number of FTE's in the Division of Compliance Monitoring, including the Office of Health Facility Complaints units assigned to home care licensing, survey, investigation and enforcement process;

(2) numbers of and descriptive information about licenses issued, complaints received and investigated, including allegations made and correction orders issued, surveys completed and timelines, and correction order reconsiderations and results;

(3) descriptions of emerging trends in home care provision and areas of concern identified by the department in its regulation of home care providers;

(4) information and data regarding performance improvement projects underway and planned by the commissioner in the area of home care surveys; and

(5) work of the Department of Health Home Care Advisory Council.

Subd. 2. **Study of correction order appeal process.** Starting July 1, 2015, the commissioner shall study whether to add a correction order appeal process conducted by an independent reviewer such as an administrative law judge or other office and submit a report to the legislature by February 1, 2016. The commissioner shall review home care regulatory systems in other states as part of that study. The commissioner shall consult with the home care providers and representatives.

Sec. 29. **INTEGRATED LICENSING SYSTEM FOR HOME CARE AND HOME AND COMMUNITY-BASED SERVICES.**

(a) The Department of Health Compliance Monitoring Division and the Department of Human Services Licensing Division shall jointly develop an integrated licensing system for providers of both home care services subject to licensure under Minnesota Statutes, chapter 144A, and for home and community-based services subject to licensure under Minnesota Statutes, chapter 245D. The integrated licensing system shall:

(1) require only one license of any provider of services under Minnesota Statutes, sections 144A.43 to 144A.482, and 245D.03, subdivision 1;

(2) promote quality services that recognize a person's individual needs and protect the person's health, safety, rights, and well-being;

(3) promote provider accountability through application requirements, compliance inspections, investigations, and enforcement actions;

(4) reference other applicable requirements in existing state and federal laws, including the federal Affordable Care Act;

(5) establish internal procedures to facilitate ongoing communications between the agencies, and with providers and services recipients about the regulatory activities;

(6) create a link between the agency Web sites so that providers and the public can access the same information regardless of which Web site is accessed initially; and

(7) collect data on identified outcome measures as necessary for the agencies to report to the Centers for Medicare and Medicaid Services.

(b) The joint recommendations for legislative changes to implement the integrated licensing system are due to the legislature by February 15, 2014.

(c) Before implementation of the integrated licensing system, providers licensed as home care providers under Minnesota Statutes, chapter 144A, may also provide home and community-based services subject to licensure under Minnesota Statutes, chapter 245D, without obtaining a home and community-based services license under Minnesota Statutes, chapter 245D. During this time, the conditions under clauses (1) to (3) shall apply to these providers:

(1) the provider must comply with all requirements under Minnesota Statutes, chapter 245D, for services otherwise subject to licensure under Minnesota Statutes, chapter 245D;

(2) a violation of requirements under Minnesota Statutes, chapter 245D, may be enforced by the Department of Health under the enforcement authority set forth in Minnesota Statutes, section 144A.475; and

(3) the Department of Health will provide information to the Department of Human Services about each provider licensed under this section, including the provider's license application, licensing documents, inspections, information about complaints received, and investigations conducted for possible violations of Minnesota Statutes, chapter 245D.

Sec. 30. **REPEALER.**

(a) Minnesota Statutes 2012, sections 144A.46; and 144A.461, are repealed.

(b) Minnesota Rules, parts 4668.0002; 4668.0003; 4668.0005; 4668.0008; 4668.0012; 4668.0016; 4668.0017; 4668.0019; 4668.0030; 4668.0035; 4668.0040; 4668.0050; 4668.0060; 4668.0065; 4668.0070; 4668.0075; 4668.0080; 4668.0100; 4668.0110; 4668.0120; 4668.0130; 4668.0140; 4668.0150; 4668.0160; 4668.0170; 4668.0180; 4668.0190; 4668.0200; 4668.0218; 4668.0220; 4668.0230; 4668.0240; 4668.0800; 4668.0805; 4668.0810; 4668.0815; 4668.0820; 4668.0825; 4668.0830; 4668.0835; 4668.0840; 4668.0845; 4668.0855; 4668.0860; 4668.0865; 4668.0870; 4669.0001; 4669.0010; 4669.0020; 4669.0030; 4669.0040; and 4669.0050, are repealed.

Sec. 31. **EFFECTIVE DATE.**

Sections 1 to 30 are effective the day following final enactment.

ARTICLE 12

HEALTH DEPARTMENT

Section 1. Minnesota Statutes 2012, section 16A.724, subdivision 2, is amended to read:

Subd. 2. **Transfers.** (a) Notwithstanding section 295.581, to the extent available resources in the health care access fund exceed expenditures in that fund, effective for the biennium beginning July 1, 2007, the commissioner of management and budget shall transfer the excess funds from the health care access fund to the general fund on June 30 of each year, provided that the amount transferred in any fiscal biennium shall not exceed $96,000,000. The purpose of this transfer is to meet the rate increase required under Laws 2003, First Special Session chapter 14, article 13C, section 2, subdivision 6.

(b) For fiscal years 2006 to 2011, MinnesotaCare shall be a forecasted program, and, if necessary, the commissioner shall reduce these transfers from the health care access

fund to the general fund to meet annual MinnesotaCare expenditures or, if necessary, transfer sufficient funds from the general fund to the health care access fund to meet annual MinnesotaCare expenditures.

(c) Notwithstanding section 295.581, to the extent available resources in the health care access fund exceed expenditures in that fund, effective for the biennium beginning July 1, 2013, the commissioner of management and budget shall transfer $1,000,000 each fiscal year from the health access fund to the medical education and research costs fund established under section 62J.692, for distribution under section 62J.692, subdivision 4, paragraph (b).

Sec. 2. **[62A.3094] COVERAGE FOR AUTISM SPECTRUM DISORDERS.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the terms defined in paragraphs (b) to (e) have the meanings given.

(b) "Autism spectrum disorders" means the conditions as determined by criteria set forth in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(c) "Health plan" has the meaning given in section 62Q.01, subdivision 3.

(d) "Medically necessary care" means health care services appropriate, in terms of type, frequency, level, setting, and duration, to the enrollee's condition, and diagnostic testing and preventative services. Medically necessary care must be consistent with generally accepted practice parameters as determined by physicians and licensed psychologists who typically manage patients who have autism spectrum disorders.

(e) "Mental health professional" has the meaning given in section 245.4871, subdivision 27.

Subd. 2. **Optional coverage required.** (a) A health plan must provide:

(1) all health benefits related to the treatment of autism spectrum disorders required by the essential health benefits required under section 1302 of the Affordable Care Act;

(2) all health benefits required by this section or any other section of Minnesota Statutes as of December 31, 2012; and

(3) an offer of one or more options for the purchase of supplemental autism coverage for young children for children under age 18 for the diagnosis, evaluation, assessment, and medically necessary care of autism spectrum disorders, including but not limited to the following:

(i) early intensive behavioral and developmental therapy based in behavioral and developmental science, including but not limited to applied behavior analysis, intensive

early intervention behavior therapy, intensive behavior intervention, and Lovaas therapy and developmental approaches;

(ii) neurodevelopmental and behavioral health treatments and management;

(iii) speech therapy;

(iv) occupational therapy;

(v) physical therapy; and

(vi) medications.

(b) The diagnosis, evaluation, and assessment must include an assessment of the child's developmental skills, functional behavior, needs, and capacities.

(c) The coverage option required under this section shall include treatment that is in accordance with an individualized treatment plan prescribed by the insured's treating physician or mental health professional.

(d) A health plan may not refuse to renew or reissue, or otherwise terminate or restrict, coverage of an individual solely because the individual is diagnosed with an autism spectrum disorder.

(e) A health plan may request an updated treatment plan only once every six months, unless the health plan and the treating physician or mental health professional agree that a more frequent review is necessary due to emerging circumstances.

(f) An independent progress evaluation conducted by a mental health professional with expertise and training in autism spectrum disorder and child development must be completed to determine if progress toward functional and generalizable gains, as determined in the treatment plan, is being made.

(g) A health plan may cap the dollar value of the supplemental coverage offered under this subdivision, but may not cap the value at less than $50,000 per calendar year per individual receiving a diagnosis of autism spectrum disorder.

Subd. 3. **No effect on other law.** Nothing in this section limits in any way the coverage required under section 62Q.47.

Subd. 4. **State health care programs.** This section does not affect benefits available under the medical assistance and MinnesotaCare programs and does not limit, restrict, or otherwise reduce coverage under these programs.

EFFECTIVE DATE. This section is effective January 1, 2014, and sunsets effective December 31, 2015, and applies to coverage offered, issued, sold, renewed, or continued as defined in Minnesota Statutes, section 60A.02, subdivision 2a, on or after that date.

Sec. 3. **[62D.0425] NET WORTH LIMIT.**

(a) Between July 1, 2013, and June 30, 2018, no health maintenance organization shall have a net worth of more than 25 percent of the sum of all expenses incurred during the most recent calendar year, except as provided in paragraph (b).

(b) A health maintenance organization may have a net worth of more than 25 percent of the sum of all expenses incurred during the most recent calendar year if necessary to maintain capital reserves at the level of the product of 2.0 and its authorized control level risk-based capital, as required pursuant to sections 60A.50 to 60A.592 and 62D.04. Paragraphs (c) and (d) do not apply to health maintenance organizations permitted, under this paragraph, to have a net worth greater than 25 percent of the sum of all expenses incurred during the most recent calendar year.

(c) By June 15, 2013, and annually thereafter until June 15, 2017, for a health maintenance organization that has a net worth of more than 25 percent of the sum of all expenses incurred during the most recent calendar year, the commissioner of health, in consultation with the commissioners of commerce and human services, shall determine:

(1) capital reserves using the National Association of Insurance Commissioners definitions of admitted assets, which shall be used in clauses (2) to (5);

(2) the proportion of capital reserves that are reasonably attributable to net underwriting gains in Minnesota public health care programs based on annual financial filings for calendar years 2003 through 2012;

(3) the proportion of capital reserves that are reasonably attributable to investment gains associated with net underwriting gains in Minnesota public health care programs based on annual financial filings for calendar years 2003 through 2012;

(4) any adjustments needed to clause (1) or (2) based on corporate reorganizations, since 2003; and

(5) any adjustments needed to account for the impact of annual financial filings for calendar years 2013 through 2016.

(d) A health maintenance organization that has a net worth of more than 25 percent of the sum of all expenses incurred during the most recent calendar year shall reduce its capital reserves as follows:

(1) as determined by paragraph (c), the proportion of capital reserves that are greater than 25 percent of the sum of all expenses incurred during the most recent calendar year and that are reasonably attributable to net underwriting gains and investment gains associated with net underwriting gains in Minnesota public health care programs shall be spent down. The health maintenance organization shall place excess capital reserves in a special restricted account under the control of the health maintenance organization. The special restricted account may only be used to pay for a portion of the health maintenance

organization's current public program enrollee premiums. The health maintenance organization shall spend no less than 50 percent of this special restricted account in any state fiscal year beginning on or after July 1, 2013; and

(2) the proportion of capital reserves that are greater than 25 percent of the sum of all expenses incurred during the most recent calendar year and that are not reasonably attributable to net underwriting gains and investment gains associated with net underwriting gains in Minnesota public health care programs shall be spent down. The health maintenance organization shall place these excess capital reserves in a second special restricted account under the control of the health maintenance organization. The health maintenance organization may use this special restricted account to benefit current enrollees by moderating variation in premium increases, assisting enrollees in accessing new benefits, reducing health disparities, promoting health, wellness and preventive services, and improving care coordination. Prior to spending down excess reserves from this special revenue account, the health maintenance organization's spenddown plan must be approved by the commissioner of health. The health maintenance organization shall spend no less than 33 percent of this special restricted account in any state fiscal year beginning July 1, 2013.

(e) The health maintenance organization must spend down all of the reserves placed in its special restricted accounts by July 1, 2018. All reserves placed in a special account must be spent according to paragraph (d), unless the reserves are necessary for the health maintenance organization to maintain capital reserves at the level of the product of 2.0 and its authorized control level risk-based capital, as required pursuant to sections 60A.50 to 60A.592 and 62D.04, in which case the health maintenance organization may transfer funds out of its special restricted accounts in a manner approved by the commissioner of health.

(f) The commissioner of health must approve all health maintenance organization expenditures for the acquisition of any asset that is not an admitted asset under National Association of Insurance Commissioners definitions. The commissioner shall disapprove any acquisition unless the health maintenance organization demonstrates that the acquisition is: (1) consistent with its long-standing business practices; or (2) more beneficial to enrollees than benefits to enrollees under paragraph (d).

Sec. 4. Minnesota Statutes 2012, section 62J.692, subdivision 4, is amended to read:

Subd. 4. **Distribution of funds.** (a) The commissioner shall annually distribute the available medical education funds to all qualifying applicants based on a distribution formula that reflects a summation of two factors:

(1) a public program volume factor, which is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool; and

(2) a supplemental public program volume factor, which is determined by providing a supplemental payment of 20 percent of each training site's grant to training sites whose public program revenue accounted for at least 0.98 percent of the total public program revenue received by all eligible training sites. Grants to training sites whose public program revenue accounted for less than 0.98 percent of the total public program revenue received by all eligible training sites shall be reduced by an amount equal to the total value of the supplemental payment.

Public program revenue for the distribution formula includes revenue from medical assistance, prepaid medical assistance, general assistance medical care, and prepaid general assistance medical care. Training sites that receive no public program revenue are ineligible for funds available under this subdivision. For purposes of determining training-site level grants to be distributed under paragraph (a), total statewide average costs per trainee for medical residents is based on audited clinical training costs per trainee in primary care clinical medical education programs for medical residents. Total statewide average costs per trainee for dental residents is based on audited clinical training costs per trainee in clinical medical education programs for dental students. Total statewide average costs per trainee for pharmacy residents is based on audited clinical training costs per trainee in clinical medical education programs for pharmacy students. Training sites whose training site level grant is less than $1,000, based on the formula described in this paragraph, are ineligible for funds available under this subdivision.

(b) Of available medical education funds, $1,000,000 shall be distributed each year for grants to family medicine residency programs located outside of the seven-county metropolitan area, as defined in section 473.121, subdivision 4, focused on eduction and training of family medicine physicians to serve communities outside the metropolitan area. To be eligible for a grant under this paragraph, a family medicine residency program must demonstrate that over the most recent three calendar years, at least 25 percent of its residents practice in Minnesota communities outside of the metropolitan area. Grant funds must be allocated proportionally based on the number of residents per eligible residency program.

(c) Funds distributed shall not be used to displace current funding appropriations from federal or state sources.

~~(c)~~ (d) Funds shall be distributed to the sponsoring institutions indicating the amount to be distributed to each of the sponsor's clinical medical education programs based on the criteria in this subdivision and in accordance with the commissioner's approval letter.

Each clinical medical education program must distribute funds allocated under paragraph (a) to the training sites as specified in the commissioner's approval letter. Sponsoring institutions, which are accredited through an organization recognized by the Department of Education or the Centers for Medicare and Medicaid Services, may contract directly with training sites to provide clinical training. To ensure the quality of clinical training, those accredited sponsoring institutions must:

(1) develop contracts specifying the terms, expectations, and outcomes of the clinical training conducted at sites; and

(2) take necessary action if the contract requirements are not met. Action may include the withholding of payments under this section or the removal of students from the site.

~~(d)~~ (e) Any funds not distributed in accordance with the commissioner's approval letter must be returned to the medical education and research fund within 30 days of receiving notice from the commissioner. The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.

~~(e)~~ (f) A maximum of $150,000 of the funds dedicated to the commissioner under section 297F.10, subdivision 1, clause (2), may be used by the commissioner for administrative expenses associated with implementing this section.

Sec. 5. Minnesota Statutes 2012, section 62Q.19, subdivision 1, is amended to read:

Subdivision 1. **Designation.** (a) The commissioner shall designate essential community providers. The criteria for essential community provider designation shall be the following:

(1) a demonstrated ability to integrate applicable supportive and stabilizing services with medical care for uninsured persons and high-risk and special needs populations, underserved, and other special needs populations; and

(2) a commitment to serve low-income and underserved populations by meeting the following requirements:

(i) has nonprofit status in accordance with chapter 317A;

(ii) has tax-exempt status in accordance with the Internal Revenue Service Code, section 501(c)(3);

(iii) charges for services on a sliding fee schedule based on current poverty income guidelines; and

(iv) does not restrict access or services because of a client's financial limitation;

(3) status as a local government unit as defined in section 62D.02, subdivision 11, a hospital district created or reorganized under sections 447.31 to 447.37, an Indian tribal

government, an Indian health service unit, or a community health board as defined in chapter 145A;

(4) a former state hospital that specializes in the treatment of cerebral palsy, spina bifida, epilepsy, closed head injuries, specialized orthopedic problems, and other disabling conditions;

(5) a sole community hospital. For these rural hospitals, the essential community provider designation applies to all health services provided, including both inpatient and outpatient services. For purposes of this section, "sole community hospital" means a rural hospital that:

(i) is eligible to be classified as a sole community hospital according to Code of Federal Regulations, title 42, section 412.92, or is located in a community with a population of less than 5,000 and located more than 25 miles from a like hospital currently providing acute short-term services;

(ii) has experienced net operating income losses in two of the previous three most recent consecutive hospital fiscal years for which audited financial information is available; and

(iii) consists of 40 or fewer licensed beds; ~~or~~

(6) a birth center licensed under section 144.615.; or

(7) a hospital, and its affiliated specialty clinics, whose inpatients are predominantly under 21 years of age and that meets the following criteria:

(i) provides intensive specialty pediatric services that are routinely provided in only four or fewer hospitals in the state; and

(ii) serves children from at least one-half of the counties in the state.

(b) Prior to designation, the commissioner shall publish the names of all applicants in the State Register. The public shall have 30 days from the date of publication to submit written comments to the commissioner on the application. No designation shall be made by the commissioner until the 30-day period has expired.

(c) The commissioner may designate an eligible provider as an essential community provider for all the services offered by that provider or for specific services designated by the commissioner.

(d) For the purpose of this subdivision, supportive and stabilizing services include at a minimum, transportation, child care, cultural, and linguistic services where appropriate.

Sec. 6. Minnesota Statutes 2012, section 103I.005, is amended by adding a subdivision to read:

Subd. 1a. **Bored geothermal heat exchanger.** "Bored geothermal heat exchanger" means an earth-coupled heating or cooling device consisting of a sealed closed-loop piping system installed in a boring in the ground to transfer heat to or from the surrounding earth with no discharge.

Sec. 7. Minnesota Statutes 2012, section 103I.521, is amended to read:

103I.521 FEES ~~DEPOSITED WITH COMMISSIONER OF MANAGEMENT AND BUDGET~~.

Unless otherwise specified, fees collected ~~for licenses or registration~~ by the commissioner under this chapter shall be deposited in the state treasury and credited to the state government special revenue fund.

Sec. 8. Minnesota Statutes 2012, section 144.123, subdivision 1, is amended to read:

~~Subdivision 1.~~ **~~Who must pay.~~** Except for the limitation contained in this section, the commissioner of health ~~shall charge a handling fee~~ may enter into a contractual agreement to recover costs incurred for analysis for diagnostic purposes for each specimen submitted to the Department of Health ~~for analysis for diagnostic purposes~~ by any hospital, ~~private~~ laboratory, ~~private~~ clinic, or physician. ~~No fee shall be charged to any entity which receives direct or indirect financial assistance from state or federal funds administered by the Department of Health, including any public health department, nonprofit community clinic, sexually transmitted disease clinic, or similar entity. No fee will be charged~~ The commissioner shall not charge for any biological materials submitted to the Department of Health as a requirement of Minnesota Rules, part 4605.7040, or for those biological materials requested by the department to gather information for disease prevention or control purposes. The commissioner of health may establish other exceptions to the handling fee as may be necessary to protect the public's health. ~~All fees collected pursuant to this section shall be deposited in the state treasury and credited to the state government special revenue fund.~~ Funds generated in a contractual agreement made pursuant to this section shall be deposited in a special account and are appropriated to the commissioner for purposes of providing the services specified in the contracts. All such contractual agreements shall be processed in accordance with the provisions of chapter 16C.

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

Sec. 9. Minnesota Statutes 2012, section 144.125, subdivision 1, is amended to read:

Subdivision 1. **Duty to perform testing.** (a) It is the duty of (1) the administrative officer or other person in charge of each institution caring for infants 28 days or less of age, (2) the person required in pursuance of the provisions of section 144.215, to register the birth of a child, or (3) the nurse midwife or midwife in attendance at the birth, to arrange to have administered to every infant or child in its care tests for heritable and congenital disorders according to subdivision 2 and rules prescribed by the state commissioner of health.

(b) Testing ~~and the~~, recording ~~and~~ of test results, reporting of test results, and follow-up of infants with heritable congenital disorders, including hearing loss detected through the early hearing detection and intervention program in section 144.966, shall be performed at the times and in the manner prescribed by the commissioner of health. ~~The commissioner shall charge a fee so that the total of fees collected will approximate the costs of conducting the tests and implementing and maintaining a system to follow-up infants with heritable or congenital disorders, including hearing loss detected through the early hearing detection and intervention program under section 144.966.~~

(c) The fee ~~is $101 per specimen. Effective July 1, 2010, the fee shall be increased to $106~~ to support the newborn screening program, including tests administered under this section and section 144.966, shall be $145 per specimen. ~~The increased fee amount shall be deposited in the general fund. Costs associated with capital expenditures and the development of new procedures may be prorated over a three-year period when calculating the amount of the fees.~~ This fee amount shall be deposited in the state treasury and credited to the state government special revenue fund.

(d) The fee to offset the cost of the support services provided under section 144.966, subdivision 3a, shall be $15 per specimen. This fee shall be deposited in the state treasury and credited to the general fund.

Sec. 10. **[144.1251] NEWBORN SCREENING FOR CRITICAL CONGENITAL HEART DISEASE (CCHD).**

Subdivision 1. **Required testing and reporting.** Each licensed hospital or state-licensed birthing center or facility that provides maternity and newborn care services shall provide screening for congenital heart disease to all newborns prior to discharge using pulse oximetry screening. This screening should occur before discharge from the nursery, after the infant turns 24 hours of age. If discharge prior to 24 hours after birth occurs, screening should occur as close as possible to the time of discharge. Results of this screening must be reported to the Department of Health.

For premature infants (less than 36 weeks of gestation) and infants admitted to a higher-level nursery (special care or intensive care), pulse oximetry should be performed when medically appropriate, but always prior to discharge.

Subd. 2. **Implementation.** The Department of Health shall:

(1) communicate the screening protocol requirements;

(2) make information and forms available to the persons with a duty to perform testing and reporting, health care providers, parents of newborns, and the public on screening and parental options;

(3) provide training to ensure compliance with and appropriate implementation of the screening;

(4) establish the mechanism for the required data collection and reporting of screening and follow-up diagnostic results to the Department of Health according to the Department of Health's recommendations;

(5) coordinate the implementation of universal standardized screening;

(6) act as a resource for providers as the screening program is implemented, and in consultation with the Advisory Committee on Heritable and Congenital Disorders, develop and implement policies for early medical and developmental intervention services and long-term follow-up services for children and their families identified with a CCHD; and

(7) comply with sections 144.125 to 144.128.

Sec. 11. **[144.492] DEFINITIONS.**

Subdivision 1. **Applicability.** For the purposes of sections 144.492 to 144.494, the terms defined in this section have the meanings given them.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 3. **Stroke.** "Stroke" means the sudden death of brain cells in a localized area due to inadequate blood flow.

Sec. 12. **[144.493] CRITERIA.**

Subdivision 1. **Comprehensive stroke center.** A hospital meets the criteria for a comprehensive stroke center if the hospital has been certified as a comprehensive stroke center by the joint commission or another nationally recognized accreditation entity.

Subd. 2. **Primary stroke center.** A hospital meets the criteria for a primary stroke center if the hospital has been certified as a primary stroke center by the joint commission or another nationally recognized accreditation entity.

Subd. 3. **Acute stroke ready hospital.** A hospital meets the criteria for an acute stroke ready hospital if the hospital has the following elements of an acute stroke ready hospital:

(1) an acute stroke team available and/or on-call 24 hours a days, seven days a week;

(2) written stroke protocols, including triage, stabilization of vital functions, initial diagnostic tests, and use of medications;

(3) a written plan and letter of cooperation with emergency medical services regarding triage and communication that are consistent with regional patient care procedures;

(4) emergency department personnel who are trained in diagnosing and treating acute stroke;

(5) the capacity to complete basic laboratory tests, electrocardiograms, and chest x-rays 24 hours a day, seven days a week;

(6) the capacity to perform and interpret brain injury imaging studies 24 hours a days, seven days a week;

(7) written protocols that detail available emergent therapies and reflect current treatment guidelines, which include performance measures and are revised at least annually;

(8) a neurosurgery coverage plan, call schedule, and a triage and transportation plan;

(9) transfer protocols and agreements for stroke patients; and

(10) a designated medical director with experience and expertise in acute stroke care.

Sec. 13. **[144.494] DESIGNATING STROKE CENTERS AND STROKE HOSPITALS.**

Subdivision 1. **Naming privileges.** Unless it has been designated as a stroke center or stroke hospital pursuant to section 144.493, no hospital shall use the term "stroke center" or "stroke hospital" in its name or its advertising or shall otherwise indicate it has stroke treatment capabilities.

Subd. 2. **Designation.** A hospital that voluntarily meets the criteria for a comprehensive stroke center, primary stroke center, or acute stroke ready hospital may apply to the commissioner for designation, and upon the commissioner's review and approval of the application, shall be designated as a comprehensive stroke center, a primary stroke center, or an acute stroke ready hospital for a three-year period. If a hospital loses its certification as a comprehensive stroke center or primary stroke center from the joint commission or other nationally recognized accreditation entity, its Minnesota designation will be immediately withdrawn. Prior to the expiration of the three-year designation, a hospital seeking to remain part of the voluntary acute stroke system may reapply to the commissioner for designation.

Sec. 14. **[144.554] HEALTH FACILITIES CONSTRUCTION PLAN SUBMITTAL AND FEES.**

For hospitals, nursing homes, boarding care homes, residential hospices, supervised living facilities, freestanding outpatient surgical centers, and end-stage renal disease facilities, the commissioner shall collect a fee for the review and approval of architectural, mechanical, and electrical plans and specifications submitted before construction begins for each project relative to construction of new buildings, additions to existing buildings, or for remodeling or alterations of existing buildings. All fees collected in this section shall be deposited in the state treasury and credited to the state government special revenue fund. Fees must be paid at the time of submission of final plans for review and are not refundable. The fee is calculated as follows:

Construction project total estimated cost	Fee
$0 - $10,000	$30
$10,001 - $50,000	$150
$50,001 - $100,000	$300
$100,001 - $150,000	$450
$150,001 - $200,000	$600
$200,001 - $250,000	$750
$250,001 - $300,000	$900
$300,001 - $350,000	$1,050
$350,001 - $400,000	$1,200
$400,001 - $450,000	$1,350
$450,001 - $500,000	$1,500
$500,001 - $550,000	$1,650
$550,001 - $600,000	$1,800
$600,001 - $650,000	$1,950
$650,001 - $700,000	$2,100
$700,001 - $750,000	$2,250
$750,001 - $800,000	$2,400
$800,001 - $850,000	$2,550
$850,001 - $900,000	$2,700
$900,001 - $950,000	$2,850
$950,001 - $1,000,000	$3,000
$1,000,001 - $1,050,000	$3,150
$1,050,001 - $1,100,000	$3,300
$1,100,001 - $1,150,000	$3,450
$1,150,001 - $1,200,000	$3,600
$1,200,001 - $1,250,000	$3,750
$1,250,001 - $1,300,000	$3,900
$1,300,001 - $1,350,000	$4,050
$1,350,001 - $1,400,000	$4,200

$1,400,001 - $1,450,000	$4,350
$1,450,001 - $1,500,000	$4,500
$1,500,001 and over	$4,800

Sec. 15. Minnesota Statutes 2012, section 144.966, subdivision 2, is amended to read:

Subd. 2. **Newborn Hearing Screening Advisory Committee.** (a) The commissioner of health shall establish a Newborn Hearing Screening Advisory Committee to advise and assist the Department of Health and the Department of Education in:

(1) developing protocols and timelines for screening, rescreening, and diagnostic audiological assessment and early medical, audiological, and educational intervention services for children who are deaf or hard-of-hearing;

(2) designing protocols for tracking children from birth through age three that may have passed newborn screening but are at risk for delayed or late onset of permanent hearing loss;

(3) designing a technical assistance program to support facilities implementing the screening program and facilities conducting rescreening and diagnostic audiological assessment;

(4) designing implementation and evaluation of a system of follow-up and tracking; and

(5) evaluating program outcomes to increase effectiveness and efficiency and ensure culturally appropriate services for children with a confirmed hearing loss and their families.

(b) The commissioner of health shall appoint at least one member from each of the following groups with no less than two of the members being deaf or hard-of-hearing:

(1) a representative from a consumer organization representing culturally deaf persons;

(2) a parent with a child with hearing loss representing a parent organization;

(3) a consumer from an organization representing oral communication options;

(4) a consumer from an organization representing cued speech communication options;

(5) an audiologist who has experience in evaluation and intervention of infants and young children;

(6) a speech-language pathologist who has experience in evaluation and intervention of infants and young children;

(7) two primary care providers who have experience in the care of infants and young children, one of which shall be a pediatrician;

(8) a representative from the early hearing detection intervention teams;

(9) a representative from the Department of Education resource center for the deaf and hard-of-hearing or the representative's designee;

(10) a representative of the Commission of Deaf, DeafBlind and Hard-of-Hearing Minnesotans;

(11) a representative from the Department of Human Services Deaf and Hard-of-Hearing Services Division;

(12) one or more of the Part C coordinators from the Department of Education, the Department of Health, or the Department of Human Services or the department's designees;

(13) the Department of Health early hearing detection and intervention coordinators;

(14) two birth hospital representatives from one rural and one urban hospital;

(15) a pediatric geneticist;

(16) an otolaryngologist;

(17) a representative from the Newborn Screening Advisory Committee under this subdivision; and

(18) a representative of the Department of Education regional low-incidence facilitators.

The commissioner must complete the appointments required under this subdivision by September 1, 2007.

(c) The Department of Health member shall chair the first meeting of the committee. At the first meeting, the committee shall elect a chair from its membership. The committee shall meet at the call of the chair, at least four times a year. The committee shall adopt written bylaws to govern its activities. The Department of Health shall provide technical and administrative support services as required by the committee. These services shall include technical support from individuals qualified to administer infant hearing screening, rescreening, and diagnostic audiological assessments.

Members of the committee shall receive no compensation for their service, but shall be reimbursed as provided in section 15.059 for expenses incurred as a result of their duties as members of the committee.

(d) This subdivision expires June 30, ~~2013~~ 2019.

Sec. 16. Minnesota Statutes 2012, section 144.966, subdivision 3a, is amended to read:

Subd. 3a. **Support services to families.** The commissioner shall contract with a nonprofit organization to provide support and assistance to families with children who are deaf or have a hearing loss. The family support provided must include:

(1) direct hearing loss specific parent-to-parent assistance and unbiased information on communication, educational, and medical options, preferably provided by a program that is part of a national organization; and

(2) individualized deaf or hard of hearing mentors who provide education, including instruction in American Sign Language.

The commissioner shall give preference to a nonprofit organization that has the ability to provide these services throughout the state.

Sec. 17. Minnesota Statutes 2012, section 144.98, subdivision 3, is amended to read:

Subd. 3. **Annual fees.** (a) An application for accreditation under subdivision 6 must be accompanied by the annual fees specified in this subdivision. The annual fees include:

(1) base accreditation fee, ~~$1,500~~ $600;

(2) sample preparation techniques fee, $200 per technique;

(3) an administrative fee for laboratories located outside this state, ~~$3,750~~ $2,000; and

(4) test category fees.

(b) For the programs in subdivision 3a, the commissioner may accredit laboratories for fields of testing under the categories listed in clauses (1) to (10) upon completion of the application requirements provided by subdivision 6 and receipt of the fees for each category under each program that accreditation is requested. The categories offered and related fees include:

(1) microbiology, ~~$450~~ $200;

(2) inorganics, ~~$450~~ $200;

(3) metals, ~~$1,000~~ $500;

(4) volatile organics, ~~$1,300~~ $1,000;

(5) other organics, ~~$1,300~~ $1,000;

(6) radiochemistry, ~~$1,500~~ $750;

(7) emerging contaminants, ~~$1,500~~ $1,000;

(8) agricultural contaminants, ~~$1,250~~ $1,000;

(9) toxicity (bioassay), ~~$1,000~~ $500; and

(10) physical characterization, $250.

(c) The total annual fee includes the base fee, the sample preparation techniques fees, the test category fees per program, and, when applicable, an administrative fee for out-of-state laboratories.

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

Sec. 18. Minnesota Statutes 2012, section 144.98, subdivision 5, is amended to read:

Subd. 5. **State government special revenue fund.** Fees collected by the commissioner under this section must be deposited in the state treasury and credited to the state government special revenue fund.

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

Sec. 19. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision to read:

Subd. 10. **Establishing a selection committee.** (a) The commissioner shall establish a selection committee for the purpose of recommending approval of qualified laboratory assessors and assessment bodies. Committee members shall demonstrate competence in assessment practices. The committee shall initially consist of seven members appointed by the commissioner as follows:

(1) one member from a municipal laboratory accredited by the commissioner;

(2) one member from an industrial treatment laboratory accredited by the commissioner;

(3) one member from a commercial laboratory located in this state and accredited by the commissioner;

(4) one member from a commercial laboratory located outside the state and accredited by the commissioner;

(5) one member from a nongovernmental client of environmental laboratories;

(6) one member from a professional organization with a demonstrated interest in environmental laboratory data and accreditation; and

(7) one employee of the laboratory accreditation program administered by the department.

(b) Committee appointments begin on January 1 and end on December 31 of the same year.

(c) The commissioner shall appoint persons to fill vacant committee positions, expand the total number of appointed positions, or change the designated positions upon the advice of the committee.

(d) The commissioner shall rescind the appointment of a selection committee member for sufficient cause as the commissioner determines, such as:

(1) neglect of duty;

(2) failure to notify the commissioner of a real or perceived conflict of interest;

(3) nonconformance with committee procedures;

(4) failure to demonstrate competence in assessment practices; or

(5) official misconduct.

(e) Members of the selection committee shall be compensated according to the provisions in section 15.059, subdivision 3.

Sec. 20. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision to read:

Subd. 11. **Activities of the selection committee.** (a) The selection committee will determine assessor and assessment body application requirements, the frequency of application submittal, and the application review schedule. The commissioner shall publish the application requirements and procedures on the accreditation program Web site.

(b) In its selection process, the committee shall ensure its application requirements and review process:

(1) meet the standards implemented in subdivision 2a;

(2) ensure assessors have demonstrated competence in technical disciplines offered for accreditation by the commissioner; and

(3) consider any history of repeated nonconformance or complaints regarding assessors or assessment bodies.

(c) The selection committee shall consider an application received from qualified applicants and shall supply a list of recommended assessors and assessment bodies to the commissioner of health no later than 90 days after the commissioner notifies the committee of the need for review of applications.

Sec. 21. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision to read:

Subd. 12. **Commissioner approval of assessors and scheduling of assessments.** (a) The commissioner shall approve assessors who:

(1) are employed by the commissioner for the purpose of accrediting laboratories and demonstrate competence in assessment practices for environmental laboratories; or

(2) are employed by a state or federal agency with established agreements for mutual assistance or recognition with the commissioner and demonstrate competence in assessment practices for environmental laboratories.

(b) The commissioner may approve other assessors or assessment bodies who are recommended by the selection committee according to subdivision 11, paragraph (c). The commissioner shall publish the list of assessors and assessment bodies approved from the recommendations.

(c) The commissioner shall rescind approval for an assessor or assessment body for sufficient cause as the commissioner determines, such as:

(1) failure to meet the minimum qualifications for performing assessments;

(2) lack of availability;

(3) nonconformance with the applicable laws, rules, standards, policies, and procedures;

(4) misrepresentation of application information regarding qualifications and training; or

(5) excessive cost to perform the assessment activities.

Sec. 22. Minnesota Statutes 2012, section 144.98, is amended by adding a subdivision to read:

Subd. 13. **Laboratory requirements for assessor selection and scheduling assessments.** (a) A laboratory accredited or seeking accreditation that requires an assessment by the commissioner must select an assessor, group of assessors, or an assessment body from the published list specified in subdivision 12, paragraph (b). An accredited laboratory must complete an assessment and make all corrective actions at least once every 24 months. Unless the commissioner grants interim accreditation, a laboratory seeking accreditation must complete an assessment and make all corrective actions prior to, but no earlier than, 18 months prior to the date the application is submitted to the commissioner.

(b) A laboratory shall not select the same assessor more than twice in succession for assessments of the same facility unless the laboratory receives written approval from the commissioner for the selection. The laboratory must supply a written request to the commissioner for approval and must justify the reason for the request and provide the alternate options considered.

(c) A laboratory must select assessors appropriate to the size and scope of the laboratory's application or existing accreditation.

(d) A laboratory must enter into its own contract for direct payment of the assessors or assessment body. The contract must authorize the assessor, assessment body, or subcontractors to release all records to the commissioner regarding the assessment activity, when the assessment is performed in compliance with this statute.

(e) A laboratory must agree to permit other assessors as selected by the commissioner to participate in the assessment activities.

(f) If the laboratory determines no approved assessor is available to perform the assessment, the laboratory must notify the commissioner in writing and provide a

justification for the determination. If the commissioner confirms no approved assessor is available, the commissioner may designate an alternate assessor from those approved in subdivision 12, paragraph (a), or the commissioner may delay the assessment until an assessor is available. If an approved alternate assessor performs the assessment, the commissioner may collect fees equivalent to the cost of performing the assessment activities.

(g) Fees collected under this section are deposited in a special account and are annually appropriated to the commissioner for the purpose of performing assessment activities.

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

Sec. 23. Minnesota Statutes 2012, section 144.99, subdivision 4, is amended to read:

Subd. 4. **Administrative penalty orders.** (a) The commissioner may issue an order requiring violations to be corrected and administratively assessing monetary penalties for violations of the statutes, rules, and other actions listed in subdivision 1. The procedures in section 144.991 must be followed when issuing administrative penalty orders. Except in the case of repeated or serious violations, the penalty assessed in the order must be forgiven if the person who is subject to the order demonstrates in writing to the commissioner before the 31st day after receiving the order that the person has corrected the violation or has developed a corrective plan acceptable to the commissioner. The maximum amount of an administrative penalty order is $10,000 for each violator for all violations by that violator identified in an inspection or review of compliance.

(b) Notwithstanding paragraph (a), the commissioner may issue to a large public water supply, serving a population of more than 10,000 persons, an administrative penalty order imposing a penalty of at least $1,000 per day per violation, not to exceed $10,000 for each violation of sections 144.381 to 144.385 and rules adopted thereunder.

(c) Notwithstanding paragraph (a), the commissioner may issue to a certified lead firm or person performing regulated lead work, an administrative penalty order imposing a penalty of at least $5,000 per violation per day, not to exceed $10,000 for each violation of sections 144.9501 to 144.9512 and rules adopted thereunder. All revenue collected from monetary penalties in this section shall be deposited in the state treasury and credited to the state government special revenue fund.

Sec. 24. **[145.4716] SAFE HARBOR FOR SEXUALLY EXPLOITED YOUTH.**

Subdivision 1. **Director.** The commissioner of health shall establish a position for a director of child sex trafficking prevention.

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

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

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

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

(4) managing grant programs established under this act;

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

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

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

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

Sec. 25. **[145.4717] REGIONAL NAVIGATOR GRANTS.**

The commissioner of health, through its director of child sex trafficking prevention, established in section 145.4716, shall provide grants to regional navigators serving six regions of the state to be determined by the commissioner. Each regional navigator must develop and annually submit a work plan to the director of child sex trafficking prevention. The work plans must include, but are not limited to, the following information:

(1) a needs statement specific to the region, including an examination of the population at risk;

(2) regional resources available to sexually exploited youth, as defined in section 260C.007, subdivision 31;

(3) grant goals and measurable outcomes; and

(4) grant activities including timelines.

Sec. 26. **[145.4718] PROGRAM EVALUATION.**

(a) The director of child sex trafficking prevention, established under section 145.4716, must conduct, or contract for, comprehensive evaluation of the statewide program for safe harbor for sexually exploited youth. The first evaluation must be completed by June 30, 2015, and must be submitted to the commissioner of health by September 1, 2015, and every two years thereafter. The evaluation must consider whether the program is reaching intended victims and whether support services are available, accessible, and adequate for sexually exploited youth, as defined in section 260C.007, subdivision 31.

(b) In conducting the evaluation, the director of child sex trafficking prevention must consider evaluation of outcomes, including whether the program increases identification of sexually exploited youth, coordination of investigations, access to services and housing available for sexually exploited youth, and improved effectiveness of services. The evaluation must also include examination of the ways in which penalties under section 609.3241 are assessed, collected, and distributed to ensure funding for investigation, prosecution, and victim services to combat sexual exploitation of youth.

Sec. 27. Minnesota Statutes 2012, section 145.986, is amended to read:

145.986 STATEWIDE HEALTH IMPROVEMENT PROGRAM.

Subdivision 1. ~~**Grants to local communities**~~ **Purpose.** The purpose of the statewide health improvement program is to:

(1) address the top three leading preventable causes of illness and death: tobacco use and exposure, poor diet, and lack of regular physical activity;

(2) promote the development, availability, and use of evidence-based, community level, comprehensive strategies to create healthy communities; and

(3) measure the impact of the evidence-based, community health improvement practices which over time work to contain health care costs and reduce chronic diseases.

Subd. 1a. **Grants to local communities.** (a) Beginning July 1, 2009, the commissioner of health shall award competitive grants to community health boards established pursuant to section 145A.09 and tribal governments to convene, coordinate, and implement evidence-based strategies targeted at reducing the percentage of Minnesotans who are obese or overweight and to reduce the use of tobacco.

(b) Grantee activities shall:

(1) be based on scientific evidence;

(2) be based on community input;

(3) address behavior change at the individual, community, and systems levels;

(4) occur in community, school, worksite, and health care settings; ~~and~~

(5) be focused on policy, systems, and environmental changes that support healthy behaviors.; and

(6) address the health disparities and inequities that exist in the grantee's community.

(c) To receive a grant under this section, community health boards and tribal governments must submit proposals to the commissioner. A local match of ten percent of the total funding allocation is required. This local match may include funds donated by community partners.

(d) In order to receive a grant, community health boards and tribal governments must submit a health improvement plan to the commissioner of health for approval. The commissioner may require the plan to identify a community leadership team, community partners, and a community action plan that includes an assessment of area strengths and needs, proposed action strategies, technical assistance needs, and a staffing plan.

(e) The grant recipient must implement the health improvement plan, evaluate the effectiveness of the ~~interventions~~ strategies, and modify or discontinue ~~interventions~~ strategies found to be ineffective.

~~(f) By January 15, 2011, the commissioner of health shall recommend whether any funding should be distributed to community health boards and tribal governments based on health disparities demonstrated in the populations served.~~

~~(g)~~ (f) Grant recipients shall report their activities and their progress toward the outcomes established under subdivision 2 to the commissioner in a format and at a time specified by the commissioner.

~~(h)~~ (g) All grant recipients shall be held accountable for making progress toward the measurable outcomes established in subdivision 2. The commissioner shall require a corrective action plan and may reduce the funding level of grant recipients that do not make adequate progress toward the measurable outcomes.

(h) Notwithstanding paragraph (a), the commissioner may award funding to convene, coordinate, and implement evidence-based strategies targeted at reducing other risk factors, aside from tobacco use and exposure, poor diet, and lack of regular physical activity, that are associated with chronic disease and may impact public health. The commissioner shall develop a criteria and procedures to allocate funding under this section.

Subd. 2. **Outcomes.** (a) The commissioner shall set measurable outcomes to meet the goals specified in subdivision 1, and annually review the progress of grant recipients in meeting the outcomes.

(b) The commissioner shall measure current public health status, using existing measures and data collection systems when available, to determine baseline data against which progress shall be monitored.

Subd. 3. **Technical assistance and oversight.** (a) The commissioner shall provide content expertise, technical expertise, ~~and~~ training to grant recipients and advice on evidence-based strategies, including those based on populations and types of communities served. The commissioner shall ensure that the statewide health improvement program meets the outcomes established under subdivision 2 by conducting a comprehensive statewide evaluation and assisting grant recipients to modify or discontinue interventions found to be ineffective.

(b) For the purposes of carrying out the grant program under this section, including for administrative purposes, the commissioner shall award contracts to appropriate entities to assist in training and provide technical assistance to grantees.

(c) Contracts awarded under paragraph (b) may be used to provide technical assistance and training in the areas of:

(1) community engagement and capacity building;

(2) tribal support;

(3) community asset building and risk behavior reduction;

(4) legal;

(5) communications;

(6) community, school, health care, work site, and other site-specific strategies; and

(7) health equity.

Subd. 4. **Evaluation.** (a) Using the outcome measures established in subdivision 3, the commissioner shall conduct ~~a biennial~~ an evaluation of the statewide health improvement program funded under this section. Grant recipients shall cooperate with the commissioner in the evaluation and provide the commissioner with the information necessary to conduct the evaluation.

(b) Grant recipients will collect, monitor, and submit to the Department of Health baseline and annual data, and provide information to improve the quality and impact of community health improvement strategies.

(c) For the purposes of carrying out the grant program under this section, including for administrative purposes, the commissioner shall award contracts to appropriate entities to assist in designing and implementing evaluation systems.

(d) Contracts awarded under paragraph (c) may be used to:

(1) develop grantee monitoring and reporting systems to track grantee progress, including aggregated and disaggregated data;

(2) manage, analyze, and report program evaluation data results; and

(3) utilize innovative support tools to analyze and predict the impact of prevention strategies on health outcomes and state health care costs over time.

Subd. 5. **Report.** The commissioner shall submit a biennial report to the legislature on the statewide health improvement program funded under this section. These reports must include information on grant recipients, activities that were conducted using grant funds, evaluation data, and outcome measures, if available. In addition, the commissioner shall provide recommendations on future areas of focus for health improvement. These reports are due by January 15 of every other year, beginning in 2010. ~~In the report due on January 15, 2010, the commissioner shall include recommendations on a sustainable funding source for the statewide health improvement program other than the health care access fund.~~

Subd. 6. **Supplantation of existing funds.** Community health boards and tribal governments must use funds received under this section to develop new programs, expand current programs that work to reduce the percentage of Minnesotans who are obese or overweight or who use tobacco, or replace discontinued state or federal funds previously used to reduce the percentage of Minnesotans who are obese or overweight or who use tobacco. Funds must not be used to supplant current state or local funding to community health boards or tribal governments used to reduce the percentage of Minnesotans who are obese or overweight or to reduce tobacco use.

Sec. 28. Minnesota Statutes 2012, section 149A.02, subdivision 1a, is amended to read:

Subd. 1a. **Alkaline hydrolysis.** "Alkaline hydrolysis" means the reduction of a dead human body to essential elements through ~~exposure to a combination of heat and alkaline hydrolysis and the repositioning or movement of the body during the process to facilitate reduction,~~ a water-based dissolution process using alkaline chemicals, heat, agitation, and pressure to accelerate natural decomposition; the processing of the hydrolyzed remains after removal from the alkaline hydrolysis ~~chamber,~~ vessel; placement of the processed remains in a hydrolyzed remains container~~,~~; and release of the hydrolyzed remains to an appropriate party. Alkaline hydrolysis is a form of final disposition.

Sec. 29. Minnesota Statutes 2012, section 149A.02, is amended by adding a subdivision to read:

Subd. 1b. **Alkaline hydrolysis container.** "Alkaline hydrolysis container" means a hydrolyzable or biodegradable closed container or pouch resistant to leakage of bodily fluids that encases the body and into which a dead human body is placed prior to insertion into an alkaline hydrolysis vessel. Alkaline hydrolysis containers may be hydrolyzable or biodegradable alternative containers or caskets.

Sec. 30. Minnesota Statutes 2012, section 149A.02, is amended by adding a subdivision to read:

Subd. 1c. **Alkaline hydrolysis facility.** "Alkaline hydrolysis facility" means a building or structure containing one or more alkaline hydrolysis vessels for the alkaline hydrolysis of dead human bodies.

Sec. 31. Minnesota Statutes 2012, section 149A.02, is amended by adding a subdivision to read:

Subd. 1d. **Alkaline hydrolysis vessel.** "Alkaline hydrolysis vessel" means the container in which the alkaline hydrolysis of a dead human body is performed.

Sec. 32. Minnesota Statutes 2012, section 149A.02, subdivision 2, is amended to read:

Subd. 2. **Alternative container.** "Alternative container" means a nonmetal receptacle or enclosure, without ornamentation or a fixed interior lining, which is designed for the encasement of dead human bodies and is made of hydrolyzable or biodegradable materials, corrugated cardboard, fiberboard, pressed-wood, or other like materials.

Sec. 33. Minnesota Statutes 2012, section 149A.02, subdivision 3, is amended to read:

Subd. 3. **Arrangements for disposition.** "Arrangements for disposition" means any action normally taken by a funeral provider in anticipation of or preparation for the entombment, burial in a cemetery, alkaline hydrolysis, or cremation of a dead human body.

Sec. 34. Minnesota Statutes 2012, section 149A.02, subdivision 4, is amended to read:

Subd. 4. **Cash advance item.** "Cash advance item" means any item of service or merchandise described to a purchaser as a "cash advance," "accommodation," "cash disbursement," or similar term. A cash advance item is also any item obtained from a third party and paid for by the funeral provider on the purchaser's behalf. Cash advance items include, but are not limited to, cemetery, alkaline hydrolysis, or crematory services, pallbearers, public transportation, clergy honoraria, flowers, musicians or singers, obituary notices, gratuities, and death records.

Sec. 35. Minnesota Statutes 2012, section 149A.02, subdivision 5, is amended to read:

Subd. 5. **Casket.** "Casket" means a rigid container which is designed for the encasement of a dead human body and is usually constructed of hydrolyzable or biodegradable materials, wood, metal, fiberglass, plastic, or like material, and ornamented and lined with fabric.

Sec. 36. Minnesota Statutes 2012, section 149A.02, is amended by adding a subdivision to read:

Subd. 12a. **Crypt.** "Crypt" means a space in a mausoleum of sufficient size, used or intended to be used, to entomb human remains, cremated remains, or hydrolyzed remains.

Sec. 37. Minnesota Statutes 2012, section 149A.02, is amended by adding a subdivision to read:

Subd. 12b. **Direct alkaline hydrolysis.** "Direct alkaline hydrolysis" means a final disposition of a dead human body by alkaline hydrolysis, without formal viewing, visitation, or ceremony with the body present.

Sec. 38. Minnesota Statutes 2012, section 149A.02, subdivision 16, is amended to read:

Subd. 16. **Final disposition.** "Final disposition" means the acts leading to and the entombment, burial in a cemetery, alkaline hydrolysis, or cremation of a dead human body.

Sec. 39. Minnesota Statutes 2012, section 149A.02, subdivision 23, is amended to read:

Subd. 23. **Funeral services.** "Funeral services" means any services which may be used to: (1) care for and prepare dead human bodies for burial, alkaline hydrolysis, cremation, or other final disposition; and (2) arrange, supervise, or conduct the funeral ceremony or the final disposition of dead human bodies.

Sec. 40. Minnesota Statutes 2012, section 149A.02, is amended by adding a subdivision to read:

Subd. 24b. **Hydrolyzed remains.** "Hydrolyzed remains" means the remains of a dead human body following the alkaline hydrolysis process. Hydrolyzed remains does not include pacemakers, prostheses, or similar foreign materials.

Sec. 41. Minnesota Statutes 2012, section 149A.02, is amended by adding a subdivision to read:

Subd. 24c. **Hydrolyzed remains container.** "Hydrolyzed remains container" means a receptacle in which hydrolyzed remains are placed. For purposes of this chapter, a hydrolyzed remains container is interchangeable with "urn" or similar keepsake storage jewelry.

Sec. 42. Minnesota Statutes 2012, section 149A.02, is amended by adding a subdivision to read:

Subd. 26a. **Inurnment.** "Inurnment" means placing hydrolyzed or cremated remains in a hydrolyzed or cremated remains container suitable for placement, burial, or shipment.

Sec. 43. Minnesota Statutes 2012, section 149A.02, subdivision 27, is amended to read:

Subd. 27. **Licensee.** "Licensee" means any person or entity that has been issued a license to practice mortuary science, to operate a funeral establishment, to operate an alkaline hydrolysis facility, or to operate a crematory by the Minnesota commissioner of health.

Sec. 44. Minnesota Statutes 2012, section 149A.02, is amended by adding a subdivision to read:

Subd. 30a. **Niche.** "Niche" means a space in a columbarium used, or intended to be used, for the placement of hydrolyzed or cremated remains.

Sec. 45. Minnesota Statutes 2012, section 149A.02, is amended by adding a subdivision to read:

Subd. 32a. **Placement.** "Placement" means the placing of a container holding hydrolyzed or cremated remains in a crypt, vault, or niche.

Sec. 46. Minnesota Statutes 2012, section 149A.02, subdivision 34, is amended to read:

Subd. 34. **Preparation of the body.** "Preparation of the body" means placement of the body into an appropriate cremation or alkaline hydrolysis container, embalming of the body or such items of care as washing, disinfecting, shaving, positioning of features, restorative procedures, application of cosmetics, dressing, and casketing.

Sec. 47. Minnesota Statutes 2012, section 149A.02, subdivision 35, is amended to read:

Subd. 35. **Processing.** "Processing" means the removal of foreign objects, drying or cooling, and the reduction of the hydrolyzed or cremated remains by mechanical means including, but not limited to, grinding, crushing, or pulverizing, to a granulated appearance appropriate for final disposition.

Sec. 48. Minnesota Statutes 2012, section 149A.02, subdivision 37, is amended to read:

Subd. 37. **Public transportation.** "Public transportation" means all manner of transportation via common carrier available to the general public including airlines, buses, railroads, and ships. For purposes of this chapter, a livery service providing transportation

to private funeral establishments, alkaline hydrolysis facilities, or crematories is not public transportation.

Sec. 49. Minnesota Statutes 2012, section 149A.02, is amended by adding a subdivision to read:

Subd. 37c. **Scattering.** "Scattering" means the authorized dispersal of hydrolyzed or cremated remains in a defined area of a dedicated cemetery or in areas where no local prohibition exists provided that the hydrolyzed or cremated remains are not distinguishable to the public, are not in a container, and that the person who has control over disposition of the hydrolyzed or cremated remains has obtained written permission of the property owner or governing agency to scatter on the property.

Sec. 50. Minnesota Statutes 2012, section 149A.02, is amended by adding a subdivision to read:

Subd. 41. **Vault.** "Vault" means a space in a mausoleum of sufficient size, used or intended to be used, to entomb human remains, cremated remains, or hydrolyzed remains. Vault may also mean a sealed and lined casket enclosure.

Sec. 51. Minnesota Statutes 2012, section 149A.03, is amended to read:

149A.03 DUTIES OF COMMISSIONER.

The commissioner shall:

(1) enforce all laws and adopt and enforce rules relating to the:

(i) removal, preparation, transportation, arrangements for disposition, and final disposition of dead human bodies;

(ii) licensure and professional conduct of funeral directors, morticians, interns, practicum students, and clinical students;

(iii) licensing and operation of a funeral establishment; ~~and~~

(iv) licensing and operation of an alkaline hydrolysis facility; and

~~(iv)~~ (v) licensing and operation of a crematory;

(2) provide copies of the requirements for licensure and permits to all applicants;

(3) administer examinations and issue licenses and permits to qualified persons and other legal entities;

(4) maintain a record of the name and location of all current licensees and interns;

(5) perform periodic compliance reviews and premise inspections of licensees;

(6) accept and investigate complaints relating to conduct governed by this chapter;

(7) maintain a record of all current preneed arrangement trust accounts;

(8) maintain a schedule of application, examination, permit, and licensure fees, initial and renewal, sufficient to cover all necessary operating expenses;

(9) educate the public about the existence and content of the laws and rules for mortuary science licensing and the removal, preparation, transportation, arrangements for disposition, and final disposition of dead human bodies to enable consumers to file complaints against licensees and others who may have violated those laws or rules;

(10) evaluate the laws, rules, and procedures regulating the practice of mortuary science in order to refine the standards for licensing and to improve the regulatory and enforcement methods used; and

(11) initiate proceedings to address and remedy deficiencies and inconsistencies in the laws, rules, or procedures governing the practice of mortuary science and the removal, preparation, transportation, arrangements for disposition, and final disposition of dead human bodies.

Sec. 52. **[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. 53. **[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. 54. Minnesota Statutes 2012, section 149A.65, is amended by adding a subdivision to read:

Subd. 6. **Alkaline hydrolysis facilities.** The initial and renewal fee for an alkaline hydrolysis facility is $300. The late fee charge for a license renewal is $25.

Sec. 55. Minnesota Statutes 2012, section 149A.65, is amended by adding a subdivision to read:

Subd. 7. **State government special revenue fund.** Fees collected by the commissioner under this section must be deposited in the state treasury and credited to the state government special revenue fund.

Sec. 56. Minnesota Statutes 2012, section 149A.70, subdivision 1, is amended to read:

Subdivision 1. **Use of titles.** Only a person holding a valid license to practice mortuary science issued by the commissioner may use the title of mortician, funeral director, or any other title implying that the licensee is engaged in the business or practice of mortuary science. Only the holder of a valid license to operate an alkaline hydrolysis facility issued by the commissioner may use the title of alkaline hydrolysis facility, water cremation, water-reduction, biocremation, green-cremation, resomation, dissolution, or any other title, word, or term implying that the licensee operates an alkaline hydrolysis facility. Only the holder of a valid license to operate a funeral establishment issued by the commissioner may use the title of funeral home, funeral chapel, funeral service, or any other title, word, or term implying that the licensee is engaged in the business or practice of mortuary science. Only the holder of a valid license to operate a crematory issued by the commissioner may use the title of crematory, crematorium, green-cremation, or any other title, word, or term implying that the licensee operates a crematory or crematorium.

Sec. 57. Minnesota Statutes 2012, section 149A.70, subdivision 2, is amended to read:

Subd. 2. **Business location.** A funeral establishment, alkaline hydrolysis facility, or crematory shall not do business in a location that is not licensed as a funeral establishment, alkaline hydrolysis facility, or crematory and shall not advertise a service that is available from an unlicensed location.

Sec. 58. Minnesota Statutes 2012, section 149A.70, subdivision 3, is amended to read:

Subd. 3. **Advertising.** No licensee, clinical student, practicum student, or intern shall publish or disseminate false, misleading, or deceptive advertising. False, misleading, or deceptive advertising includes, but is not limited to:

(1) identifying, by using the names or pictures of, persons who are not licensed to practice mortuary science in a way that leads the public to believe that those persons will provide mortuary science services;

(2) using any name other than the names under which the funeral establishment, alkaline hydrolysis facility, or crematory is known to or licensed by the commissioner;

(3) using a surname not directly, actively, or presently associated with a licensed funeral establishment, alkaline hydrolysis facility, or crematory, unless the surname had been previously and continuously used by the licensed funeral establishment, alkaline hydrolysis facility, or crematory; and

(4) using a founding or establishing date or total years of service not directly or continuously related to a name under which the funeral establishment, alkaline hydrolysis facility, or crematory is currently or was previously licensed.

Any advertising or other printed material that contains the names or pictures of persons affiliated with a funeral establishment, alkaline hydrolysis facility, or crematory shall state the position held by the persons and shall identify each person who is licensed or unlicensed under this chapter.

Sec. 59. Minnesota Statutes 2012, section 149A.70, subdivision 5, is amended to read:

Subd. 5. **Reimbursement prohibited.** No licensee, clinical student, practicum student, or intern shall offer, solicit, or accept a commission, fee, bonus, rebate, or other reimbursement in consideration for recommending or causing a dead human body to be disposed of by a specific body donation program, funeral establishment, alkaline hydrolysis facility, crematory, mausoleum, or cemetery.

Sec. 60. Minnesota Statutes 2012, section 149A.71, subdivision 2, is amended to read:

Subd. 2. **Preventive requirements.** (a) To prevent unfair or deceptive acts or practices, the requirements of this subdivision must be met.

(b) Funeral providers must tell persons who ask by telephone about the funeral provider's offerings or prices any accurate information from the price lists described in paragraphs (c) to (e) and any other readily available information that reasonably answers the questions asked.

(c) Funeral providers must make available for viewing to people who inquire in person about the offerings or prices of funeral goods or burial site goods, separate printed or typewritten price lists using a ten-point font or larger. Each funeral provider must have a separate price list for each of the following types of goods that are sold or offered for sale:

(1) caskets;

(2) alternative containers;

(3) outer burial containers;

(4) alkaline hydrolysis containers;

~~(4)~~ (5) cremation containers;

(6) hydrolyzed remains containers;

~~(5)~~ (7) cremated remains containers;

~~(6)~~ (8) markers; and

~~(7)~~ (9) headstones.

(d) Each separate price list must contain the name of the funeral provider's place of business, address, and telephone number and a caption describing the list as a price list for one of the types of funeral goods or burial site goods described in paragraph (c), clauses (1) to ~~(7)~~ (9). The funeral provider must offer the list upon beginning discussion of, but in any event before showing, the specific funeral goods or burial site goods and must provide a photocopy of the price list, for retention, if so asked by the consumer. The list must contain, at least, the retail prices of all the specific funeral goods and burial site goods offered which do not require special ordering, enough information to identify each, and the effective date for the price list. However, funeral providers are not required to make a specific price list available if the funeral providers place the information required by this paragraph on the general price list described in paragraph (e).

(e) Funeral providers must give a printed price list, for retention, to persons who inquire in person about the funeral goods, funeral services, burial site goods, or burial site services or prices offered by the funeral provider. The funeral provider must give the list upon beginning discussion of either the prices of or the overall type of funeral service or disposition or specific funeral goods, funeral services, burial site goods, or burial site services offered by the provider. This requirement applies whether the discussion takes place in the funeral establishment or elsewhere. However, when the deceased is removed for transportation to the funeral establishment, an in-person request for authorization to embalm does not, by itself, trigger the requirement to offer the general price list. If the provider, in making an in-person request for authorization to embalm, discloses that embalming is not required by law except in certain special cases, the provider is not required to offer the general price list. Any other discussion during that time about prices or the selection of funeral goods, funeral services, burial site goods, or burial site services triggers the requirement to give the consumer a general price list. The general price list must contain the following information:

(1) the name, address, and telephone number of the funeral provider's place of business;

(2) a caption describing the list as a "general price list";

(3) the effective date for the price list;

(4) the retail prices, in any order, expressed either as a flat fee or as the prices per hour, mile, or other unit of computation, and other information described as follows:

(i) forwarding of remains to another funeral establishment, together with a list of the services provided for any quoted price;

(ii) receiving remains from another funeral establishment, together with a list of the services provided for any quoted price;

(iii) separate prices for each alkaline hydrolysis or cremation offered by the funeral provider, with the price including an alternative container or alkaline hydrolysis or cremation container, any alkaline hydrolysis or crematory charges, and a description of the services and container included in the price, where applicable, and the price of alkaline hydrolysis or cremation where the purchaser provides the container;

(iv) separate prices for each immediate burial offered by the funeral provider, including a casket or alternative container, and a description of the services and container included in that price, and the price of immediate burial where the purchaser provides the casket or alternative container;

(v) transfer of remains to the funeral establishment or other location;

(vi) embalming;

(vii) other preparation of the body;

(viii) use of facilities, equipment, or staff for viewing;

(ix) use of facilities, equipment, or staff for funeral ceremony;

(x) use of facilities, equipment, or staff for memorial service;

(xi) use of equipment or staff for graveside service;

(xii) hearse or funeral coach;

(xiii) limousine; and

(xiv) separate prices for all cemetery-specific goods and services, including all goods and services associated with interment and burial site goods and services and excluding markers and headstones;

(5) the price range for the caskets offered by the funeral provider, together with the statement "A complete price list will be provided at the funeral establishment or casket sale location." or the prices of individual caskets, as disclosed in the manner described in paragraphs (c) and (d);

(6) the price range for the alternative containers offered by the funeral provider, together with the statement "A complete price list will be provided at the funeral establishment or alternative container sale location." or the prices of individual alternative containers, as disclosed in the manner described in paragraphs (c) and (d);

(7) the price range for the outer burial containers offered by the funeral provider, together with the statement "A complete price list will be provided at the funeral

establishment or outer burial container sale location." or the prices of individual outer burial containers, as disclosed in the manner described in paragraphs (c) and (d);

(8) the price range for the alkaline hydrolysis container offered by the funeral provider, together with the statement: "A complete price list will be provided at the funeral establishment or alkaline hydrolysis container sale location.", or the prices of individual alkaline hydrolysis containers, as disclosed in the manner described in paragraphs (c) and (d);

(9) the price range for the hydrolyzed remains container offered by the funeral provider, together with the statement: "A complete price list will be provided at the funeral establishment or hydrolyzed remains container sale location.", or the prices of individual hydrolyzed remains container, as disclosed in the manner described in paragraphs (c) and (d);

~~(8)~~ (10) the price range for the cremation containers offered by the funeral provider, together with the statement "A complete price list will be provided at the funeral establishment or cremation container sale location." or the prices of individual cremation containers ~~and cremated remains containers~~, as disclosed in the manner described in paragraphs (c) and (d);

~~(9)~~ (11) the price range for the cremated remains containers offered by the funeral provider, together with the statement, "A complete price list will be provided at the funeral establishment or ~~cremation~~ cremated remains container sale location," or the prices of individual cremation containers as disclosed in the manner described in paragraphs (c) and (d);

~~(10)~~ (12) the price for the basic services of funeral provider and staff, together with a list of the principal basic services provided for any quoted price and, if the charge cannot be declined by the purchaser, the statement "This fee for our basic services will be added to the total cost of the funeral arrangements you select. (This fee is already included in our charges for alkaline hydrolysis, direct cremations, immediate burials, and forwarding or receiving remains.)" If the charge cannot be declined by the purchaser, the quoted price shall include all charges for the recovery of unallocated funeral provider overhead, and funeral providers may include in the required disclosure the phrase "and overhead" after the word "services." This services fee is the only funeral provider fee for services, facilities, or unallocated overhead permitted by this subdivision to be nondeclinable, unless otherwise required by law;

~~(11)~~ (13) the price range for the markers and headstones offered by the funeral provider, together with the statement "A complete price list will be provided at the funeral

establishment or marker or headstone sale location." or the prices of individual markers and headstones, as disclosed in the manner described in paragraphs (c) and (d); and

~~(12)~~ (14) any package priced funerals offered must be listed in addition to and following the information required in paragraph (e) and must clearly state the funeral goods and services being offered, the price being charged for those goods and services, and the discounted savings.

(f) Funeral providers must give an itemized written statement, for retention, to each consumer who arranges an at-need funeral or other disposition of human remains at the conclusion of the discussion of the arrangements. The itemized written statement must be signed by the consumer selecting the goods and services as required in section 149A.80. If the statement is provided by a funeral establishment, the statement must be signed by the licensed funeral director or mortician planning the arrangements. If the statement is provided by any other funeral provider, the statement must be signed by an authorized agent of the funeral provider. The statement must list the funeral goods, funeral services, burial site goods, or burial site services selected by that consumer and the prices to be paid for each item, specifically itemized cash advance items (these prices must be given to the extent then known or reasonably ascertainable if the prices are not known or reasonably ascertainable, a good faith estimate shall be given and a written statement of the actual charges shall be provided before the final bill is paid), and the total cost of goods and services selected. At the conclusion of an at-need arrangement, the funeral provider is required to give the consumer a copy of the signed itemized written contract that must contain the information required in this paragraph.

(g) Upon receiving actual notice of the death of an individual with whom a funeral provider has entered a preneed funeral agreement, the funeral provider must provide a copy of all preneed funeral agreement documents to the person who controls final disposition of the human remains or to the designee of the person controlling disposition. The person controlling final disposition shall be provided with these documents at the time of the person's first in-person contact with the funeral provider, if the first contact occurs in person at a funeral establishment, alkaline hydrolysis facility, crematory, or other place of business of the funeral provider. If the contact occurs by other means or at another location, the documents must be provided within 24 hours of the first contact.

Sec. 61. Minnesota Statutes 2012, section 149A.71, subdivision 4, is amended to read:

Subd. 4. **Casket, alternate container, alkaline hydrolysis containers, and cremation container sales; records; required disclosures.** Any funeral provider who sells or offers to sell a casket, alternate container, alkaline hydrolysis container, hydrolyzed

remains container, or cremation container, or cremated remains container to the public must maintain a record of each sale that includes the name of the purchaser, the purchaser's mailing address, the name of the decedent, the date of the decedent's death, and the place of death. These records shall be open to inspection by the regulatory agency. Any funeral provider selling a casket, alternate container, or cremation container to the public, and not having charge of the final disposition of the dead human body, shall provide a copy of the statutes and rules controlling the removal, preparation, transportation, arrangements for disposition, and final disposition of a dead human body. This subdivision does not apply to morticians, funeral directors, funeral establishments, crematories, or wholesale distributors of caskets, alternate containers, alkaline hydrolysis containers, or cremation containers.

Sec. 62. Minnesota Statutes 2012, section 149A.72, subdivision 3, is amended to read:

Subd. 3. **Casket for alkaline hydrolysis or cremation provisions; deceptive acts or practices.** In selling or offering to sell funeral goods or funeral services to the public, it is a deceptive act or practice for a funeral provider to represent that a casket is required for alkaline hydrolysis or cremations by state or local law or otherwise.

Sec. 63. Minnesota Statutes 2012, section 149A.72, is amended by adding a subdivision to read:

Subd. 3a. **Casket for alkaline hydrolysis provision; preventive measures.** To prevent deceptive acts or practices, funeral providers must place the following disclosure in immediate conjunction with the prices shown for alkaline hydrolysis: "Minnesota law does not require you to purchase a casket for alkaline hydrolysis. If you want to arrange for alkaline hydrolysis, you can use an alkaline hydrolysis container. An alkaline hydrolysis container is a hydrolyzable or biodegradable closed container or pouch resistant to leakage of bodily fluids that encases the body and into which a dead human body is placed prior to insertion into an alkaline hydrolysis vessel. The containers we provide are (specify containers provided)." This disclosure is required only if the funeral provider arranges alkaline hydrolysis.

Sec. 64. Minnesota Statutes 2012, section 149A.72, subdivision 9, is amended to read:

Subd. 9. **Deceptive acts or practices.** In selling or offering to sell funeral goods, funeral services, burial site goods, or burial site services to the public, it is a deceptive act or practice for a funeral provider to represent that federal, state, or local laws, or particular cemeteries, alkaline hydrolysis facilities, or crematories, require the purchase of any funeral goods, funeral services, burial site goods, or burial site services when that is not the case.

Sec. 65. Minnesota Statutes 2012, section 149A.73, subdivision 1, is amended to read:

Subdivision 1. **Casket for alkaline hydrolysis or cremation provisions; deceptive acts or practices.** In selling or offering to sell funeral goods, funeral services, burial site goods, or burial site services to the public, it is a deceptive act or practice for a funeral provider to require that a casket be purchased for alkaline hydrolysis or cremation.

Sec. 66. Minnesota Statutes 2012, section 149A.73, subdivision 2, is amended to read:

Subd. 2. **Casket for alkaline hydrolysis or cremation; preventive requirements.** To prevent unfair or deceptive acts or practices, if funeral providers arrange for alkaline hydrolysis or cremations, they must make ~~a~~ an alkaline hydrolysis container or cremation container available for alkaline hydrolysis or cremations.

Sec. 67. Minnesota Statutes 2012, section 149A.73, subdivision 4, is amended to read:

Subd. 4. **Required purchases of funeral goods or services; preventive requirements.** To prevent unfair or deceptive acts or practices, funeral providers must place the following disclosure in the general price list, immediately above the prices required by section 149A.71, subdivision 2, paragraph (e), clauses (4) to (10): "The goods and services shown below are those we can provide to our customers. You may choose only the items you desire. If legal or other requirements mean that you must buy any items you did not specifically ask for, we will explain the reason in writing on the statement we provide describing the funeral goods, funeral services, burial site goods, and burial site services you selected." However, if the charge for "services of funeral director and staff" cannot be declined by the purchaser, the statement shall include the sentence "However, any funeral arrangements you select will include a charge for our basic services." between the second and third sentences of the sentences specified in this subdivision. The statement may include the phrase "and overhead" after the word "services" if the fee includes a charge for the recovery of unallocated funeral overhead. If the funeral provider does not include this disclosure statement, then the following disclosure statement must be placed in the statement of funeral goods, funeral services, burial site goods, and burial site services selected, as described in section 149A.71, subdivision 2, paragraph (f): "Charges are only for those items that you selected or that are required. If we are required by law or by a cemetery, alkaline hydrolysis facility, or crematory to use any items, we will explain the reasons in writing below." A funeral provider is not in violation of this subdivision by failing to comply with a request for a combination of goods or services which would be impossible, impractical, or excessively burdensome to provide.

Sec. 68. Minnesota Statutes 2012, section 149A.74, is amended to read:

149A.74 FUNERAL SERVICES PROVIDED WITHOUT PRIOR APPROVAL.

Subdivision 1. **Services provided without prior approval; deceptive acts or practices.** In selling or offering to sell funeral goods or funeral services to the public, it is a deceptive act or practice for any funeral provider to embalm a dead human body unless state or local law or regulation requires embalming in the particular circumstances regardless of any funeral choice which might be made, or prior approval for embalming has been obtained from an individual legally authorized to make such a decision. In seeking approval to embalm, the funeral provider must disclose that embalming is not required by law except in certain circumstances; that a fee will be charged if a funeral is selected which requires embalming, such as a funeral with viewing; and that no embalming fee will be charged if the family selects a service which does not require embalming, such as direct alkaline hydrolysis, direct cremation, or immediate burial.

Subd. 2. **Services provided without prior approval; preventive requirement.** To prevent unfair or deceptive acts or practices, funeral providers must include on the itemized statement of funeral goods or services, as described in section 149A.71, subdivision 2, paragraph (f), the statement "If you selected a funeral that may require embalming, such as a funeral with viewing, you may have to pay for embalming. You do not have to pay for embalming you did not approve if you selected arrangements such as direct alkaline hydrolysis, direct cremation, or immediate burial. If we charged for embalming, we will explain why below."

Sec. 69. Minnesota Statutes 2012, section 149A.91, subdivision 9, is amended to read:

Subd. 9. **~~Embalmed~~ Bodies awaiting final disposition.** All ~~embalmed~~ bodies awaiting final disposition shall be kept in an appropriate holding facility or preparation and embalming room. The holding facility must be secure from access by anyone except the authorized personnel of the funeral establishment, preserve the dignity and integrity of the body, and protect the health and safety of the personnel of the funeral establishment.

Sec. 70. Minnesota Statutes 2012, section 149A.93, subdivision 3, is amended to read:

Subd. 3. **Disposition permit.** A disposition permit is required before a body can be buried, entombed, alkaline hydrolyzed, or cremated. No disposition permit shall be issued until a fact of death record has been completed and filed with the local or state registrar of vital statistics.

Sec. 71. Minnesota Statutes 2012, section 149A.93, subdivision 6, is amended to read:

Subd. 6. **Conveyances permitted for transportation.** A dead human body may be transported by means of private vehicle or private aircraft, provided that the body must be encased in an appropriate container, that meets the following standards:

(1) promotes respect for and preserves the dignity of the dead human body;

(2) shields the body from being viewed from outside of the conveyance;

(3) has ample enclosed area to accommodate a cot, stretcher, rigid tray, casket, alternative container, alkaline hydrolysis container, or cremation container in a horizontal position;

(4) is designed to permit loading and unloading of the body without excessive tilting of the cot, stretcher, rigid tray, casket, alternative container, alkaline hydrolysis container, or cremation container; and

(5) if used for the transportation of more than one dead human body at one time, the vehicle must be designed so that a body or container does not rest directly on top of another body or container and that each body or container is secured to prevent the body or container from excessive movement within the conveyance.

A vehicle that is a dignified conveyance and was specified for use by the deceased or by the family of the deceased may be used to transport the body to the place of final disposition.

Sec. 72. Minnesota Statutes 2012, section 149A.94, is amended to read:

149A.94 FINAL DISPOSITION.

Subdivision 1. **Generally.** Every dead human body lying within the state, except unclaimed bodies delivered for dissection by the medical examiner, those delivered for anatomical study pursuant to section 149A.81, subdivision 2, or lawfully carried through the state for the purpose of disposition elsewhere; and the remains of any dead human body after dissection or anatomical study, shall be decently buried, or entombed in a public or private cemetery, alkaline hydrolyzed or cremated, within a reasonable time after death. Where final disposition of a body will not be accomplished within 72 hours following death or release of the body by a competent authority with jurisdiction over the body, the body must be properly embalmed, refrigerated, or packed with dry ice. A body may not be kept in refrigeration for a period exceeding six calendar days, or packed in dry ice for a period that exceeds four calendar days, from the time of death or release of the body from the coroner or medical examiner.

Subd. 3. **Permit required.** No dead human body shall be buried, entombed, or cremated without a disposition permit. The disposition permit must be filed with the person

in charge of the place of final disposition. Where a dead human body will be transported out of this state for final disposition, the body must be accompanied by a certificate of removal.

Subd. 4. **Alkaline hydrolysis or cremation.** Inurnment of alkaline hydrolyzed or cremated remains and release to an appropriate party is considered final disposition and no further permits or authorizations are required for transportation, interment, entombment, or placement of the cremated remains, except as provided in section 149A.95, subdivision 16.

Sec. 73. **[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 bodies 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. 74. Minnesota Statutes 2012, section 149A.96, subdivision 9, is amended to read:

Subd. 9. **Hydrolyzed and cremated remains.** Subject to section 149A.95, subdivision 16, inurnment of the hydrolyzed or cremated remains and release to an appropriate party is considered final disposition and no further permits or authorizations are required for disinterment, transportation, or placement of the hydrolyzed or cremated remains.

Sec. 75. Laws 2011, First Special Session chapter 9, article 2, section 27, is amended to read:

Sec. 27. **MINNESOTA TASK FORCE ON PREMATURITY.**

Subdivision 1. **Establishment.** The Minnesota Task Force on Prematurity is established to evaluate and make recommendations on methods for reducing prematurity and improving premature infant health care in the state.

Subd. 2. **Membership; meetings; staff.** (a) The task force shall be composed of at least the following members, who serve at the pleasure of their appointing authority:

(1) 15 representatives of the Minnesota Prematurity Coalition including, but not limited to, health care providers who treat pregnant women or neonates, organizations focused on preterm births, early childhood education and development professionals, and families affected by prematurity;

(2) one representative appointed by the commissioner of human services;

(3) two representatives appointed by the commissioner of health;

(4) one representative appointed by the commissioner of education;

(5) two members of the house of representatives, one appointed by the speaker of the house and one appointed by the minority leader; and

(6) two members of the senate, appointed according to the rules of the senate.

(b) Members of the task force serve without compensation or payment of expenses.

(c) The commissioner of health must convene the first meeting of the Minnesota Task Force on Prematurity by July 31, 2011. The task force must continue to meet at least quarterly. Staffing and technical assistance shall be provided by the Minnesota Perinatal Coalition.

Subd. 3. **Duties.** The task force must report the current state of prematurity in Minnesota and develop recommendations on strategies for reducing prematurity and improving premature infant health care in the state by ~~considering the following~~:

(1) promoting adherence to standards of care for premature infants born less than 37 weeks gestational age, including ~~recommendations to improve~~ utilization of appropriate hospital discharge and follow-up care procedures;

(2) coordination of information among appropriate professional and advocacy organizations on measures to improve health care for infants born prematurely;

(3) identification and centralization of available resources to improve access and awareness for caregivers of premature infants; and

~~(4) development and dissemination of evidence-based practices through networking and educational opportunities;~~

~~(5) a review of relevant evidence-based research regarding the causes and effects of premature births in Minnesota;~~

~~(6) a review of relevant evidence-based research regarding premature infant health care, including methods for improving quality of and access to care for premature infants;~~

~~(7)~~ (4) a review of the potential improvements in health status related to the use of health care homes to provide and coordinate pregnancy-related services~~; and~~.

~~(8) identification of gaps in public reporting measures and possible effects of these measures on prematurity rates.~~

Subd. 4. **Report; expiration.** (a) By ~~November 30, 2011~~ January 15, 2015, the task force must submit a final report to the chairs and ranking minority members of the legislative policy committees on health and human services on the ~~current~~ state of prematurity in Minnesota ~~to the chairs of the legislative policy committees on health and human services~~, including any recommendations to reduce premature births and improve premature infant health in the state.

~~(b) By January 15, 2013, the task force must report its final recommendations, including any draft legislation necessary for implementation, to the chairs of the legislative policy committees on health and human services.~~

~~(c)~~ (b) This task force expires on January 31, ~~2013~~ 2015, or upon submission of the final report required in paragraph ~~(b)~~ (a), whichever is earlier.

Sec. 76. **FUNERAL ESTABLISHMENTS; BRANCH LOCATIONS.**

The commissioner of health shall review the statutory requirements for preparation and embalming rooms and develop legislation with input from stakeholders that provides appropriate health and safety protection for funeral home locations where deceased bodies are present but are branch locations associated through a majority ownership of a licensed funeral establishment that meets the requirements of Minnesota Statutes, sections 149A.50 and 149A.92, subdivisions 2 to 10. The review shall include consideration of distance between the main location and branch and other health and safety issues.

Sec. 77. **STAFFING PLAN DISCLOSURE ACT.**

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

(b) "Core staffing plan" means the projected number of full-time equivalent nonmanagerial care staff that will be assigned in a 24-hour period to an inpatient care unit.

(c) "Nonmanagerial care staff" means registered nurses, licensed practical nurses, and other health care workers, which may include but is not limited to nursing assistants,

nursing aides, patient care technicians, and patient care assistants, who perform nonmanagerial direct patient care functions for more than 50 percent of their scheduled hours on a given patient care unit.

(d) "Inpatient care unit" means a designated inpatient area for assigning patients and staff for which a distinct staffing plan exists and that operates 24 hours per day, seven days per week in a hospital setting. Inpatient care unit does not include any hospital-based clinic, long-term care facility, or outpatient hospital department.

(e) "Staffing hours per patient day" means the number of full-time equivalent nonmanagerial care staff who will ordinarily be assigned to provide direct patient care divided by the expected average number of patients upon which such assignments are based.

(f) "Patient acuity tool" means a system for measuring an individual patient's need for nursing care. This includes utilizing a professional registered nursing assessment of patient condition to assess staffing need.

Subd. 2. **Hospital staffing report.** (a) The chief nursing executive or nursing designee of every reporting hospital in Minnesota under section 144.50 will develop a core staffing plan for each patient care unit.

(b) Core staffing plans shall specify the full-time equivalent for each patient care unit for each 24-hour period.

(c) Prior to submitting the core staffing plan, as required in subdivision 3, hospitals shall consult with representatives of the hospital medical staff, managerial and nonmanagerial care staff, and other relevant hospital personnel about the core staffing plan and the expected average number of patients upon which the staffing plan is based.

Subd. 3. **Standard electronic reporting developed.** (a) Hospitals must submit the core staffing plans to the Minnesota Hospital Association by January 1, 2014. The Minnesota Hospital Association shall include each reporting hospital's core staffing plan on the Minnesota Hospital Association's Minnesota Hospital Quality Report Web site by April 1, 2014. Any substantial changes to the core staffing plan shall be updated within 30 days.

(b) The Minnesota Hospital Association shall include on its Web site for each reporting hospital on a quarterly basis the actual direct patient care hours per patient and per unit. Hospitals must submit the direct patient care report to the Minnesota Hospital Association by July 1, 2014, and quarterly thereafter.

Sec. 78. **STUDY; NURSE STAFFING LEVELS AND PATIENT OUTCOMES.**

The Department of Health shall convene a work group to study the correlation between nurse staffing levels and patient outcomes. This report shall be presented to the

chairs and ranking minority members of the health and human services committees in the house of representatives and the senate by January 15, 2015.

Sec. 79. **TRAUMA CENTERS.**

The commissioner of health, through the Office of Rural Health and Primary Care, and in consultation with the commissioner of human services, shall study the 24-hour costs of maintaining a level of readiness in hospitals designated as trauma centers under Minnesota Statutes, section 144.605, and shall present recommendations to the legislature, by December 15, 2013, on a state public programs level of readiness payment modifier for hospitals designated as trauma centers.

Sec. 80. **HEALTH EQUITY REPORT.**

By February 1, 2014, the commissioner of health, in consultation with local public health, health care, and community partners, must submit a report to the chairs and ranking minority members of the committees with jurisdiction over health policy and finance, on a plan for advancing health equity in Minnesota. The report must include the following:

(1) assessment of health disparities that exist in the state and how these disparities relate to health equity;

(2) identification of policies, processes, and systems that contribute to health inequity in the state;

(3) recommendations for changes to policies, processes and systems within the Department of Health that would increase the department's leadership in addressing health inequities;

(4) identification of best practices for local public health, health care, and community partners to provide culturally responsive services and advance health equity; and

(5) recommendations for strategies for the use of data to document and monitor existing health inequities and to evaluate effectiveness of policies, processes, systems, and environmental changes that will advance health equity.

Sec. 81. **ELIMINATING HEALTH DISPARITIES GRANTS; ORGANIZATIONS WITH LIMITED FISCAL CAPACITY.**

For grants awarded from the general fund under Minnesota Statutes, section 145.928, during the fiscal years ending June 30, 2013, and June 30, 2014, the commissioner of health may provide working capital advanced to grantees determined during the application process to have limited financial capacity, in accordance with Office of Grant Management Policies.

Sec. 82. **ASSESSMENT OF QUALITY METRICS FOR MEASURING THE SCREENING, DIAGNOSIS, AND TREATMENT OF YOUNG CHILDREN WITH AUTISM SPECTRUM DISORDER.**

As part of the annual review and ongoing development of quality measures under Minnesota Statutes, section 62U.02, the commissioner of health shall assess the medical evidence and feasibility of adding a set of quality metrics for measuring the screening, diagnosis, and treatment of young children with autism spectrum disorder.

Sec. 83. **REVISOR'S INSTRUCTION.**

The revisor shall substitute the term "vertical heat exchangers" or "vertical heat exchanger" with "bored geothermal heat exchangers" or "bored geothermal heat exchanger" wherever it appears in Minnesota Statutes, sections 103I.005, subdivisions 2 and 12; 103I.101, subdivisions 2 and 5; 103I.105; 103I.205, subdivision 4; 103I.208, subdivision 2; 103I.501; 103I.531, subdivision 5; and 103I.641, subdivisions 1, 2, and 3.

Sec. 84. **REPEALER.**

(a) Minnesota Statutes 2012, sections 103I.005, subdivision 20; 149A.025; 149A.20, subdivision 8; 149A.30, subdivision 2; 149A.40, subdivision 8; 149A.45, subdivision 6; 149A.50, subdivision 6; 149A.51, subdivision 7; 149A.52, subdivision 5a; 149A.53, subdivision 9; and 485.14, are repealed.

(b) Minnesota Statutes 2012, section 144.123, subdivision 2, is repealed effective July 1, 2014.

ARTICLE 13

HUMAN SERVICES FORECAST ADJUSTMENTS

Section 1. **COMMISSIONER OF HUMAN SERVICES**

Subdivision 1. **Total Appropriation** **$** **(161,031,000)**

Appropriations by Fund	2013
General Fund	(158,668,000)
Health Care Access	(7,179,000)
TANF	4,816,000

Subd. 2. **Forecasted Programs**

(a) **MFIP/DWP Grants**

	Appropriations by Fund	
General Fund	(8,211,000)	
TANF	4,399,000	
(b) **MFIP Child Care Assistance Grants**		10,113,000
(c) **General Assistance Grants**		3,230,000
(d) **Minnesota Supplemental Aid Grants**		(1,008,000)
(e) **Group Residential Housing Grants**		(5,423,000)
(f) **MinnesotaCare Grants**		(7,179,000)
This appropriation is from the health care access fund.		
(g) **Medical Assistance Grants**		(159,733,000)
(h) **Alternative Care Grants**		-0-
(i) **CD Entitlement Grants**		2,364,000
Subd. 3. **Technical Activities**		417,000
This appropriation is from the TANF fund.		

Sec. 2. **EFFECTIVE DATE.**

Section 1 is effective the day following final enactment.

ARTICLE 14

HEALTH AND HUMAN SERVICES APPROPRIATIONS

Section 1. **SUMMARY OF APPROPRIATIONS.**

The amounts shown in this section summarize direct appropriations, by fund, made in this article.

	2014	**2015**	**Total**
General	$ 5,644,039,000	$ 5,876,951,000	$ 11,520,990,000
State Government Special Revenue	69,619,000	74,135,000	143,754,000
Health Care Access	664,161,000	427,466,000	1,091,628,000
Federal TANF	269,628,000	266,526,000	536,154,000
Lottery Prize Fund	1,667,000	1,668,000	3,335,000
Total	**$ 6,649,113,000**	**$ 6,646,747,000**	**$ 13,295,860,000**

Sec. 2. **HEALTH AND HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2014" and "2015" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2014, or June 30, 2015, respectively. "The first year" is fiscal year 2014. "The second year" is fiscal year 2015. "The biennium" is fiscal years 2014 and 2015.

	APPROPRIATIONS Available for the Year Ending June 30	
	2014	**2015**
Sec. 3. **COMMISSIONER OF HUMAN SERVICES**		
Subdivision 1. **Total Appropriation**	**$ 6,454,078,000**	**$ 6,455,116,000**

Appropriations by Fund

	2014	2015
General	5,558,517,000	5,796,553,000
State Government Special Revenue	4,099,000	6,332,000
Health Care Access	631,881,000	395,749,000
Federal TANF	257,915,000	254,813,000
Lottery Prize Fund	1,667,000	1,668,000

Receipts for Systems Projects.

Appropriations and federal receipts for information systems projects for MAXIS, PRISM, MMIS, and SSIS must be deposited in the state system account authorized in Minnesota Statutes, section 256.014. Money appropriated for computer projects approved by the commissioner of Minnesota information technology services, funded by the legislature, and approved by the commissioner of management and budget, may be transferred from one project to another and from development to operations as the commissioner of human services considers necessary. Any unexpended

balance in the appropriation for these projects does not cancel but is available for ongoing development and operations.

Nonfederal Share Transfers. The nonfederal share of activities for which federal administrative reimbursement is appropriated to the commissioner may be transferred to the special revenue fund.

ARRA Supplemental Nutrition Assistance Benefit Increases. The funds provided for food support benefit increases under the Supplemental Nutrition Assistance Program provisions of the American Recovery and Reinvestment Act (ARRA) of 2009 must be used for benefit increases beginning July 1, 2009.

Supplemental Nutrition Assistance Program Employment and Training. (1) Notwithstanding Minnesota Statutes, sections 256D.051, subdivisions 1a, 6b, and 6c, and 256J.626, federal Supplemental Nutrition Assistance employment and training funds received as reimbursement of MFIP consolidated fund grant expenditures for diversionary work program participants and child care assistance program expenditures must be deposited in the general fund. The amount of funds must be limited to $4,900,000 per year in fiscal years 2014 and 2015, and to $4,400,000 per year in fiscal years 2016 and 2017, contingent on approval by the federal Food and Nutrition Service.

(2) Consistent with the receipt of the federal funds, the commissioner may adjust the level of working family credit expenditures

claimed as TANF maintenance of effort. Notwithstanding any contrary provision in this article, this rider expires June 30, 2017.

TANF Maintenance of Effort. (a) In order to meet the basic maintenance of effort (MOE) requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1, the commissioner may only report nonfederal money expended for allowable activities listed in the following clauses as TANF/MOE expenditures:

(1) MFIP cash, diversionary work program, and food assistance benefits under Minnesota Statutes, chapter 256J;

(2) the child care assistance programs under Minnesota Statutes, sections 119B.03 and 119B.05, and county child care administrative costs under Minnesota Statutes, section 119B.15;

(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 256J and 256K;

(4) state, county, and tribal MFIP employment services under Minnesota Statutes, chapters 256J and 256K;

(5) expenditures made on behalf of legal noncitizen MFIP recipients who qualify for the MinnesotaCare program under Minnesota Statutes, chapter 256L;

(6) qualifying working family credit expenditures under Minnesota Statutes, section 290.0671;

(7) qualifying Minnesota education credit expenditures under Minnesota Statutes, section 290.0674; and

(8) qualifying Head Start expenditures under Minnesota Statutes, section 119A.50.

(b) The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's TANF/MOE requirements. For the activities listed in paragraph (a), clauses (2) to (8), the commissioner may only report expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

(c) For fiscal years beginning with state fiscal year 2003, the commissioner shall ensure that the maintenance of effort used by the commissioner of management and budget for the February and November forecasts required under Minnesota Statutes, section 16A.103, contains expenditures under paragraph (a), clause (1), equal to at least 16 percent of the total required under Code of Federal Regulations, title 45, section 263.1.

(d) The requirement in Minnesota Statutes, section 256.011, subdivision 3, that federal grants or aids secured or obtained under that subdivision be used to reduce any direct appropriations provided by law, do not apply if the grants or aids are federal TANF funds.

(e) For the federal fiscal years beginning on or after October 1, 2007, the commissioner may not claim an amount of TANF/MOE in excess of the 75 percent standard in Code

of Federal Regulations, title 45, section 263.1(a)(2), except:

(1) to the extent necessary to meet the 80 percent standard under Code of Federal Regulations, title 45, section 263.1(a)(1), if it is determined by the commissioner that the state will not meet the TANF work participation target rate for the current year;

(2) to provide any additional amounts under Code of Federal Regulations, title 45, section 264.5, that relate to replacement of TANF funds due to the operation of TANF penalties; and

(3) to provide any additional amounts that may contribute to avoiding or reducing TANF work participation penalties through the operation of the excess MOE provisions of Code of Federal Regulations, title 45, section 261.43(a)(2).

For the purposes of clauses (1) to (3), the commissioner may supplement the MOE claim with working family credit expenditures or other qualified expenditures to the extent such expenditures are otherwise available after considering the expenditures allowed in this subdivision and subdivisions 2 and 3.

(f) Notwithstanding any contrary provision in this article, paragraphs (a) to (e) expire June 30, 2017.

Working Family Credit Expenditures as TANF/MOE. The commissioner may claim as TANF maintenance of effort up to $6,707,000 per year of working family credit expenditures in each fiscal year.

Subd. 2. **Working Family Credit to be Claimed for TANF/MOE**

The commissioner may count the following amounts of working family credit expenditures as TANF/MOE:

(1) fiscal year 2014, $43,576,000; and

(2) fiscal year 2015, $43,548,000.

Subd. 3. **TANF Transfer to Federal Child Care and Development Fund**

(a) The following TANF fund amounts are appropriated to the commissioner for purposes of MFIP/transition year child care assistance under Minnesota Statutes, section 119B.05:

(1) fiscal year 2014; $14,020,000; and

(2) fiscal year 2015, $14,020,000.

(b) The commissioner shall authorize the transfer of sufficient TANF funds to the federal child care and development fund to meet this appropriation and shall ensure that all transferred funds are expended according to federal child care and development fund regulations.

Subd. 4. **Central Office**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Operations

	Appropriations by Fund	
General	88,410,000	89,985,000
State Government Special Revenue	3,974,000	6,207,000
Health Care Access	13,252,000	13,154,000
Federal TANF	117,000	100,000

Return on Taxpayer Investment Implementation Study. $100,000 is appropriated in fiscal year 2014 from the general fund to the commissioner of human services for transfer to the commissioner of management and budget to develop recommendations for implementing a return on taxpayer investment (ROTI) methodology and practice related to human services and corrections programs administered and funded by state and county government. The scope of the study shall include assessments of ROTI initiatives in other states, design implications for Minnesota, and identification of one or more Minnesota institutions of higher education capable of providing rigorous and consistent nonpartisan institutional support for ROTI. The scope of the study shall also include recommendations on methods to evaluate the value of prepaid medical assistance services (PMAP) versus other ways of delivering public health care programs. The commissioner shall consult with representatives of other state agencies, counties, legislative staff, Minnesota institutions of higher education, and other stakeholders in developing recommendations. The commissioner shall report findings and recommendations to the governor and legislature by November 30, 2013.

DHS Receipt Center Accounting. The commissioner is authorized to transfer appropriations to, and account for DHS receipt center operations in, the special revenue fund.

Administrative Recovery; Set-Aside. The commissioner may invoice local entities through the SWIFT accounting system as an alternative means to recover the actual cost of administering the following provisions:

(1) Minnesota Statutes, section 125A.744, subdivision 3;

(2) Minnesota Statutes, section 245.495, paragraph (b);

(3) Minnesota Statutes, section 256B.0625, subdivision 20, paragraph (k);

(4) Minnesota Statutes, section 256B.0924, subdivision 6, paragraph (g);

(5) Minnesota Statutes, section 256B.0945, subdivision 4, paragraph (d); and

(6) Minnesota Statutes, section 256F.10, subdivision 6, paragraph (b).

Systems Modernization. The following amounts are appropriated for transfer to the state systems account authorized in Minnesota Statutes, section 256.014:

(1) $1,825,000 in fiscal year 2014 and $2,502,000 in fiscal year 2015 is for the state share of Medicaid-allocated costs of the health insurance exchange information technology and operational structure. The funding base is $3,222,000 in fiscal year 2016 and $3,037,000 in fiscal year 2017 but shall not be included in the base thereafter; and

(2) Any unexpended balance from the contingent system modernization appropriation in article 15 must be transferred from the Department of Human Services state systems account to the Office

of Enterprise Technology when the Office of Enterprise Technology has negotiated a federally approved internal service fund rates and billing process with sufficient internal accounting controls to properly maximize federal reimbursement to Minnesota for human services system modernization projects, but not later than June 30, 2015.

Base Adjustment. The general fund base is increased by $6,099,000 in fiscal year 2016 and $1,185,000 in fiscal year 2017. The health access fund base is decreased by $551,000 in fiscal years 2016 and 2017.

(b) Children and Families

	Appropriations by Fund	
General	7,626,000	7,634,000
Federal TANF	2,282,000	2,282,000

Financial Institution Data Match and Payment of Fees. The commissioner is authorized to allocate up to $310,000 each year in fiscal years 2014 and 2015 from the PRISM special revenue account to make payments to financial institutions in exchange for performing data matches between account information held by financial institutions and the public authority's database of child support obligors as authorized by Minnesota Statutes, section 13B.06, subdivision 7.

Base Adjustment. The general fund base is decreased by $300,000 in fiscal years 2016 and 2017, and the federal TANF fund base is increased by $300,000 in fiscal years 2016 and 2017.

(c) Health Care

	Appropriations by Fund	
General	13,924,000	13,795,000
Health Care Access	26,599,000	30,306,000

Base Adjustment. The health care access fund base is increased by $8,177,000 in fiscal year 2016 and by $6,712,000 in fiscal year 2017.

Medical assistance costs for inmates. The commissioner of corrections, for fiscal years 2014 through 2017, shall transfer to the commissioner of human services an amount equal to the state share of medical assistance costs related to implementation of Minnesota Statutes, section 256B.055, subdivision 14, paragraph (c).

(d) Continuing Care

	Appropriations by Fund	
General	18,734,000	19,272,000
State Government Special Revenue	125,000	125,000

Base Adjustment. The general fund base is increased by $3,324,000 in fiscal year 2016 and by $3,324,000 in fiscal year 2017.

(e) Chemical and Mental Health

	Appropriations by Fund	
General	4,480,000	4,300,000
Lottery Prize Fund	159,000	160,000

Subd. 5. **Forecasted Programs**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) MFIP/DWP

	Appropriations by Fund	
General	72,583,000	74,634,000
Federal TANF	83,104,000	80,510,000

(b) MFIP Child Care Assistance 59,662,000 59,393,000

Notwithstanding Minnesota Statutes, section 256J.021, TANF funds may be used to pay for any additional costs related to repeal of the MFIP family cap for individuals identified under Minnesota Statutes, section 256J.021.

(c) General Assistance 54,787,000 56,068,000

General Assistance Standard. The commissioner shall set the monthly standard of assistance for general assistance units consisting of an adult recipient who is childless and unmarried or living apart from parents or a legal guardian at $203. The commissioner may reduce this amount according to Laws 1997, chapter 85, article 3, section 54.

Emergency General Assistance. The amount appropriated for emergency general assistance funds is limited to no more than $6,729,812 in fiscal year 2014 and $6,729,812 in fiscal year 2015. Funds to counties shall be allocated by the commissioner using the allocation method in Minnesota Statutes, section 256D.06.

(d) MN Supplemental Assistance 38,646,000 39,821,000

(e) Group Residential Housing 140,447,000 149,984,000

(f) MinnesotaCare

Health Care Access 296,272,000 226,606,000

(g) Medical Assistance

	Appropriations by Fund	
General	4,368,215,000	4,592,196,000
Health Care Access	292,771,000	123,507,000

The Departments of Human Services and Management and Budget shall identify general fund medical assistance populations costing $239,934,000 for fiscal year 2016 and $218,047,000 for fiscal year 2017 and transfer those costs to the HCAF. The base for these costs shall be counted in the health care access fund for fiscal years 2016 and 2017.

Newborn Screening. $121,000 in fiscal year 2014 and $141,000 in fiscal year 2015 are appropriated from the general fund, and $10,000 in fiscal year 2014 and $13,000 in fiscal year 2015 are appropriated from the health care access fund to the commissioner of human services for the hospital reimbursement increase in Minnesota Statutes, section 256.969, subdivision 29. The base for this appropriation in fiscal year 2016 is $14,000.

Transfer. $704,000 in fiscal year 2014 and $2,090,000 in fiscal year 2015 is transferred from the health care access fund to the general fund to provide increases in dental payment rates under Minnesota Statutes, section 256B.76, subdivision 2, paragraph (j).

(h) Alternative Care	47,197,000	45,084,000

Alternative Care Transfer. Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but shall be transferred to the medical assistance account.

(i) CD Treatment Fund	81,440,000	74,875,000

Balance Transfer. The commissioner must transfer $18,188,000 from the consolidated

chemical dependency treatment fund to the general fund by September 30, 2013.

Subd. 6. **Grant Programs**

The amounts that may be spent from this appropriation for each purpose are as follows:

(a) Support Services Grants

	Appropriations by Fund	
General	8,715,000	8,715,000
Federal TANF	91,832,000	90,952,000

MFIP Housing Assistance Grants. MFIP housing assistance grants under Minnesota Statutes, section 256J.35, paragraph (d), must be paid out of support services grants under this paragraph.

Paid Work Experience. $2,168,000 each year is from the general fund for paid work experience for long-term MFIP recipients. Paid work includes full and partial wage subsidies and other related services such as job development, marketing, preworksite training, job coaching, and postplacement services. These are onetime appropriations. Unexpended funds for fiscal year 2014 do not cancel but are available to the commissioner for this purpose in fiscal year 2015.

Work Study Funding for MFIP Participants. $250,000 each year is from the general fund to pilot work study jobs for MFIP recipients in approved postsecondary education programs. This is a onetime appropriation. Unexpended funds for fiscal year 2014 do not cancel but are available for this purpose in fiscal year 2015.

Local Strategies to Reduce Disparities. $2,000,000 each year is from the general fund, for local projects that focus on services for subgroups within the MFIP caseload who are experiencing poor employment outcomes. These are onetime appropriations. Unexpended funds for fiscal year 2014 do not cancel but are available to the commissioner for this purpose in fiscal year 2015.

Home Visiting Collaborations for MFIP Teen Parents. $200,000 each year is from the general fund for technical assistance and training to support local collaborations that provide home visiting services for MFIP teen parents. The TANF fund base is increased by $200,000 in fiscal years 2016 and 2017.

Base Adjustment. The general fund base is decreased by $4,618,000 in fiscal years 2016 and 2017. The TANF fund base is increased by $1,700,000 in fiscal years 2016 and 2017.

(b) Basic Sliding Fee Child Care Assistance Grants	38,356,000	38,681,000

Base Adjustment. The general fund base is increased by $1,278,000 in fiscal year 2016 and by $1,349,000 in fiscal year 2017.

(c) Child Care Development Grants	1,487,000	1,487,000
(d) Child Support Enforcement Grants	50,000	50,000

Federal Child Support Demonstration Grants. Federal administrative reimbursement resulting from the federal child support grant expenditures authorized under United States Code, title 42, section 1315, is appropriated to the commissioner for this activity.

(e) Children's Services Grants

	Appropriations by Fund	
General	47,438,000	47,801,000
Federal TANF	140,000	140,000

Adoption Assistance and Relative Custody Assistance. The commissioner may transfer unencumbered appropriation balances for adoption assistance and relative custody assistance between fiscal years and between programs.

Privatized Adoption Grants. Federal reimbursement for privatized adoption grant and foster care recruitment grant expenditures is appropriated to the commissioner for adoption grants and foster care and adoption administrative purposes.

Adoption Assistance Incentive Grants. Federal funds available during fiscal years 2014 and 2015 for adoption incentive grants are appropriated to the commissioner for these purposes.

Base Adjustment. The general fund base is increased by $5,139,000 in fiscal year 2016 and by $9,155,000 in fiscal year 2017.

(f) Child and Community Service Grants	53,301,000	53,301,000
(g) Child and Economic Support Grants	16,572,000	16,573,000

Minnesota Food Assistance Program. Unexpended funds for the Minnesota food assistance program for fiscal year 2014 do not cancel but are available for this purpose in fiscal year 2015.

Family Assets for Independence. $250,000 each year is for the Family Assets for Independence Minnesota program. This

appropriation is available in either year of the biennium and may be transferred between fiscal years. This appropriation is added to the base.

(h) Health Care Grants

	Appropriations by Fund	
General	90,000	90,000
Health Care Access	2,228,000	1,413,000

Premium Subsidy. $..... is appropriated from the general fund in fiscal year 2014 and fiscal year 2015 to the commissioner of human services for the purpose of providing a premium subsidy to families purchasing supplemental autism coverage for young children on the private market if a family has an income below 400 percent of the federal poverty level. The commissioner may utilize the existing eligibility and enrollment system described in Minnesota Statutes, section 252.27, to determine a family's eligibility for subsidies under this section. This appropriation is available until expended and does not become part of the base.

Base Adjustment. The health care access fund is decreased by $1,223,000 in fiscal years 2016 and 2017.

(i) Aging and Adult Services Grants	22,149,000	23,015,000
(j) Deaf and Hard-of-Hearing Grants	1,767,000	1,767,000
(k) Disabilities Grants	17,984,000	17,861,000

(a) $180,000 each year from the general fund is for a grant to the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS) to support nonprofit Fetal Alcohol Spectrum Disorders (FASD) outreach prevention

programs in Olmsted County. This is a onetime appropriation.

Base Adjustment. The general fund base is increased by $502,000 in fiscal year 2016 and by $676,000 in fiscal year 2017.

(l) Adult Mental Health Grants

	Appropriations by Fund	
General	71,257,000	69,588,000
Health Care Access	750,000	750,000
Lottery Prize	1,508,000	1,508,000

Funding Usage. Up to 75 percent of a fiscal year's appropriations for adult mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

Base Adjustment. The general fund base is decreased by $4,461,000 in fiscal years 2016 and 2017.

Mental Health Pilot Project. $230,000 each year is for a grant to the Zumbro Valley Mental Health Center. The grant shall be used to implement a pilot project to test an integrated behavioral health care coordination model. The grant recipient must report measurable outcomes and savings to the commissioner of human services by January 15, 2016. This is a onetime appropriation.

High-risk adults. $100,000 in fiscal year 2014 and $100,000 in fiscal year 2015 are appropriated from the general fund to the commissioner of human services for a grant to the nonprofit organization selected to administer the demonstration project for high-risk adults under Laws 2007, chapter

54, article 1, section 19, in order to complete the project. This is a onetime appropriation.

(m) Child Mental Health Grants	17,599,000	19,988,000

Funding Usage. Up to 75 percent of a fiscal year's appropriation for child mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

(n) CD Treatment Support Grants	1,516,000	1,516,000

Base Adjustment. The general fund base is decreased by $300,000 in fiscal years 2016 and 2017.

Subd. 7. **State-Operated Services**	186,744,000	188,183,000

Transfer Authority Related to State-Operated Services. Money appropriated for state-operated services may be transferred between fiscal years of the biennium with the approval of the commissioner of management and budget.

The amounts that may be spent from the appropriation for each purpose are as follows:

(a) SOS Mental Health	116,598,000	117,467,000

Dedicated Receipts Available. Of the revenue received under Minnesota Statutes, section 246.18, subdivision 8, paragraph (a), $1,000,000 each year is available for the purposes of paragraph (b), clause (1), of that subdivision, $1,000,000 each year is available to transfer to the adult mental health budget activity for the purposes of paragraph (b), clause (2), of that subdivision, and up to $2,713,000 each year is available for the purposes of paragraph (b), clause (3), of that subdivision.

(b) SOS MN Security Hospital		70,146,000	70,715,000
Subd. 8. **Sex Offender Program**		77,341,000	80,895,000

Transfer Authority Related to Minnesota Sex Offender Program. Money appropriated for the Minnesota sex offender program may be transferred between fiscal years of the biennium with the approval of the commissioner of management and budget.

Subd. 9. **Technical Activities**		80,440,000	80,829,000

This appropriation is from the federal TANF fund.

Base Adjustment. The federal TANF fund base is decreased by $22,000 in fiscal year 2016 and by $49,000 in fiscal year 2017.

Subd. 10. **Transfer.**

The commissioner of management and budget must transfer $65,000,000 in fiscal year 2014 from the general fund to the health care access fund. This is a onetime transfer.

Sec. 4. **COMMISSIONER OF HEALTH**

Subdivision 1. **Total Appropriation**	**$**	**172,440,000**	**$** **168,946,000**

Appropriations by Fund

	2014	2015
General	80,151,000	75,001,000
State Government Special Revenue	48,296,000	50,515,000
Health Care Access	32,280,000	31,717,000
Federal TANF	11,713,000	11,713,000

The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Health Improvement**

	Appropriations by Fund	
General	53,475,000	48,260,000
State Government Special Revenue	1,040,000	1,047,000
Health Care Access	21,725,000	21,731,000
Federal TANF	11,713,000	11,713,000

Notwithstanding the cancellation requirement in Minnesota Statutes, section 256J.02, subdivision 6, TANF funds awarded under Minnesota Statutes, section 145.928, during fiscal year 2013 to grantees determined during the application process to have limited financial capacity, are available until June 30, 2014.

Statewide Health Improvement Program. $20,000,000 in fiscal year 2014 and $20,000,000 in fiscal year 2015 are appropriated from the health care access fund for the statewide health improvement program under Minnesota Statutes, section 145.986.

Statewide Cancer Surveillance System. Of the general fund appropriation, $350,000 in fiscal year 2014 and $350,000 in fiscal year 2015 are appropriated to develop and implement a new cancer reporting system under Minnesota Statutes, sections 144.671 to 144.69. Any information technology development or support costs necessary for the cancer surveillance system must be incorporated into the agency's service level agreement and paid to the Office of Enterprise Technology.

Eliminating Reproductive Health Disparities. To the extent funds are available for fiscal years 2014 and 2015

for grants provided pursuant to Minnesota Statutes, section 145.928, the commissioner may provide a grant to a Somali-based organization located in Minnesota to develop a reproductive health strategic plan to eliminate reproductive health disparities for Somali women. The plan shall develop initiatives to provide educational and information resources to health care providers, community organizations, and Somali women to ensure effective interaction with Somali culture and western medicine and the delivery of appropriate health care services, and the achievement of better health outcomes for Somali women. The plan must engage health care providers, the Somali community, and Somali health-centered organizations. The commissioner shall submit a report to the chairs and ranking minority members of the senate and house committees with jurisdiction over health policy on the strategic plan developed under this grant for eliminating reproductive health disparities for Somali women. The report must be submitted by February 15, 2014.

TANF Appropriations. (1) $1,156,000 of the TANF funds is appropriated each year of the biennium to the commissioner for family planning grants under Minnesota Statutes, section 145.925.

(2) $3,579,000 of the TANF funds is appropriated each year of the biennium to the commissioner for home visiting and nutritional services listed under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funds must be distributed

to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1.

(3) $2,000,000 of the TANF funds is appropriated each year of the biennium to the commissioner for decreasing racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7.

(4) $4,978,000 of the TANF funds is appropriated each year of the biennium to the commissioner for the family home visiting grant program according to Minnesota Statutes, section 145A.17. $4,000,000 of the funding must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1. $978,000 of the funding must be distributed to tribal governments based on Minnesota Statutes, section 145A.14, subdivision 2a.

(5) The commissioner may use up to 6.23 percent of the funds appropriated each fiscal year to conduct the ongoing evaluations required under Minnesota Statutes, section 145A.17, subdivision 7, and training and technical assistance as required under Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

TANF Carryforward. Any unexpended balance of the TANF appropriation in the first year of the biennium does not cancel but is available for the second year.

Subd. 3. **Policy Quality and Compliance**

	Appropriations by Fund	
General	9,400,000	9,409,000

State Government		
Special Revenue	14,481,000	16,548,000
Health Care Access	10,555,000	9,986,000

Base Level Adjustment. The state government special revenue fund base shall be reduced by $2,000 in fiscal year 2017. The health care access base shall be increased by $600,000 in fiscal year 2015.

Subd. 4. **Health Protection**

	Appropriations by Fund	
General	9,503,000	9,558,000
State Government		
Special Revenue	32,775,000	32,920,000

Infectious Disease Laboratory. Of the general fund appropriation, $200,000 in fiscal year 2014 and $200,000 in fiscal year 2015 are appropriated to the commissioner to monitor infectious disease trends and investigate infectious disease outbreaks.

Surveillance for Elevated Blood Lead Levels. Of the general fund appropriation, $100,000 in fiscal year 2014 and $100,000 in fiscal year 2015 are appropriated to the commissioner for the blood lead surveillance system under Minnesota Statutes, section 144.9502.

Newborn Screening. (a) $365,000 in fiscal year 2014 and $349,000 in fiscal year 2015 are appropriated for the purpose of providing support services to families as required under Minnesota Statutes, section 144.966, subdivision 3a.

(b) $164,000 in fiscal year 2014 and $156,000 in fiscal year 2015 are appropriated for home-based education in American Sign

Language for families with children who are deaf or have hearing loss, as required under Minnesota Statutes, section 144.966, subdivision 3a.

Sexual Violence Prevention. Within available appropriations, by January 15, 2015, the commissioner must report to the legislature on its activities to prevent sexual violence, including activities to promote coordination of existing state programs and services to achieve maximum impact on addressing the root causes of sexual violence.

Safe Harbor for Sexually Exploited Youth. (a) $1,000,000 in fiscal year 2014 and $1,000,000 in fiscal year 2015 are for supportive service grants for the safe harbor for sexually exploited youth program, under Minnesota Statutes, section 145.4716, including advocacy services, civil legal services, health care services, mental and chemical health services, education and employment services, aftercare and relapse prevention, and family reunification services. This appropriation shall be added to the base.

(b) $381,000 in fiscal year 2014 and $381,000 in fiscal year 2015 are for grants to six regional navigators under Minnesota Statutes, section 145.4717. This appropriation shall be added to the base.

(c) $82,500 in fiscal year 2014 and $82,500 in fiscal year 2015 are for the director of child sex trafficking prevention position. This appropriation shall be added to the base.

(d) $72,900 in fiscal year 2015 is for program evaluation required under

Minnesota Statutes, section 145.4718. This appropriation shall be added to the base.

Base Level Adjustment. The state government special revenue base is increased by $6,000 in fiscal year 2016 and by $27,000 in fiscal year 2017.

Subd. 5. **Administrative Support Services**	7,773,000	7,774,000

Regional Support for Local Public Health Departments. $350,000 in fiscal year 2014 and $350,000 in fiscal year 2015 are appropriated to the commissioner for regional staff who provide specialized expertise to local public health departments.

Sec. 5. **HEALTH-RELATED BOARDS**

Subdivision 1. **Total Appropriation**	**$ 17,224,000**	**$ 17,288,000**

This appropriation is from the state government special revenue fund. The amounts that may be spent for each purpose are specified in the following subdivisions.

Subd. 2. **Board of Chiropractic Examiners**	473,000	477,000
Subd. 3. **Board of Dentistry**	1,835,000	1,850,000

Health Professional Services Program. Of this appropriation, $704,000 in fiscal year 2014 and $704,000 in fiscal year 2015 from the state government special revenue fund are for the health professional services program.

Subd. 4. **Board of Dietetic and Nutrition Practice**	112,000	112,000
Subd. 5. **Board of Marriage and Family Therapy**	169,000	170,000
Subd. 6. **Board of Medical Practice**	3,883,000	3,900,000
Subd. 7. **Board of Nursing**	3,664,000	3,692,000

Subd. 8. **Board of Nursing Home Administrators**	1,630,000	1,586,000

Administrative Services Unit - Operating Costs. Of this appropriation, $676,000 in fiscal year 2014 and $626,000 in fiscal year 2015 are for operating costs of the administrative services unit. The administrative services unit may receive and expend reimbursements for services performed by other agencies.

Administrative Services Unit - Volunteer Health Care Provider Program. Of this appropriation, $150,000 in fiscal year 2014 and $150,000 in fiscal year 2015 are to pay for medical professional liability coverage required under Minnesota Statutes, section 214.40.

Administrative Services Unit - Contested Cases and Other Legal Proceedings. Of this appropriation, $200,000 in fiscal year 2014 and $200,000 in fiscal year 2015 are for costs of contested case hearings and other unanticipated costs of legal proceedings involving health-related boards funded under this section. Upon certification of a health-related board to the administrative services unit that the costs will be incurred and that there is insufficient money available to pay for the costs out of money currently available to that board, the administrative services unit is authorized to transfer money from this appropriation to the board for payment of those costs with the approval of the commissioner of management and budget. This appropriation does not cancel.

Any unencumbered and unspent balances remain available for these expenditures in subsequent fiscal years.

Criminal Background Checks. $390,000 each year from the state government special revenue fund is for the Administrative Support Services Unit for the implementation of a criminal background check program.

Subd. 9. **Board of Optometry**	108,000	108,000
Subd. 10. **Board of Pharmacy**	2,362,000	2,380,000

Prescription Electronic Reporting. Of this appropriation, $356,000 in fiscal year 2014 and $356,000 in fiscal year 2015 from the state government special revenue fund are to the board to operate the prescription electronic reporting system in Minnesota Statutes, section 152.126.

Subd. 11. **Board of Physical Therapy**	348,000	351,000
Subd. 12. **Board of Podiatry**	76,000	77,000
Subd. 13. **Board of Psychology**	853,000	861,000
Subd. 14. **Board of Social Work**	1,061,000	1,069,000
Subd. 15. **Board of Veterinary Medicine**	232,000	234,000
Subd. 16. **Board of Behavioral Health and Therapy**	418,000	421,000

Sec. 6. **EMERGENCY MEDICAL SERVICES REGULATORY BOARD** **$ 2,749,000 $ 2,756,000**

Regional Grants. $585,000 in fiscal year 2014 and $585,000 in fiscal year 2015 are for regional emergency medical services programs, to be distributed equally to the eight emergency medical service regions.

Cooper/Sams Volunteer Ambulance Program. $700,000 in fiscal year 2014 and

$700,000 in fiscal year 2015 are for the Cooper/Sams volunteer ambulance program under Minnesota Statutes, section 144E.40.

(a) Of this amount, $611,000 in fiscal year 2014 and $611,000 in fiscal year 2015 are for the ambulance service personnel longevity award and incentive program under Minnesota Statutes, section 144E.40.

(b) Of this amount, $89,000 in fiscal year 2014 and $89,000 in fiscal year 2015 are for the operations of the ambulance service personnel longevity award and incentive program under Minnesota Statutes, section 144E.40.

Ambulance Training Grant. $361,000 in fiscal year 2014 and $361,000 in fiscal year 2015 are for training grants.

EMSRB Board Operations. $1,095,000 in fiscal year 2014 and $1,095,000 in fiscal year 2015 are for operations.

Sec. 7. **COUNCIL ON DISABILITY** **$ 618,000 $ 622,000**

Sec. 8. **OMBUDSMAN FOR MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES** **$ 1,668,000 $ 1,680,000**

Sec. 9. **OMBUDSPERSON FOR FAMILIES** **$ 336,000 $ 339,000**

Sec. 10. Minnesota Statutes 2012, section 256.01, subdivision 34, is amended to read:

Subd. 34. **Federal administrative reimbursement dedicated.** Federal administrative reimbursement resulting from the following activities is appropriated to the commissioner for the designated purposes:

(1) reimbursement for the Minnesota senior health options project; ~~and~~

(2) reimbursement related to prior authorization and inpatient admission certification by a professional review organization. A portion of these funds must be used for activities to decrease unnecessary pharmaceutical costs in medical assistance~~.~~; and

(3) reimbursement resulting from the federal child support grant expenditures authorized under United States Code, title 42, section 1315.

Sec. 11. Minnesota Statutes 2012, section 256.01, is amended by adding a subdivision to read:

Subd. 35. **Federal reimbursement for privatized adoption grants.** Federal reimbursement for privatized adoption grant and foster care recruitment grant expenditures is appropriated to the commissioner for adoption grants and foster care and adoption administrative purposes.

Sec. 12. Minnesota Statutes 2012, section 256.01, is amended by adding a subdivision to read:

Subd. 36. **DHS receipt center accounting.** The commissioner may transfer appropriations to, and account for DHS receipt center operations in, the special revenue fund.

Sec. 13. **TRANSFERS.**

Subdivision 1. **Grants.** The commissioner of human services, with the approval of the commissioner of management and budget, may transfer unencumbered appropriation balances for the biennium ending June 30, 2015, within fiscal years among the MFIP, general assistance, general assistance medical care under Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 3, medical assistance, MinnesotaCare, MFIP child care assistance under Minnesota Statutes, section 119B.05, Minnesota supplemental aid, group residential housing programs, the entitlement portion of the chemical dependency consolidated treatment fund, and between fiscal years of the biennium. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance Division and the house of representatives Health and Human Services Finance Committee quarterly about transfers made under this provision.

Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within the Departments of Human Services and Health as the commissioners consider necessary, with the advance approval of the commissioner of management and budget. The commissioner shall inform the chairs and ranking minority members of the senate Health and Human Services Finance Division and the house of representatives Health and Human Services Finance Committee quarterly about transfers made under this provision.

Sec. 14. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

The commissioners of health and human services shall not use indirect cost allocations to pay for the operational costs of any program for which they are responsible.

Sec. 15. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2015, unless a different expiration date is explicit.

Sec. 16. **EFFECTIVE DATE.**

This article is effective July 1, 2013, unless a different effective date is specified.

ARTICLE 15

HUMAN SERVICES CONTINGENT APPROPRIATIONS

Section 1. **HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are added to or, if shown in parentheses, subtracted from the appropriations in article 14 to the agencies and for the purposes specified in this article. The appropriations are from the general fund or other named fund and are available for the fiscal years indicated for each purpose. The figures "2014" and "2015" used in this article mean that the addition to or subtraction from the appropriation listed under them is available for the fiscal year ending June 30, 2014, or June 30, 2015, respectively. Supplemental appropriations and reductions to appropriations for the fiscal year ending June 30, 2014, are effective the day following final enactment unless a different effective date is explicit.

	APPROPRIATIONS Available for the Year Ending June 30	
	2014	**2015**
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**		
Subdivision 1. **Total Appropriation**	**$ 1,906,000**	**$ 2,047,000**
Appropriations by Fund		
	2014	2015
General	1,906,000	2,047,000
Reform 2020 Contingency. The appropriation from the general fund may be adjusted as provided in article 2, section		

49, in order to implement Reform 2020 and systems modernization.

Subd. 2. **Central Office Operations**

(a) **Operations**	3,384,000	14,506,000

Systems Modernization Transfer. If contingent funding is fully or partially disbursed as provided in article 2, section 49, and transferred to the state systems account, the unexpended balance of that appropriation must be transferred to the Office of Enterprise Technology in accordance with clause (2) of the systems modernization provision in article 14. Contingent funding under this provision must not exceed $16,992,000 for the biennium.

(b) **Children and Families**	109,000	206,000
(c) **Health Care**	100,000	100,000
(d) **Continuing Care**	5,236,000	5,541,000

Subd. 3. **Forecasted Programs**

(a) **Group Residential Housing**	(1,166,000)	(8,602,000)
(b) **Medical Assistance**	(3,770,000)	(10,086,000)
(c) **Alternative Care**	(6,981,000)	(4,394,000)

Subd. 4. **Grant Programs**

(a) **Child and Community Services Grants**	3,000,000	3,000,000
(b) **Aging and Adult Services Grants**	1,430,000	1,237,000
(c) **Disability Grants**	564,000	539,000

APPENDIX
Article locations in H1233-1

103I.005 DEFINITIONS.

Subd. 20. **Vertical heat exchanger.** "Vertical heat exchanger" means an earth-coupled heating or cooling device consisting of a sealed closed-loop piping system installed vertically in the ground to transfer heat to or from the surrounding earth with no discharge.

144.123 FEES FOR DIAGNOSTIC LABORATORY SERVICES; EXCEPTIONS.

Subd. 2. **Fee amounts.** The commissioner of health shall charge a handling fee prescribed in subdivision 1. The fee shall approximate the costs to the department of handling specimens including reporting, postage, specimen kit preparation, and overhead costs. The fee prescribed in subdivision 1 shall be $25 per specimen.

144A.46 LICENSURE.

Subdivision 1. **License required.** (a) A home care provider may not operate in the state without a current license issued by the commissioner of health. A home care provider may hold a separate license for each class of home care licensure.

(b) Within ten days after receiving an application for a license, the commissioner shall acknowledge receipt of the application in writing. The acknowledgment must indicate whether the application appears to be complete or whether additional information is required before the application will be considered complete. Within 90 days after receiving a complete application, the commissioner shall either grant or deny the license. If an applicant is not granted or denied a license within 90 days after submitting a complete application, the license must be deemed granted. An applicant whose license has been deemed granted must provide written notice to the commissioner before providing a home care service.

(c) Each application for a home care provider license, or for a renewal of a license, shall be accompanied by a fee to be set by the commissioner under section 144.122 and information sufficient to show that the applicant meets the requirements of licensure.

Subd. 2. **Exemptions.** The following individuals or organizations are exempt from the requirement to obtain a home care provider license:

(1) a person who is licensed as a registered nurse under sections 148.171 to 148.285 and who independently provides nursing services in the home without any contractual or employment relationship to a home care provider or other organization;

(2) a personal care assistant who provides services to only one individual under the medical assistance program as authorized under sections 256B.0625, subdivision 19a, and 256B.04, subdivision 16;

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

(4) a person who is licensed under sections 148.65 to 148.78 and who independently provides physical therapy services in the home without any contractual or employment relationship to a home care provider or other organization;

(5) a provider that is licensed by the commissioner of human services to provide semi-independent living services under Minnesota Rules, parts 9525.0500 to 9525.0660 when providing home care services to a person with a developmental disability;

(6) a provider that is licensed by the commissioner of human services to provide home and community-based services under Minnesota Rules, parts 9525.2000 to 9525.2140 when providing home care services to a person with a developmental disability;

(7) a person or organization that provides only home management services, if the person or organization is registered under section 144A.461; or

(8) a person who is licensed as a social worker under chapter 148D and who provides social work services in the home independently and not through any contractual or employment relationship with a home care provider or other organization.

An exemption under this subdivision does not excuse the individual from complying with applicable provisions of the home care bill of rights.

Subd. 3. **Enforcement.** (a) The commissioner may refuse to grant or renew a license, may suspend or revoke a license, or may impose a conditional license for violation of statutes or rules relating to home care services or for conduct detrimental to the welfare of the consumer. A suspension may include terms that must be completed before a suspension is lifted. Terms for a suspension or conditional license may include one or more of the following and the scope of each will be determined by the commissioner:

(1) requiring a consultant to review, evaluate, and make recommended changes to the provider's practices and submit reports to the commissioner at the cost of the provider;

(2) requiring supervision of the provider's practices at the cost of the provider by an unrelated person who has sufficient knowledge and qualifications to oversee the practices and who will submit reports to the commissioner;

(3) requiring the provider or the provider's employees to obtain training at the cost of the provider;

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

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

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

(b) Prior to any suspension, revocation, or refusal to renew a license, the home care provider shall be entitled to notice and a hearing as provided by sections 14.57 to 14.69. In addition to any other remedy provided by law, the commissioner may, without a prior contested case hearing, temporarily suspend a license or prohibit delivery of services by a provider for not more than 60 days if the commissioner determines that the health or safety of a consumer is in imminent danger, provided: (1) advance notice is given to the provider; (2) after notice, the provider fails to correct the problem; (3) the commissioner has reason to believe that other administrative remedies are not likely to be effective; and (4) there is an opportunity for a contested case hearing within the 60 days.

(c) The process of suspending or revoking a license must include a plan for transferring affected clients to other providers by the provider, which will be monitored by the commissioner. Within three business days of being notified of the final revocation or suspension action, the provider shall provide the commissioner, the lead agencies as defined in section 256B.0911, and the ombudsman for long-term care with the following information: (1) a list of all clients, including full names and all contact information on file; (2) a list of each client's contact person, including full names and all contact information on file; (3) the location of each client; (4) the payor sources for each client, including payor source identification numbers; and (5) for each client, a copy of the client's service agreement, and a list of the types of services being provided. The revocation or suspension notification requirement is satisfied by mailing the notice to the address in the license record. The provider shall cooperate with the commissioner and the lead agencies during the process of transferring care of clients to qualified providers. Within three business days of being notified of the final revocation or suspension action, the provider must notify and disclose to each of the provider's clients, or the client's contact persons, that the commissioner is taking action against the provider's license by providing a copy of the revocation or suspension notice issued by the commissioner. When the home care provider voluntarily discontinues services, the provider will notify the commissioner, lead agencies, and the ombudsman for long-term care about its clients as required in this section.

(d) The owner and managerial officials, as defined in the home care licensure rules, Minnesota Rules, chapter 4668, of a home care provider whose Minnesota license has not been renewed or has been revoked because of noncompliance with applicable law or rule shall not be eligible to apply for nor will be granted a home care license, including other licenses in this chapter, or be given status as an enrolled personal care assistance provider agency or personal care assistant by the Department of Human Services pursuant to section 256B.0659 for five years following the effective date of the nonrenewal or revocation. If the owner and managerial officials already have enrollment status, their enrollment will be terminated by the Department of Human Services.

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

(f) Notwithstanding the provisions of paragraph (a), the commissioner shall not renew, or shall suspend or revoke the license of any home care provider which includes any individual as an owner or managerial official who was an owner or managerial official of a home care provider whose Minnesota license was not renewed or was revoked as described in paragraph (d) for five years following the effective date of the nonrenewal or revocation. The commissioner shall notify the home care provider 30 days in advance of the date of nonrenewal, suspension, or revocation of the license. Within ten days after the receipt of this notification, the home care provider may request, in writing, that the commissioner stay the nonrenewal, revocation, or suspension of the license. The home care provider shall specify the reasons for requesting the stay; the steps that will be taken to attain or maintain compliance with the licensure laws and regulations; any limits on the authority or responsibility of the owners or managerial officials whose actions resulted

in the notice of nonrenewal, revocation, or suspension; and any other information to establish that the continuing affiliation with these individuals will not jeopardize client health, safety, or well being. The commissioner shall determine whether the stay will be granted within 30 days of receiving the provider's request. The commissioner may propose additional restrictions or limitations on the provider's license and require that the granting of the stay be contingent upon compliance with those provisions. The commissioner shall take into consideration the following factors when determining whether the stay should be granted:

(1) the threat that continued involvement of the owners and managerial officials in the home care provider poses to client health, safety, and well being;

(2) the compliance history of the home care provider; and

(3) the appropriateness of any limits suggested by the home care provider.

If the commissioner grants the stay, the order shall include any restrictions or limitation on the provider's license. The failure of the provider to comply with any restrictions or limitations shall result in the immediate removal of the stay and the commissioner shall take immediate action to suspend, revoke, or not renew the license.

(g) The provisions contained in paragraphs (d) and (e) shall apply to any nonrenewal or revocation of a home care license occurring after June 1, 1993, the effective date of the home care licensure rules.

(h) For the purposes of this subdivision, owners of a home care provider are those individuals whose ownership interest provides sufficient authority or control to affect or change decisions related to the operation of the home care provider. An owner includes a sole proprietor, a general partner, or any other individual whose individual ownership interest can affect the management and direction of the policies of the home care provider. For the purposes of this subdivision, managerial officials are those individuals who had the responsibility for the ongoing management or direction of the policies, services, or employees of the home care provider relating to the areas of noncompliance which led to the license revocation or nonrenewal.

Subd. 3a. **Injunctive relief.** In addition to any other remedy provided by law, the commissioner may bring an action in district court to enjoin a person who is involved in the management, operation, or control of a home care provider, or an employee of the home care provider from illegally engaging in activities regulated by sections 144A.43 to 144A.47. The commissioner may bring an action under this subdivision in the district court in Ramsey County or in the district in which a home care provider is providing services. The court may grant a temporary restraining order in the proceeding if continued activity by the person who is involved in the management, operation, or control of a home care provider, or by an employee of the home care provider, would create an imminent risk of harm to a recipient of home care services.

Subd. 3b. **Subpoena.** In matters pending before the commissioner under sections 144A.43 to 144A.47, the commissioner may issue subpoenas and compel the attendance of witnesses and the production of all necessary papers, books, records, documents, and other evidentiary material. If a person fails or refuses to comply with a subpoena or order of the commissioner to appear or testify regarding any matter about which the person may be lawfully questioned or to produce any papers, books, records, documents, or evidentiary materials in the matter to be heard, the commissioner may apply to the district court in any district, and the court shall order the person to comply with the commissioner's order or subpoena. The commissioner of health may administer oaths to witnesses, or take their affirmation. Depositions may be taken in or outside the state in the manner provided by law for the taking of depositions in civil actions. A subpoena or other process or paper may be served upon a named person anywhere within the state by an officer authorized to serve subpoenas in civil actions, with the same fees and mileage and in the same manner as prescribed by law for process issued out of a district court. A person subpoenaed under this subdivision shall receive the same fees, mileage, and other costs that are paid in proceedings in district court.

Subd. 3c. **Time limits for appeals.** To appeal the assessment of civil penalties under section 144A.45, subdivision 2, clause (4), a denial of a waiver or variance, and an action against a license under subdivision 3, a provider must request a hearing no later than 15 days after the provider receives notice of the action.

Subd. 4. **Relation to other regulatory programs.** In the exercise of the authority granted under sections 144A.43 to 144A.47, the commissioner shall not duplicate or replace standards and requirements imposed under another state regulatory program. The commissioner shall not impose additional training or education requirements upon members of a licensed or registered occupation or profession, except as necessary to address or prevent problems that are unique to the delivery of services in the home or to enforce and protect the rights of consumers listed in section 144A.44. The commissioner of health shall not require a home care provider certified under the Medicare program to comply with a rule adopted under section 144A.45 if the home care provider is required to comply with any equivalent federal law or regulation relating to the

same subject matter. The commissioner of health shall specify in the rules those provisions that are not applicable to certified home care providers. To the extent possible, the commissioner shall coordinate the inspections required under sections 144A.45 to 144A.47 with the health facility licensure inspections required under sections 144.50 to 144.58 or 144A.10 when the health care facility is also licensed under the provisions of Laws 1987, chapter 378.

Subd. 5. **Prior criminal convictions.** (a) Before the commissioner issues an initial or renewal license, an owner or managerial official shall be required to complete a background study under section 144.057. No person may be involved in the management, operation, or control of a provider, if the person has been disqualified under the provisions of chapter 245C. Individuals disqualified under these provisions can request a reconsideration, and if the disqualification is set aside are then eligible to be involved in the management, operation or control of the provider. For purposes of this section, owners of a home care provider subject to the background check requirement are those individuals whose ownership interest provides sufficient authority or control to affect or change decisions related to the operation of the home care provider. An owner includes a sole proprietor, a general partner, or any other individual whose individual ownership interest can affect the management and direction of the policies of the home care provider. For the purposes of this section, managerial officials subject to the background check requirement are those individuals who provide "direct contact" as defined in section 245C.02, subdivision 11, or those individuals who have the responsibility for the ongoing management or direction of the policies, services, or employees of the home care provider. Data collected under this subdivision shall be classified as private data under section 13.02, subdivision 12.

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

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

144A.461 REGISTRATION.

A person or organization that provides only home management services defined as home care services under section 144A.43, subdivision 3, clause (8), may not operate in the state without a current certificate of registration issued by the commissioner of health. To obtain a certificate of registration, the person or organization must annually submit to the commissioner the name, address, and telephone number of the person or organization and a signed statement declaring that the person or organization is aware that the home care bill of rights applies to their clients and that the person or organization will comply with the bill of rights provisions contained in section 144A.44. A person who provides home management services under this section must, within 120 days after beginning to provide services, attend an orientation session approved by the commissioner that provides training on the bill of rights and an orientation on the aging process and the needs and concerns of elderly and disabled persons. An organization applying for a certificate must also provide the name, business address, and telephone number of each of the individuals responsible for the management or direction of the organization. The commissioner shall charge an annual registration fee of $20 for individuals and $50 for organizations. A home care provider that provides home management services and other home care services must be licensed, but licensure requirements other than the home care bill of rights do not apply to those employees or volunteers who provide only home management services to clients who do not receive any other home care services from the provider. A licensed home care provider need not be registered as a home management service provider, but must provide an orientation on the home care bill of rights to its employees or volunteers who provide home management services. The commissioner may suspend or revoke a provider's certificate of registration or assess fines for violation of the home care bill of rights. Any fine assessed for a violation of the bill of rights by a provider registered under this section shall be in the amount established in the licensure rules for home care providers. As a condition of registration, a provider must cooperate fully with any investigation conducted by the commissioner, including providing specific information requested by the commissioner on clients served and the employees and volunteers who provide services. The commissioner may use any of the powers granted in sections 144A.43 to 144A.47 to administer the registration system and enforce the home care bill of rights under this section.

149A.025 ALKALINE HYDROLYSIS.

For purposes of this chapter, the disposal of a dead human body through the process of alkaline hydrolysis shall be subject to the same licensing requirements and regulations that apply to cremation, crematories, and cremated remains as described in this chapter. The licensing requirements and regulations of this chapter shall also apply to the entities where the process of alkaline hydrolysis occurs and to the remains that result from the alkaline hydrolysis process.

149A.20 LICENSE TO PRACTICE MORTUARY SCIENCE.

Subd. 8. **Fees.** Fees shall be paid to the commissioner of management and budget, state of Minnesota, and shall be credited to the state government special revenue fund in the state treasury.

149A.30 RECIPROCAL LICENSING.

Subd. 2. **Fees.** Fees shall be paid to the commissioner of management and budget, state of Minnesota, and shall be credited to the state government special revenue fund in the state treasury.

149A.40 RENEWAL OF LICENSE TO PRACTICE MORTUARY SCIENCE.

Subd. 8. **Renewal fees.** The renewal fees shall be paid to the commissioner of management and budget, state of Minnesota, and shall be credited to the state government special revenue fund in the state treasury.

149A.45 EMERITUS REGISTRATION FOR MORTUARY SCIENCE PRACTITIONERS.

Subd. 6. **Fees.** The renewal fees shall be paid to the commissioner of management and budget and shall be credited to the state government special revenue fund in the state treasury.

149A.50 LICENSE TO OPERATE A FUNERAL ESTABLISHMENT.

Subd. 6. **Initial licensure and inspection fees.** The licensure and inspection fees shall be paid to the commissioner of management and budget, state of Minnesota, to the credit of the state government special revenue fund in the state treasury.

149A.51 RENEWAL OF LICENSE TO OPERATE A FUNERAL ESTABLISHMENT.

Subd. 7. **Renewal and reinspection fees.** The renewal and reinspection fees shall be paid to the commissioner of management and budget, state of Minnesota, and shall be credited to the state government special revenue fund in the state treasury.

149A.52 LICENSE TO OPERATE A CREMATORY.

Subd. 5a. **Initial licensure and inspection fees.** The licensure and inspection fees shall be paid to the commissioner of management and budget and shall be credited to the state government special revenue fund in the state treasury.

149A.53 RENEWAL OF LICENSE TO OPERATE CREMATORY.

Subd. 9. **Renewal and reinspection fees.** The renewal and reinspection fees shall be paid to the commissioner of management and budget and shall be credited to the state government special revenue fund in the state treasury.

245A.655 FEDERAL GRANTS TO ESTABLISH AND MAINTAIN A SINGLE COMMON ENTRY POINT FOR REPORTING MALTREATMENT OF A VULNERABLE ADULT.

(a) The commissioner of human services shall seek federal funding to design, implement, maintain, and evaluate the common entry point for reports of suspected maltreatment made under Minnesota Statutes, section 626.557. The purpose of the federal grant funds is to establish a common entry point with a statewide toll-free telephone number and Web site-based system to report known or suspected abuse, neglect, or exploitation of a vulnerable adult.

(b) A common entry point must be operated in a manner that enables the common entry point staff to:

(1) operate under Minnesota Statutes, section 626.557, subdivision 9, paragraph (b); and subdivision 9a;

(2) when appropriate, refer calls that do not allege the abuse, neglect, or exploitation of a vulnerable adult to other organizations that might better resolve the reporter's concerns; and

(3) immediately identify and locate prior reports of abuse, neglect, or exploitation.

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

(1) track critical steps in the investigative process to ensure compliance with all requirements for all reports;

(2) maintain data to facilitate the production of aggregate statistical reports for monitoring patterns of abuse, neglect, or exploitation;

(3) serve as a resource for the evaluation, management, and planning of preventative and remedial services for vulnerable adults who have been subject to abuse, neglect, or exploitation;

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

(5) develop a system to manage consumer complaints related to the common entry point.

(d) The commissioner of human services may take the actions necessary to design and implement the common entry point in paragraph (a). Funds awarded by the federal government for the purposes of this section are appropriated to the commissioner of human services.

245B.01 RULE CONSOLIDATION.

This chapter establishes new methods to ensure the quality of services to persons with developmental disabilities, and streamlines and simplifies regulation of services and supports for persons with developmental disabilities. Sections 245B.02 to 245B.07 establish new standards that eliminate duplication and overlap of regulatory requirements by consolidating and replacing rule parts from four program rules. Section 245B.08 authorizes the commissioner of human services to develop and use new regulatory strategies to maintain compliance with the streamlined requirements.

245B.02 DEFINITIONS.

Subdivision 1. **Scope.** The terms used in this chapter have the meanings given them.

Subd. 2. **Applicant.** "Applicant" has the meaning given in section 245A.02, subdivision 3.

Subd. 3. **Case manager.** "Case manager" means the individual designated by the county board under rules of the commissioner to provide case management services as delineated in section 256B.092 or successor provisions.

Subd. 4. **Consumer.** "Consumer" means a person who has been determined eligible to receive and is receiving services or support for persons with developmental disabilities.

Subd. 5. **Commissioner.** "Commissioner" means the commissioner of the Department of Human Services or the commissioner's designated representative.

Subd. 6. **Day training and habilitation services; developmental disabilities.** "Day training and habilitation services for adults with developmental disabilities" has the meaning given in sections 252.40 to 252.46.

Subd. 7. **Department.** "Department" means the Department of Human Services.

Subd. 8. **Direct service.** "Direct service" means, for a consumer receiving residential-based services, day training and habilitation services, or respite care services, one or more of the following: supervision, assistance, or training.

Subd. 8a. **Emergency.** "Emergency" means any fires, severe weather, natural disasters, power failures, or any event that affects the ordinary daily operation of the program, including, but not limited to, events that threaten the immediate health and safety of a person receiving services and that require calling 911, emergency evacuation, moving to an emergency shelter, or temporary closure or relocation of the program to another facility or service site.

Subd. 9. **Health services.** "Health services" means any service or treatment consistent with the health needs of the consumer, such as medication administration and monitoring, medical, dental, nutritional, health monitoring, wellness education, and exercise.

Subd. 10. **Incident.** "Incident" means an occurrence that affects the ordinary provision of services to a person and includes any of the following:

(1) serious injury as determined by section 245.91, subdivision 6;

(2) a consumer's death;

(3) any medical emergency, unexpected serious illness, or significant unexpected changes in an illness or medical condition, or the mental health status of a person that requires calling 911 or a mental health mobile crisis intervention team, physician treatment, or hospitalization;

(4) a consumer's unauthorized or unexplained absence;

(5) physical aggression by a consumer against another consumer that causes physical pain, injury, or persistent emotional distress, including, but not limited to, hitting, slapping, kicking, scratching, pinching, biting, pushing, and spitting;

(6) any sexual activity between consumers involving force or coercion as defined under section 609.341, subdivisions 3 and 14; or

(7) a report of child or vulnerable adult maltreatment under section 626.556 or 626.557.

Subd. 11. **Individual service plan.** "Individual service plan" has the meaning given in section 256B.092 or successor provisions.

Subd. 12. **Individual who is related.** "Individual who is related" has the meaning given in section 245A.02, subdivision 13.

Subd. 12a. **Interdisciplinary team.** "Interdisciplinary team" means a team composed of the case manager, the person, the person's legal representative and advocate, if any, and representatives of providers of the service areas relevant to the needs of the person as described in the individual service plan.

Subd. 13. **Intermediate care facility for persons with developmental disabilities.** "Intermediate care facility for persons with developmental disabilities" or "ICF/MR" means a residential program licensed to provide services to persons with developmental disabilities under section 252.28 and chapter 245A and a physical facility licensed as a supervised living facility under chapter 144, which together are certified by the Department of Health as an intermediate care facility for persons with developmental disabilities.

Subd. 14. **Least restrictive environment.** "Least restrictive environment" means an environment where services:

(1) are delivered with minimum limitation, intrusion, disruption, or departure from typical patterns of living available to persons without disabilities;

(2) do not subject the consumer or others to unnecessary risks to health or safety; and

(3) maximize the consumer's level of independence, productivity, and inclusion in the community.

Subd. 15. **Legal representative.** "Legal representative" means the parent or parents of a consumer who is under 18 years of age or a guardian, conservator, or guardian ad litem authorized by the court, or other legally authorized representative to make decisions about services for a consumer.

Subd. 16. **License.** "License" has the meaning given in section 245A.02, subdivision 8.

Subd. 17. **License holder.** "License holder" has the meaning given in section 245A.02, subdivision 9.

Subd. 18. **Person with developmental disability.** "Person with developmental disability" means a person who has been diagnosed under section 256B.092 as having substantial limitations in present functioning, manifested as significantly subaverage intellectual functioning, existing concurrently with demonstrated deficits in adaptive behavior, and who manifests these conditions before the person's 22nd birthday. A person with a related condition means a person who meets the diagnostic definition under section 252.27, subdivision 1a.

Subd. 19. **Psychotropic medication use checklist.** "Psychotropic medication use checklist" means the psychotropic medication monitoring checklist and manual used to govern the administration of psychotropic medications. The commissioner may revise or update the psychotropic medication use checklist to comply with legal requirements or to meet professional standards or guidelines in the area of developmental disabilities. For purposes of this chapter, psychotropic medication means any medication prescribed to treat mental illness and associated behaviors or to control or alter behavior. The major classes of psychotropic medication are antipsychotic (neuroleptic), antidepressant, antianxiety, antimania, stimulant, and sedative or hypnotic. Other miscellaneous medications are considered to be a psychotropic medication when they are specifically prescribed to treat a mental illness or to control or alter behavior.

Subd. 20. **Residential-based habilitation.** "Residential-based habilitation" means care, supervision, and training provided primarily in the consumer's own home or place of residence but also including community-integrated activities following the individual service plan. Residential habilitation services are provided in coordination with the provision of day training and habilitation services for those persons receiving day training and habilitation services under sections 252.40 to 252.46.

Subd. 21. **Respite care.** "Respite care" has the meaning given in section 245A.02, subdivision 15.

Subd. 22. **Service.** "Service" means care, supervision, activities, or training designed to achieve the outcomes assigned to the license holder.

Subd. 23. **Semi-independent living services or SILS** "Semi-independent living services" or "SILS" has the meaning given in section 252.275.

Subd. 23a. **Supported employment.** "Supported employment" services include individualized counseling, individualized job development and placement that produce an appropriate job match for the individual and the employer, on-the-job training in work and related work skills required for job performance, ongoing supervision and monitoring of the person's performance, long-term support services to assure job retention, training in related skills essential to obtaining and retaining employment such as the effective use of community resources, use of break and lunch areas, transportation and mobility training, and transportation between the individual's place of residence and the work place when other forms of transportation are unavailable or inaccessible.

Subd. 24. **Volunteer.** "Volunteer" means an individual who, under the direction of the license holder, provides direct services without pay to consumers served by the license holder.

245B.03 APPLICABILITY AND EFFECT.

Subdivision 1. **Applicability.** The standards in this chapter govern services to persons with developmental disabilities receiving services from license holders providing residential-based habilitation; day training and habilitation services for adults; supported employment; semi-independent living services; residential programs that serve more than four consumers, including intermediate care facilities for persons with developmental disabilities; and respite care provided outside the consumer's home for more than four consumers at the same time at a single site.

Subd. 2. **Relationship to other standards governing services at ICF's/MR.** (a) ICF's/MR are exempt from:

(1) section 245B.04;

(2) section 245B.06, subdivisions 4 and 6; and

(3) section 245B.07, subdivisions 4, paragraphs (b) and (c); 7; and 8, paragraph (a), clause (4), and paragraph (b).

(b) License holders also licensed under chapter 144 as a supervised living facility are exempt from section 245B.04.

(c) Residential service sites controlled by license holders licensed under this chapter for home and community-based waivered services for four or fewer adults are exempt from compliance with Minnesota Rules, parts 9543.0040, subpart 2, item C; 9555.5505; 9555.5515, items B and G; 9555.5605; 9555.5705; 9555.6125, subparts 3, item C, subitem (2), and 4 to 6; 9555.6185; 9555.6225, subpart 8; 9555.6245; 9555.6255; and 9555.6265; and as provided under section 245B.06, subdivision 2, the license holder is exempt from the program abuse prevention plans and individual abuse prevention plans otherwise required under sections 245A.65, subdivision 2, and 626.557, subdivision 14. The commissioner may approve alternative methods of providing overnight supervision using the process and criteria for granting a variance in section 245A.04, subdivision 9. This chapter does not apply to foster care homes that do not provide residential habilitation services funded under the home and community-based waiver programs defined in section 256B.092.

(d) Residential service sites controlled by license holders licensed under this chapter for home and community-based waivered services for four or fewer children are exempt from compliance with Minnesota Rules, parts 2960.3060, subpart 3, items B and C; 2960.3070; 2960.3100, subpart 1, items C, F, and I; and 2960.3210.

(e) The commissioner may exempt license holders from applicable standards of this chapter when the license holder meets the standards under section 245A.09, subdivision 7. License holders that are accredited by an independent accreditation body shall continue to be licensed under this chapter.

(f) License holders governed by sections 245B.02 to 245B.07 must also meet the licensure requirements in chapter 245A.

(g) Nothing in this chapter prohibits license holders from concurrently serving consumers with and without developmental disabilities provided this chapter's standards are met as well as other relevant standards.

(h) The documentation that sections 245B.02 to 245B.07 require of the license holder meets the individual program plan required in section 256B.092 or successor provisions.

Subd. 3. **Continuity of care.** (a) When a consumer changes service to the same type of service provided under a different license held by the same license holder and the policies and

procedures under section 245B.07, subdivision 8, are substantially similar, the license holder is exempt from the requirements in sections 245B.06, subdivisions 2, paragraphs (e) and (f), and 4; and 245B.07, subdivision 9, clause (2).

(b) When a direct service staff person begins providing direct service under one or more licenses other than the license for which the staff person initially received the staff orientation requirements under section 245B.07, subdivision 5, the license holder is exempt from all staff orientation requirements under section 245B.07, subdivision 5, except that:

(1) if the service provision location changes, the staff person must receive orientation regarding any policies or procedures under section 245B.07, subdivision 8, that are specific to the service provision location; and

(2) if the staff person provides direct service to one or more consumers for whom the staff person has not previously provided direct service, the staff person must review each consumer's: (i) service plans and risk management plan in accordance with section 245B.07, subdivision 5, paragraph (b), clause (1); and (ii) medication administration in accordance with section 245B.07, subdivision 5, paragraph (b), clause (6).

245B.031 ACCREDITATION, ALTERNATIVE INSPECTION, AND DEEMED COMPLIANCE.

Subdivision 1. **Day training and habilitation or supported employment services programs; alternative inspection status.** (a) A license holder providing day training and habilitation services or supported employment services according to this chapter, with a three-year accreditation from the Commission on Rehabilitation Facilities, that has had at least one on-site inspection by the commissioner following issuance of the initial license, may request alternative inspection status under this section.

(b) The request for alternative inspection status must be made in the manner prescribed by the commissioner, and must include:

(1) a copy of the license holder's application to the Commission on Rehabilitation Facilities for accreditation;

(2) the most recent Commission on Rehabilitation Facilities accreditation survey report; and

(3) the most recent letter confirming the three-year accreditation and approval of the license holder's quality improvement plan.

Based on the request and the accompanying materials, the commissioner may approve alternative inspection status.

(c) Following approval of alternative inspection status, the commissioner may terminate the alternative inspection status or deny a subsequent alternative inspection status if the commissioner determines that any of the following conditions have occurred after approval of the alternative inspection process:

(1) the license holder has not maintained full three-year accreditation;

(2) the commissioner has substantiated maltreatment for which the license holder or facility is determined to be responsible during the three-year accreditation period; and

(3) during the three-year accreditation period, the license holder has been issued an order for conditional license, a fine, suspension, or license revocation that has not been reversed upon appeal.

(d) The commissioner's decision that the conditions for approval for the alternative licensing inspection status have not been met is final and not subject to appeal under the provisions of chapter 14.

Subd. 2. **Programs with three-year accreditation, exempt from certain statutes.** (a) A license holder approved for alternative inspection status under this section is exempt from the requirements under:

(1) section 245B.04;

(2) section 245B.05, subdivisions 5 and 6;

(3) section 245B.06, subdivisions 1, 3, 4, 5, and 6; and

(4) section 245B.07, subdivisions 1, 4, and 6.

(b) Upon receipt of a complaint regarding a requirement under paragraph (a), the commissioner shall refer the complaint to the Commission on Rehabilitation Facilities for possible follow-up.

Subd. 3. **Programs with three-year accreditation, deemed to be in compliance with nonexempt licensing requirements.** (a) License holders approved for alternative inspection status under this section are required to maintain compliance with all licensing standards from which they are not exempt under subdivision 2, paragraph (a).

(b) License holders approved for alternative inspection status under this section shall be deemed to be in compliance with all nonexempt statutes, and the commissioner shall not perform routine licensing inspections.

(c) Upon receipt of a complaint regarding the services of a license holder approved for alternative inspection under this section that is not related to a licensing requirement from which the license holder is exempt under subdivision 2, the commissioner shall investigate the complaint and may take any action as provided under section 245A.06 or 245A.07.

Subd. 4. **Investigations of alleged maltreatment of minors or vulnerable adults.** Nothing in this section changes the commissioner's responsibilities to investigate alleged or suspected maltreatment of a minor under section 626.556 or vulnerable adult under section 626.557.

Subd. 5. **Request to Commission on Rehabilitation Facilities to expand accreditation survey.** The commissioner shall submit a request to the Commission on Rehabilitation Facilities to routinely inspect for compliance with standards that are similar to the following nonexempt licensing requirements:

(1) section 245A.65;
(2) section 245A.66;
(3) section 245B.05, subdivisions 1, 2, and 7;
(4) section 245B.055;
(5) section 245B.06, subdivisions 2, 7, 9, and 10;
(6) section 245B.07, subdivisions 2, 5, and 8, paragraph (a), clause (7);
(7) section 245C.04, subdivision 1, paragraph (f);
(8) section 245C.07;
(9) section 245C.13, subdivision 2;
(10) section 245C.20; and
(11) Minnesota Rules, parts 9525.2700 to 9525.2810.

245B.04 CONSUMER RIGHTS.

Subdivision 1. **License holder's responsibility for consumers' rights.** The license holder must:

(1) provide the consumer or the consumer's legal representative a copy of the consumer's rights on the day that services are initiated and an explanation of the rights in subdivisions 2 and 3 within five working days of service initiation and annually thereafter. Reasonable accommodations shall be made by the license holder to provide this information in other formats as needed to facilitate understanding of the rights by the consumer and the consumer's legal representative, if any;

(2) document the consumer's or the consumer's legal representative's receipt of a copy of the rights and an explanation of the rights; and

(3) ensure the exercise and protection of the consumer's rights in the services provided by the license holder and authorized in the individual service plan.

Subd. 2. **Service-related rights.** A consumer's service-related rights include the right to:

(1) refuse or terminate services and be informed of the consequences of refusing or terminating services;

(2) know, in advance, limits to the services available from the license holder;

(3) know conditions and terms governing the provision of services, including the license holder's policies and procedures related to initiation and termination;

(4) know what the charges are for services, regardless of who will be paying for the services, and be notified upon request of changes in those charges;

(5) know, in advance, whether services are covered by insurance, government funding, or other sources, and be told of any charges the consumer or other private party may have to pay; and

(6) receive licensed services from individuals who are competent and trained, who have professional certification or licensure, as required, and who meet additional qualifications identified in the individual service plan.

Subd. 3. **Protection-related rights.** (a) The consumer's protection-related rights include the right to:

(1) have personal, financial, services, and medical information kept private, and be advised of the license holder's policies and procedures regarding disclosure of such information;

(2) access records and recorded information about the person in accordance with applicable state and federal law, regulation, or rule;

(3) be free from maltreatment;

(4) be treated with courtesy and respect for the consumer's individuality, mode of communication, and culture, and receive respectful treatment of the consumer's property;

(5) reasonable observance of cultural and ethnic practice and religion;

(6) be free from bias and harassment regarding race, gender, age, disability, spirituality, and sexual orientation;

(7) be informed of and use the license holder's grievance policy and procedures, including knowing how to contact persons responsible for addressing problems and to appeal under section 256.045;

(8) know the name, telephone number, and the Web site, e-mail, and street addresses of protection and advocacy services, including the appropriate state-appointed ombudsman, and a brief description of how to file a complaint with these offices;

(9) voice grievances, know the contact persons responsible for addressing problems and how to contact those persons;

(10) any procedures for grievance or complaint resolution and the right to appeal under section 256.045;

(11) know the name and address of the state, county, or advocacy agency to contact for additional information or assistance;

(12) assert these rights personally, or have them asserted by the consumer's family or legal representative, without retaliation;

(13) give or withhold written informed consent to participate in any research or experimental treatment;

(14) have daily, private access to and use of a non-coin-operated telephone for local calls and long-distance calls made collect or paid for by the resident;

(15) receive and send, without interference, uncensored, unopened mail or electronic correspondence or communication;

(16) marital privacy for visits with the consumer's spouse and, if both are residents of the site, the right to share a bedroom and bed;

(17) associate with other persons of the consumer's choice;

(18) personal privacy; and

(19) engage in chosen activities.

(b) Restriction of a person's rights under paragraph (a), clauses (13) to (15), or this paragraph is allowed only if determined necessary to ensure the health, safety, and well-being of the person. Any restriction of these rights must be documented in the service plan for the person and must include the following information:

(1) the justification for the restriction based on an assessment of the person's vulnerability related to exercising the right without restriction;

(2) the objective measures set as conditions for ending the restriction;

(3) a schedule for reviewing the need for the restriction based on the conditions for ending the restriction to occur, at a minimum, every three months for persons who do not have a legal representative and annually for persons who do have a legal representative from the date of initial approval; and

(4) signed and dated approval for the restriction from the person, or the person's legal representative, if any. A restriction may be implemented only when the required approval has been obtained. Approval may be withdrawn at any time. If approval is withdrawn, the right must be immediately and fully restored.

245B.05 CONSUMER PROTECTION STANDARDS.

Subdivision 1. **Environment.** The license holder must:

(1) ensure that services are provided in a safe and hazard-free environment when the license holder is the owner, lessor, or tenant of the service site. All other license holders shall inform the consumer or the consumer's legal representative and case manager about any environmental safety concerns in writing;

(2) ensure that doors are locked or toxic substances or dangerous items normally accessible to persons served by the program are stored in locked cabinets, drawers, or containers only to protect the safety of consumers and not as a substitute for staff supervision or interactions with consumers. If doors are locked or toxic substances or dangerous items normally accessible to persons served by the program are stored in locked cabinets, drawers, or containers, the license holder must justify and document how this determination was made in consultation with the person or the person's legal representative and how access will otherwise be provided to the person and all other affected persons receiving services;

(3) follow procedures that minimize the consumer's health risk from communicable diseases; and

(4) maintain equipment, vehicles, supplies, and materials owned or leased by the license holder in good condition.

Subd. 2. **Licensed capacity for facility-based day training and habilitation services.** The licensed capacity of each day training and habilitation service site must be determined by the amount of primary space available, the scheduling of activities at other service sites, and the space requirements of consumers receiving services at the site. Primary space does not include hallways, stairways, closets, utility areas, bathrooms, kitchens, and floor areas beneath stationary equipment. A facility-based day training and habilitation site must have a minimum of 40 square feet of primary space available for each consumer who is present at the site at any one time. Licensed capacity under this subdivision does not apply to: (1) consumers receiving community-based day training and habilitation services; and (2) the temporary use of a facility-based training and habilitation service site for the limited purpose of providing transportation to consumers receiving community-based day training and habilitation services from the license holder. The license holder must comply at all times with all applicable fire and safety codes under section 245A.04, subdivision 2a, and adequate supervision requirements under section 245B.055 for all persons receiving day training and habilitation services.

Subd. 3. **Residential service sites for more than four consumers; four-bed ICF's/MR.** Residential service sites licensed to serve more than four consumers and four-bed ICF's/MR must meet the fire protection provisions of either the Residential Board and Care Occupancies Chapter or the Health Care Occupancies Chapter of the Life Safety Code (LSC), National Fire Protection Association, 1985 edition, or its successors. Sites meeting the definition of a residential board and care occupancy for 16 or less beds must have the emergency evacuation capability of residents evaluated in accordance with Appendix F of the LSC or its successors, except for those sites that meet the LSC Health Care Occupancies Chapter or its successors.

Subd. 5. **Consumer health.** The license holder is responsible for meeting the health service needs assigned to the license holder in the individual service plan and for bringing health needs as discovered by the license holder promptly to the attention of the consumer, the consumer's legal representative, and the case manager. The license holder is required to maintain documentation on how the consumer's health needs will be met, including a description of procedures the license holder will follow for the consumer regarding medication monitoring and administration and seizure monitoring, if needed. The medication administration procedures are those procedures necessary to implement medication and treatment orders issued by appropriately licensed professionals, and must be established in consultation with a registered nurse, nurse practitioner, physician's assistant, or medical doctor.

Subd. 6. **First aid.** When the license holder is providing direct service and supervision to a consumer who requires a 24-hour plan of care and receives services at a site licensed under this chapter, the license holder must have available a staff person trained in first aid, and, if needed under section 245B.07, subdivision 6, paragraph (d), cardiopulmonary resuscitation from a qualified source, as determined by the commissioner.

Subd. 7. **Reporting incidents.** (a) The license holder must maintain information about and report incidents under section 245B.02, subdivision 10, clauses (1) to (7), to the consumer's legal representative, other licensed caregiver, if any, and case manager within 24 hours of the occurrence, or within 24 hours of receipt of the information unless the incident has been reported by another license holder. An incident under section 245B.02, subdivision 10, clause (8), must be reported as required under paragraph (c) unless the incident has been reported by another license holder.

(b) When the incident involves more than one consumer, the license holder must not disclose personally identifiable information about any other consumer when making the report to each consumer's legal representative, other licensed caregiver, if any, and case manager unless the license holder has the consent of a consumer or a consumer's legal representative.

(c) Within 24 hours of reporting maltreatment as required under section 626.556 or 626.557, the license holder must inform the consumer's legal representative and case manager of the report unless there is reason to believe that the legal representative or case manager is involved in the suspected maltreatment. The information the license holder must disclose is the nature of the activity or occurrence reported, the agency that receives the report, and the telephone number of the Department of Human Services Licensing Division.

(d) Except as provided in paragraph (e), death or serious injury of the consumer must also be reported to the Department of Human Services Licensing Division and the ombudsman, as required under sections 245.91 and 245.94, subdivision 2a.

(e) When a death or serious injury occurs in a facility certified as an intermediate care facility for persons with developmental disabilities, the death or serious injury must be reported to

the Department of Health, Office of Health Facility Complaints, and the ombudsman, as required under sections 245.91 and 245.94, subdivision 2a.

245B.055 STAFFING FOR DAY TRAINING AND HABILITATION SERVICES.

Subdivision 1. **Scope.** This section applies only to license holders that provide day training and habilitation services.

Subd. 2. **Factors.** (a) The number of direct service staff members that a license holder must have on duty at a given time to meet the minimum staffing requirements established in this section varies according to:

(1) the number of persons who are enrolled and receiving direct services at that given time;

(2) the staff ratio requirement established under subdivision 3 for each of the persons who is present; and

(3) whether the conditions described in subdivision 8 exist and warrant additional staffing beyond the number determined to be needed under subdivision 7.

(b) The commissioner shall consider the factors in paragraph (a) in determining a license holder's compliance with the staffing requirements and shall further consider whether the staff ratio requirement established under subdivision 3 for each person receiving services accurately reflects the person's need for staff time.

Subd. 3. **Staff ratio requirement for each person receiving services.** The case manager, in consultation with the interdisciplinary team shall determine at least once each year which of the ratios in subdivisions 4, 5, and 6 is appropriate for each person receiving services on the basis of the characteristics described in subdivisions 4, 5, and 6. The ratio assigned each person and the documentation of how the ratio was arrived at must be kept in each person's individual service plan. Documentation must include an assessment of the person with respect to the characteristics in subdivisions 4, 5, and 6 recorded on a standard assessment form required by the commissioner.

Subd. 4. **Person requiring staff ratio of one to four.** A person who has one or more of the following characteristics must be assigned a staff ratio requirement of one to four:

(1) on a daily basis the person requires total care and monitoring or constant hand-over-hand physical guidance to successfully complete at least three of the following activities: toileting, communicating basic needs, eating, or ambulating; or

(2) the person assaults others, is self-injurious, or manifests severe dysfunctional behaviors at a documented level of frequency, intensity, or duration requiring frequent daily ongoing intervention and monitoring as established in an approved behavior management program.

Subd. 5. **Person requiring staff ratio of one to eight.** A person who has all of the following characteristics must be assigned a staff ratio requirement of one to eight:

(1) the person does not meet the requirements in subdivision 4; and

(2) on a daily basis the person requires verbal prompts or spot checks and minimal or no physical assistance to successfully complete at least three of the following activities: toileting, communicating basic needs, eating, or ambulating.

Subd. 6. **Person requiring staff ratio of one to six.** A person who does not have any of the characteristics described in subdivision 4 or 5 must be assigned a staff ratio requirement of one to six.

Subd. 7. **Determining number of direct service staff required.** The minimum number of direct service staff members required at any one time to meet the combined staff ratio requirements of the persons present at that time can be determined by following the steps in clauses (1) through (4):

(1) assign each person in attendance the three-digit decimal below that corresponds to the staff ratio requirement assigned to that person. A staff ratio requirement of one to four equals 0.250. A staff ratio requirement of one to eight equals 0.125. A staff ratio requirement of one to six equals 0.166. A staff ratio requirement of one to ten equals 0.100;

(2) add all of the three-digit decimals (one three-digit decimal for every person in attendance) assigned in clause (1);

(3) when the sum in clause (2) falls between two whole numbers, round off the sum to the larger of the two whole numbers; and

(4) the larger of the two whole numbers in clause (3) equals the number of direct service staff members needed to meet the staff ratio requirements of the persons in attendance.

Subd. 8. **Conditions requiring additional direct service staff.** The license holder shall increase the number of direct service staff members present at any one time beyond the number arrived at in subdivision 4 if necessary when any one or combination of the following circumstances can be documented by the commissioner as existing:

(1) the health and safety needs of the persons receiving services cannot be met by the number of staff members available under the staffing pattern in effect even though the number has been accurately calculated under subdivision 7; or

(2) the behavior of a person presents an immediate danger and the person is not eligible for a special needs rate exception under Minnesota Rules, parts 9510.1020 to 9510.1140.

Subd. 9. **Supervision requirements.** At no time shall one direct service staff member be assigned responsibility for supervision and training of more than ten persons receiving supervision and training, except as otherwise stated in each person's risk management plan.

245B.06 SERVICE STANDARDS.

Subdivision 1. **Outcome-based services.** (a) The license holder must provide outcome-based services in response to the consumer's identified needs as specified in the individual service plan.

(b) Services must be based on the needs and preferences of the consumer and the consumer's personal goals and be consistent with the principles of least restrictive environment, self-determination, and consistent with:

(1) the recognition of each consumer's history, dignity, and cultural background;

(2) the affirmation and protection of each consumer's civil and legal rights;

(3) the provision of services and supports for each consumer which:

(i) promote community inclusion and self-sufficiency;

(ii) provide services in the least restrictive environment;

(iii) promote social relationships, natural supports, and participation in community life;

(iv) allow for a balance between safety and opportunities; and

(v) provide opportunities for the development and exercise of age-appropriate skills, decision making and choice, personal advocacy, and communication; and

(4) the provision of services and supports for families which address the needs of the consumer in the context of the family and support family self-sufficiency.

(c) The license holder must make available to the consumer opportunities to participate in the community, functional skill development, reduced dependency on care providers, and opportunities for development of decision-making skills. "Outcome" means the behavior, action, or status attained by the consumer that can be observed, measured, and can be determined reliable and valid. Outcomes are the equivalent of the long-range goals and short-term goals referenced in section 256B.092, and any rules promulgated under that section.

Subd. 2. **Risk management plan.** (a) The license holder must develop, document in writing, and implement a risk management plan that meets the requirements of this subdivision. License holders licensed under this chapter are exempt from sections 245A.65, subdivision 2, and 626.557, subdivision 14, if the requirements of this subdivision are met.

(b) The risk management plan must identify areas in which the consumer is vulnerable, based on an assessment, at a minimum, of the following areas:

(1) an adult consumer's susceptibility to physical, emotional, and sexual abuse as defined in section 626.5572, subdivision 2, and financial exploitation as defined in section 626.5572, subdivision 9; a minor consumer's susceptibility to sexual and physical abuse as defined in section 626.556, subdivision 2; and a consumer's susceptibility to self-abuse, regardless of age;

(2) the consumer's health needs, considering the consumer's physical disabilities; allergies; sensory impairments; seizures; diet; need for medications; and ability to obtain medical treatment;

(3) the consumer's safety needs, considering the consumer's ability to take reasonable safety precautions; community survival skills; water survival skills; ability to seek assistance or provide medical care; and access to toxic substances or dangerous items;

(4) environmental issues, considering the program's location in a particular neighborhood or community; the type of grounds and terrain surrounding the building; and the consumer's ability to respond to weather-related conditions, open locked doors, and remain alone in any environment; and

(5) the consumer's behavior, including behaviors that may increase the likelihood of physical aggression between consumers or sexual activity between consumers involving force or coercion, as defined under section 245B.02, subdivision 10, clauses (6) and (7).

(c) When assessing a consumer's vulnerability, the license holder must consider only the consumer's skills and abilities, independent of staffing patterns, supervision plans, the environment, or other situational elements.

(d) License holders jointly providing services to a consumer shall coordinate and use the resulting assessment of risk areas for the development of each license holder's risk management or the shared risk management plan. The license holder's plan must include the specific actions a staff person will take to protect the consumer and minimize risks for the identified vulnerability

areas. The specific actions must include the proactive measures being taken, training being provided, or a detailed description of actions a staff person will take when intervention is needed.

(e) Prior to or upon initiating services, a license holder must develop an initial risk management plan that is, at a minimum, verbally approved by the consumer or consumer's legal representative and case manager. The license holder must document the date the license holder receives the consumer's or consumer's legal representative's and case manager's verbal approval of the initial plan.

(f) As part of the meeting held within 45 days of initiating service, as required under section 245B.06, subdivision 4, the license holder must review the initial risk management plan for accuracy and revise the plan if necessary. The license holder must give the consumer or consumer's legal representative and case manager an opportunity to participate in this plan review. If the license holder revises the plan, or if the consumer or consumer's legal representative and case manager have not previously signed and dated the plan, the license holder must obtain dated signatures to document the plan's approval.

(g) After plan approval, the license holder must review the plan at least annually and update the plan based on the individual consumer's needs and changes to the environment. The license holder must give the consumer or consumer's legal representative and case manager an opportunity to participate in the ongoing plan development. The license holder shall obtain dated signatures from the consumer or consumer's legal representative and case manager to document completion of the annual review and approval of plan changes.

Subd. 3. **Assessments.** (a) The license holder shall assess and reassess the consumer within stated time lines and assessment areas specified in the individual service plan or as requested in writing by the case manager.

(b) For each area of assessment requested, the license holder must provide a written summary, analysis, and recommendations for use in the development of the individual service plan.

(c) All assessments must include information about the consumer that is descriptive of:

(1) the consumer's strengths and functional skills; and

(2) the level of support and supervision the consumer needs to achieve the outcomes in subdivision 1.

Subd. 4. **Supports and methods.** The license holder, in coordination with other service providers, shall meet with the consumer, the consumer's legal representative, case manager, and other members of the interdisciplinary team within 45 days of service initiation. Within ten working days after the meeting, the license holder shall develop and document in writing:

(1) the methods that will be used to support the individual or accomplish the outcomes in subdivision 1, including information about physical and social environments, the equipment and materials required, and techniques that are consistent with the consumer's communication mode and learning style specified as the license holder's responsibility in the individual service plan;

(2) the projected starting date for service supports and the criteria for identifying when the desired outcome has been achieved and when the service supports need to be reviewed; and

(3) the names of the staff, staff position, or contractors responsible for implementing each outcome.

Subd. 5. **Progress reviews.** The license holder must participate in progress review meetings following stated time lines established in the consumer's individual service plan or as requested in writing by the consumer, the consumer's legal representative, or the case manager, at a minimum of once a year. The license holder must summarize the progress toward achieving the desired outcomes and make recommendations in a written report sent to the consumer or the consumer's legal representative and case manager prior to the review meeting.

Subd. 6. **Reports.** The license holder shall provide written reports regarding the consumer's status as requested by the consumer, or the consumer's legal representative and case manager.

Subd. 7. **Staffing requirements.** The license holder must provide supervision to ensure the health, safety, and protection of rights of each consumer and to be able to implement each consumer's individual service plan. Day training and habilitation programs must meet the minimum staffing requirements as specified in sections 252.40 to 252.46 and rules promulgated under those sections.

Subd. 8. **Leaving the residence.** Each consumer requiring a 24-hour plan of care shall receive services during the day outside the residence unless otherwise specified in the individual's service plan. License holders, providing services to consumers living in a licensed site, shall ensure that they are prepared to care for consumers whenever they are at the residence during the day because of illness, work schedules, or other reasons.

Subd. 9. **Day training and habilitation service days.** Day training and habilitation services must meet a minimum of 195 available service days.

Subd. 10. **Prohibition.** Psychotropic medication and the use of aversive and deprivation procedures, as referenced in section 245.825 and rules promulgated under that section, cannot be used as a substitute for adequate staffing, as punishment, or for staff convenience.

245B.07 MANAGEMENT STANDARDS.

Subdivision 1. **Consumer data file.** The license holder must maintain the following information for each consumer:

(1) identifying information that includes date of birth, medications, legal representative, history, medical, and other individual-specific information, and names and telephone numbers of contacts;

(2) consumer health information, including individual medication administration and monitoring information;

(3) the consumer's individual service plan. When a consumer's case manager does not provide a current individual service plan, the license holder shall make a written request to the case manager to provide a copy of the individual service plan and inform the consumer or the consumer's legal representative of the right to an individual service plan and the right to appeal under section 256.045. In the event the case manager fails to provide an individual service plan after a written request from the license holder, the license holder shall not be sanctioned or penalized financially for not having a current individual service plan in the consumer's data file;

(4) copies of assessments, analyses, summaries, and recommendations;

(5) progress review reports;

(6) incidents involving the consumer;

(7) reports required under section 245B.05, subdivision 7;

(8) discharge summary, when applicable;

(9) record of other license holders serving the consumer that includes a contact person and telephone numbers, services being provided, services that require coordination between two license holders, and name of staff responsible for coordination;

(10) information about verbal aggression directed at the consumer by another consumer; and

(11) information about self-abuse.

Subd. 2. **Access to records.** The license holder must ensure that the following people have access to the information in subdivision 1:

(1) the consumer, the consumer's legal representative, and anyone properly authorized by the consumer or legal representative;

(2) the consumer's case manager;

(3) staff providing direct services to the consumer unless the information is not relevant to carrying out the individual service plan; and

(4) the county adult foster care licensor, when services are also licensed as an adult foster home. Adult foster home means a licensed residence operated by an operator who, for financial gain or otherwise, provides 24-hour foster care to no more than four functionally impaired residents.

Subd. 3. **Retention of consumer's records.** The license holder must retain the records required for consumers for at least three years following termination of services.

Subd. 4. **Staff qualifications.** (a) The license holder must ensure that staff is competent through training, experience, and education to meet the consumer's needs and additional requirements as written in the individual service plan. Staff qualifications must be documented. Staff under 18 years of age may not perform overnight duties or administer medication.

(b) Delivery and evaluation of services provided by the license holder to a consumer must be coordinated by a designated person. The designated person or coordinator must minimally have a four-year degree in a field related to service provision, and one year work experience with consumers with developmental disabilities, a two-year degree in a field related to service provision, and two years of work experience with consumers with developmental disabilities, or a diploma in community-based developmental disability services from an accredited postsecondary institution and two years of work experience with consumers with developmental disabilities. The coordinator must provide supervision, support, and evaluation of activities that include:

(1) oversight of the license holder's responsibilities designated in the individual service plan;

(2) instruction and assistance to staff implementing the individual service plan areas;

(3) evaluation of the effectiveness of service delivery, methodologies, and progress on consumer outcomes based on the condition set for objective change; and

(4) review of incident and emergency reports, identification of incident patterns, and implementation of corrective action as necessary to reduce occurrences.

(c) The coordinator is responsible for taking the action necessary to facilitate the accomplishment of the outcomes for each consumer as specified in the consumer's individual service plan.

(d) The license holder must provide for adequate supervision of direct care staff to ensure implementation of the individual service plan.

Subd. 5. **Staff orientation.** (a) Within 60 days of hiring staff who provide direct service, the license holder must provide 30 hours of staff orientation. Direct care staff must complete 15 of the 30 hours orientation before providing any unsupervised direct service to a consumer. If the staff person has received orientation training from a license holder licensed under this chapter, or provides semi-independent living services only, the 15-hour requirement may be reduced to eight hours. The total orientation of 30 hours may be reduced to 15 hours if the staff person has previously received orientation training from a license holder licensed under this chapter.

(b) The 30 hours of orientation must combine supervised on-the-job training with review of and instruction on the following material:

(1) review of the consumer's service plans and risk management plan to achieve an understanding of the consumer as a unique individual and staff responsibilities related to implementation of those plans;

(2) review and instruction on implementation of the license holder's policies and procedures, including their location and access;

(3) staff responsibilities related to emergency procedures;

(4) explanation of specific job functions, including implementing objectives from the consumer's individual service plan;

(5) explanation of responsibilities related to section 245A.65; sections 626.556 and 626.557, governing maltreatment reporting and service planning for children and vulnerable adults; and section 245.825, governing use of aversive and deprivation procedures;

(6) medication administration as it applies to the individual consumer, from a training curriculum developed by a health services professional described in section 245B.05, subdivision 5, and when the consumer meets the criteria of having overriding health care needs, then medication administration taught by a health services professional. Staff may administer medications only after they demonstrate the ability, as defined in the license holder's medication administration policy and procedures. Once a consumer with overriding health care needs is admitted, staff will be provided with remedial training as deemed necessary by the license holder and the health professional to meet the needs of that consumer.

For purposes of this section, overriding health care needs means a health care condition that affects the service options available to the consumer because the condition requires:

(i) specialized or intensive medical or nursing supervision; and

(ii) nonmedical service providers to adapt their services to accommodate the health and safety needs of the consumer;

(7) consumer rights and staff responsibilities related to protecting and ensuring the exercise of the consumer rights; and

(8) other topics necessary as determined by the consumer's individual service plan or other areas identified by the license holder.

(c) The license holder must document each employee's orientation received.

Subd. 6. **Staff training.** (a) A license holder providing semi-independent living services shall ensure that direct service staff annually complete hours of training equal to one percent of the number of hours the staff person worked. All other license holders shall ensure that direct service staff annually complete hours of training as follows:

(1) if the direct services staff have been employed for one to 24 months and:

(i) the average number of work hours scheduled per week is 30 to 40 hours, the staff must annually complete 40 training hours;

(ii) the average number of work hours scheduled per week is 20 to 29 hours, the staff must annually complete 30 training hours; and

(iii) the average number of work hours scheduled per week is one to 19 hours, the staff must annually complete 20 training hours; or

(2) if the direct services staff have been employed for more than 24 months and:

(i) the average number of work hours scheduled per week is 30 to 40 hours, the staff must annually complete 20 training hours;

(ii) the average number of work hours scheduled per week is 20 to 29 hours, the staff must annually complete 15 training hours; and

(iii) the average number of work hours scheduled per week is one to 19 hours, the staff must annually complete 12 training hours.

If direct service staff has received training from a license holder licensed under a program rule identified in this chapter or completed course work regarding disability-related issues from a postsecondary educational institute, that training may also count toward training requirements for other services and for other license holders.

(b) The license holder must document the training completed by each employee.

(c) Training shall address staff competencies necessary to address the consumer needs as identified in the consumer's individual service plan and ensure consumer health, safety, and protection of rights. Training may also include other areas identified by the license holder.

(d) For consumers requiring a 24-hour plan of care, the license holder shall provide training in cardiopulmonary resuscitation, from a qualified source determined by the commissioner, if the consumer's health needs as determined by the consumer's physician indicate trained staff would be necessary to the consumer.

Subd. 7. **Volunteers.** The license holder must ensure that volunteers who provide direct services to consumers receive the training and orientation necessary to fulfill their responsibilities.

Subd. 7a. **Subcontractors.** If the license holder uses a subcontractor to perform services licensed under this chapter on the license holder's behalf, the license holder must ensure that the subcontractor meets and maintains compliance with all requirements under this chapter that apply to the services to be provided.

Subd. 8. **Policies and procedures.** The license holder must develop and implement the policies and procedures in paragraphs (a) to (c).

(a) Policies and procedures that promote consumer health and safety by ensuring:

(1) consumer safety in emergency situations;

(2) consumer health through sanitary practices;

(3) safe transportation, when the license holder is responsible for transportation of consumers, with provisions for handling emergency situations;

(4) a system of record keeping for both individuals and the organization, for review of incidents and emergencies, and corrective action if needed;

(5) a plan for responding to all incidents, as defined in section 245B.02, subdivision 10, and reporting all incidents required to be reported under section 245B.05, subdivision 7;

(6) safe medication administration as identified in section 245B.05, subdivision 5, incorporating an observed skill assessment to ensure that staff demonstrate the ability to administer medications consistent with the license holder's policy and procedures;

(7) psychotropic medication monitoring when the consumer is prescribed a psychotropic medication, including the use of the psychotropic medication use checklist. If the responsibility for implementing the psychotropic medication use checklist has not been assigned in the individual service plan and the consumer lives in a licensed site, the residential license holder shall be designated; and

(8) criteria for admission or service initiation developed by the license holder.

(b) Policies and procedures that protect consumer rights and privacy by ensuring:

(1) consumer data privacy, in compliance with the Minnesota Data Practices Act, chapter 13; and

(2) that complaint procedures provide consumers with a simple process to bring grievances and consumers receive a response to the grievance within a reasonable time period. The license holder must provide a copy of the program's grievance procedure and time lines for addressing grievances. The program's grievance procedure must permit consumers served by the program and the authorized representatives to bring a grievance to the highest level of authority in the program.

(c) Policies and procedures that promote continuity and quality of consumer supports by ensuring:

(1) continuity of care and service coordination, including provisions for service termination, temporary service suspension, and efforts made by the license holder to coordinate services with other vendors who also provide support to the consumer. The policy must include the following requirements:

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

(ii) notice of the proposed termination of services, including those situations that began with a temporary service suspension, must be given at least 60 days before the proposed termination is to become effective;

(iii) the license holder must provide information requested by the consumer or consumer's legal representative or case manager when services are temporarily suspended or upon notice of termination;

(iv) use of temporary service suspension procedures are restricted to situations in which the consumer's behavior causes immediate and serious danger to the health and safety of the individual or others;

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

(vi) during the period of temporary service suspension, the license holder will work with the appropriate county agency to develop reasonable alternatives to protect the individual and others; and

(2) quality services measured through a program evaluation process including regular evaluations of consumer satisfaction and sharing the results of the evaluations with the consumers and legal representatives.

Subd. 9. **Availability of current written policies and procedures.** The license holder shall:

(1) review and update, as needed, the written policies and procedures in this chapter;

(2) inform consumers or the consumer's legal representatives of the written policies and procedures in this chapter upon service initiation. Copies of policies and procedures affecting a consumer's rights under section 245D.04 must be provided upon service initiation. Copies of all other policies and procedures must be available to consumers or the consumer's legal representatives, case managers, the county where services are located, and the commissioner upon request;

(3) provide all consumers or the consumers' legal representatives and case managers a copy of the revised policies and procedures and explanation of the revisions that affect consumers' service-related or protection-related rights under section 245B.04 and maltreatment reporting policies and procedures. Unless there is reasonable cause, the license holder must provide this notice at least 30 days before implementing the revised policy and procedure. The license holder must document the reason for not providing the notice at least 30 days before implementing the revisions;

(4) annually notify all consumers or the consumers' legal representatives and case managers of any revised policies and procedures under this chapter, other than those in clause (3). Upon request, the license holder must provide the consumer or consumer's legal representative and case manager copies of the revised policies and procedures;

(5) before implementing revisions to policies and procedures under this chapter, inform all employees of the revisions and provide training on implementation of the revised policies and procedures; and

(6) document and maintain relevant information related to the policies and procedures in this chapter.

Subd. 10. **Consumer funds.** (a) The license holder must ensure that consumers retain the use and availability of personal funds or property unless restrictions are justified in the consumer's individual service plan.

(b) The license holder must ensure separation of consumer funds from funds of the license holder, the program, or program staff.

(c) Whenever the license holder assists a consumer with the safekeeping of funds or other property, the license holder must have written authorization to do so by the consumer or the consumer's legal representative, and the case manager. In addition, the license holder must:

(1) document receipt and disbursement of the consumer's funds or the property;

(2) annually survey, document, and implement the preferences of the consumer, consumer's legal representative, and the case manager for frequency of receiving a statement that itemizes receipts and disbursements of consumer funds or other property; and

(3) return to the consumer upon the consumer's request, funds and property in the license holder's possession subject to restrictions in the consumer's individual service plan, as soon as possible, but no later than three working days after the date of the request.

(d) License holders and program staff must not:

(1) borrow money from a consumer;

(2) purchase personal items from a consumer;

(3) sell merchandise or personal services to a consumer;

(4) require a consumer to purchase items for which the license holder is eligible for reimbursement;

(5) use consumer funds in a manner that would violate section 256B.04, or any rules promulgated under that section; or

(6) accept powers-of-attorney from a person receiving services from the license holder for any purpose, and may not accept an appointment as guardian or conservator of a person receiving services from the license holder. This does not apply to license holders that are Minnesota counties or other units of government.

Subd. 11. **Travel time to and from a day training and habilitation site.** Except in unusual circumstances, the license holder must not transport a consumer receiving services for longer than 90 minutes per one-way trip. Nothing in this subdivision relieves the provider of the obligation to provide the number of program hours as identified in the individualized service plan.

Subd. 12. **Separate license required for separate sites.** The license holder shall apply for separate licenses for each day training and habilitation service site owned or leased by the license holder at which persons receiving services and the provider's employees who provide training and habilitation services are present for a cumulative total of more than 30 days within any 12-month period, and for each residential service site. Notwithstanding this subdivision, a separate license is not required for:

(1) a day training and habilitation service site used only for the limited purpose of providing transportation to consumers receiving community-based day training and habilitation services from a license holder;

(2) a day training and habilitation program that is in a separate building that is adjacent to the central operation of the day training and habilitation program; or

(3) a satellite day training and habilitation program. For purposes of this clause, a satellite day training and habilitation program is a program that is affiliated with the central operations of an existing day training and habilitation program and is in a separate nonadjacent building in the same county as the central operation day training and habilitation program.

Subd. 13. **Variance.** The commissioner may grant a variance to any of the requirements in sections 245B.02 to 245B.07 except section 245B.07, subdivision 8(1)(vii), or provisions governing data practices and information rights of consumers if the conditions in section 245A.04, subdivision 9 are met. Upon the request of the license holder, the commissioner shall continue variances from the standards in this chapter previously granted under Minnesota Rules that are repealed as a result of this chapter. The commissioner may approve variances for a license holder on a program, geographic, or organizational basis.

245B.08 COMPLIANCE STRATEGIES.

Subdivision 1. **Alternative methods of determining compliance.** (a) In addition to methods specified in chapters 245A and 245C, the commissioner may use alternative methods and new regulatory strategies to determine compliance with this section. The commissioner may use sampling techniques to ensure compliance with this section. Notwithstanding section 245A.09, subdivision 7, paragraph (e), the commissioner may also extend periods of licensure, not to exceed five years, for license holders who have demonstrated substantial and consistent compliance with sections 245B.02 to 245B.07 and have consistently maintained the health and safety of consumers and have demonstrated by alternative methods in paragraph (b) that they meet or exceed the requirements of this section. For purposes of this section, "substantial and consistent compliance" means that during the current licensing period:

(1) the license holder's license has not been made conditional, suspended, or revoked;

(2) there have been no substantiated allegations of maltreatment against the license holder;

(3) there have been no program deficiencies that have been identified that would jeopardize the health or safety of consumers being served; and

(4) the license holder is in substantial compliance with the other requirements of chapters 245A and 245C and other applicable laws and rules.

(b) To determine the length of a license, the commissioner shall consider:

(1) information from affected consumers, and the license holder's responsiveness to consumers' concerns and recommendations;

(2) self assessments and peer reviews of the standards of this section, corrective actions taken by the license holder, and sharing the results of the inspections with consumers, the consumers' families, and others, as requested;

(3) length of accreditation by an independent accreditation body, if applicable;

(4) information from the county where the license holder is located; and

(5) information from the license holder demonstrating performance that meets or exceeds the minimum standards of this chapter.

(c) The commissioner may reduce the length of the license if the license holder fails to meet the criteria in paragraph (a) and the conditions specified in paragraph (b).

Subd. 2. **Additional measures.** The commissioner may require the license holder to implement additional measures on a time-limited basis to ensure the health and safety of consumers when the health and safety of consumers has been determined to be at risk as determined by substantiated incidents of maltreatment under sections 626.556 and 626.557. The license holder may request reconsideration of the actions taken by the commissioner under this subdivision according to section 245A.06.

Subd. 3. **Sanctions available.** Nothing in this subdivision shall be construed to limit the commissioner's authority to suspend or revoke a license or issue a fine at any time under section 245A.07; make correction orders and make a license conditional for failure to comply with applicable laws or rules under section 245A.06; or deny an application for license under section 245A.05.

Subd. 4. **Efficient application.** The commissioner shall establish application procedures for license holders licensed under this chapter to reduce the need to submit duplicative material.

Subd. 5. **Information.** The commissioner shall make information available to consumers and interested others regarding the licensing status of a license holder.

Subd. 6. **Implementation.** The commissioner shall seek advice from parties affected by the implementation of this chapter.

Subd. 7. **Deem status.** The commissioner may exempt a license holder from duplicative standards if the license holder is already licensed under chapter 245A.

245D.08 RECORD REQUIREMENTS.

Subdivision 1. **Record-keeping systems.** The license holder must ensure that the content and format of service recipient, personnel, and program records are uniform, legible, and in compliance with the requirements of this chapter.

Subd. 2. **Service recipient record.** (a) The license holder must:

(1) maintain a record of current services provided to each person on the premises where the services are provided or coordinated; and

(2) protect service recipient records against loss, tampering, or unauthorized disclosure in compliance with sections 13.01 to 13.10 and 13.46.

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

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

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

(3) service information, including service initiation information, verification of the person's eligibility for services, and documentation verifying that services have been provided as identified in the service plan according to paragraph (a);

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

(i) current orders for medication, treatments, or medical equipment;

(ii) medication administration procedures;

(iii) a medication administration record documenting the implementation of the medication administration procedures, including any agreements for administration of injectable medications by the license holder; and

(iv) a medical appointment schedule;

(5) the person's current service plan or that portion of the plan assigned to the license holder. When a person's case manager does not provide a current service plan, the license holder must make a written request to the case manager to provide a copy of the service plan and inform the person of the right to a current service plan and the right to appeal under section 256.045;

(6) a record of other service providers serving the person when the person's service plan identifies the need for coordination between the service providers that includes a contact person and telephone numbers, services being provided, and names of staff responsible for coordination;

(7) documentation of orientation to the service recipient rights according to section 245D.04, subdivision 1, and maltreatment reporting policies and procedures according to section 245A.65, subdivision 1, paragraph (c);

(8) copies of authorizations to handle a person's funds according to section 245D.06, subdivision 4, paragraph (a);

(9) documentation of complaints received and grievance resolution;

(10) incident reports required under section 245D.06, subdivision 1;

(11) copies of written reports regarding the person's status when requested according to section 245D.07, subdivision 3; and

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

Subd. 3. **Access to service recipient records.** The license holder must ensure that the following people have access to the information in subdivision 1 in accordance with applicable state and federal law, regulation, or rule:

(1) the person, the person's legal representative, and anyone properly authorized by the person;

(2) the person's case manager;

(3) staff providing services to the person unless the information is not relevant to carrying out the service plan; and

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

Subd. 4. **Personnel records.** The license holder must maintain a personnel record of each employee, direct service volunteer, and subcontractor to document and verify staff qualifications, orientation, and training. For the purposes of this subdivision, the terms "staff" and "staff person" mean paid employee, direct service volunteer, or subcontractor. The personnel record must include:

(1) the staff person's date of hire, completed application, a position description signed by the staff person, documentation that the staff person meets the position requirements as determined by the license holder, the date of first supervised direct contact with a person served by the program, and the date of first unsupervised direct contact with a person served by the program;

(2) documentation of staff qualifications, orientation, training, and performance evaluations as required under section 245D.09, subdivisions 3, 4, and 5, including the date the training was completed, the number of hours per subject area, and the name and qualifications of the trainer or instructor; and

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

256B.055 ELIGIBILITY CATEGORIES.

Subd. 3. **AFDC families.** Until March 31, 1998, medical assistance may be paid for a person who is eligible for or receiving, or who would be eligible for, except for excess income or assets, public assistance under the aid to families with dependent children program in effect as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193.

Subd. 5. **Pregnant women; dependent unborn child.** Medical assistance may be paid for a pregnant woman who has written verification of a positive pregnancy test from a physician or licensed registered nurse, who meets the other eligibility criteria of this section and who would be categorically eligible for assistance under the state's AFDC plan in effect as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193, if the child had been born and was living with the woman. For purposes of this subdivision, a woman is considered pregnant for 60 days postpartum.

Subd. 10b. **Children.** This subdivision supersedes subdivision 10 as long as the Minnesota health care reform waiver remains in effect. When the waiver expires, the commissioner of human services shall publish a notice in the State Register and notify the revisor of statutes. Medical assistance may be paid for a child less than two years of age with countable family income as established for infants under section 256B.057, subdivision 1.

256B.056 ELIGIBILITY REQUIREMENTS FOR MEDICAL ASSISTANCE.

Subd. 5b. **Individuals with low income.** Recipients of medical assistance not residing in a long-term care facility who have slightly fluctuating income which is below the medical assistance income limit shall report and verify their income on a semiannual basis.

256B.057 ELIGIBILITY REQUIREMENTS FOR SPECIAL CATEGORIES.

Subd. 1c. **No asset test for pregnant women.** Beginning September 30, 1998, eligibility for medical assistance for a pregnant woman must be determined without regard to asset standards established in section 256B.056, subdivision 3.

Subd. 2. **Children.** (a) Except as specified in subdivision 1b, effective October 1, 2003, a child one through 18 years of age in a family whose countable income is no greater than 150 percent of the federal poverty guidelines for the same family size, is eligible for medical assistance.

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

256B.0911 LONG-TERM CARE CONSULTATION SERVICES.

Subd. 4a. **Preadmission screening activities related to nursing facility admissions.** (a) All applicants to Medicaid certified nursing facilities, including certified boarding care facilities, must be screened prior to admission regardless of income, assets, or funding sources for nursing facility care, except as described in subdivision 4b. The purpose of the screening is to determine the need for nursing facility level of care as described in paragraph (d) and to complete activities required under federal law related to mental illness and developmental disability as outlined in paragraph (b).

(b) A person who has a diagnosis or possible diagnosis of mental illness or developmental disability must receive a preadmission screening before admission regardless of the exemptions outlined in subdivision 4b, paragraph (b), to identify the need for further evaluation and specialized services, unless the admission prior to screening is authorized by the local mental health authority or the local developmental disabilities case manager, or unless authorized by the county agency according to Public Law 101-508.

The following criteria apply to the preadmission screening:

(1) the lead agency must use forms and criteria developed by the commissioner to identify persons who require referral for further evaluation and determination of the need for specialized services; and

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

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

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

(c) The local county mental health authority or the state developmental disability authority under Public Laws 100-203 and 101-508 may prohibit admission to a nursing facility if the individual does not meet the nursing facility level of care criteria or needs specialized services as defined in Public Laws 100-203 and 101-508. For purposes of this section, "specialized services" for a person with developmental disability means active treatment as that term is defined under Code of Federal Regulations, title 42, section 483.440 (a)(1).

(d) The determination of the need for nursing facility level of care must be made according to criteria developed by the commissioner, and in section 256B.092, using forms developed by the commissioner. Effective no sooner than on or after July 1, 2012, for individuals age 21 and older, and on or after October 1, 2019, for individuals under age 21, the determination of need for nursing facility level of care shall be based on criteria in section 144.0724, subdivision 11. In assessing a person's needs, consultation team members shall have a physician available for consultation and shall consider the assessment of the individual's attending physician, if any. The individual's physician must be included if the physician chooses to participate. Other personnel may be included on the team as deemed appropriate by the lead agency.

Subd. 4b. **Exemptions and emergency admissions.** (a) Exemptions from the federal screening requirements outlined in subdivision 4a, paragraphs (b) and (c), are limited to:

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

(2) a person transferring from one certified nursing facility in Minnesota to another certified nursing facility in Minnesota; and

(3) a person, 21 years of age or older, who satisfies the following criteria, as specified in Code of Federal Regulations, title 42, section 483.106(b)(2):

(i) the person is admitted to a nursing facility directly from a hospital after receiving acute inpatient care at the hospital;

(ii) the person requires nursing facility services for the same condition for which care was provided in the hospital; and

(iii) the attending physician has certified before the nursing facility admission that the person is likely to receive less than 30 days of nursing facility services.

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

(1) persons described in paragraph (a);

(2) an individual who has a contractual right to have nursing facility care paid for indefinitely by the veterans' administration;

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

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

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

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

(1) a person is admitted from the community to a certified nursing or certified boarding care facility during county nonworking hours;

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

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

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

(5) the county is contacted on the first working day following the emergency admission. Transfer of a patient from an acute care hospital to a nursing facility is not considered an emergency except for a person who has received hospital services in the following situations: hospital admission for observation, care in an emergency room without hospital admission, or following hospital 24-hour bed care.

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

Subd. 4c. **Screening requirements.** (a) A person may be screened for nursing facility admission by telephone or in a face-to-face screening interview. Certified assessors shall identify each individual's needs using the following categories:

(1) the person needs no face-to-face screening interview to determine the need for nursing facility level of care based on information obtained from other health care professionals;

(2) the person needs an immediate face-to-face screening interview to determine the need for nursing facility level of care and complete activities required under subdivision 4a; or

(3) the person may be exempt from screening requirements as outlined in subdivision 4b, but will need transitional assistance after admission or in-person follow-along after a return home.

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

(c) The lead agency screening or intake activity must include processes to identify persons who may require transition assistance as described in subdivision 3b.

256B.0917 SENIORS' AGENDA FOR INDEPENDENT LIVING (SAIL) PROJECTS.

Subdivision 1. **Purpose, mission, goals, and objectives.** (a) The purpose of implementing seniors' agenda for independent living (SAIL) projects under this section is to demonstrate a new cooperative strategy for the long-term care system in the state of Minnesota.

The projects are part of the initial plan for a 20-year strategy. The mission of the 20-year strategy is to create a new community-based care paradigm for long-term care in Minnesota in order to maximize independence of the older adult population, and to ensure cost-effective use of financial and human resources. The goals for the 20-year strategy are to:

(1) achieve a broad awareness and use of low-cost home care and other residential alternatives to nursing homes;

(2) develop a statewide system of information and assistance to enable easy access to long-term care services;

(3) develop sufficient alternatives to nursing homes to serve the increased number of people needing long-term care;

(4) maintain the moratorium on new construction of nursing home beds and to lower the percentage of elderly persons served in institutional settings; and

(5) build a community-based approach and community commitment to delivering long-term care services for elderly persons in their homes.

(b) The objective for the fiscal years 1994 and 1995 biennial plan is to continue at least four but not more than six projects in anticipation of a statewide program. These projects will continue the process of implementing:

(1) a coordinated planning and administrative process;

(2) a refocused function of the preadmission screening program;

(3) the development of additional home, community, and residential alternatives to nursing homes;

(4) a program to support the informal caregivers for elderly persons;

(5) programs to strengthen the use of volunteers; and

(6) programs to support the building of community commitment to provide long-term care for elderly persons.

The services offered through these projects are available to those who have their own funds to pay for services, as well as to persons who are eligible for medical assistance and to persons who are 180-day eligible clients to the extent authorized in this section.

Subd. 2. **Design of SAIL projects; local long-term care coordinating team.** (a) The commissioner of human services shall contract with SAIL projects in four to six counties or groups of counties to demonstrate the feasibility and cost-effectiveness of a local long-term care strategy that is consistent with the state's long-term care goals identified in subdivision 1. The commissioner shall publish a notice in the State Register announcing the availability of project funding and giving instructions for making an application. The instructions for the application shall identify the amount of funding available for project components.

(b) To be selected for the project, a county board or boards must establish a long-term care coordinating team consisting of county social service agencies, public health nursing service agencies, local boards of health, a representative of local nursing home providers, a representative of local home care providers, and the area agencies on aging in a geographic area which is responsible for:

(1) developing a local long-term care strategy consistent with state goals and objectives;

(2) submitting an application to be selected as a project;

(3) coordinating planning for funds to provide services to elderly persons, including funds received under title III of the Older Americans Act, title XX of the Social Security Act and the Local Public Health Act; and

(4) ensuring efficient services provision and nonduplication of funding.

(c) The board or boards shall designate a public agency to serve as the lead agency. The lead agency receives and manages the project funds from the state and is responsible for the implementation of the local strategy. If selected as a project, the local long-term care coordinating team must semiannually evaluate the progress of the local long-term care strategy in meeting state measures of performance and results as established in the contract.

(d) Each member of the local coordinating team must indicate its endorsement of the local strategy. The local long-term care coordinating team may include in its membership other units of government which provide funding for services to the frail elderly. The team must cooperate with consumers and other public and private agencies, including nursing homes, in the geographic area in order to develop and offer a variety of cost-effective services to the elderly and their caregivers.

(e) The board or boards shall apply to be selected as a project. If the project is selected, the commissioner of human services shall contract with the lead agency for the project and shall provide additional administrative funds for implementing the provisions of the contract, within the appropriation available for this purpose.

(f) Projects shall be selected according to the following conditions.

No project may be selected unless it demonstrates that:

(i) the objectives of the local project will help to achieve the state's long-term care goals as defined in subdivision 1;

(ii) in the case of a project submitted jointly by several counties, all of the participating counties are contiguous;

(iii) there is a designated local lead agency that is empowered to make contracts with the state and local vendors on behalf of all participants;

(iv) the project proposal demonstrates that the local cooperating agencies have the ability to perform the project as described and that the implementation of the project has a reasonable chance of achieving its objectives;

(v) the project will serve an area that covers at least four counties or contains at least 2,500 persons who are 85 years of age or older, according to the projections of the state demographer or the census if the data is more recent; and

(vi) the local coordinating team documents efforts of cooperation with consumers and other agencies and organizations, both public and private, in planning for service delivery.

Subd. 3. **Local long-term care strategy.** The local long-term care strategy must list performance outcomes and indicators which meet the state's objectives. The local strategy must provide for:

(1) accessible information, assessment, and preadmission screening activities as described in subdivision 4;

(2) an increase in numbers of alternative care clients served under section 256B.0913, including those who are relocated from nursing homes, which results in a reduction of the medical assistance nursing home caseload; and

(3) the development of additional services such as adult family foster care homes; family adult day care; assisted living projects and congregate housing service projects in apartment buildings; expanded home care services for evenings and weekends; expanded volunteer services; and caregiver support and respite care projects.

The county or groups of counties selected for the projects shall be required to comply with federal regulations, alternative care funding policies in section 256B.0913, and the federal waiver programs' policies in section 256B.0915. The requirements for preadmission screening are defined in section 256B.0911, subdivisions 1 to 6. Requirements for an access, screening, and assessment function are defined in subdivision 4. Requirements for the service development and service provision are defined in subdivision 5.

Subd. 4. **Information, screening, and assessment function.** (a) The projects selected by and under contract with the commissioner shall establish an accessible information, screening, and assessment function for persons who need assistance and information regarding long-term care. This accessible information, screening, and assessment activity shall include information and referral, early intervention, follow-up contacts, telephone screening, home visits, assessments, preadmission screening, and relocation case management for the frail elderly and their caregivers in the area served by the county or counties. The purpose is to ensure that information and help is provided to elderly persons and their families in a timely fashion, when they are making decisions about long-term care. These functions may be split among various agencies, but must be coordinated by the local long-term care coordinating team.

(b) Accessible information, screening, and assessment functions shall be reimbursed as follows:

(1) The screenings of all persons entering nursing homes shall be reimbursed as defined in section 256B.0911, subdivision 6; and

(2) Additional state administrative funds shall be available for the access, screening, and assessment activities that are not reimbursed under clause (1). This amount shall not exceed the amount authorized in the guidelines and in instructions for the application and must be within the amount appropriated for this activity.

(c) Any information and referral functions funded by other sources, such as title III of the Older Americans Act and title XX of the Social Security Act, shall be considered by the local long-term care coordinating team in establishing this function to avoid duplication and to ensure access to information for persons needing help and information regarding long-term care.

(d) The lead agency or the agencies under contract with the lead agency which are responsible for the accessible information, screening, and assessment function must complete the forms and reports required by the commissioner as specified in the contract.

Subd. 5. **Service development and delivery.** (a) In addition to the access, screening, and assessment activity, each local strategy may include provisions for the following:

(1) the addition of a full-time staff person who is responsible to develop the following services and recruit providers as established in the contract:

(i) additional adult family foster care homes;

(ii) family adult day care providers as defined in section 256B.0919, subdivision 2;

(iii) an assisted living program in an apartment;

(iv) a congregate housing service project in a subsidized housing project; and

(v) the expansion of evening and weekend coverage of home care services as deemed necessary by the local strategic plan;

(2) small incentive grants to new adult family care providers for renovations needed to meet licensure requirements;

(3) a plan to divert new applicants to nursing homes and to relocate a targeted population from nursing homes, using the individual's own resources or the funding available for services;

(4) one or more caregiver support and respite care projects, as described in subdivision 6; and

(5) one or more living-at-home/block nurse projects, as described in subdivisions 7 to 10.

(b) The expansion of alternative care clients under paragraph (a) shall be accomplished with the funds provided under section 256B.0913, and includes the allocation of targeted funds. The funding for all participating counties must be coordinated by the local long-term care coordinating team and must be part of the local long-term care strategy. Alternative care funds may be transferred from one SAIL county to another within a designated SAIL project area during a fiscal year as authorized by the local long-term care coordinating team and approved by the commissioner. The base allocation used for a future year shall reflect the final transfer. Each county retains responsibility for reimbursement as defined in section 256B.0913, subdivision 12. All other requirements for the alternative care program must be met unless an exception is provided in this section. The commissioner may establish by contract a reimbursement mechanism for alternative care that does not require invoice processing through the Medical Assistance Management Information System (MMIS). The commissioner and local agencies must assure that the same client and reimbursement data is obtained as is available under MMIS.

(c) The administration of these components is the responsibility of the agencies selected by the local coordinating team and under contract with the local lead agency. However, administrative funds for paragraph (a), clauses (2) to (4), and grant funds for paragraph (a), clause (5), shall be granted to the local lead agency. The funding available for each component is based on the plan submitted and the amount negotiated in the contract.

Subd. 7. **Contract.** (a) The commissioner of human services shall execute a contract with Living at Home/Block Nurse Program, Inc. (LAH/BN, Inc.). The contract shall require LAH/BN, Inc. to:

(1) develop criteria for and award grants to establish community-based organizations that will implement living-at-home/block nurse programs throughout the state;

(2) award grants to enable living-at-home/block nurse programs to continue to implement the combined living-at-home/block nurse program model;

(3) serve as a state technical assistance center to assist and coordinate the living-at-home/block nurse programs established; and

(4) manage contracts with individual living-at-home/block nurse programs.

(b) The contract shall be effective July 1, 1997, and section 16B.17 shall not apply.

Subd. 8. **Living-at-home/block nurse program grant.** (a) The organization awarded the contract under subdivision 7, shall develop and administer a grant program to establish or expand up to 33 community-based organizations that will implement living-at-home/block nurse programs that are designed to enable senior citizens to live as independently as possible in their homes and in their communities. At least one-half of the programs must be in counties outside the seven-county metropolitan area. Nonprofit organizations and units of local government are eligible to apply for grants to establish the community organizations that will implement living-at-home/block nurse programs. In awarding grants, the organization awarded the contract under subdivision 7 shall give preference to nonprofit organizations and units of local government from communities that:

(1) have high nursing home occupancy rates;

(2) have a shortage of health care professionals;

(3) are located in counties adjacent to, or are located in, counties with existing living-at-home/block nurse programs; and

(4) meet other criteria established by LAH/BN, Inc., in consultation with the commissioner.

(b) Grant applicants must also meet the following criteria:

(1) the local community demonstrates a readiness to establish a community model of care, including the formation of a board of directors, advisory committee, or similar group, of which at least two-thirds is comprised of community citizens interested in community-based care for older persons;

(2) the program has sponsorship by a credible, representative organization within the community;

(3) the program has defined specific geographic boundaries and defined its organization, staffing and coordination/delivery of services;

(4) the program demonstrates a team approach to coordination and care, ensuring that the older adult participants, their families, the formal and informal providers are all part of the effort to plan and provide services; and

(5) the program provides assurances that all community resources and funding will be coordinated and that other funding sources will be maximized, including a person's own resources.

(c) Grant applicants must provide a minimum of five percent of total estimated development costs from local community funding. Grants shall be awarded for four-year periods, and the base amount shall not exceed $80,000 per applicant for the grant period. The organization under contract may increase the grant amount for applicants from communities that have socioeconomic characteristics that indicate a higher level of need for assistance. Subject to the availability of funding, grants and grant renewals awarded or entered into on or after July 1, 1997, shall be renewed by LAH/BN, Inc. every four years, unless LAH/BN, Inc. determines that the grant recipient has not satisfactorily operated the living-at-home/block nurse program in compliance with the requirements of paragraphs (b) and (d). Grants provided to living-at-home/block nurse programs under this paragraph may be used for both program development and the delivery of services.

(d) Each living-at-home/block nurse program shall be designed by representatives of the communities being served to ensure that the program addresses the specific needs of the community residents. The programs must be designed to:

(1) incorporate the basic community, organizational, and service delivery principles of the living-at-home/block nurse program model;

(2) provide senior citizens with registered nurse directed assessment, provision and coordination of health and personal care services on a sliding fee basis as an alternative to expensive nursing home care;

(3) provide information, support services, homemaking services, counseling, and training for the client and family caregivers;

(4) encourage the development and use of respite care, caregiver support, and in-home support programs, such as adult foster care and in-home adult day care;

(5) encourage neighborhood residents and local organizations to collaborate in meeting the needs of senior citizens in their communities;

(6) recruit, train, and direct the use of volunteers to provide informal services and other appropriate support to senior citizens and their caregivers; and

(7) provide coordination and management of formal and informal services to senior citizens and their families using less expensive alternatives.

Subd. 9. **State technical assistance center.** The organization under contract shall be the state technical assistance center to provide orientation and technical assistance, and to coordinate the living-at-home/block nurse programs established. The state resource center shall:

(1) provide communities with criteria in planning and designing their living-at-home/block nurse programs;

(2) provide general orientation and technical assistance to communities who desire to establish living-at-home/block nurse programs;

(3) provide ongoing analysis and data collection of existing and newly established living-at-home/block nurse programs and provide data to the organization performing the independent assessment; and

(4) serve as the living-at-home/block nurse programs' liaison to the legislature and other state agencies.

Subd. 10. **Implementation plan.** The organization under contract shall develop a plan that specifies a strategy for implementing living-at-home/block nurse programs statewide. The plan must also analyze the data collected by the state technical assistance center and describe the effectiveness of services provided by living-at-home/block nurse programs, including the program's impact on acute care costs. The organization shall report to the commissioner of human services and to the legislature by January 1, 1993.

Subd. 11. **SAIL evaluation and expansion.** The commissioner shall evaluate the success of the SAIL projects against the objective stated in subdivision 1, paragraph (b), and recommend to the legislature the continuation or expansion of the long-term care strategy by February 15, 1995.

Subd. 12. **Public awareness campaign.** The commissioner, with assistance from the commissioner of health and with the advice of the long-term care planning committee, shall contract for a public awareness campaign to educate the general public, seniors, consumers, caregivers, and professionals about the aging process, the long-term care system, and alternatives available including alternative care and residential alternatives. Particular emphasis will be given to informing consumers on how to access the alternatives and obtain information on the long-term care system. The commissioner shall pursue the development of new names for preadmission screening, alternative care, foster care, and other services as deemed necessary for the public awareness campaign.

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

(b) Within the limits of the appropriation and not to exceed $400 per person per month, funding must be available to a person who:

(1) is age 65 or older;

(2) is not eligible for medical assistance;

(3) would otherwise be financially eligible for the alternative care program under section 256B.0913, subdivision 4;

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

(5) has a community support plan; and

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

(i) caregiver support;

(ii) homemaker;

(iii) chore; or

(iv) a personal emergency response device or system.

(c) The person receiving any of the essential community supports in this subdivision must also receive service coordination as part of their community support plan.

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

(e) The commissioner shall allocate grants to counties and tribes under contract with the department based upon the historic use of the medical assistance elderly waiver and alternative care grant programs and other criteria as determined by the commissioner.

256B.096 QUALITY MANAGEMENT, ASSURANCE, AND IMPROVEMENT SYSTEM FOR MINNESOTANS RECEIVING DISABILITY SERVICES.

Subdivision 1. **Scope.** In order to improve the quality of services provided to Minnesotans with disabilities and to meet the requirements of the federally approved home and community-based waivers under section 1915c of the Social Security Act, a statewide quality assurance and improvement system for Minnesotans receiving disability services shall be developed. The disability services included are the home and community-based services waiver programs for persons with developmental disabilities under section 256B.092, subdivision 4, and for persons with disabilities under section 256B.49.

Subd. 2. **Stakeholder advisory group.** The commissioner shall consult with a stakeholder advisory group on the development and implementation of the state quality management, assurance, and improvement system, including representatives of disability service recipients, disability service providers, disability advocacy groups, county human service agencies, and state agency staff from the Departments of Human Services and Health, and the ombudsman for mental health and developmental disabilities on the development of a statewide quality assurance and improvement system.

Subd. 3. **Annual survey of service recipients.** The commissioner, in consultation with the stakeholder advisory group, shall develop an annual independent random statewide survey of between five and ten percent of service recipients to determine the effectiveness and quality of disability services. The survey shall be consistent with the system performance expectations of the Centers for Medicare and Medicaid Services quality management requirements and framework. The survey shall analyze whether desired outcomes have been achieved for persons with different demographic, diagnostic, health, and functional needs receiving different types of services, in different settings, with different costs. The survey shall be field tested during 2008. The biennial report established in subdivision 5 shall include recommendations on statewide and regional reports of the survey results that, if published, would be useful to regions, counties, and providers to plan and measure the impact of quality improvement activities.

Subd. 4. **Improvements for incident reporting, investigation, analysis, and follow-up.** In consultation with the stakeholder advisory group, the commissioner shall identify the information, data sources, and technology needed to improve the system of incident reporting, including:

(1) reports made under the Maltreatment of Minors and Vulnerable Adults Acts; and

(2) investigation, analysis, and follow-up for disability services.

The commissioner must ensure that the federal home and community-based waiver requirements are met and that incidents that may have jeopardized safety and health or violated service-related assurances, civil and human rights, and other protections designed to prevent abuse, neglect, and exploitation, are reviewed, investigated, and acted upon in a timely manner.

256B.14 RELATIVE'S RESPONSIBILITY.

Subd. 3a. **Spousal contribution.** (a) For purposes of this subdivision, the following terms have the meanings given:

(1) "commissioner" means the commissioner of human services;

(2) "community spouse" means the spouse, who lives in the community, of an individual receiving long-term care services in a long-term care facility or home care services pursuant to the Medicaid waiver for elderly services under section 256B.0915 or the alternative care program under section 256B.0913. A community spouse does not include a spouse living in the community who receives a monthly income allowance under section 256B.058, subdivision 2, or who receives home and community-based services under section 256B.0915, 256B.092, or 256B.49, or the alternative care program under section 256B.0913;

(3) "cost of care" means the actual fee-for-service costs or capitated payments for the long-term care spouse;

(4) "department" means the Department of Human Services;

(5) "disabled child" means a blind or permanently and totally disabled son or daughter of any age based on the Social Security Administration disability standards;

(6) "income" means earned and unearned income, attributable to the community spouse, used to calculate the adjusted gross income on the prior year's income tax return. Evidence of income includes, but is not limited to, W-2 and 1099 forms; and

(7) "long-term care spouse" means the spouse who is receiving long-term care services in a long-term care facility or home and community based services pursuant to the Medicaid waiver for elderly services under section 256B.0915 or the alternative care program under section 256B.0913.

(b) The community spouse of a long-term care spouse who receives medical assistance or alternative care services has an obligation to contribute to the cost of care. The community spouse must pay a monthly fee on a sliding fee scale based on the community spouse's income. If a minor or disabled child resides with and receives care from the community spouse, then no fee shall be assessed.

(c) For a community spouse with an income equal to or greater than 250 percent of the federal poverty guidelines for a family of two and less than 545 percent of the federal poverty guidelines for a family of two, the spousal contribution shall be determined using a sliding fee scale established by the commissioner that begins at 7.5 percent of the community spouse's income and increases to 15 percent for those with an income of up to 545 percent of the federal poverty guidelines for a family of two.

(d) For a community spouse with an income equal to or greater than 545 percent of the federal poverty guidelines for a family of two and less than 750 percent of the federal poverty guidelines for a family of two, the spousal contribution shall be determined using a sliding fee scale established by the commissioner that begins at 15 percent of the community spouse's income and increases to 25 percent for those with an income of up to 750 percent of the federal poverty guidelines for a family of two.

(e) For a community spouse with an income equal to or greater than 750 percent of the federal poverty guidelines for a family of two and less than 975 percent of the federal poverty guidelines for a family of two, the spousal contribution shall be determined using a sliding fee scale established by the commissioner that begins at 25 percent of the community spouse's income and increases to 33 percent for those with an income of up to 975 percent of the federal poverty guidelines for a family of two.

(f) For a community spouse with an income equal to or greater than 975 percent of the federal poverty guidelines for a family of two, the spousal contribution shall be 33 percent of the community spouse's income.

(g) The spousal contribution shall be explained in writing at the time eligibility for medical assistance or alternative care is being determined. In addition to explaining the formula used to determine the fee, the county or tribal agency shall provide written information describing how to request a variance for undue hardship, how a contribution may be reviewed or redetermined, the right to appeal a contribution determination, and that the consequences for not complying with a request to provide information shall be an assessment against the community spouse for the full cost of care for the long-term care spouse.

(h) The contribution shall be assessed for each month the long-term care spouse has a community spouse and is eligible for medical assistance payment of long-term care services or alternative care.

(i) The spousal contribution shall be reviewed at least once every 12 months and when there is a loss or gain in income in excess of ten percent. Thirty days prior to a review or redetermination, written notice must be provided to the community spouse and must contain the amount the spouse is required to contribute, notice of the right to redetermination and appeal, and the telephone number of the division at the agency that is responsible for redetermination and review. If, after review, the contribution amount is to be adjusted, the county or tribal agency shall mail a written notice to the community spouse 30 days in advance of the effective date of the change in the amount of the contribution.

(1) The spouse shall notify the county or tribal agency within 30 days of a gain or loss in income in excess of ten percent and provide the agency supporting documentation to verify the need for redetermination of the fee.

(2) When a spouse requests a review or redetermination of the contribution amount, a request for information shall be sent to the spouse within ten calendar days after the county or tribal agency receives the request for review.

(3) No action shall be taken on a review or redetermination until the required information is received by the county or tribal agency.

(4) The review of the spousal contribution shall be completed within ten days after the county or tribal agency receives completed information that verifies a loss or gain in income in excess of ten percent.

(5) An increase in the contribution amount is effective in the month in which the increase in income occurs.

(6) A decrease in the contribution amount is effective in the month the spouse verifies the reduction in income, retroactive to no longer than six months.

(j) In no case shall the spousal contribution exceed the amount of medical assistance expended or the cost of alternative care services for the care of the long-term care spouse. Annually, upon redetermination, or at termination of eligibility, the total amount of medical assistance paid or costs of alternative care for the care of the long-term care spouse and the total amount of the spousal contribution shall be compared. If the total amount of the spousal contribution exceeds the total amount of medical assistance expended or cost of alternative care, then the agency shall reimburse the community spouse the excess amount if the long-term care spouse is no longer receiving services, or apply the excess amount to the spousal contribution due until the excess amount is exhausted.

(k) A community spouse may request a variance by submitting a written request and supporting documentation that payment of the calculated contribution would cause an undue hardship. An undue hardship is defined as the inability to pay the calculated contribution due to medical expenses incurred by the community spouse. Documentation must include proof of medical expenses incurred by the community spouse since the last annual redetermination of the contribution amount that are not reimbursable by any public or private source, and are a type, regardless of amount, that would be allowable as a federal tax deduction under the Internal Revenue Code.

(1) A spouse who requests a variance from a notice of an increase in the amount of spousal contribution shall continue to make monthly payments at the lower amount pending determination of the variance request. A spouse who requests a variance from the initial determination shall not be required to make a payment pending determination of the variance request. Payments made pending outcome of the variance request that result in overpayment must be returned to the spouse, if the long-term care spouse is no longer receiving services, or applied to the spousal contribution in the current year. If the variance is denied, the spouse shall pay the additional amount due from the effective date of the increase or the total amount due from the effective date of the original notice of determination of the spousal contribution.

(2) A spouse who is granted a variance shall sign a written agreement in which the spouse agrees to report to the county or tribal agency any changes in circumstances that gave rise to the undue hardship variance.

(3) When the county or tribal agency receives a request for a variance, written notice of a grant or denial of the variance shall be mailed to the spouse within 30 calendar days after the county or tribal agency receives the financial information required in this clause. The granting of a variance will necessitate a written agreement between the spouse and the county or tribal agency with regard to the specific terms of the variance. The variance will not become effective until the written agreement is signed by the spouse. If the county or tribal agency denies in whole or

in part the request for a variance, the denial notice shall set forth in writing the reasons for the denial that address the specific hardship and right to appeal.

(4) If a variance is granted, the term of the variance shall not exceed 12 months unless otherwise determined by the county or tribal agency.

(5) Undue hardship does not include action taken by a spouse which divested or diverted income in order to avoid being assessed a spousal contribution.

(l) A spouse aggrieved by an action under this subdivision has the right to appeal under subdivision 4. If the spouse appeals on or before the effective date of an increase in the spousal fee, the spouse shall continue to make payments to the county or tribal agency in the lower amount while the appeal is pending. A spouse appealing an initial determination of a spousal contribution shall not be required to make monthly payments pending an appeal decision. Payments made that result in an overpayment shall be reimbursed to the spouse if the long-term care spouse is no longer receiving services, or applied to the spousal contribution remaining in the current year. If the county or tribal agency's determination is affirmed, the community spouse shall pay within 90 calendar days of the order the total amount due from the effective date of the original notice of determination of the spousal contribution. The commissioner's order is binding on the spouse and the agency and shall be implemented subject to section 256.045, subdivision 7. No additional notice is required to enforce the commissioner's order.

(m) If the county or tribal agency finds that notice of the payment obligation was given to the community spouse and the spouse was determined to be able to pay, but that the spouse failed or refused to pay, a cause of action exists against the community spouse for that portion of medical assistance payment of long-term care services or alternative care services granted after notice was given to the community spouse. The action may be brought by the county or tribal agency in the county where assistance was granted for the assistance together with the costs of disbursements incurred due to the action. In addition to granting the county or tribal agency a money judgment, the court may, upon a motion or order to show cause, order continuing contributions by a community spouse found able to repay the county or tribal agency. The order shall be effective only for the period of time during which a contribution shall be assessed.

(n) Counties and tribes are entitled to one-half of the nonfederal share of contributions made under this section for long-term care spouses on medical assistance that are directly attributed to county or tribal efforts. Counties and tribes are entitled to 25 percent of the contributions made under this section for long-term care spouses on alternative care directly attributed to county or tribal efforts.

256B.49 HOME AND COMMUNITY-BASED SERVICE WAIVERS FOR DISABLED.

Subd. 16a. **Medical assistance reimbursement.** (a) The commissioner shall seek federal approval for medical assistance reimbursement of independent living skills services, foster care waiver service, supported employment, prevocational service, and structured day service under the home and community-based waiver for persons with a brain injury, the community alternatives for disabled individuals waivers, and the community alternative care waivers.

(b) Medical reimbursement shall be made only when the provider demonstrates evidence of its capacity to meet basic health, safety, and protection standards through the following methods:

(1) for independent living skills services, supported employment, prevocational service, and structured day service through one of the methods in paragraphs (c) and (d); and

(2) for foster care waiver services through the method in paragraph (e).

(c) The provider is licensed to provide services under chapter 245B and agrees to apply these standards to services funded through the brain injury, community alternatives for disabled persons, or community alternative care home and community-based waivers.

(d) The commissioner shall certify that the provider has policies and procedures governing the following:

(1) protection of the consumer's rights and privacy;

(2) risk assessment and planning;

(3) record keeping and reporting of incidents and emergencies with documentation of corrective action if needed;

(4) service outcomes, regular reviews of progress, and periodic reports;

(5) complaint and grievance procedures;

(6) service termination or suspension;

(7) necessary training and supervision of direct care staff that includes:

(i) documentation in personnel files of 20 hours of orientation training in providing training related to service provision;

(ii) training in recognizing the symptoms and effects of certain disabilities, health conditions, and positive behavioral supports and interventions;

(iii) a minimum of five hours of related training annually; and

(iv) when applicable:

(A) safe medication administration;

(B) proper handling of consumer funds; and

(C) compliance with prohibitions and standards developed by the commissioner to satisfy federal requirements regarding the use of restraints and restrictive interventions. The commissioner shall review at least biennially that each service provider's policies and procedures governing basic health, safety, and protection of rights continue to meet minimum standards.

(e) The commissioner shall seek federal approval for Medicaid reimbursement of foster care services under the home and community-based waiver for persons with a brain injury, the community alternatives for disabled individuals waiver, and community alternative care waiver when the provider demonstrates evidence of its capacity to meet basic health, safety, and protection standards. The commissioner shall verify that the adult foster care provider is licensed under Minnesota Rules, parts 9555.5105 to 9555.6265; that the child foster care provider is licensed as a family foster care or a foster care residence under Minnesota Rules, parts 2960.3000 to 2960.3340, and certify that the provider has policies and procedures that govern:

(1) compliance with prohibitions and standards developed by the commissioner to meet federal requirements regarding the use of restraints and restrictive interventions;

(2) documentation of service needs and outcomes, regular reviews of progress, and periodic reports; and

(3) safe medication management and administration.

The commissioner shall review at least biennially that each service provider's policies and procedures governing basic health, safety, and protection of rights standards continue to meet minimum standards.

(f) The commissioner shall seek federal waiver approval for Medicaid reimbursement of family adult day services under all disability waivers. After the waiver is granted, the commissioner shall include family adult day services in the common services menu that is currently under development.

256B.4913 PAYMENT METHODOLOGY DEVELOPMENT.

Subdivision 1. **Research period and rates.** (a) For the purposes of this section, "research rate" means a proposed payment rate for the provision of home and community-based waivered services to meet federal requirements and assess the implications of changing resources on the provision of services and "research period" means the time period during which the research rate is being assessed by the commissioner.

(b) The commissioner shall determine and publish initial frameworks and values to generate research rates for individuals receiving home and community-based services.

(c) The initial values issued by the commissioner shall ensure projected spending for home and community-based services for each service area is equivalent to projected spending under current law in the most recent expenditure forecast.

(d) The initial values issued shall be based on the most updated information and cost data available on supervision, employee-related costs, client programming and supports, programming planning supports, transportation, administrative overhead, and utilization costs. These service areas are:

(1) residential services, defined as corporate foster care, family foster care, residential care, supported living services, customized living, and 24-hour customized living;

(2) day program services, defined as adult day care, day training and habilitation, prevocational services, structured day services, and transportation;

(3) unit-based services with programming, defined as in-home family support, independent living services, supported living services, supported employment, behavior programming, and housing access coordination; and

(4) unit-based services without programming, defined as respite, personal support, and night supervision.

(e) The commissioner shall make available the underlying assessment information, without any identifying information, and the statistical modeling used to generate the initial research rate and calculate budget neutrality.

Subd. 2. **Framework values.** (a) The commissioner shall propose legislation with the specific payment methodology frameworks, process for calculation, and specific values to populate the frameworks by February 15, 2013.

(b) The commissioner shall provide underlying data and information used to formulate the final frameworks and values to the existing stakeholder workgroup by January 15, 2013.

(c) The commissioner shall provide recommendations for the final frameworks and values, and the basis for the recommendations, to the legislative committees with jurisdiction over health and human services finance by February 15, 2013.

(d) The commissioner shall review the following topics during the research period and propose, as necessary, recommendations to address the following research questions:

(1) underlying differences in the cost to provide services throughout the state;

(2) a data-driven process for determining labor costs and customizations for staffing classifications included in each rate framework based on the services performed;

(3) the allocation of resources previously established under section 256B.501, subdivision 4b;

(4) further definition and development of unit-based services;

(5) the impact of splitting the allocation of resources for unit-based services for those with programming aspects and those without;

(6) linking assessment criteria to future assessment processes for determination of customizations;

(7) recognition of cost differences in the use of monitoring technology where it is appropriate to substitute for supervision;

(8) implications for day services of reimbursement based on a unit rate and a daily rate;

(9) a definition of shared and individual staffing for unit-based services;

(10) the underlying costs of providing transportation associated with day services; and

(11) an exception process for individuals with exceptional needs that cannot be met under the initial research rate, and an alternative payment structure for those individuals.

(e) The commissioner shall develop a comprehensive plan based on information gathered during the research period that uses statistically reliable and valid assessment data to refine payment methodologies.

(f) The commissioner shall make recommendations and provide underlying data and information used to formulate these research recommendations to the existing stakeholder workgroup by January 15, 2013.

Subd. 3. **Data collection.** (a) The commissioner shall conduct any necessary research and gather additional data for the further development and refinement of payment methodology components. These include but are not limited to:

(1) levels of service utilization and patterns of use;

(2) staffing patterns for each service;

(3) profiles of individual service needs; and

(4) cost factors involved in providing transportation services.

(b) The commissioner shall provide this information to the existing stakeholder workgroup by January 15, 2013.

Subd. 4. **Rate stabilization adjustment.** Beginning January 1, 2014, the commissioner shall adjust individual rates determined by the new payment methodology so that the new rate varies no more than one percent per year from the rate effective on December 31 of the prior calendar year. This adjustment is made annually and is effective for three calendar years from the date of implementation. This subdivision expires January 1, 2017.

256B.5012 ICF/MR PAYMENT SYSTEM IMPLEMENTATION.

Subd. 13. **ICF/DD rate decrease effective July 1, 2013.** Notwithstanding subdivision 12, and if the commissioner has not received federal approval before July 1, 2013, of the Long-Term Care Realignment Waiver application submitted under Laws 2011, First Special Session chapter 9, article 7, section 52, or only receives approval to implement portions of the waiver request, for each facility reimbursed under this section for services provided from July 1, 2013, through December 31, 2013, the commissioner shall decrease operating payments up to 1.67 percent of the operating payment rates in effect on June 30, 2013. The commissioner shall prorate the reduction in the event that only portions of the waiver request are approved and after application of the continuing care provider payment delay provision in Laws 2012, chapter 247, article 6, section 2, subdivision 4, paragraph (f). For each facility, the commissioner shall apply the rate reduction based on occupied beds, using the percentage specified in this subdivision multiplied by the total payment rate, including the variable rate but excluding the property-related payment rate,

in effect on the preceding date. The total rate reduction shall include the adjustment provided in section 256B.501, subdivision 12.

256J.24 FAMILY COMPOSITION; ASSISTANCE STANDARDS; EXIT LEVEL.

Subd. 6. **Family cap.** (a) MFIP assistance units shall not receive an increase in the cash portion of the transitional standard as a result of the birth of a child, unless one of the conditions under paragraph (b) is met. The child shall be considered a member of the assistance unit according to subdivisions 1 to 3, but shall be excluded in determining family size for purposes of determining the amount of the cash portion of the transitional standard under subdivision 5. The child shall be included in determining family size for purposes of determining the food portion of the transitional standard. The transitional standard under this subdivision shall be the total of the cash and food portions as specified in this paragraph. The family wage level under this subdivision shall be based on the family size used to determine the food portion of the transitional standard.

(b) A child shall be included in determining family size for purposes of determining the amount of the cash portion of the MFIP transitional standard when at least one of the following conditions is met:

(1) for families receiving MFIP assistance on July 1, 2003, the child is born to the adult parent before May 1, 2004;

(2) for families who apply for the diversionary work program under section 256J.95 or MFIP assistance on or after July 1, 2003, the child is born to the adult parent within ten months of the date the family is eligible for assistance;

(3) the child was conceived as a result of a sexual assault or incest, provided that the incident has been reported to a law enforcement agency;

(4) the child's mother is a minor caregiver as defined in section 256J.08, subdivision 59, and the child, or multiple children, are the mother's first birth;

(5) the child is the mother's first child subsequent to a pregnancy that did not result in a live birth; or

(6) any child previously excluded in determining family size under paragraph (a) shall be included if the adult parent or parents have not received benefits from the diversionary work program under section 256J.95 or MFIP assistance in the previous ten months. An adult parent or parents who reapply and have received benefits from the diversionary work program or MFIP assistance in the past ten months shall be under the ten-month grace period of their previous application under clause (2).

(c) Income and resources of a child excluded under this subdivision, except child support received or distributed on behalf of this child, must be considered using the same policies as for other children when determining the grant amount of the assistance unit.

(d) The caregiver must assign support and cooperate with the child support enforcement agency to establish paternity and collect child support on behalf of the excluded child. Failure to cooperate results in the sanction specified in section 256J.46, subdivisions 2 and 2a. Current support paid on behalf of the excluded child shall be distributed according to section 256.741, subdivision 15.

(e) County agencies must inform applicants of the provisions under this subdivision at the time of each application and at recertification.

(f) Children excluded under this provision shall be deemed MFIP recipients for purposes of child care under chapter 119B.

256K.45 RUNAWAY AND HOMELESS YOUTH ACT.

Subd. 2. **Homeless and runaway youth report.** The commissioner shall develop a report for homeless youth, youth at risk of homelessness, and runaways. The report shall include coordination of services as defined under subdivisions 3 to 5.

256L.01 DEFINITIONS.

Subd. 4a. **Gross individual or gross family income.** (a) "Gross individual or gross family income" for nonfarm self-employed means income calculated for the 12-month period of eligibility using as a baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year and adding back in depreciation, and carryover net operating loss amounts that apply to the business in which the family is currently engaged.

(b) "Gross individual or gross family income" for farm self-employed means income calculated for the 12-month period of eligibility using as the baseline the adjusted gross income reported on the applicant's federal income tax form for the previous year.

(c) "Gross individual or gross family income" means the total income for all family members, calculated for the 12-month period of eligibility.

256L.031 HEALTHY MINNESOTA CONTRIBUTION PROGRAM.

Subdivision 1. **Defined contributions to enrollees.** (a) Beginning July 1, 2012, the commissioner shall provide each MinnesotaCare enrollee eligible under section 256L.04, subdivision 7, with family income equal to or greater than 200 percent of the federal poverty guidelines with a monthly defined contribution to purchase health coverage under a health plan as defined in section 62A.011, subdivision 3.

(b) Enrollees eligible under this section shall not be charged premiums under section 256L.15 and are exempt from the managed care enrollment requirement of section 256L.12.

(c) Sections 256L.03; 256L.05, subdivision 3; and 256L.11 do not apply to enrollees eligible under this section unless otherwise provided in this section. Covered services, cost sharing, disenrollment for nonpayment of premium, enrollee appeal rights and complaint procedures, and the effective date of coverage for enrollees eligible under this section shall be as provided under the terms of the health plan purchased by the enrollee.

(d) Unless otherwise provided in this section, all MinnesotaCare requirements related to eligibility, income and asset methodology, income reporting, and program administration, continue to apply to enrollees obtaining coverage under this section.

Subd. 2. **Use of defined contribution; health plan requirements.** (a) An enrollee may use up to the monthly defined contribution to pay premiums for coverage under a health plan as defined in section 62A.011, subdivision 3, or as provided in section 256L.031, subdivision 6.

(b) An enrollee must select a health plan within four calendar months of approval of MinnesotaCare eligibility. If a health plan is not selected and purchased within this time period, the enrollee must reapply and must meet all eligibility criteria. The commissioner may determine criteria under which an enrollee has more than four calendar months to select a health plan.

(c) Coverage purchased under this section must:

(1) include mental health and chemical dependency treatment services; and

(2) comply with the coverage limitations specified in section 256L.03, subdivision 1, paragraph (b).

Subd. 3. **Determination of defined contribution amount.** (a) The commissioner shall determine the defined contribution sliding scale using the base contribution specified in this paragraph for the specified age ranges. The commissioner shall use a sliding scale for defined contributions that provides:

(1) persons with household incomes equal to 200 percent of the federal poverty guidelines with a defined contribution of 93 percent of the base contribution;

(2) persons with household incomes equal to 250 percent of the federal poverty guidelines with a defined contribution of 80 percent of the base contribution; and

(3) persons with household incomes in evenly spaced increments between the percentages of the federal poverty guideline or income level specified in clauses (1) and (2) with a base contribution that is a percentage interpolated from the defined contribution percentages specified in clauses (1) and (2).

19-29	$125
30-34	$135
35-39	$140
40-44	$175
45-49	$215
50-54	$295
55-59	$345
60+	$360

(b) The commissioner shall multiply the defined contribution amounts developed under paragraph (a) by 1.20 for enrollees who purchase coverage through the Minnesota Comprehensive Health Association.

Subd. 4. **Administration by commissioner.** (a) The commissioner shall administer the defined contributions. The commissioner shall:

(1) calculate and process defined contributions for enrollees; and

(2) pay the defined contribution amount to health plan companies or the Minnesota Comprehensive Health Association, as applicable, for enrollee health plan coverage.

(b) Nonpayment of a health plan premium shall result in disenrollment from MinnesotaCare effective the first day of the calendar month following the calendar month for which the premium was due. Persons disenrolled for nonpayment or who voluntarily terminate coverage may not reenroll until four calendar months have elapsed.

Subd. 5. **Assistance to enrollees.** The commissioner of human services, in consultation with the commissioner of commerce, shall develop an efficient and cost-effective method of referring eligible applicants to professional insurance agent associations.

Subd. 6. **Minnesota Comprehensive Health Association (MCHA).** Beginning July 1, 2012, MinnesotaCare enrollees eligible for coverage through a health plan offered by the Minnesota Comprehensive Health Association may enroll in MCHA in accordance with section 62E.14. Any difference between the revenue and actual covered losses to MCHA related to the implementation of this section are appropriated annually to the commissioner of human services from the health care access fund and shall be paid to MCHA.

Subd. 7. **Federal approval.** The commissioner shall seek federal financial participation for the adult enrollees eligible under this section.

256L.04 ELIGIBLE PERSONS.

Subd. 1b. **Children with family income greater than 275 percent of federal poverty guidelines.** Children with family income greater than 275 percent of federal poverty guidelines for the applicable family size shall be eligible for MinnesotaCare. All other provisions of sections 256L.01 to 256L.18, including the insurance-related barriers to enrollment under section 256L.07, shall apply unless otherwise specified.

Subd. 9. **General assistance medical care.** A person cannot have coverage under both MinnesotaCare and general assistance medical care in the same month. Eligibility for MinnesotaCare cannot be replaced by eligibility for general assistance medical care, and eligibility for general assistance medical care cannot be replaced by eligibility for MinnesotaCare.

Subd. 10a. **Sponsor's income and resources deemed available; documentation.** (a) When determining eligibility for any federal or state benefits under sections 256L.01 to 256L.18, the income and resources of all noncitizens whose sponsor signed an affidavit of support as defined under United States Code, title 8, section 1183a, shall be deemed to include their sponsors' income and resources as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law 104-193, sections 421 and 422, and subsequently set out in federal rules. To be eligible for the program, noncitizens must provide documentation of their immigration status.

(b) Beginning July 1, 2010, or upon federal approval, whichever is later, sponsor deeming does not apply to pregnant women and children who are qualified noncitizens, as described in section 256B.06, subdivision 4, paragraph (b).

256L.05 APPLICATION PROCEDURES.

Subd. 3b. **Reapplication.** Beginning January 1, 1999, families and individuals must reapply after a lapse in coverage of one calendar month or more and must meet all eligibility criteria.

256L.07 ELIGIBILITY FOR MINNESOTACARE.

Subd. 5. **Voluntary disenrollment for members of military.** Notwithstanding section 256L.05, subdivision 3b, MinnesotaCare enrollees who are members of the military and their families, who choose to voluntarily disenroll from the program when one or more family members are called to active duty, may reenroll during or following that member's tour of active duty. Those individuals and families shall be considered to have good cause for voluntary termination under section 256L.06, subdivision 3, paragraph (d). Income and asset increases reported at the time of reenrollment shall be disregarded. All provisions of sections 256L.01 to 256L.18 shall apply to individuals and families enrolled under this subdivision upon 12-month renewal.

Subd. 8. **Automatic eligibility for certain children.** Any child who was residing in foster care or a juvenile residential correctional facility on the child's 18th birthday is automatically deemed eligible for MinnesotaCare upon termination or release until the child reaches the age of 21, and is exempt from the requirements of this section and section 256L.15. To be enrolled under this section, a child must complete an initial application for MinnesotaCare. The commissioner shall contact individuals enrolled under this section annually to ensure the individual continues to reside in the state and is interested in continuing MinnesotaCare coverage.

Subd. 9. **Firefighters; volunteer ambulance attendants.** (a) For purposes of this subdivision, "qualified individual" means:

(1) a volunteer firefighter with a department as defined in section 299N.01, subdivision 2, who has passed the probationary period; and

(2) a volunteer ambulance attendant as defined in section 144E.001, subdivision 15.

(b) A qualified individual who documents to the satisfaction of the commissioner status as a qualified individual by completing and submitting a one-page form developed by the commissioner is eligible for MinnesotaCare without meeting other eligibility requirements of this chapter, but must pay premiums equal to the average expected capitation rate for adults with no children paid under section 256L.12. Individuals eligible under this subdivision shall receive coverage for the benefit set provided to adults with no children.

256L.11 PROVIDER PAYMENT.

Subd. 5. **Enrollees younger than 18.** Payment for inpatient hospital services provided to MinnesotaCare enrollees who are younger than 18 years old on the date of admission to the inpatient hospital shall be at the medical assistance rate.

256L.12 MANAGED CARE.

Subdivision 1. **Selection of vendors.** In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall, where possible, contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for managed care plans which may include: prepaid capitation programs, competitive bidding programs, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided.

Subd. 2. **Geographic area.** The commissioner shall designate the geographic areas in which eligible individuals must receive services through managed care plans.

Subd. 3. **Limitation of choice.** Persons enrolled in the MinnesotaCare program who reside in the designated geographic areas must enroll in a managed care plan to receive their health care services. Enrollees must receive their health care services from health care providers who are part of the managed care plan provider network, unless authorized by the managed care plan, in cases of medical emergency, or when otherwise required by law or by contract.

If only one managed care option is available in a geographic area, the managed care plan may require that enrollees designate a primary care provider from which to receive their health care. Enrollees will be permitted to change their designated primary care provider upon request to the managed care plan. Requests to change primary care providers may be limited to once annually. If more than one managed care plan is offered in a geographic area, enrollees will be enrolled in a managed care plan for up to one year from the date of enrollment, but shall have the right to change to another managed care plan once within the first year of initial enrollment. Enrollees may also change to another managed care plan during an annual 30-day open enrollment period. Enrollees shall be notified of the opportunity to change to another managed care plan before the start of each annual open enrollment period.

Enrollees may change managed care plans or primary care providers at other than the above designated times for cause as determined through an appeal pursuant to section 256.045.

Subd. 4. **Exemptions to limitations on choice.** All contracts between the Department of Human Services and prepaid health plans to serve medical assistance, general assistance medical care, and MinnesotaCare recipients must comply with the requirements of United States Code, title 42, section 1396a (a)(23)(B), notwithstanding any waivers authorized by the United States Department of Health and Human Services pursuant to United States Code, title 42, section 1315.

Subd. 5. **Eligibility for other state programs.** MinnesotaCare enrollees who become eligible for medical assistance will remain in the same managed care plan if the managed care plan has a contract for that population. MinnesotaCare enrollees who were formerly eligible for general assistance medical care pursuant to section 256D.03, subdivision 3, within six months of MinnesotaCare enrollment and were enrolled in a prepaid health plan pursuant to section 256D.03, subdivision 4, paragraph (c), must remain in the same managed care plan if the managed care plan has a contract for that population. Managed care plans must participate in the MinnesotaCare program under a contract with the Department of Human Services in service areas where they participate in the medical assistance program.

Subd. 6. **Co-payments and benefit limits.** Enrollees are responsible for all co-payments in section 256L.03, subdivision 5, and shall pay co-payments to the managed care plan or to its participating providers. The enrollee is also responsible for payment of inpatient hospital charges which exceed the MinnesotaCare benefit limit.

Subd. 7. **Managed care plan vendor requirements.** The following requirements apply to all counties or vendors who contract with the Department of Human Services to serve MinnesotaCare recipients. Managed care plan contractors:

(1) shall authorize and arrange for the provision of the full range of services listed in section 256L.03 in order to ensure appropriate health care is delivered to enrollees;

(2) shall accept the prospective, per capita payment or other contractually defined payment from the commissioner in return for the provision and coordination of covered health care services for eligible individuals enrolled in the program;

(3) may contract with other health care and social service practitioners to provide services to enrollees;

(4) shall provide for an enrollee grievance process as required by the commissioner and set forth in the contract with the department;

(5) shall retain all revenue from enrollee co-payments;

(6) shall accept all eligible MinnesotaCare enrollees, without regard to health status or previous utilization of health services;

(7) shall demonstrate capacity to accept financial risk according to requirements specified in the contract with the department. A health maintenance organization licensed under chapter 62D, or a nonprofit health plan licensed under chapter 62C, is not required to demonstrate financial risk capacity, beyond that which is required to comply with chapters 62C and 62D; and

(8) shall submit information as required by the commissioner, including data required for assessing enrollee satisfaction, quality of care, cost, and utilization of services.

Subd. 8. **Chemical dependency assessments.** The managed care plan shall be responsible for assessing the need and placement for chemical dependency services according to criteria set forth in Minnesota Rules, parts 9530.6600 to 9530.6660.

Subd. 9. **Rate setting; performance withholds.** (a) Rates will be prospective, per capita, where possible. The commissioner may allow health plans to arrange for inpatient hospital services on a risk or nonrisk basis. The commissioner shall consult with an independent actuary to determine appropriate rates.

(b) For services rendered on or after January 1, 2004, the commissioner shall withhold five percent of managed care plan payments and county-based purchasing plan payments under this section pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions, when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. The managed care plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, such as characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if performance targets in the contract are achieved.

(c) For services rendered on or after January 1, 2011, the commissioner shall withhold an additional three percent of managed care plan or county-based purchasing plan payments under this section. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year. The return of the withhold under this paragraph is not subject to the requirements of paragraph (b).

(d) Effective for services rendered on or after January 1, 2011, through December 31, 2011, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's emergency room utilization rate for state health care program enrollees by a measurable rate of five percent from the plan's utilization rate for the previous calendar year. Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined

by the commissioner. For 2012, the reductions shall be based on the health plan's utilization in 2009. To earn the return of the withhold each subsequent year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's utilization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in section 256B.69, subdivisions 23 and 28, compared to the previous measurement year, until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than five percent of the plan's hospital admission rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in section 256B.69, subdivisions 23 and 28, compared to the previous calendar year, until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph shall continue until there is a 25 percent reduction in the hospitals admission rate compared to the hospital admission rate for calendar year 2011 as determined by the commissioner. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved. The hospital admissions in this performance target do not include the admissions applicable to the subsequent hospital admission performance target under paragraph (f).

(f) Effective for services provided on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's hospitalization rate for a subsequent hospitalization within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of the subsequent hospital admissions rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in section 256B.69, subdivisions 23 and 28, of no less than five percent compared to the previous calendar year until the final performance target is reached.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the subsequent hospitalization rate was achieved. The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.

The withhold described in this paragraph must continue for each consecutive contract period until the plan's subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved.

(g) A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this section that is reasonably expected to be returned.

Subd. 9a. **Rate setting; ratable reduction.** For services rendered on or after October 1, 2003, the total payment made to managed care plans under the MinnesotaCare program is reduced 1.0 percent. This provision excludes payments for mental health services added as covered benefits after December 31, 2007.

Subd. 9b. **Rate setting; ratable reduction.** In addition to the reduction in subdivision 9a, the total payment made to managed care plans under the MinnesotaCare program shall be reduced for services provided on or after January 1, 2006, to reflect a 6.0 percent reduction in reimbursement for inpatient hospital services.

Subd. 10. **Childhood immunization.** Each managed care plan contracting with the Department of Human Services under this section shall collaborate with the local public health agencies to ensure childhood immunization to all enrolled families with children. As part of this collaboration the plan must provide the families with a recommended immunization schedule.

Subd. 11. **Coverage at Indian health service facilities.** For American Indian enrollees of MinnesotaCare, MinnesotaCare shall cover health care services provided at Indian health service facilities and facilities operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title III of the Indian Self-Determination and Education Act, Public Law 93-638, if those services would otherwise be covered under section 256L.03. Payments for services provided under this subdivision shall be made on a fee-for-service basis, and may, at the option of the tribe or organization, be made at the rates authorized under sections 256.969, subdivision 16, and 256B.0625, subdivision 34, for those MinnesotaCare enrollees eligible for coverage at medical assistance rates. For purposes of this subdivision, "American Indian" has the meaning given to persons to whom services will be provided for in Code of Federal Regulations, title 42, section 36.12.

256L.17 ASSET REQUIREMENT FOR MINNESOTACARE.

Subdivision 1. **Definitions.** For purposes of this section, the following definitions apply.

(a) "Asset" means cash and other personal property, as well as any real property, that a family or individual owns which has monetary value.

(b) "Homestead" means the home that is owned by, and is the usual residence of, the family or individual, together with the surrounding property which is not separated from the home by intervening property owned by others. Public rights-of-way, such as roads that run through the surrounding property and separate it from the home, will not affect the exemption of the property. "Usual residence" includes the home from which the family or individual is temporarily absent due to illness, employment, or education, or because the home is temporarily not habitable due to casualty or natural disaster.

(c) "Net asset" means the asset's fair market value minus any encumbrances including, but not limited to, liens and mortgages.

Subd. 2. **Limit on total assets.** (a) Effective July 1, 2002, or upon federal approval, whichever is later, in order to be eligible for the MinnesotaCare program, a household of two or more persons must not own more than $20,000 in total net assets, and a household of one person must not own more than $10,000 in total net assets.

(b) For purposes of this subdivision, assets are determined according to section 256B.056, subdivision 3c, except that workers' compensation settlements received due to a work-related injury shall not be considered.

(c) State-funded MinnesotaCare is not available for applicants or enrollees who are otherwise eligible for medical assistance but fail to verify assets. Enrollees who become eligible for federally funded medical assistance shall be terminated from state-funded MinnesotaCare and transferred to medical assistance.

Subd. 3. **Documentation.** (a) The commissioner of human services shall require individuals and families, at the time of application or renewal, to indicate on a form developed by the commissioner whether they satisfy the MinnesotaCare asset requirement.

(b) The commissioner may require individuals and families to provide any information the commissioner determines necessary to verify compliance with the asset requirement, if the

commissioner determines that there is reason to believe that an individual or family has assets that exceed the program limit.

Subd. 4. **Penalties.** Individuals or families who are found to have knowingly misreported the amount of their assets as described in this section shall be subject to the penalties in section 256.98. The commissioner shall present recommendations on additional penalties to the 1998 legislature.

Subd. 5. **Exemption.** This section does not apply to pregnant women or children. For purposes of this subdivision, a woman is considered pregnant for 60 days postpartum.

485.14 VITAL STATISTICS, RECORDS RECEIVED FOR PRESERVATION.

The court administrators of the district court may, at their option as county registrars of vital statistics, receive for preservation records or certificates of live birth, death or stillbirth from town clerks, statutory city clerks, city agents of a board of health as authorized under section 145A.04 of cities which do not maintain local registration of vital statistics under section 144.214, or other local officers, who may have lawful custody and possession thereof in their respective counties. The court administrators taking possession of such records and certificates shall with regard to them be subject to all applicable provisions of sections 144.211 to 144.227.

609.093 JUVENILE PROSTITUTES; DIVERSION OR CHILD PROTECTION PROCEEDINGS.

Subdivision 1. **First-time prostitution offense; applicability; procedure.** (a) This section applies to a 16 or 17 year old child alleged to have engaged in prostitution as defined in section 609.321, subdivision 9, who:

(1) has not been previously adjudicated delinquent for engaging in prostitution as defined in section 609.321, subdivision 9;

(2) has not previously participated in or completed a diversion program for engaging in prostitution as defined in section 609.321, subdivision 9;

(3) has not previously been placed on probation without an adjudication or received a continuance under section 260B.198, subdivision 7, for engaging in prostitution as defined in section 609.321, subdivision 9;

(4) has not previously been found to be a child in need of protection or services for engaging in prostitution as defined in section 609.321, subdivision 9, or because the child is a sexually exploited youth as defined in section 260C.007, subdivision 31, clause (1); and

(5) agrees to successfully complete a diversion program under section 388.24 or fully comply with a disposition order under sections 260C.201, 260C.202, and 260C.204.

(b) The prosecutor shall refer a child described in paragraph (a) to a diversion program under section 388.24 or file a petition under section 260C.141 alleging the child to be in need of protection or services.

Subd. 2. **Failure to comply.** If a child fails to successfully complete diversion or fails to fully comply with a disposition order under sections 260C.201, 260C.202, and 260C.204, the child may be referred back to the court for further proceedings under chapter 260B.

Subd. 3. **Dismissal of charge.** The court shall dismiss the charge against the child if any of the following apply:

(1) the prosecutor referred the child to a diversion program and the prosecutor notifies the court that the child successfully completed the program;

(2) the prosecutor filed a petition under section 260C.141 and the court does not find that the child is in need of protection or services; or

(3) the prosecutor filed a petition under section 260C.141, the court entered an order under sections 260C.201, 260C.202, and 260C.204, and the child fully complied with the order.

Laws 2011, First Special Session chapter 9, article 7, section 54, as amended by Laws 2012, chapter 247, article 4, section 42; as amended by Laws 2012, chapter 298, section 3

Sec. 42. Laws 2011, First Special Session chapter 9, article 7, section 54, is amended to read:

Sec. 54. **CONTINGENCY PROVIDER RATE AND GRANT REDUCTIONS.**

(a) Notwithstanding any other rate reduction in this article, if the commissioner of human services has not received federal approval before July 1, 2013, of the long-term care realignment waiver application submitted under Laws 2011, First Special Session chapter 9, article 7, section 52, or only receives approval to implement portions of the waiver request, the commissioner shall decrease grants, allocations, reimbursement rates, individual limits, and rate limits, as applicable, by 1.67 percent effective July 1, 2013, for services rendered from July 1, 2013, through December 31, 2013. The commissioner shall prorate the reduction in the event that only portions of the waiver request are approved and after application of the continuing care provider payment delay provision in article 6, section 2, subdivision 4, paragraph (f). County or tribal contracts for services specified in this section must be amended to pass through these rate reductions within 60 days of the effective date of the decrease, and must be retroactive from the effective date of the rate decrease.

(b) The rate changes described in this section must be provided to:

(1) home and community-based waivered services for persons with developmental disabilities or related conditions, including consumer-directed community supports, under Minnesota Statutes, section 256B.501;

(2) home and community-based waivered services for the elderly, including consumer-directed community supports, under Minnesota Statutes, section 256B.0915;

(3) waivered services under community alternatives for disabled individuals, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(4) community alternative care waivered services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(5) traumatic brain injury waivered services, including consumer-directed community supports, under Minnesota Statutes, section 256B.49;

(6) nursing services and home health services under Minnesota Statutes, section 256B.0625, subdivision 6a;

(7) personal care services and qualified professional supervision of personal care services under Minnesota Statutes, section 256B.0625, subdivisions 6a and 19a;

(8) private duty nursing services under Minnesota Statutes, section 256B.0625, subdivision 7;

(9) day training and habilitation services for adults with developmental disabilities or related conditions, under Minnesota Statutes, sections 252.40 to 252.46, including the additional cost of rate adjustments on day training and habilitation services, provided as a social service under Minnesota Statutes, section 256M.60; and

(10) alternative care services under Minnesota Statutes, section 256B.0913.

(c) A managed care plan receiving state payments for the services in this section must include these decreases in their payments to providers. To implement the rate reductions in this section, capitation rates paid by the commissioner to managed care organizations under Minnesota Statutes, section 256B.69, shall reflect up to a 1.67 percent reduction for the specified services for the period of July 1, 2013, through December 31, 2013.

The above payment rate reduction, allocation rates, and rate limits shall expire for services rendered on December 31, 2013.

4668.0002 APPLICABILITY, AUTHORITY, AND SCOPE.

This chapter implements the licensing of home care providers under Minnesota Statutes, sections 144A.43 to 144A.47, under the authority of Minnesota Statutes, sections 144A.45, subdivision 1, and 144A.4605. Unless otherwise provided, all licensed home care providers must meet the requirements of this chapter. Provisions that apply only to specified classes of licensees are identified by those provisions. The commissioner may delegate any authority or responsibility to an agent of the department. This chapter must be read together with Minnesota Statutes, sections 144A.43 to 144A.47.

4668.0003 DEFINITIONS.

Subpart 1. **Scope.** As used in parts 4668.0002 to 4668.0870, the terms in subparts 2 to 45 have the meanings given them.

Subp. 2. **Ambulatory.** "Ambulatory" means the ability to move about and transfer between locations without the assistance of another person, either with or without the assistance of a walking device or wheel chair.

Subp. 2a. **Assistance with self-administration of medication.** "Assistance with self-administration of medication" means performing a task to enable a client to self-administer medication, including:

A. bringing the medication to the client;

B. opening a container containing medications set up by a nurse, physician, or pharmacist;

C. emptying the contents from the container into the client's hand;

D. providing liquids or nutrition to accompany medication that a client is self-administering; or

E. reporting information to a nurse regarding concerns about a client's self-administration of medication.

Subp. 2b. **Class F home care provider.** "Class F home care provider" has the meaning given in Minnesota Statutes, section 144A.4605, subdivision 1.

Subp. 2c. **Assisted living home care service.** "Assisted living home care service" means a nursing service, delegated nursing service, other service performed by an unlicensed person, or central storage of medications provided solely for a resident of a housing with services establishment registered under Minnesota Statutes, chapter 144D.

Subp. 3. **Assisted living services.** "Assisted living services," as provided under a class E home care license, means individualized home care aide tasks or home management tasks provided to clients of a residential center in their living units, and provided either by the management of the residential center or by providers under contract with the management. In this subpart, "individualized" means chosen and designed specifically for each client's needs, rather than provided or offered to all clients regardless of their illnesses, disabilities, or physical conditions.

Subp. 4. **Business.** "Business" means an individual or other legal entity that provides services to persons in their homes.

Subp. 5. **Client.** "Client" means a person to whom a home care provider provides home care services.

Subp. 6. **Commissioner.** "Commissioner" means the commissioner of health.

Subp. 7. **Contract.** "Contract" means a legally binding agreement, whether in writing or not.

Subp. 8. **Department.** "Department" means the Minnesota Department of Health.

Subp. 9. **Home care aide tasks.** "Home care aide tasks" means those services specified in part 4668.0110, subpart 1.

Subp. 10. **Home care provider or provider.** "Home care provider" or "provider" has the meaning given to home care provider by Minnesota Statutes, section 144A.43, subdivision 4.

Subp. 11. **Home care service.** "Home care service" has the meaning given it in Minnesota Statutes, section 144A.43, subdivision 3.

Subp. 12. **Home health aide tasks.** "Home health aide tasks" means those tasks allowed in part 4668.0100, subpart 1.

Subp. 13. **Home management services.** "Home management services" has the meaning given it in Minnesota Statutes, section 144A.43, subdivision 3, clause (8).

Subp. 14. **Home management tasks.** "Home management tasks" means all home management services that are not home health aide or home care aide tasks.

Subp. 15. [Repealed, 28 SR 1639]

Subp. 16. **Hospital.** "Hospital" means a facility licensed as a hospital under chapter 4640 and Minnesota Statutes, sections 144.50 to 144.56.

Subp. 17. **Inpatient facility.** "Inpatient facility" means a hospital or nursing home.

Subp. 17a. **Legend drug.** "Legend drug" has the meaning given in Minnesota Statutes, section 151.01, subdivision 17.

Subp. 18. **Licensee.** "Licensee" means a home care provider that is licensed under parts 4668.0002 to 4668.0870 and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 19. **Licensed practical nurse.** "Licensed practical nurse" has the meaning given it by Minnesota Statutes, section 148.171, subdivision 8.

Subp. 20. **Managerial official.** "Managerial official" means a director, officer, trustee, or employee of a provider, however designated, who has the authority to establish or control business policy.

Subp. 21. **Medical social work or medical social services.** "Medical social work" or "medical social services" means social work related to the medical, health, or supportive care of clients.

Subp. 21a. **Medication administration.** "Medication administration" means performing a task to ensure a client takes a medication, and includes the following tasks, performed in the following order:

A. checking the client's medication record;

B. preparing the medication for administration;

C. administering the medication to the client;

D. documenting after administration, or the reason for not administering the medication as ordered; and

E. reporting information to a nurse regarding concerns about the medication or the client's refusal to take the medication.

Subp. 21b. **Medication reminder.** "Medication reminder" means providing a verbal or visual reminder to a client to take medication.

Subp. 22. **Nurse.** "Nurse" means a registered nurse or licensed practical nurse.

Subp. 23. **Nursing home.** "Nursing home" means a facility licensed under Minnesota Statutes, sections 144A.01 to 144A.16.

Subp. 24. **Nutritional services.** "Nutritional services" means the services provided by a dietitian, including evaluation of a client's nutritional status and recommendation for changes in nutritional care; planning, organizing, and coordinating nutritional parts of other health services; adapting a medically ordered diet to the needs and understanding of the client; and translating the recommendations for nutritional care into appropriate food selection and food preparation guidelines.

Subp. 25. **Occupational therapist.** "Occupational therapist" means a person who performs occupational therapy.

Subp. 26. **Occupational therapy.** "Occupational therapy" means services designed to assist a client, who has functional disabilities related to developmental, restorative, or health needs, to adapt the client's environment and skills to aid in the performance of daily living tasks.

Subp. 26a. **Oral hygiene.** "Oral hygiene" means care of teeth, gums, and oral prosthetic devices.

Subp. 26b. **Over-the-counter drug.** "Over-the-counter drug" means a drug that is not required by federal law to bear the statement "Caution: Federal law prohibits dispensing without prescription," and as a result, may be sold without a prescription.

Subp. 27. **Owner.** "Owner" means a:

A. proprietor;

B. general partner;

C. limited partner who has five percent or more of equity interest in a limited partnership;

D. person who owns or controls voting stock in a corporation in an amount equal to or greater than five percent of the shares issued and outstanding; or

E. corporation that owns an equity interest in a licensee or applicant for a license.

Subp. 28. **Paraprofessional.** "Paraprofessional" means a person who performs home health aide, home care aide, or home management tasks.

Subp. 28a. **Pharmacist.** "Pharmacist" means a person currently licensed under Minnesota Statutes, chapter 151.

Subp. 29. **Physical therapist.** "Physical therapist" has the meaning given by Minnesota Statutes, section 148.65, subdivision 2.

Subp. 30. **Physical therapy.** "Physical therapy" has the meaning given by Minnesota Statutes, section 148.65, subdivision 1.

Subp. 31. **Physician.** "Physician" means a person licensed under Minnesota Statutes, chapter 147.

Subp. 32. **Prescriber.** "Prescriber" means a person who is authorized by law to prescribe legend drugs.

Subp. 33. **Registered nurse.** "Registered nurse" has the meaning given it by Minnesota Statutes, section 148.171, subdivision 20.

Subp. 34. **Regularly scheduled.** "Regularly scheduled" means ordered or planned to be completed at predetermined times or according to a predetermined routine.

Subp. 35. **Residential center.** "Residential center" means a building or complex of contiguous or adjacent buildings in which clients rent or own distinct living units.

Subp. 36. **Respiratory therapist.** "Respiratory therapist" means a person who performs respiratory therapy.

Subp. 37. **Respiratory therapy.** "Respiratory therapy" means therapeutic services provided under medical orders for the assessment, treatment, management, diagnostic evaluation, and care of clients with deficiencies, abnormalities, and diseases of the cardiopulmonary system.

Subp. 38. **Responsible person.** "Responsible person" means a person who, because of the client's incapacity, makes decisions about the client's care on behalf of the client. A responsible person may be a guardian, conservator, attorney-in-fact, family member, or other agent of the client. Nothing in this chapter expands or diminishes the rights of persons to act on behalf of clients under other law.

Subp. 39. **Social work.** "Social work" has the meaning of "social work practice" as defined by Minnesota Statutes, section 148B.18, subdivision 11.

Subp. 40. **Speech therapy.** "Speech therapy" means diagnostic, screening, preventive, or corrective services for clients with speech, hearing, and language disorders.

Subp. 41. **Survey.** "Survey" means an inspection of a licensee or applicant for licensure for compliance with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47. Surveys include investigations of complaints.

Subp. 42. **Surveyor.** "Surveyor" means a representative of the department authorized by the commissioner to conduct surveys of licensees.

Subp. 43. **Therapist.** "Therapist" means a respiratory therapist, physical therapist, occupational therapist, speech therapist, or provider of nutritional services.

Subp. 44. **Unit of government.** "Unit of government" means every city, county, town, school district, other political subdivisions of the state, and any agency of the state or the United States, and includes any instrumentality of a unit of government.

Subp. 44a. **Unlicensed person.** "Unlicensed person" means a person who is employed by the licensee and who is not a nurse. Unlicensed person does not include nonemployee family members, nonemployee significant others, and nonemployee responsible persons.

Subp. 45. **Verbal.** "Verbal" means oral and not in writing.

4668.0005 PROFESSIONAL LICENSES.

Nothing in this chapter limits or expands the rights of health care professionals to provide services within the scope of their licenses or registrations, as provided by Minnesota law.

4668.0008 SERVICES INCLUDED IN AND EXCLUDED FROM LICENSURE.

Subpart 1. **Purpose.** This part implements Minnesota Statutes, section 144A.43, and establishes a process for determining what businesses are subject to licensure under this chapter. This part must be read together with Minnesota Statutes, section 144A.43. A business that is not required to be licensed under this chapter may obtain a license for the purpose of excluding individual contractors under subpart 6 or for other lawful purposes.

Subp. 2. **Determination of direct services.** As defined in Minnesota Statutes, section 144A.43, subdivision 4, a home care provider is a business that provides at least one home care

service directly. A service that is provided directly means a service provided to a client by the provider or employees of the provider, and not by contract with an independent contractor. The administration of a contract for home care services is not in itself a direct service. Factors that shall be considered in determining whether a business provides home care services directly include whether the business:

A. has the right to control and does control the types of services provided;

B. has the right to control and does control when and how the services are provided;

C. establishes the charges;

D. collects fees from the clients or receives payment from third party payers on the clients' behalf;

E. pays compensation on an hourly, weekly, or similar time basis;

F. treats the individuals as employees for purposes of payroll taxes and workers' compensation insurance; and

G. holds itself out as a provider of services or acts in a manner that leads clients or potential clients reasonably to believe that it is a provider of services.

None of the factors listed in items A to G is solely determinative.

Subp. 3. **Contract services.** If a licensee contracts for a home care service with a business that is not subject to licensure under this chapter, it must require, in the contract, that the business comply with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 4. **Coordination of providers of home care services.** The coordination of home care services is not itself a home care service. Coordination of home care services means one or more of the following:

A. Determination whether a client needs home care services, what services are needed, and whether existing services need to continue or be modified.

B. Referral of clients to home care providers.

C. Administration of payments for home care services.

Subp. 5. **Determination of regularly engaged.** As used in Minnesota Statutes, section 144A.43, subdivision 4, "regularly engaged" means providing, or offering to provide, home care services as a regular part of a provider's business. The following factors shall be considered by the commissioner in determining whether a person is regularly engaged in providing home care services:

A. whether the person markets services specifically to individuals whose illnesses, disabilities, or physical conditions create needs for the services;

B. whether the services are designed and intended specifically to assist the individuals;

C. whether the individuals constitute a substantial part of the person's clientele; and

D. whether the home care services are other than occasional or incidental to the provision of services that are not home care services.

None of the factors listed in items A to D is solely determinative.

Subp. 6. **Exclusion for a paraprofessional not regularly engaged in delivering home care services.** For purposes of subpart 5, an individual who performs home care aide tasks or home management tasks for no more than 14 hours each calendar week to no more than one client, is not regularly engaged in the delivery of home care services, and is not subject to licensure under this chapter.

Subp. 7. **Exclusion of individual contractors.** An individual who is not an employee of a licensed provider need not be licensed under this chapter, if the person:

A. only provides services as an independent contractor with one or more licensed providers;

B. provides no services under direct agreements with clients; and

C. is contractually bound to perform services in compliance with the contracting providers' policies and service agreements.

Individuals excluded from licensure under this subpart must comply with the same requirements of this chapter as employees of the contracting licensee.

Subp. 8. **Governmental providers.** Except as otherwise provided in this chapter or in law, home care services that are provided by the state, counties, or other units of government must be licensed under this chapter.

Subp. 9. **Exclusion of certain instructional and incidental services.** A business is not subject to Minnesota Statutes, sections 144A.43 to 144A.47, and is not required to be licensed under this chapter if the business only provides services that are primarily instructional and not medical services or health-related support services.

Subp. 10. **Temporary staffing agencies.** A business that provides staff to home care providers, such as temporary employment agencies, is not required to be licensed under this chapter if the business:

A. only provides staff under contract to licensed or exempt providers;

B. provides no services under direct agreements with clients; and

C. is contractually bound to perform services under the contracting providers' direction and supervision.

Subp. 11. **Status of temporary staff.** For purposes of this chapter, staff of businesses excluded from licensure under subpart 10 shall be treated as if they are employees of the contracting licensee.

Subp. 12. **Medical equipment provider.** A provider of medical supplies and equipment is subject to this chapter only if:

A. the provider provides a home care service;

B. the provider makes more than one visit to a client's residence to provide the home care service; and

C. the supplies or equipment are ordered by a physician, osteopath, dentist, podiatrist, chiropractor, or other prescriber.

In this subpart, home care service does not include maintenance of supplies or equipment or instruction in their use.

4668.0012 LICENSURE.

Subpart 1. **License issued.** If a provider complies with the requirements of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47, the commissioner shall issue to the provider a certificate of licensure that will contain:

A. the provider's name and address;

B. the class of license as provided in subpart 3;

C. the beginning and expiration dates; and

D. a unique license number.

Subp. 2. **Multiple units.** Multiple units of a provider must share the same management that supervises and administers services provided by all units. Multiple units of a provider must be separately licensed if the commissioner determines that the units cannot adequately share supervision and administration of services with the main office because of distinct organizational structures.

Subp. 3. **Classes of licenses.** In issuing a license under this part, the commissioner shall assign a license classification according to items A and B. A provider performing only home management tasks must be registered according to Minnesota Statutes, section 144A.461, and need not obtain a home care license.

A. A provider must apply for one of the classes of the home care license listed in subitems (1) to (5).

(1) Class A, or professional home care agency license. Under this license, a provider may provide all home care services in a place of residence, including a residential center, at least one of which is nursing, physical therapy, speech therapy, respiratory therapy, occupational therapy, nutritional services, medical social services, home health aide tasks, or the provision of medical supplies and equipment when accompanied by the provision of a home care service.

(2) Class B, or paraprofessional agency license. Under this license, a provider may perform home care aide tasks and home management tasks, as provided by parts 4668.0110 and 4668.0120.

(3) Class C, or individual paraprofessional license. Under this license, a provider may perform home health aide, home care aide, and home management tasks.

(4) Class E, or assisted living programs license. Under this license, a provider may only provide assisted living services to residents of a residential center.

(5) Class F home care provider license. Under this license, a provider may provide assisted living home care services solely for residents of one or more registered housing with services establishments, as provided by Minnesota Statutes, section 144A.4605.

B. If a provider meets the requirements of more than one license class, the commissioner shall issue to the provider a separate license for each applicable class of home care licensure.

Subp. 4. **Applicability of rules to classes.**

A. A class A licensee must comply with parts 4668.0002 to 4668.0180, and 4668.0218 to 4668.0240, except that one certified for Medicare as a home health agency under Code of Federal Regulations, title 42, part 484, need not comply with the requirements listed in part 4668.0180, subpart 10.

B. A class B licensee must comply with parts 4668.0002 to 4668.0080, 4668.0110 to 4668.0170, 4668.0190, and 4668.0218 to 4668.0240.

C. A class C licensee must comply with parts 4668.0002 to 4668.0035, 4668.0050 to 4668.0065, 4668.0075 to 4668.0170, 4668.0200, and 4668.0218 to 4668.0240.

D. A class E licensee must comply with parts 4668.0002 to 4668.0080, 4668.0110 to 4668.0170, 4668.0215, and 4668.0218 to 4668.0240.

E. A class F home care provider licensee must comply with parts 4668.0002 to 4668.0050, 4668.0065, 4668.0070, 4668.0170, 4668.0218 to 4668.0240, and 4668.0800to 4668.0870.

Subp. 5. **New license.** A license shall be issued to an applicant that is not currently licensed if the applicant completes the application, pays the fee in full, and complies with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47. A license is effective for one year after the date the license is issued.

Subp. 6. **License application.** To apply for a license under this chapter, an applicant must follow the procedures in items A and B.

A. An applicant for a license under this chapter must provide the following information on forms provided by the commissioner:

(1) the applicant's name and address, including the name of the county in which the applicant resides or has its principal place of business;

(2) address and telephone number of the principal administrative office;

(3) address and telephone number of each branch office, if any;

(4) names and addresses of all owners and managerial officials;

(5) documentation of compliance with the background study requirements of Minnesota Statutes, section 144A.46, subdivision 5, for all persons involved in the management, operation, or control of a provider;

(6) evidence of workers' compensation coverage, as required by Minnesota Statutes, sections 176.181 and 176.182;

(7) in the case of class C applicants, proof that the applicant is not contagious with tuberculosis, as required by part 4668.0065, subparts 1 and 2;

(8) in the case of class C applicants, proof that the applicant has met any applicable training and supervision requirements for paraprofessionals, as provided by parts 4668.0100 and 4668.0110; and

(9) a list of those home care services listed in Minnesota Statutes, section 144A.43, subdivision 3, or 144A.4605, that will be made available to clients.

B. An application on behalf of a corporation, association, or unit of government must be signed by an officer or managing agent.

Subp. 7. **Agent.** Each application for a home care provider license or for renewal of a home care provider license shall designate one or more owners, managerial officials, or employees, as an agent:

A. who is authorized to transact business with the commissioner of health on all matters provided for in this chapter and Minnesota Statutes, sections 144A.43 to 144A.47; and

B. upon whom all notices and orders shall be served, and who is authorized to accept service of notices and orders on behalf of the licensee, in proceedings under this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

The designation of one or more persons under this subpart shall not affect the legal responsibility of any other owner or managerial official under this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 8. **Notification of changes in information.** The licensee shall notify the commissioner in writing within ten working days after any change in the information required to be provided by subparts 6 and 7, except for the information required by subpart 6, item A, subitem (4), which will be required at the time of license renewal, and except for services reported under subpart 6, item A, subitem (9), that are discontinued for less than 90 days.

Subp. 9. **Application processing.** The commissioner shall process an application in the manner provided by Minnesota Statutes, section 144A.46, subdivision 1, paragraph (b). No application shall be processed without payment of the license fee in full, in the amount provided by subpart 18.

Subp. 10. **Prelicensing survey.** Before granting a license, the commissioner may investigate the applicant for compliance with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 11. **Denial of license.** A license shall be denied if:

A. the applicant; an owner of the applicant, individually or as an owner of another home care provider; or another home care provider of which an owner of the applicant also was or is an owner; has ever been issued a correction order for failing to assist its clients, in violation of part 4668.0050, subpart 2, upon the licensee's decision to cease doing business as a home care provider;

B. the applicant is not in compliance with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;

C. the applicant is disqualified under Minnesota Statutes, sections 144.057and 245A.04;

D. the applicant or an owner or managerial official has been unsuccessful in having a disqualification under Minnesota Statutes, section 144.057 or 245A.04, set aside; or

E. the commissioner determines that an owner or managerial official, as an owner or managerial official of another licensee, was substantially responsible for the other licensee's failure to substantially comply with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 12. **Change of classification.** A licensee may change to a different class of license under subpart 3, by submitting a new application under subpart 6 and meeting all applicable requirements of this chapter. An application under this subpart shall be accompanied by the fee provided by subpart 18.

Subp. 13. **License renewals.** Except as provided in subpart 14 or 15, a license will be renewed for a period of one year if the licensee satisfies items A to C. The licensee must:

A. submit an application for renewal on forms provided by the commissioner at least 30 days before expiration of the license;

B. submit the renewal fee, in the amount provided by subpart 18; and

C. comply with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 14. **Conditional license.** If a licensee is not in full compliance with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47, at the time of expiration of its license, and the violations do not warrant denial of renewal of the license, the commissioner shall issue a license for a limited period conditioned on the licensee achieving full compliance within the term of the license or the term of any correction orders.

Subp. 15. **Suspension, revocation, or denial of renewal of license.** The commissioner may deny renewal of a license, or may suspend, revoke, or make conditional a license, if the licensee, or an owner or managerial official of the licensee:

A. is in violation, or during the term of the license has violated, any of the requirements of this chapter or Minnesota Statutes, sections 144A.43 to 144A.47;

B. permits, aids, or abets the commission of any illegal act in the provision of home care;

C. performs any act detrimental to the welfare of a client;

D. obtained the license by fraud or misrepresentation;

E. knowingly made or makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;

F. denies representatives of the commissioner access to any part of the provider, its books, records, or files, or employees;

G. interferes with or impedes a representative of the commissioner in contacting the provider's clients;

H. interferes with or impedes a representative of the commissioner in the enforcement of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;

I. destroys or makes unavailable any records or other evidence relating to the licensee's compliance with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;

J. refuses to initiate a background study under Minnesota Statutes, section 144.057 or 245A.04; or

K. has failed to timely pay any fines assessed under part 4668.0230 or 4668.0800, subpart 6.

Subp. 16. **Transfers prohibited; changes in ownership.** A license issued under this part may not be transferred to another party. Before changing ownership, a prospective provider must apply for a new license under this part. A change of ownership means a transfer of operational control to a different business entity, and includes:

A. transfer of the business to a different or new corporation;

B. in the case of a partnership, the dissolution or termination of the partnership under Minnesota Statutes, chapter 323A, with the business continuing by a successor partnership or other entity;

C. relinquishment of control of the provider by the licensee to another party, including to a contract management firm that is not under the control of the owner of the business' assets;

D. transfer of the business by a sole proprietor to another party or entity; or

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

Subp. 17. **Display of license.** The original license must be displayed in the provider's principal business office and copies must be displayed in all other offices. The licensee must provide a copy of the license to any person who requests it.

Subp. 18. **Fees.** Each application for a license must include payment in full of the fee according to the schedule in chapter 4669.

4668.0016 WAIVERS AND VARIANCES.

Subpart 1. **Definitions.** For purposes of this part:

A. "waiver" means an exemption from compliance with a requirement of this chapter; and

B. "variance" means a specified alternative to a requirement of this chapter.

Subp. 2. **Criteria for waiver or variance.** Upon application of a licensee, the commissioner shall waive or vary any provision of this chapter, except for those provisions relating to criminal disqualification, part 4668.0020, and to the home care bill of rights, part 4668.0030, if the commissioner finds that:

A. the waiver or variance is necessary because of the unavailability of services or resources in the provider's geographic area; or

B. enforcement of a requirement would result in unreasonable hardship on the licensee; and

C. the waiver or variance will not adversely affect the health, safety, or welfare of any client.

Subp. 3. **Experimental variance.** A variance may be granted to allow a provider to offer home care services of a type or in a manner that is innovative, will not impair the services provided, will not adversely affect the health, safety, or welfare of the clients, and is likely to improve the services provided.

Subp. 4. **Conditions.** The commissioner may impose conditions on the granting of a waiver or variance that the commissioner considers necessary.

Subp. 5. **Duration and renewal.** The commissioner may limit the duration of any waiver or variance, and may renew a limited waiver or variance.

Subp. 6. **Applications.** An application for waiver or variance from the requirements of this chapter may be made at any time, must be made in writing to the commissioner, and must specify the following:

A. the rule from which the waiver or variance is requested;

B. the time period for which the waiver or variance is requested;

C. if the request is for a variance, the specific alternative action that the licensee proposes;

D. the reasons for the request; and

E. justification that subpart 2 or 3 will be satisfied.

The commissioner may require additional information from the licensee before acting on the request.

Subp. 7. **Grants and denials.** The commissioner shall grant or deny each request for waiver or variance in writing. Notice of a denial shall contain the reasons for the denial. The terms of a requested variance may be modified upon agreement between the commissioner and a licensee.

Subp. 8. **Violation of variances.** A failure to comply with the terms of a variance shall be deemed to be a violation of this chapter.

Subp. 9. **Revocation or denial of renewal.** The commissioner shall revoke or deny renewal of a waiver or variance if:

A. it is determined that the waiver or variance is adversely affecting the health, safety, or welfare of the licensee's clients;

B. the licensee has failed to comply with the terms of the variance;

C. the licensee notifies the commissioner in writing that it wishes to relinquish the waiver or variance and be subject to the rule previously waived or varied; or

D. the revocation or denial is required by a change in law.

Subp. 10. **Hearings.** A denial of a waiver or variance may be contested by requesting a hearing as provided by part 4668.0017. The licensee bears the burden of proving that the denial of a waiver or variance was in error.

4668.0017 HEARINGS.

Subpart 1. **Hearing rights.** An applicant for a license or a licensee that has been assessed a fine under part 4668.0230 or 4668.0800, subpart 6, that has had a waiver or variance denied or revoked under part 4668.0016, or that has a right to a hearing under Minnesota Statutes, section 144A.46, subdivision 3, may request a hearing to contest that action or decision according to the rights and procedures provided by Minnesota Statutes, chapter 14, and this part.

Subp. 2. **Request for hearing.** A request for a hearing shall be in writing and shall:

A. be mailed or delivered to the commissioner or the commissioner's designee;

B. contain a brief and plain statement describing every matter or issue contested; and

C. contain a brief and plain statement of any new matter that the licensee believes constitutes a defense or mitigating factor.

Subp. 3. **Informal conference.** At any time, the licensee and the commissioner may hold an informal conference to exchange information, clarify issues, or resolve any or all issues.

4668.0019 ADVERTISING.

Licensees shall not use false, fraudulent, or misleading advertising in the marketing of services. For purposes of this part, advertising includes any means of communicating to potential clients the availability, nature, or terms of home care services.

4668.0030 HOME CARE BILL OF RIGHTS.

Subpart 1. **Scope and enforcement against those exempt from licensure.** All home care providers, including those exempt from licensure under Minnesota Statutes, section 144A.46, subdivision 2, must comply with this part and the home care bill of rights, as provided by Minnesota Statutes, section 144A.44. The commissioner shall enforce this part and the home care bill of rights against providers exempt from licensure in the same manner as against licensees.

Subp. 2. **Notification of client.** The provider shall give a written copy of the home care bill of rights, as required by Minnesota Statutes, section 144A.44, to each client or each client's responsible person.

Subp. 3. **Time of notice.** The provider shall deliver the bill of rights at the time that the provider and the client or the client's responsible person agree to a service agreement, or before services are initiated, whichever is earlier.

Subp. 4. **Content of notice.** In addition to the text of the bill of rights in Minnesota Statutes, section 144A.44, subdivision 1, the written notice to the client must include the following:

A. a statement, printed prominently in capital letters, that is substantially the same as the following:

IF YOU HAVE A COMPLAINT ABOUT THE AGENCY OR PERSON PROVIDING YOU HOME CARE SERVICES, YOU MAY CALL, WRITE, OR VISIT THE OFFICE OF

HEALTH FACILITY COMPLAINTS, MINNESOTA DEPARTMENT OF HEALTH. YOU MAY ALSO CONTACT THE OMBUDSMAN FOR OLDER MINNESOTANS.

B. the telephone number, mailing address, and street address, of the Office of Health Facility Complaints;

C. the telephone number and address of the office of the ombudsman for older Minnesotans; and

D. the licensee's name, address, telephone number, and name or title of the person to whom problems or complaints may be directed.

The information required by items B and C shall be provided by the commissioner to licensees upon issuance of licenses and whenever changes are made.

Subp. 5. **Acknowledgment of receipt.** The provider shall obtain written acknowledgment of the client's receipt of the bill of rights or shall document why an acknowledgment cannot be obtained. The acknowledgment may be obtained from the client or the client's responsible person.

Subp. 6. **Documentation.** The licensee shall retain in the client's record documentation of compliance with this part.

Subp. 7. **Prohibition against waivers.** The licensee may not request nor obtain from clients any waiver of any of the rights enumerated in Minnesota Statutes, section 144A.44, subdivision 1. Any waiver obtained in violation of this subpart is void.

4668.0035 HANDLING OF CLIENTS' FINANCES AND PROPERTY.

Subpart 1. **Powers-of-attorney.** A licensee may not accept powers-of-attorney from clients for any purpose, and may not accept appointments as guardians or conservators of clients, unless the licensee maintains a clear organizational separation between the home care service and the program that accepts guardianship or conservatorship appointments. This subpart does not apply to licensees that are Minnesota counties or other units of government.

Subp. 2. **Handling clients' finances.** A licensee may assist clients with household budgeting, including paying bills and purchasing household goods, but may not otherwise manage a client's property. A licensee must provide a client with receipts for all transactions and purchases paid with the clients' funds. When receipts are not available, the transaction or purchase must be documented. A licensee must maintain records of all such transactions.

Subp. 3. **Security of clients' property.** A licensee may not borrow a client's property, nor in any way convert a client's property to the licensee's possession, except in payment of a fee at the fair market value of the property.

Subp. 4. **Gifts and donations.** Nothing in this part precludes a licensee or its staff from accepting bona fide gifts of minimal value, or precludes the acceptance of donations or bequests made to a licensee that are exempt from income tax under section 501(c) of the Internal Revenue Code of 1986.

4668.0040 COMPLAINT PROCEDURE.

Subpart 1. **Complaint procedure.** A licensee that has more than one direct care staff person must establish a system for receiving, investigating, and resolving complaints from its clients.

Subp. 2. **Informing clients.** The system required by subpart 1 must provide written notice to each client that includes:

A. the client's right to complain to the licensee about the services received;

B. the name or title of the person or persons to contact with complaints;

C. the method of submitting a complaint to the licensee;

D. the right to complain to the Minnesota Department of Health, Office of Health Facility Complaints; and

E. a statement that the provider will in no way retaliate because of a complaint.

Subp. 3. **Prohibition against retaliation.** A licensee must not take any action that negatively affects a client in retaliation for a complaint made by the client.

Subp. 4. **Scope.** This part applies to all licensees except class C licensees.

4668.0050 ACCEPTANCE, RETENTION, DISCONTINUATION OF SERVICES, AND DISCHARGE OF CLIENTS.

Subpart 1. **Acceptance of clients.** No licensee may accept a person as a client unless the licensee has staff, sufficient in qualifications and numbers, to adequately provide the services

agreed to in the service agreement, under part 4668.0140 for class A, B, and C licensees, or the service plan, under part 4668.0815, for class F home care provider licensees.

Subp. 2. **Assistance upon discontinuance of services.** If the licensee discontinues a home care service to a client for any reason and the client continues to need the home care service, the licensee shall provide to the client a list of home care providers that provide similar services in the client's geographic area.

This subpart does not apply to a licensee that discontinues a service to a client because of the client's failure to pay for the service.

4668.0060 ADMINISTRATION.

Subpart 1. **Services by contract.** The licensee may contract for services to be provided to its clients. Personnel providing services under contract must meet the same requirements required by this chapter of personnel employed by the licensee.

Subp. 2. **Responsibility of licensee for contractors.** A violation of this chapter by a contractor of the licensee will be considered to be a violation by the licensee.

Subp. 3. **Fulfillment of services.** The licensee shall provide all services required by the client's service agreement, required by part 4668.0140.

Subp. 4. **Scheduled appointments for nonessential services.** If a licensee, contractor, or employee of a licensee is unable, for any reason, to keep a scheduled appointment for a service that is not essential for medical or safety reasons, the licensee shall:

A. follow the procedure, if any, established in the service agreement;

B. provide a replacement person; or

C. notify the client that the appointment will not be kept, and schedule a new appointment or arrange for some other reasonable alternative.

Subp. 5. **Scheduled appointments for essential services.** If, for medical or safety reasons, a service to be provided must be completed at the scheduled time, and the licensee, contractor, or employee of a licensee is unable, for any reason, to keep the scheduled appointment, the licensee shall make arrangements to complete the service through a contract with another provider or through other reasonable means.

Subp. 6. **Availability of contact person.** Every class A or class B licensee that provides home health aide or home care aide tasks, must have a contact person available for consultation whenever a paraprofessional is performing home health aide or home care aide tasks for a client. The contact person must be available to the paraprofessional in person, by telephone, or by other means.

4668.0065 INFECTION CONTROL.

Subpart 1. **Tuberculosis screening.** No person who is contagious with tuberculosis may provide services that require direct contact with clients. All individual licensees and employees and contractors of licensees must document the following before providing services that require direct contact with clients:

A. the person must provide documentation of having received a negative reaction to a Mantoux test administered within the 12 months before working in a position involving direct client contact, and no later than every 24 months after the most recent Mantoux test; or

B. if the person has had a positive reaction to a Mantoux test upon employment or within the two years before working in a position involving direct client contact, or has a positive reaction to a Mantoux test in repeat testing during the course of employment, the person must provide:

(1) documentation of a negative chest x-ray administered within the three months before working in a position involving direct client contact; or

(2) documentation of a negative chest x-ray administered each 12 months, for two years after the positive reaction to a Mantoux test or documentation of completing or currently taking a course of tuberculosis preventative therapy; or

C. if the person has had a positive reaction to a Mantoux test more than two years before working in a position involving direct client contact, the person must provide documentation of a negative chest x-ray taken within the previous 12 months or documentation of completing or currently taking a course of tuberculosis preventative therapy.

In this subpart, "Mantoux test" means a Mantoux tuberculin skin test.

Subp. 2. **Exposure to tuberculosis.** In addition to the requirements of subpart 1, a person who has been exposed to active tuberculosis must document a negative result of a Mantoux test or chest x-ray administered no earlier than ten weeks and no later than 14 weeks after the exposure.

Subp. 3. **Infection control in-service training.** For each 12 months of employment, all licensees and employees and contractors of licensees who have contact with clients in their residences, and their supervisors, shall complete in-service training about infection control techniques used in the home. This subpart does not apply to a person who performs only home management tasks. The training must include:

A. hand washing techniques;

B. the need for and use of protective gloves, gowns, and masks;

C. disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades;

D. disinfecting reusable equipment; and

E. disinfecting environmental surfaces.

4668.0070 PERSONNEL RECORDS.

Subpart 1. **Scope.** This part applies to all licensees except class C licensees.

Subp. 2. **Personnel records.** The licensee must maintain a record of each employee, of each individual contractor excluded under part 4668.0008, subpart 7, and of other individual contractors. The record must include the following information:

A. evidence of current professional licensure, registration, or certification, if licensure, registration, or certification is required by this chapter, statute, or other rules;

B. records of training required by this chapter; and

C. evidence of licensure under this chapter, if required.

Subp. 3. **Job descriptions.** The licensee shall maintain current job descriptions, including qualifications, responsibilities, and identification of supervisors, if any, for each job classification.

Subp. 4. **Retention of personnel records.** Each personnel record must be retained for at least three years after an employee or contractor ceases to be employed by the licensee.

4668.0075 ORIENTATION TO HOME CARE REQUIREMENTS.

Subpart 1. **Orientation.** Every individual applicant for a license, and every person who provides direct care, supervision of direct care, or management of services for a licensee, shall complete an orientation to home care requirements before providing home care services to clients. This orientation may be incorporated into the training required of paraprofessionals under part 4668.0130. This orientation need only be completed once.

Subp. 2. **Content.** The orientation required by subpart 1 must contain the following topics:

A. an overview of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;

B. handling of emergencies and use of emergency services;

C. reporting the maltreatment of vulnerable minors or adults under Minnesota Statutes, sections 626.556 and 626.557;

D. home care bill of rights;

E. handling of clients' complaints and reporting of complaints to the Office of Health Facility Complaints; and

F. services of the ombudsman for older Minnesotans.

Subp. 3. **Sources of orientation.** The orientation training required by this part may be provided by the licensee or may be obtained from other sources. The commissioner shall provide a curriculum and materials that may be used to present the orientation.

Subp. 4. **Verification and documentation.** Each licensee shall retain evidence that each person required under subpart 1, has completed the orientation training required by this part.

Subp. 5. **Transferability.** Licensees may accept from another provider written verification that a person has completed the orientation.

4668.0080 QUALIFICATIONS OF PROFESSIONAL PERSONNEL.

Subpart 1. **Occupational therapy.** A person who provides occupational therapy as a licensee or as an employee or contractor of a licensee must:

A. have earned a baccalaureate degree from an occupational therapy program accredited jointly by the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Occupational Therapy Association;

B. be registered as an occupational therapist by the American Occupational Therapy Certification Board; or

C. meet the standards established for registration by the American Occupational Therapy Certification Board, in effect on June 1, 1990.

Subp. 2. **Speech therapy.** A person who provides speech therapy as a licensee or as an employee or contractor of a licensee must be registered with the department as a speech- language pathologist, under parts 4750.0010 to 4750.0700.

Subp. 3. **Respiratory therapy.** A person who provides respiratory therapy as a licensee or as an employee or contractor of a licensee must have completed a respiratory care program accredited by the American Medical Association's Committee on Allied Health Education and Accreditation and the Joint Review Committee for Respiratory Therapy Education or by an accrediting agency approved by the commissioner.

Subp. 4. **Dietitians.** A person who provides nutritional services as a licensee or as an employee or contractor of a licensee, must have a baccalaureate degree in nutrition or a comparable program, including at least six months of supervised experience, or be registered by the Commission on Dietetic Registration of the American Dietetic Association.

Subp. 5. **Physical therapy.** A person who provides physical therapy as an employee or contractor of a licensee must be registered as a physical therapist with the Board of Medical Practice under Minnesota Statutes, sections 148.65 to 148.78.

4668.0100 HOME HEALTH AIDE TASKS.

Subpart 1. **Home health aide tasks.** For a class A or C licensee, a registered nurse may delegate medical or nursing services as tasks or a therapist may assign therapy services as tasks only to a person who satisfies the requirements of subpart 5. These delegated or assigned tasks, as set forth in this part, include home care aide tasks as set forth in part 4668.0110. Class A licensees providing home care aide tasks must satisfy the training and supervision requirements of this part, and not part 4668.0110. These tasks include:

A. administration of medications, as provided by subpart 2;

B. performing routine delegated medical or nursing or assigned therapy procedures, as provided by subpart 4, except items C to H;

C. assisting with body positioning or transfers of clients who are not ambulatory;

D. feeding of clients who, because of their condition, are at risk of choking;

E. assistance with bowel and bladder control, devices, and training programs;

F. assistance with therapeutic or passive range of motion exercises;

G. providing skin care, including full or partial bathing and foot soaks; and

H. during episodes of serious disease or acute illness, providing services performed for a client or to assist a client to maintain the hygiene of the client's body and immediate environment, to satisfy nutritional needs, and to assist with the client's mobility, including movement, change of location, and positioning, and bathing, oral hygiene, dressing, hair care, toileting, bedding changes, basic housekeeping, and meal preparation. Oral hygiene means care of teeth, gums, and oral prosthetic devices.

Subp. 2. **Administration of medications.** A person who satisfies the requirements of subpart 5 may administer medications, whether oral, suppository, eye drops, ear drops, inhalant, topical, or administered through a gastrostomy tube, if:

A. the medications are regularly scheduled;

B. in the case of pro re nata medications, the administration of the medication is reported to a registered nurse either:

(1) within 24 hours after its administration; or

(2) within a time period that is specified by a registered nurse prior to the administration;

C. prior to the administration, the person is instructed by a registered nurse in the procedures to administer the medications to each client;

D. a registered nurse specifies, in writing, and documents in the clients' records, the procedures to administer the medications; and

E. prior to the administration, the person demonstrates to a registered nurse the person's ability to competently follow the procedure.

For purposes of this subpart, "pro re nata medication," commonly called p.r.n. medication, means a medication that is ordered to be administered to or taken by a client as necessary.

Subp. 3. **Limitations on administering medications.** A person who administers medications under subpart 2 may not inject medications into veins, muscle, or skin.

Subp. 4. **Performance of routine procedures.** A person who satisfies the requirements of subpart 5 may perform delegated medical or nursing and assigned therapy procedures, if:

A. prior to performing the procedures, the person is instructed by a registered nurse or therapist, respectively, in the proper methods to perform the procedures with respect to each client;

B. a registered nurse or therapist, respectively, specifies, in writing, specific instructions for performing the procedures for each client;

C. prior to performing the procedures, the person demonstrates to a registered nurse or therapist, respectively, the person's ability to competently follow the procedures; and

D. the procedures for each client are documented in the clients' records.

Subp. 5. **Qualifications for persons who perform home health aide tasks.** A person may only offer or perform home health aide tasks, or be employed to perform home health aide tasks, if the person has:

A. successfully completed the training and passed the competency evaluation required by part 4668.0130, subpart 1;

B. passed the competency evaluation required by part 4668.0130, subpart 3;

C. successfully completed training in another jurisdiction substantially equivalent to that required by item A;

D. satisfied the requirements of Medicare for training or competency of home health aides, as provided by Code of Federal Regulations, title 42, section 484.36;

E. satisfied subitems (1) and (2):

(1) meets the requirements of title XVIII of the Social Security Act for nursing assistants in nursing facilities certified for participation in the Medicare program, or has successfully completed a nursing assistant training program approved by the state; and

(2) has had at least 20 hours of supervised practical training or experience performing home health aide tasks in a home setting under the supervision of a registered nurse, or completes the supervised practical training or experience within one month after beginning work performing home health aide tasks, except that a class C licensee must have completed this supervised training or experience before a license will be issued; or

F. before April 19, 1993, completed a training course of at least 60 hours for home health aides that had been approved by the department.

Subp. 6. **In-service training and demonstration of competence.** For each person who performs home health aide tasks, the licensee must comply with items A to C.

A. For each 12 months of employment, each person who performs home health aide tasks shall complete at least eight hours of in-service training in topics relevant to the provision of home care services, including that required by part 4668.0065, subpart 3, obtained from the licensee or another source.

B. Licensees shall retain documentation of satisfying this part and shall provide documentation to persons who have completed the in-service training.

C. If a person has not performed home health aide tasks for a continuous period of 24 consecutive months, the person must demonstrate to a registered nurse competence in the skills listed in part 4668.0130, subpart 3, item A, subitem (1).

Subp. 7. **Documentation.** Class A licensees shall verify that persons employed or contracted by the licensees to perform home health aide tasks have satisfied the requirements of this part and shall retain documentation in the personnel records. Persons who perform home health aide tasks must provide documentation to the employing or contracting licensees of satisfying this part. Class C licensees shall retain documentation of satisfying this part.

Subp. 8. **Initiation of home health aide tasks.** Prior to the initiation of home health aide tasks, a registered nurse or therapist shall orient each person who is to perform home health aide tasks to each client and to the tasks to be performed.

Subp. 9. **Periodic supervision of home health aide tasks.** After the orientation required by subpart 8, a therapist or a registered nurse shall supervise, or a licensed practical nurse, under

the direction of a registered nurse, shall monitor persons who perform home health aide tasks at the client's residence to verify that the work is being performed adequately, to identify problems, and to assess the appropriateness of the care to the client's needs. This supervision or monitoring must be provided no less often than the following schedule:

A. within 14 days after initiation of home health aide tasks; and

B. every 14 days thereafter, or more frequently if indicated by a clinical assessment, for home health aide tasks described in subparts 2 to 4; or

C. every 60 days thereafter, or more frequently if indicated by a clinical assessment, for all home health aide tasks other than those described in subparts 2 to 4.

If monitored by a licensed practical nurse, the client must be supervised at the residence by a registered nurse at least every other visit, and the licensed practical nurse must be under the direction of a registered nurse, according to Minnesota Statutes, sections 148.171 to 148.285.

4668.0110 HOME CARE AIDE TASKS.

Subpart 1. **Home care aide tasks.** For a class B or C licensee, only a person who satisfies the requirements of subpart 2 or part 4668.0100, subpart 5, may perform the following services for clients:

A. preparing modified diets, such as diabetic or low sodium diets;

B. reminding clients to take regularly scheduled medications or perform exercises;

C. household chores in the presence of technically sophisticated medical equipment or episodes of acute illness or infectious disease;

D. household chores when the client's care requires the prevention of exposure to infectious disease or containment of infectious disease; and

E. assisting with dressing, oral hygiene, hair care, grooming, and bathing, if the client is ambulatory, and if the client has no serious acute illness or infectious disease. Oral hygiene means care of teeth, gums, and oral prosthetic devices.

Subp. 2. **Qualifications for persons who perform home care aide tasks.** No person may offer or perform home care aide tasks, or be employed to perform home care aide tasks, unless the person has:

A. successfully completed training and passed the competency evaluation required by part 4668.0130, subpart 1;

B. passed the competency evaluation required by part 4668.0130, subpart 3;

C. successfully completed training in another jurisdiction comparable to that required by item A; or

D. satisfied the requirements of part 4668.0100.

Subp. 3. **Documentation.** Class B licensees shall verify that the persons employed or contracted by the licensees to perform home care aide tasks have satisfied the requirements of this part and shall retain documentation in the personnel records. Persons who perform home care aide tasks must provide documentation to the employing or contracting licensees of satisfying this part. Class C licensees shall retain documentation of satisfying this part.

Subp. 4. **In-service training.** For each person who performs home care aide tasks, the licensee must comply with items A to C.

A. For each 12 months of employment, each person who performs home care aide tasks must complete at least six hours of in-service training in topics relevant to the provision of home care services, including that required by part 4668.0065, subpart 3, obtained from the licensee or another source.

B. Licensees shall retain documentation of satisfying this part and shall provide documentation to persons who have completed the in-service training.

Subp. 5. [Repealed, L 2009 c 174 art 2 s 12]

Subp. 6. **Class E visits.** A class E licensee must visit the client and observe the provision of home care services every 60 days after initiation of home care aide tasks to verify that the work is being performed adequately and to identify problems.

4668.0120 HOME MANAGEMENT TASKS.

Subpart 1. **Home management tasks.** Any person may perform services that are not listed in part 4668.0100, subpart 1, or part 4668.0110, subpart 1, including housekeeping, meal preparation, and shopping.

Subp. 2. **Training of persons who perform home management tasks.** Except for the orientation training required by Minnesota Statutes, section 144A.461, no training is required of persons who perform home management tasks.

4668.0130 TRAINING AND COMPETENCY EVALUATION FOR PERSONS WHO PERFORM HOME HEALTH AIDE AND HOME CARE AIDE TASKS.

Subpart 1. **Scope of training course and instructor.** The training required by part 4668.0100, subpart 5, and by part 4668.0110, subpart 2, must:

A. include the topics and course requirements specified in subpart 2 and use a curriculum approved by the commissioner;

B. be taught by a registered nurse with experience or training in home care, except that specific topics required by subpart 2 may be taught by another instructor in conjunction with the registered nurse; and

C. include a competency evaluation required by subpart 3.

Subp. 2. **Curriculum.** The training required in part 4668.0100, subpart 5 for home health aide tasks must contain the topics described in items A to N, and must contain no less than 75 hours of classroom and laboratory instruction. The training required in part 4668.0110, subpart 2 for home care aide tasks, must contain the topics described in items A to G, and must contain no less than 24 hours of classroom and laboratory instruction. The required topics are:

A. those topics required in the orientation training required by part 4668.0075;

B. observation, reporting, and documentation of client status and of the care or services provided;

C. basic infection control;

D. maintenance of a clean, safe, and healthy environment;

E. medication reminders;

F. appropriate and safe techniques in personal hygiene and grooming, including bathing and skin care, the care of teeth, gums, and oral prosthetic devices, and assisting with toileting;

G. adequate nutrition and fluid intake including basic meal preparation and special diets;

H. communication skills;

I. reading and recording temperature, pulse, and respiration;

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

K. recognition of and handling emergencies;

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

M. safe transfer techniques and ambulation; and

N. range of motion and positioning.

Subp. 3. **Competency evaluation.** The competency evaluation tests must be approved by the commissioner.

A. To qualify to perform home health aide tasks, the person must pass the following:

(1) a practical skill test, administered by a registered nurse, that tests the subjects described in subpart 2, items E, F, I, M, and N; and

(2) a written, oral, or practical test of the topics listed in subpart 2, items A to D, G, H, and J to L.

B. To qualify to perform home care aide tasks, the person must pass the competency evaluation for home health aide tasks, or the following:

(1) a practical skill test, administered by a registered nurse, that tests the subjects described in subpart 2, items E and F; and

(2) a written, oral, or practical test of the topics in subpart 2, items A to D and G.

Subp. 4. **Evidence of qualifications.** A licensee that provides the training and the competency evaluation required by this part shall provide each person who completes the training or passes the competency evaluation with written certification of satisfying this part.

4668.0140 SERVICE AGREEMENTS.

Subpart 1. **Service agreements.** No later than the second visit to a client, a licensee shall enter into a written service agreement with the client or the client's responsible person. Any modifications of the service agreement must be in writing and agreed to by the client or the client's responsible person.

Subp. 2. **Contents of service agreement.** The service agreement required by subpart 1 must include:

A. a description of the services to be provided, and their frequency;

B. identification of the persons or categories of persons who are to provide the services;

C. the schedule or frequency of sessions of supervision or monitoring required, if any;

D. fees for services;

E. a plan for contingency action that includes:

(1) the action to be taken by the licensee, client, and responsible persons, if scheduled services cannot be provided;

(2) the method for a client or responsible person to contact a representative of the licensee whenever staff are providing services;

(3) who to contact in case of an emergency or significant adverse change in the client's condition;

(4) the method for the licensee to contact a responsible person of the client, if any; and

(5) circumstances in which emergency medical services are not to be summoned, consistent with the Adult Health Care Decisions Act, Minnesota Statutes, chapter 145B, and declarations made by the client under that act.

Class C licensees need not comply with items B and C and this item, subitems (2) and (5). Subitems (3) and (5) are not required for clients receiving only home management services.

4668.0150 MEDICATION AND TREATMENT ORDERS.

Subpart 1. **Scope.** This part applies to medications and treatments that are ordered by a physician, osteopath, dentist, podiatrist, chiropractor, or other prescriber to be administered by the licensee.

Subp. 2. **Medication and treatment orders.** Medications and treatments must be administered by a nurse or therapist qualified to perform the order or by a person who performs home health aide tasks under the direction and supervision of the nurse or therapist consistent with part 4668.0100, subparts 2 to 4.

Subp. 3. **Authorizations.** All orders for medications and treatments must be dated and signed by the prescriber, except as provided by subpart 5.

Subp. 4. **Content of orders.** All orders for medications must contain the name of the drug, dosage, and directions for use.

Subp. 5. **Verbal orders.** Upon receiving an order verbally from a prescriber, the nurse or therapist shall:

A. record and sign the order; and

B. forward the written order to the prescriber for the prescriber's signature no later than seven days after receipt of the verbal order.

Subp. 6. **Renewal of orders.** All orders must be renewed at least every three months.

4668.0160 CLIENT RECORDS.

Subpart 1. **Maintenance of client record.** The licensee shall maintain a record for each client.

Subp. 2. **Security.** The licensee shall establish written procedures to control use and removal of client records from the provider's offices and for security in client residences and to establish criteria for release of information. The client record must be readily accessible to personnel authorized by the licensee to use the client record.

Subp. 3. **Retention.** A client's record must be retained for at least five years following discharge. Arrangements must be made for secure storage and retrieval of client records if the licensee ceases business.

Subp. 4. **Transfer of client.** If a client transfers to another home care provider, other health care practitioner or provider, or is admitted to an inpatient facility, the licensee, upon request of the client, shall send a copy or summary of the client's record to the new provider or facility or to the client.

Subp. 5. **Form of entries.** All entries in the client record must be:

A. legible, permanently recorded in ink, dated, and authenticated with the name and title of the person making the entry; or

B. recorded in an electronic media in a secure manner.

Subp. 6. **Content of client record.** The client record must contain:

A. the following information about the client:

(1) name;

(2) address;

(3) telephone number;

(4) date of birth;

(5) dates of the beginning and end of services; and

(6) names, addresses, and telephone numbers of any responsible persons;

B. a service agreement as required by part 4668.0140;

C. medication and treatment orders, if any;

D. notes summarizing each contact with the client in the client's residence, signed by each individual providing service including volunteers, and entered in the record no later than two weeks after the contact;

E. names, addresses, and telephone numbers of the client's medical services providers and other home care providers, if known;

F. a summary following the termination of services, which includes the reason for the initiation and termination of services, and the client's condition at the termination of services.

Class C licensees need only include the information required by items A, B, and E. Class E licensees need only include the information required by items A, B, D, and E.

Subp. 7. **Confidentiality.** The licensee shall not disclose to any other person any personal, financial, medical, or other information about the client, except:

A. as may be required by law;

B. to staff, contractors of the licensee, another home care provider, other health care practitioner or provider, or inpatient facility who require information in order to provide services to the client, but only such information that is necessary to the provision of services;

C. to persons authorized in writing by the client or the client's responsible person to receive the information, including third-party payers; and

D. representatives of the commissioner authorized to survey or investigate home care providers.

4668.0170 REQUEST BY CLIENT FOR DISCONTINUATION OF LIFE SUSTAINING TREATMENT.

Subpart 1. **Action by person receiving request.** If a client, family member, or other caregiver of the client requests that an employee or other agent of the licensee discontinue a life sustaining treatment, the employee or other agent of the licensee receiving the request:

A. shall take no action to discontinue the treatment; and

B. shall promptly inform the person's supervisor or other representative of the licensee of the client's request.

Subp. 2. **Action by licensee.** Upon being informed of a request for termination of treatment, the licensee shall promptly:

A. inform the client that the request will be made known to the physician who ordered the client's treatment; and

B. inform the physician of the client's request.

Subp. 3. **Right to maintain treatment.** This part does not require the licensee to discontinue treatment, except as may be required by law or court order.

Subp. 4. **Rights of clients.** This part does not diminish the rights of clients to control their treatments or terminate their relationships with providers.

Subp. 5. **Health care declarations.** This part shall be construed in a manner consistent with the Adult Health Care Decisions Act, Minnesota Statutes, chapter 145B, and declarations made by clients under that act.

4668.0180 CLASS A PROVIDER, PROFESSIONAL HOME CARE AGENCY.

Subpart 1. **Scope.** This part applies only to a professional home care agency with a class A license under part 4668.0012, subpart 3.

Subp. 2. **Required services.** The licensee shall provide at least one of the following home care services directly:

A. professional nursing;

B. physical therapy;

C. speech therapy;

D. respiratory therapy;

E. occupational therapy;

F. nutritional services;

G. medical social services;

H. home health aide tasks; or

I. provision of medical supplies and equipment when accompanied by the provision of a home care service.

Subp. 3. **Scope of services.** The licensee may provide all home care services, except that the licensee may provide a hospice program only if licensed as a hospice program under part 4664.0010, as provided by Minnesota Statutes, section 144A.753, subdivision 1.

Subp. 4. **Medical social services.** If provided, medical social services must be provided in compliance with Minnesota Statutes, sections 148B.18 to 148B.28.

Subp. 5. **Nursing services.** If provided, nursing services must be provided according to Minnesota Statutes, sections 148.171 to 148.285.

Subp. 6. **Physical therapy.** If provided, physical therapy must be provided according to Minnesota Statutes, sections 148.65 to 148.78.

Subp. 7. **Other services.** Other services not addressed in this chapter may be provided.

Subp. 8. **Referrals.** If a licensee reasonably believes that a client is in need of another medical or health service, including that of a physician, osteopath, dentist, podiatrist, chiropractor, other health professional, or social service provider, the licensee shall:

A. inform the client of the possible need;

B. determine the client's preferences with respect to obtaining the service; and

C. if the client desires the service, inform the client about available providers or referral services.

Subp. 9. **Quality assurance.** The licensee shall establish and implement a quality assurance plan, described in writing, in which the licensee must:

A. monitor and evaluate two or more selected components of its services at least once every 12 months; and

B. document the collection and analysis of data and the action taken as a result.

Subp. 10. **Equivalent requirements for certified providers.** A class A licensee that is certified for participation in Medicare as a home health agency under Code of Federal Regulations, title 42, part 484, need not comply with this part, or with the following items, if the Medicare certification is based on compliance with the federal conditions of participation, and on survey and enforcement by the Minnesota Department of Health as agent for the United States Department of Health and Human Services:

A. part 4668.0040;

B. part 4668.0050;

C. part 4668.0060, subparts 1, 2, 3, and 6;

D. part 4668.0070, subparts 2 and 3;

E. part 4668.0080, subparts 1 and 2;

F. part 4668.0100, subparts 1 and 4 to 9;

G. part 4668.0110;

H. part 4668.0130;

I. part 4668.0140, subparts 1 and 2, items A to D;

J. part 4668.0150;

K. part 4668.0160;

L. part 4668.0180, subparts 1 to 9.

4668.0190 CLASS B PROVIDER, PARAPROFESSIONAL AGENCY.

A paraprofessional agency with a class B license under part 4668.0012, subpart 3, may perform home care aide tasks and home management tasks.

4668.0200 CLASS C PROVIDER, INDIVIDUAL PARAPROFESSIONALS.

Subpart 1. **Scope.** This part applies only to a paraprofessional with a class C license under part 4668.0012, subpart 3.

Subp. 2. **Services.** The licensee may perform:

A. home health aide tasks;

B. home care aide tasks; and

C. home management tasks.

Subp. 3. **Training.** The licensee who performs home health aide tasks or home care aide tasks must meet the requirements of part 4668.0130 before a license will be issued.

Subp. 4. **Record of supervision.** The licensee who performs home health aide tasks must maintain a record of the supervision required by part 4668.0100, subpart 9.

Subp. 5. **Records.** The licensee must maintain a written record of the services provided at each visit to clients.

Subp. 6. **Notice of clientele.** Upon request of the commissioner, class C licensees shall provide the name, address, and telephone numbers of all or specified clients and the clients' responsible persons.

4668.0218 INFORMATION AND REFERRAL SERVICES.

The commissioner shall request from licensees information necessary to establish and maintain information and referral services required by Minnesota Statutes, section 144A.47, and licensees shall provide the requested information. This information may be required to be provided together with the licensing information required by part 4668.0012, or may be required to be provided separately.

4668.0220 SURVEYS AND INVESTIGATIONS.

Subpart 1. **Surveys.** Except as provided in subpart 3 or 10, the commissioner may survey each applicant or licensee before issuing a new license or renewing an existing license. An applicant for a license that is certified and surveyed by the Minnesota Department of Health for Medicare or medical assistance shall be surveyed at the time of its next certification survey. Applicants and licensees shall provide any and all information requested by the surveyor or investigator that is within the scope of licensure.

Subp. 2. **Coordination of surveys.** If feasible, the commissioner shall survey licensees to determine compliance with this chapter at the same time as surveys for certification for Medicare and medical assistance if Medicare certification is based on compliance with the federal conditions of participation and on survey and enforcement by the Minnesota Department of Health as agent for the United States Department of Health and Human Services.

Subp. 3. **Biennial surveys.** A licensee that has been licensed for at least two consecutive years and that has been in substantial compliance with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47, and has had no serious violations in that period, may be surveyed every second license term rather than during each license term.

Subp. 4. **Complaint investigations.** Upon receiving information that a licensee may be violating or may have violated a requirement of this chapter or Minnesota Statutes, sections 144A.43 to 144A.47, the commissioner shall investigate the complaint.

Subp. 5. **Scheduling surveys.** Surveys and investigations shall be conducted without advance notice to licensees. Surveyors may contact licensees on the day of a survey to arrange for someone to be available at the survey site. The contact does not constitute advance notice.

Subp. 6. **Contacting and visiting clients.** Surveyors may contact or visit a licensee's clients without notice to the licensee. Licensees shall provide a list of current and past clients and responsible persons with addresses and telephone numbers upon request of a surveyor. Before visiting a client, a surveyor shall obtain the client's or responsible person's permission by

telephone, by mail, or in person. Surveyors shall inform all clients and responsible persons of their right to decline permission for a visit.

Subp. 7. **Information from clients.** The commissioner may solicit information from clients by telephone, mail, or other means.

Subp. 8. **Client information.** Upon the commissioner's request, licensees shall provide to the commissioner information identifying some or all of its clients and any other information about the licensee's services to the clients.

Subp. 9. **Sampling of clientele.** The commissioner may conduct a written survey of all or a sampling of home care clients to determine their satisfaction with the services provided.

Subp. 10. **Surveys of class C licensees.** The commissioner may survey class C licensees by telephoning, visiting, or writing to the licensees' clients. Office visits may be conducted, but are not required.

4668.0230 FINES FOR UNCORRECTED VIOLATIONS.

Subpart 1. **Authority.** The fines provided under this part are under the authority of Minnesota Statutes, sections 144.653, subdivision 6, and 144A.45, subdivision 2, clause (4).

Subp. 2. **Fines for license classes.** Class A and class B licensees shall be assessed fines at 100 percent of the amounts provided in subpart 3. Class C licensees shall be assessed fines at 25 percent of the amounts provided in subpart 3.

Subp. 3. **Schedule of fines for violations of statutory provisions.** For each violation of a statutory provision subject to a fine under Minnesota Statutes, section 144.653, subdivision 6, the following fines shall be assessed for the respective provision that was violated in Minnesota Statutes:

A. section 144A.44, subdivision 1, clause (1), $250;

B. section 144A.44, subdivision 1, clause (2), $250;

C. section 144A.44, subdivision 1, clause (3), $50;

D. section 144A.44, subdivision 1, clause (4), $350;

E. section 144A.44, subdivision 1, clause (5), $250;

F. section 144A.44, subdivision 1, clause (6), $250;

G. section 144A.44, subdivision 1, clause (7), $50;

H. section 144A.44, subdivision 1, clause (8), $250;

I. section 144A.44, subdivision 1, clause (9), $250;

J. section 144A.44, subdivision 1, clause (10), $250;

K. section 144A.44, subdivision 1, clause (11), $350;

L. section 144A.44, subdivision 1, clause (12), $250;

M. section 144A.44, subdivision 1, clause (13), $500;

N. section 144A.44, subdivision 1, clause (14), $250;

O. section 144A.44, subdivision 1, clause (15), $350;

P. section 144A.44, subdivision 1, clause (16), $250;

Q. section 144A.44, subdivision 1, clause (17), $500; and

R. section 144A.44, subdivision 2, $250.

Subp. 4. **Schedule of fines for violations of Vulnerable Adults Act.** For each violation of a statutory provision subject to a fine under Minnesota Statutes, section 626.557, the following fines shall be assessed:

A. subdivision 3, $250;

B. subdivision 3a, $100;

C. subdivision 4, $250;

D. subdivision 9, $250; and

E. subdivision 17, $250.

Subp. 5. **Schedule of fines for violations of rules.** For each violation of a rule provision subject to a fine under Minnesota Statutes, section 144.653, subdivision 6, the following fines shall be assessed for the respective rule that was violated:

A. part 4668.0008, subpart 3, $300;

B. for providing false information required by part 4668.0012, subpart 6, $500;

C. part 4668.0012, subpart 8, $100;

D. part 4668.0012, subpart 17, $50;

E. a variance, under part 4668.0016, subpart 8, the fine shall be the amount of the fine established for the rule that was varied;

F. part 4668.0019, $250;

G. part 4668.0030, subpart 2, $250;

H. part 4668.0030, subpart 3, $50;

I. part 4668.0030, subpart 4, $50;

J. part 4668.0030, subpart 5, $50;

K. part 4668.0030, subpart 6, $50;

L. part 4668.0030, subpart 7, $250;

M. part 4668.0035, subpart 1, $250;

N. part 4668.0035, subpart 2, $100;

O. part 4668.0035, subpart 3, $100;

P. part 4668.0040, subpart 1, $250;

Q. part 4668.0040, subpart 2, $50;

R. part 4668.0040, subpart 3, $250;

S. part 4668.0050, subpart 1, $350;

T. part 4668.0050, subpart 2, $100;

U. part 4668.0060, subpart 1, $50;

V. part 4668.0060, subpart 3, $350;

W. part 4668.0060, subpart 4, $350;

X. part 4668.0060, subpart 5, $500;

Y. part 4668.0060, subpart 6, $300;

Z. part 4668.0065, subpart 1, $500;

AA. part 4668.0065, subpart 2, $500;

BB. part 4668.0065, subpart 3, $300;

CC. part 4668.0070, subpart 2, $50;

DD. part 4668.0070, subpart 3, $50;

EE. part 4668.0070, subpart 4, $50;

FF. part 4668.0075, subpart 1, $300;

GG. part 4668.0075, subpart 2, $100;

HH. part 4668.0075, subpart 4, $50;

II. part 4668.0080, subpart 1, $300;

JJ. part 4668.0080, subpart 2, $300;

KK. part 4668.0080, subpart 3, $300;

LL. part 4668.0080, subpart 4, $300;

MM. part 4668.0080, subpart 5, $300;

NN. part 4668.0100, subpart 1, $350;

OO. part 4668.0100, subpart 2, $350;

PP. part 4668.0100, subpart 3, $500;

QQ. part 4668.0100, subpart 4, $350;

RR. part 4668.0100, subpart 5, $300;

SS. part 4668.0100, subpart 6, $300;

TT. part 4668.0100, subpart 7, $50;

UU. part 4668.0100, subpart 8, $350;

VV. part 4668.0100, subpart 9, $350;

WW. part 4668.0110, subpart 1, $350;

XX. part 4668.0110, subpart 2, $300;

YY. part 4668.0110, subpart 3, $50;

ZZ. part 4668.0110, subpart 4, $300;

AAA. part 4668.0110, subpart 5, $350;
BBB. part 4668.0110, subpart 6, $350;
CCC. part 4668.0120, subpart 2, $50;
DDD. part 4668.0130, subpart 1, $300;
EEE. part 4668.0130, subpart 2, $300;
FFF. part 4668.0130, subpart 3, $300;
GGG. part 4668.0130, subpart 4, $50;
HHH. part 4668.0140, subpart 1, $250;
III. part 4668.0140, subpart 2, $50;
JJJ. part 4668.0150, subpart 2, $350;
KKK. part 4668.0150, subpart 3, $350;
LLL. part 4668.0150, subpart 4, $350;
MMM. part 4668.0150, subpart 5, $350;
NNN. part 4668.0150, subpart 6, $350;
OOO. part 4668.0160, subpart 1, $100;
PPP. part 4668.0160, subpart 2, $100;
QQQ. part 4668.0160, subpart 3, $50;
RRR. part 4668.0160, subpart 4, $100;
SSS. part 4668.0160, subpart 5, $50;
TTT. part 4668.0160, subpart 6, $100;
UUU. part 4668.0160, subpart 7, $350;
VVV. part 4668.0170, subpart 1, $500;
WWW. part 4668.0170, subpart 2, $500;
XXX. part 4668.0180, subpart 3, $500;
YYY. part 4668.0180, subpart 4, $300;
ZZZ. part 4668.0180, subpart 5, $300;
AAAA. part 4668.0180, subpart 6, $300;
BBBB. part 4668.0180, subpart 8, $200;
CCCC. part 4668.0180, subpart 9, $100;
DDDD. part 4668.0190, $500;
EEEE. part 4668.0200, subpart 2, $500;
FFFF. part 4668.0200, subpart 4, $100;
GGGG. part 4668.0200, subpart 5, $50;
HHHH. part 4668.0200, subpart 6, $500;
IIII. part 4668.0220, subpart 6, $500; and
JJJJ. part 4668.0220, subpart 8, $500.

4668.0240 FAILURE TO CORRECT DEFICIENCY AFTER FINE HAS BEEN IMPOSED.

If, upon subsequent reinspection after a fine has been imposed under part 4668.0230, the deficiency has still not been corrected, another fine shall be assessed. This fine shall be double the amount of the previous fine.

4668.0800 CLASS F HOME CARE PROVIDER.

Subpart 1. **Scope of license.** A class F home care provider licensee may provide nursing services, delegated nursing services, other services performed by unlicensed personnel, or central storage of medications, solely for residents of one or more housing with services establishments registered under Minnesota Statutes, chapter 144D.

Subp. 2. **Required services.** A class F home care provider licensee must provide at least one of the following assisted living home care services directly:

A. professional nursing services;
B. delegated nursing services;
C. non-nursing services performed by unlicensed personnel; or
D. central storage of medications.

Subp. 3. **Fulfillment of services.** A class F home care provider licensee must provide all services required by a client's service plan under part 4668.0815.

Subp. 4. **Referrals.** If a class F home care provider licensee reasonably believes that a client is in need of another medical or health service, including that of a physician, osteopath, dentist, podiatrist, chiropractor, other health professional, or social service provider, the licensee must:

A. inform the client of the possible need;

B. determine the client's preferences with respect to obtaining the service; and

C. if the client desires the service, inform the client about available providers or referral services.

Subp. 5. **Availability of contact person.** A class F home care provider licensee must have a contact person available for consultation whenever an unlicensed person employed by the licensee is performing assisted living home care services for a client. The contact person must be available to unlicensed personnel in person, by telephone, or by other means of direct communication.

Subp. 6. **Violations of rules.** For each violation of parts 4668.0800 to 4668.0870subject to a fine under Minnesota Statutes, section 144.653, subdivisions 5 to 8, a fine shall be assessed according to the schedules established in parts 4668.0800 to 4668.0870.

Subp. 7. **Failure to correct deficiency.** If, upon subsequent reinspection after a fine has been imposed under subpart 6, the deficiency has still not been corrected, another fine must be assessed. This fine must be double the amount of the previous fine.

Subp. 8. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

A. subpart 3, $350;

B. subpart 4, $200; and

C. subpart 5, $300.

4668.0805 ORIENTATION TO HOME CARE REQUIREMENTS.

Subpart 1. **Orientation.** An individual applicant for a class F home care provider license and a person who provides direct care, supervision of direct care, or management of services for a licensee must complete an orientation to home care requirements before providing home care services to clients. The orientation may be incorporated into the training of unlicensed personnel required under part 4668.0835, subpart 2. The orientation need only be completed once.

Subp. 2. **Content.** The orientation required under subpart 1 must contain the following topics:

A. an overview of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;

B. handling emergencies and using emergency services;

C. reporting the maltreatment of vulnerable minors or adults under Minnesota Statutes, sections 626.556 and 626.557;

D. the home care bill of rights, Minnesota Statutes, section 144A.44;

E. handling of clients' complaints and how clients and staff may report complaints to the Office of Health Facility Complaints; and

F. the services of the ombudsman for older Minnesotans.

Subp. 3. **Sources of orientation.** The orientation training required by this part may be provided by a class F home care provider licensee or may be obtained from other sources. The commissioner must provide a curriculum and materials that may be used to present the orientation.

Subp. 4. **Verification and documentation.** A class F home care provider licensee must retain evidence that each person has completed the orientation training required under this part.

Subp. 5. **Transferability.** A class F home care provider licensee may accept written verification from another provider that a person has completed the orientation required under this part.

Subp. 6. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

A. subpart 1, $300;

B. subpart 2, $100; and

C. subpart 4, $50.

4668.0810 CLIENT RECORDS.

Subpart 1. **Maintenance of client record.** A class F home care provider licensee must maintain a record for each client at the housing with services establishment where the services are provided. The client record must be readily accessible to personnel authorized by the licensee to use the client record.

Subp. 2. **Security.** A class F home care provider licensee must establish and implement written procedures for security of client records, including:

A. the use of client records;

B. the removal of client records from the establishment; and

C. the criteria for release of client information.

Subp. 3. **Retention.** A class F home care provider licensee must retain a client's record for at least five years following the client's discharge or discontinuation of services. Arrangements must be made for secure storage and retrieval of client records if the licensee ceases business.

Subp. 4. **Transfer of client.** If a client transfers to another home care provider or other health care practitioner or provider or is admitted to an inpatient facility, a class F home care provider licensee, upon request of the client, must send a copy or summary of the client's record to the new provider or facility or to the client.

Subp. 5. **Form of entries.** Except as required by subpart 6, items F and G, documentation of a class F home care service must be created and signed by the staff person providing the service no later than the end of the work period. The documentation must be entered into the client record no later than two weeks after the end of the day service was provided. All entries in the client record must be:

A. legible, permanently recorded in ink, dated, and authenticated with the name and title of the person making the entry; or

B. recorded in an electronic media in a manner that ensures the confidentiality and security of the electronic information, according to current standards of practice in health information management, and that allows for a printed copy to be created.

Subp. 6. **Content of client record.** The client record must be accurate, up to date, and available to all persons responsible for assessing, planning, and providing assisted living home care services. The record must contain:

A. the following information about the client:

(1) name;

(2) address;

(3) telephone number;

(4) date of birth;

(5) dates of the beginning and end of services;

(6) names, addresses, and telephone numbers of any responsible persons;

(7) primary diagnosis and any other relevant current diagnoses;

(8) allergies, if any; and

(9) the client's advance directive, if any;

B. an evaluation and service plan as required under part 4668.0815;

C. a nursing assessment for nursing services, delegated nursing services, or central storage of medications, if any;

D. medication and treatment orders, if any;

E. the client's current tuberculosis infection status, if known;

F. documentation of each instance of assistance with self-administration of medication and of medication administration, if any;

G. documentation on the day of occurrence of any significant change in the client's status or any significant incident, including a fall or a refusal to take medications, and any actions by staff in response to the change or incident;

H. documentation at least weekly of the client's status and the home care services provided, if not addressed under item F or G;

I. the names, addresses, and telephone numbers of the client's medical services providers and other home care providers, if known;

J. a summary following the discontinuation of services, which includes the reason for the initiation and discontinuation of services and the client's condition at the discontinuation of services; and

K. any other information necessary to provide care for each individual client.

Subp. 7. **Confidentiality.** A Class F home care provider licensee must not disclose to any other person any personal, financial, medical, or other information about the client, except:

A. as may be required by law;

B. to staff, another home care provider, a health care practitioner or provider, or an inpatient facility that requires information to provide services to the client, but only the information that is necessary to provide services;

C. to persons authorized in writing by the client or the client's responsible person to receive the information, including third-party payers; or

D. to representatives of the commissioner authorized to survey or investigate home care providers.

Subp. 8. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

A. subpart 1, $100;

B. subpart 2, $100;

C. subpart 3, $50;

D. subpart 4, $100;

E. subpart 5, $50;

F. subpart 6, $100; and

G. subpart 7, $350.

4668.0815 EVALUATION AND SERVICE PLAN.

Subpart 1. **Evaluation; documentation.** No later than two weeks after the initiation of assisted living home care services to a client, a registered nurse must complete an individualized evaluation of the client's needs and must establish, with the client or the client's responsible person, a suitable and up-to-date service plan for providing assisted living home care services in accordance with accepted standards of practice for professional nursing. The service plan must be in writing and include a signature or other authentication by the class F home care provider licensee and by the client or the client's responsible person documenting agreement on the services to be provided.

Subp. 2. **Reevaluation.** A registered nurse must review and revise a client's evaluation and service plan at least annually or more frequently when there is a change in the client's condition that requires a change in services.

Subp. 3. **Modifications.** A modification of the service plan must be in writing and agreed to by the client or the client's responsible person before the modification is initiated. A modification must be authenticated by the client or the client's responsible person and must be entered into the client's record no later than two weeks after the modification is initiated.

Subp. 4. **Contents of service plan.** The service plan required under subpart 1 must include:

A. a description of the assisted living home care service or services to be provided and the frequency of each service, according to the individualized evaluation required under subpart 1;

B. the identification of the persons or categories of persons who are to provide the services;

C. the schedule or frequency of sessions of supervision or monitoring required by law, rule, or the client's condition for the services or the persons providing those services, if any;

D. the fees for each service; and

E. a plan for contingency action that includes:

(1) the action to be taken by the class F home care provider licensee, client, and responsible person if scheduled services cannot be provided;

(2) the method for a client or responsible person to contact a representative of the class F home care provider licensee whenever staff are providing services;

(3) the name and telephone number of the person to contact in case of an emergency or significant adverse change in the client's condition;

(4) the method for the class F home care provider licensee to contact a responsible person of the client, if any; and

(5) the circumstances in which emergency medical services are not to be summoned, consistent with Minnesota Statutes, chapters 145B and 145C, and declarations made by the client under those chapters.

Subp. 5. **Scheduled appointments for nonessential services.** If a class F home care provider licensee or employee of a licensee is unable, for any reason, to keep a scheduled appointment for a service that is not essential for medical or safety reasons, the licensee must:

A. follow the procedure established in the service plan;

B. provide a replacement person; or

C. notify the client that the appointment will not be kept and schedule a new appointment or arrange for some other reasonable alternative.

Subp. 6. **Scheduled appointments for essential services.** If, for medical or safety reasons, a service to be provided must be completed at the scheduled time and the class F home care provider licensee or employee of a licensee is unable, for any reason, to keep the scheduled appointment, the licensee must make arrangements to complete the service through a contract with another provider or through other reasonable means.

Subp. 7. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

A. subpart 1, $250;

B. subpart 2, $250;

C. subpart 3, $250;

D. subpart 4, $50;

E. subpart 5, $350; and

F. subpart 6, $500.

4668.0820 NURSING SERVICES.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides nursing services.

Subp. 2. **Compliance with Minnesota Nurse Practice Act.** Nursing services must be provided according to Minnesota Statutes, sections 148.171 to 148.285, and rules adopted thereunder.

4668.0825 DELEGATED NURSING SERVICES.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides nursing services delegated to unlicensed personnel.

Subp. 2. **Nursing assessment and service plan.** Before initiating delegated nursing services for a client, a registered nurse must conduct a nursing assessment of the client's functional status and need for nursing services and must develop a service plan for providing the services according to the client's needs and preferences. The service plan must include the frequency of supervision of the task and of the person providing the service for the client according to part 4668.0845. The service plan for delegated nursing services must be maintained as part of the service plan required under part 4668.0815.

Subp. 3. **Nursing services delegated to unlicensed personnel.** A registered nurse may delegate the nursing services specified in items A to I only to a person who satisfies the requirements of part 4668.0835 and possesses the knowledge and skills consistent with the complexity of the nursing task being delegated, only in accordance with Minnesota Statutes, sections 148.171 to 148.285. Nursing services that may be delegated are:

A. performing assistance with self-administration of medication and medication administration according to part 4668.0855;

B. performing routine delegated medical or nursing procedures, as provided under subpart 4;

C. assisting with body positioning or transfer of a client;

D. feeding a client who, because of the client's condition, is at risk of choking;

E. assisting with bowel and bladder control, devices, and training programs;

F. assisting with therapeutic or passive range of motion exercises;

G. providing skin care, including full or partial bathing and foot soaks;

H. during episodes of serious disease or acute illness, providing the following services or assisting a client to:

(1) maintain the hygiene of the client's body and immediate environment;

(2) satisfy nutritional needs;

(3) assist with the client's mobility, including movement, change of location, and positioning;

(4) bathe;

(5) maintain oral hygiene;

(6) dress;

(7) care for hair;

(8) use the toilet;

(9) change bedding;

(10) perform basic housekeeping; and

(11) prepare meals; and

I. providing central storage of medications, according to part 4668.0865.

Subp. 4. **Performance of routine procedures.** A person who satisfies the requirements of part 4668.0835, subpart 2, may perform delegated nursing procedures if:

A. before performing the procedures, the person is instructed by a registered nurse in the proper methods to perform the procedures with respect to each client;

B. a registered nurse specifies in writing specific instructions for performing the procedures for each client;

C. before performing the procedures, the person demonstrates to a registered nurse the person's ability to competently follow the procedures;

D. the procedures for each client are documented in the client's record; and

E. the class F home care provider licensee retains documentation by the registered nurse regarding the person's demonstrated competency.

Subp. 5. **Information to determine delegation.** The licensee must establish and implement policies to communicate up-to-date information to the registered nurse regarding the current available unlicensed personnel and their training and qualifications, so the registered nurse has sufficient information to determine the appropriateness of delegating tasks in individual situations.

Subp. 6. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

A. subpart 2, $250;

B. subpart 3, $350;

C. subpart 4, $350; and

D. subpart 5, $350.

4668.0830 OTHER SERVICES PERFORMED BY UNLICENSED PERSONNEL.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides other services performed by unlicensed personnel.

Subp. 2. **Other services.** A person who satisfies the requirements of part 4668.0835may perform services in the registered housing with services establishment including:

A. preparing modified diets, including diabetic or low sodium diets;

B. providing medication reminders;

C. performing household chores in the presence of technically sophisticated medical equipment or episodes of acute illness or infectious disease;

D. performing household chores when the client's care requires the prevention of exposure to infectious disease or containment of infectious disease;

E. assisting with dressing, oral hygiene, hair care, grooming, and bathing; and

F. performing home management tasks.

Subp. 3. **Schedule of fines.** A fine of $350 shall be assessed for a violation of subpart 2.

4668.0835 QUALIFICATIONS FOR UNLICENSED PERSONNEL WHO PERFORM ASSISTED LIVING HOME CARE SERVICES.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides assisted living home care services using unlicensed personnel.

Subp. 2. **Qualifications.** An unlicensed person may offer to perform, or be employed to perform nursing services delegated to unlicensed personnel as provided under part 4668.0825, other services performed by unlicensed personnel as provided under part 4668.0830, or central storage of medications as provided under part 4668.0865, only if the person has:

A. successfully completed the training and passed the competency evaluation according to part 4668.0840, subpart 2;

B. successfully completed the training under part 4668.0840, subpart 3, and passed a competency evaluation according to part 4668.0840, subpart 4; or

C. satisfied the requirements of part 4668.0100, subpart 5.

Subp. 3. **In-service training and demonstration of competency.** For each unlicensed person who performs assisted living home care services, a class F home care provider licensee must comply with items A to C.

A. For each 12 months of employment, a person who performs assisted living home care services must complete at least eight hours of in-service training in topics relevant to the provision of home care services, including training in infection control required under part 4668.0065, subpart 3, obtained from the licensee or another source.

B. If a person has not performed assisted living home care services for a continuous period of 24 consecutive months, the person must demonstrate to a registered nurse competence according to part 4668.0840, subpart 4, item C.

C. A licensee must retain documentation of satisfying this part and must provide documentation to a person who completes the in-service training.

Subp. 4. **Documentation.**

A. An unlicensed person who performs assisted living home care services must provide documentation to the employing licensee of satisfying this part.

B. A class F home care provider licensee must verify that unlicensed persons employed by the licensee to perform assisted living home care services have satisfied the requirements of this part, and must retain documentation in the personnel records.

Subp. 5. **Initiation of services by unlicensed personnel.** Before initiating delegated nursing services by unlicensed personnel, a registered nurse must orient each person who is to perform assisted living home care services to each client and to the assisted living home care services to be performed. Based on the professional judgment of the registered nurse and on the individual needs of the client, the orientation may occur onsite, verbally, or in writing.

Subp. 6. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

A. subpart 2, $300;

B. subpart 3, $300;

C. subpart 4, $50; and

D. subpart 5, $350.

4668.0840 TRAINING AND COMPETENCY EVALUATION FOR UNLICENSED PERSONNEL.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides assisted living home care services using unlicensed personnel.

Subp. 2. **Scope of training course and instructor.** The training required under part 4668.0835, subpart 2, must:

A. include each assisted living home care service offered to clients that the unlicensed person will perform, taught by a registered nurse with experience or training in the subject being taught;

B. include the core training requirements specified in subpart 3;

C. include the competency evaluation required under subpart 4; and

D. use a curriculum that meets the requirements of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 3. **Core training of unlicensed personnel.**

A. An unlicensed person performing assisted living home care services must successfully complete training or demonstrate competency in the topics described in subitems (1) to (12). The required topics are:

(1) an overview of this chapter and Minnesota Statutes, sections 144A.43to 144A.47;

(2) recognizing and handling emergencies and using emergency services;

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

(4) the home care bill of rights, Minnesota Statutes, section 144A.44;

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

(6) the services of the ombudsman for older Minnesotans;

(7) communication skills;

(8) observing, reporting, and documenting client status and the care or services provided;

(9) basic infection control;

(10) maintaining a clean, safe, and healthy environment;

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

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

B. The core training of unlicensed personnel must be taught by a registered nurse with experience or training in home care, except that item A, subitems (1) to (7), may be taught by another instructor under the direction of the registered nurse.

C. The core training curriculum must meet the requirements of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 4. **Competency evaluation.**

A. The competency evaluation tests required under part 4668.0835, subpart 2, items A and B, must meet the requirements of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

B. A registered nurse must complete and document each competency evaluation.

C. To qualify to perform assisted living home care services, a person must demonstrate competency by successfully completing:

(1) a written, oral, or practical test of the topics in subpart 3; and

(2) a written, oral, or practical test of all assisted living home care provider services that the person will perform.

Subp. 5. **Evidence of qualifications.** A class F home care provider licensee that provides the training and the competency evaluation required by this part must provide each person who successfully completes the training or passes the competency evaluation with written verification of satisfying this part.

Subp. 6. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

A. subpart 2, $300;

B. subpart 3, $300;

C. subpart 4, $300; and

D. subpart 5, $50.

4668.0845 PERIODIC SUPERVISION OF UNLICENSED PERSONNEL.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides assisted living home care services using unlicensed personnel.

Subp. 2. **Services that require supervision by a registered nurse.**

A. After the orientation required under part 4668.0835, subpart 5, a registered nurse must supervise, or a licensed practical nurse under the direction of a registered nurse must monitor, unlicensed persons who perform assisted living home care services that require supervision by

a registered nurse at the housing with services establishment, to verify that the work is being performed adequately, identify problems, and assess the appropriateness of the care to the client's needs. Supervision or monitoring must be provided no less often than the following schedule:

(1) within 14 days after initiation of assisted living home care services that require supervision by a registered nurse; and

(2) at least every 62 days thereafter, or more frequently if indicated by a nursing assessment and the client's individualized service plan.

B. If the unlicensed person is monitored by a licensed practical nurse, the client must be supervised by a registered nurse at the housing with services establishment at least every other visit and the licensed practical nurse must be under the direction of a registered nurse, according to Minnesota Statutes, sections 148.171 to 148.285.

Subp. 3. **Services that do not require supervision by a registered nurse.** After the orientation required under part 4668.0835, subpart 5, unlicensed persons who perform services listed under part 4668.0830, subpart 2, or other assisted living home care services that do not require supervision by a registered nurse must be supervised at the housing with services establishment, to verify that the work is being performed adequately, identify problems, and assess the appropriateness of the care to the client's needs. The service plan developed under part 4668.0815 must address the frequency of the supervision of each service and the appropriate person to perform the supervision.

Subp. 4. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

A. subpart 2, $350; and

B. subpart 3, $300.

4668.0855 MEDICATION ADMINISTRATION AND ASSISTANCE WITH SELF-ADMINISTRATION OF MEDICATION.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides medication administration or assistance with self-administration of medication by unlicensed personnel.

Subp. 2. **Nursing assessment and service plan.** For each client who will be provided with assistance with self-administration of medication or medication administration, a registered nurse must conduct a nursing assessment of each client's functional status and need for assistance with self-administration of medication or medication administration, and develop a service plan for the provision of the services according to the client's needs and preferences. The service plan must include the frequency of supervision of the task and of the person providing the service for the client according to part 4668.0845, and must be maintained as part of the service plan required under part 4668.0815.

Subp. 3. **Delegation by a registered nurse.** A registered nurse may delegate medication administration or assistance with self-administration of medication only to a person who satisfies the requirements of part 4668.0835, subpart 2, and possesses the knowledge and skills consistent with the complexity of medication administration or assistance with self-administration of medication, only in accordance with Minnesota Statutes, sections 148.171 to 148.285.

Subp. 4. **Training for assistance with self-administration of medication or medication administration.** Before the registered nurse delegates the task of assistance with self-administration of medication or the task of medication administration, a registered nurse must instruct the unlicensed person on the following:

A. the complete procedure for checking a client's medication record;

B. preparation of the medication for administration;

C. administration of the medication to the client;

D. assistance with self-administration of medication;

E. documentation, after assistance with self-administration of medication or medication administration, of the date, time, dosage, and method of administration of all medications, or the reason for not assisting with self-administration of medication or medication administration as ordered, and the signature of the nurse or authorized person who assisted or administered and observed the same; and

F. the type of information regarding assistance with self-administration of medication and medication administration reportable to a nurse.

Subp. 5. **Administration of medications.** A person who satisfies the requirements of subpart 4 and has been delegated the responsibility by a registered nurse, may administer medications, orally, by suppository, through eye drops, through ear drops, by use of an inhalant, topically, by injection, or through a gastrostomy tube, if:

A. the medications are regularly scheduled; and

B. in the case of pro re nata medications, the administration of the medication is reported to a registered nurse either:

(1) within 24 hours after its administration; or

(2) within a time period that is specified by a registered nurse prior to the administration.

Subp. 6. **Limitations on administering medications.** A person who administers medications under subpart 3 may not draw up injectables. Medication administered by injection under subpart 5 is limited to insulin.

Subp. 7. **Performance of routine procedures.** A person who satisfies the training requirements of subpart 4 may perform assistance with self-administration of medication or medication administration if:

A. before performing the procedures, the person is instructed by a registered nurse in the proper methods to perform the procedures with respect to each client;

B. a registered nurse specifies in writing specific instructions for performing the procedures for each client;

C. before performing the procedures, the person demonstrates to a registered nurse the person's ability to competently follow the procedures;

D. the procedures for each client are documented in the client's records; and

E. the class F home care provider licensee retains documentation by the registered nurse regarding the person's demonstrated competency.

Subp. 8. **Documentation.** A class F home care provider licensee must retain documentation in the personnel records of the unlicensed personnel who have satisfied the training requirements of this part.

Subp. 9. **Medication records.** The name, date, time, quantity of dosage, and the method of administration of all prescribed legend and over-the-counter medications, and the signature and title of the authorized person who provided assistance with self-administration of medication or medication administration must be recorded in the client's record following the assistance with self-administration of medication or medication administration. If assistance with self-administration of medication or medication administration was not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided.

Subp. 10. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

A. subpart 2, $350;

B. subpart 3, $350;

C. subpart 4, $300;

D. subpart 5, $350;

E. subpart 6, $500;

F. subpart 7, $350;

G. subpart 8, $50; and

H. subpart 9, $300.

4668.0860 MEDICATION AND TREATMENT ORDERS.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee when an authorized prescriber orders a medication or treatment to be administered by the licensee.

Subp. 2. **Prescriber's order required.** There must be a written prescriber's order for a drug for which a class F home care provider licensee provides assistance with self-administration of medication or medication administration, including an over-the-counter drug.

Subp. 3. **Medication and treatment orders.** A medication or treatment must be administered by a nurse qualified to implement the order or by an unlicensed person under the direction of a nurse and the supervision of a registered nurse, according to part 4668.0845.

Subp. 4. **Authorizations.** An order for medication or treatment must be dated and signed by the prescriber, except as provided by subparts 6 and 7, and must be current and consistent with the nursing assessment required under part 4668.0855, subpart 2.

Subp. 5. **Content of medication orders.** An order for medication must contain the name of the drug, dosage indication, and directions for use.

Subp. 6. **Verbal orders.** Upon receiving an order verbally from a prescriber, a nurse must:

A. record and sign the order; and

B. forward the written order to the prescriber for the prescriber's signature no later than seven days after receipt of the verbal order.

Subp. 7. **Electronically transmitted orders.**

A. An order received by telephone, facsimile machine, or other electronic means must be kept confidential according to Minnesota Statutes, sections 144.291to 144.298 and 144A.44.

B. An order received by telephone, facsimile machine, or other electronic means must be communicated to the supervising registered nurse within one hour of receipt.

C. An order received by electronic means, not including facsimile machine, must be immediately recorded or placed in the client's record by a nurse and must be countersigned by the prescriber within 62 days.

D. An order received by facsimile machine must have been signed by the prescriber and must be immediately recorded or a durable copy placed in the client's record by a person authorized by the class F home care provider licensee.

Subp. 8. **Implementation of order.** When an order is received, the class F home care provider licensee or an employee of the licensee must take action to implement the order within 24 hours of receipt of the order.

Subp. 9. **Renewal of orders.** A medication or treatment order must be renewed at least every 12 months or more frequently as indicated by the nursing assessment required under part 4668.0855, subpart 2.

Subp. 10. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

A. subpart 2, $350;

B. subpart 3, $350;

C. subpart 4, $350;

D. subpart 5, $350;

E. subpart 6, $350;

F. subpart 7, item A, $250;

G. subpart 7, item B, $300;

H. subpart 7, item C, $300;

I. subpart 7, item D, $300;

J. subpart 8, $500 per day; and

K. subpart 9, $100.

4668.0865 CENTRAL STORAGE OF MEDICATION.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides central storage of medications.

Subp. 2. **Nursing assessment and service plan.** For a client for whom medications will be centrally stored, a registered nurse must conduct a nursing assessment of a client's functional status and need for central medication storage, and develop a service plan for the provision of that service according to the client's needs and preferences. The service plan must include the frequency of supervision of the task and of the person providing the service for the client according to part 4668.0845. The service plan for central storage of medication must be maintained as part of the service plan required under part 4668.0815.

Subp. 3. **Control of medications.**

A. A registered nurse or pharmacist must establish and maintain a system that addresses the control of medications, handling of medications, medication containers, medication records, and disposition of medications.

B. The system must contain at least the following provisions:

(1) a statement of whether the staff will provide medication reminders, assistance with self-administration of medication, medication administration, or a combination of those services;

(2) a description of how the distribution and storage of medications will be handled, including a description of suitable storage facilities;

(3) the procedures for recording medications that clients are taking;

(4) the procedures for storage of legend and over-the-counter drugs;

(5) a method of refrigeration of biological medications; and

(6) the procedures for notifying a registered nurse when a problem with administration, record keeping, or storage of medications is discovered.

Subp. 4. **Over-the-counter drugs.** An over-the-counter drug may be retained in general stock supply and must be kept in the original labeled container.

Subp. 5. **Legend drugs.** A legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of a time-dated drug, directions for use, client's name, prescriber's name, date of issue, and the name and address of the licensed pharmacy that issued the medications.

Subp. 6. **Medication samples.** A sample of medication provided to a client by an authorized prescriber may be used by that client, and must be kept in its original container bearing the original label with legible directions for use. If assistance with self-administration of medication or medication administration is provided by the class F home care provider licensee, a client's plan of care must address the use of a medication sample.

Subp. 7. **Prohibitions.** No legend drug supply for one client may be used or saved for the use of another client.

Subp. 8. **Storage of drugs.** A class F home care provider licensee providing central storage of medications must store all drugs in locked compartments under proper temperature controls and permit only authorized nursing personnel to have access to keys.

Subp. 9. **Storage of Schedule II drugs.** A class F home care provider licensee providing central storage of medications must provide separately locked compartments, permanently affixed to the physical plant or medication cart, for storage of controlled drugs listed in Minnesota Statutes, section 152.02, subdivision 3.

Subp. 10. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

A. subpart 2, $350;

B. subpart 3, $300;

C. subpart 4, $300;

D. subpart 5, $300;

E. subpart 6, $300;

F. subpart 7, $300;

G. subpart 8, $300; and

H. subpart 9, $300.

4668.0870 DISPOSITION OF MEDICATIONS.

Subpart 1. **Scope.** This part applies to a class F home care provider licensee that provides central storage of medications.

Subp. 2. **Drugs given to discharged clients.** Current medications belonging to a client must be given to the client, or the client's responsible person, when the client is discharged or moves from the housing with services establishment. A class F home care provider licensee must document in the client's record to whom the medications were given.

Subp. 3. **Disposition of medications.**

A. Unused portions of a controlled substance remaining in a housing with services establishment after death or discharge of the client for whom the controlled substance was prescribed, or any controlled substance discontinued permanently, must be disposed of by contacting the Minnesota Board of Pharmacy, which shall furnish the necessary instructions and forms, a copy of which shall be kept on file by the class F home care provider licensee for two years.

B. Unused portions of a legend drug remaining in a housing with services establishment after the death or discharge of the client for whom the legend drug was prescribed, or any legend drug permanently discontinued, must be destroyed by the class F home care provider licensee or a designee of the licensee, in the presence of a pharmacist or nurse who shall witness the destruction. A notation of the destruction listing the date, quantity, name of drug, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded in the client's record.

Subp. 4. **Loss or spillage.** When a loss or spillage of a Schedule II drug occurs, an explanatory notation must be made in the client's record. The notation must be signed by the person responsible for the loss or spillage and by one witness who must also observe the destruction of any remaining contaminated drug by flushing into the sewer system or wiping up the spill.

Subp. 5. **Schedule of fines.** For a violation of the following subparts, the stated fine shall be assessed:

A. subpart 2, $300;

B. subpart 3, $300; and

C. subpart 4, $300.

4669.0001 AUTHORITY.

This chapter establishes fees for the licensing of home care providers, as required by Minnesota Statutes, section 144A.46, subdivision 1, paragraph (c), and part 4668.0012, subpart 18.

4669.0010 DEFINITIONS.

Subpart 1. **Applicant.** "Applicant" means a provider of home care services that applies for a new license or renewal license under chapter 4668.

Subp. 2. **Commissioner.** "Commissioner" means the commissioner of the Department of Health.

Subp. 3. **Provider.** "Provider" means a home care provider required to be licensed under Minnesota Statutes, sections 144A.43 to 144A.47.

Subp. 4. **Revenues.** "Revenues" means all money or the value of property or services received by a registrant and derived from the provision of home care services, including fees for services, grants, bequests, gifts, donations, appropriations of public money, and earned interest or dividends.

4669.0020 LICENSE FEE.

An applicant for a new license or renewal license under chapter 4668 shall pay a fee to the commissioner based on revenues derived from the provision of home care services during the calendar year prior to the year in which the application is submitted, according to the formula in part 4669.0050.

4669.0030 PROCEDURE FOR PAYING LICENSE FEE.

Subpart 1. **Payment of fee.** An applicant shall submit the fee required by part 4669.0050 to the commissioner together with the application for the license.

Subp. 2. **Verification of revenues.** Under a circumstance listed in item A or B, the commissioner shall require each applicant to verify its revenues by providing a copy of an income tax return; informational tax return, such as an Internal Revenue Service form 1065 partnership return or form 990 tax-exempt organization return; Medicare cost report; certified financial statement; or other documentation that verifies the accuracy of the revenues derived from the provision of home care services for the reporting period on which the fee is based if either:

A. the commissioner has received information that a revenue report may be inaccurate; or

B. the provider has been randomly selected for compliance verification.

4669.0040 FEE LIMITATION.

A provider is subject to one license fee, regardless of the number of distinct programs through which home care services are provided unless the provider operates under multiple units as set forth in part 4668.0012, subpart 2. The fee shall be based on the total revenue of all home care services.

4669.0050 FEE SCHEDULE.

Subpart 1. **Fees for classes A and B.** The amount of the fee for class A and class B providers shall be determined according to the following schedule:

A. for revenues greater than $1,500,000, $4,000;

B. for revenues greater than $1,275,000 and no more than $1,500,000, $3,500;

C. for revenues greater than $1,100,000 and no more than $1,275,000, $3,000;

D. for revenues greater than $950,000 and no more than $1,100,000, $2,500;

E. for revenues greater than $850,000 and no more than $950,000, $2,250;

F. for revenues greater than $750,000 and no more than $850,000, $2,000;

G. for revenues greater than $650,000 and no more than $750,000, $1,750;

H. for revenues greater than $550,000 and no more than $650,000, $1,500;

I. for revenues greater than $450,000 and no more than $550,000, $1,250;

J. for revenues greater than $350,000 and no more than $450,000, $1,000;

K. for revenues greater than $250,000 and no more than $350,000, $750;

L. for revenues greater than $100,000 and no more than $250,000, $500;

M. for revenues greater than $25,000 and no more than $100,000, $250; and

N. for revenues no more than $25,000, $100.

Subp. 2. **Fees for class C.** The amount of the fee for class C providers shall be as follows:

A. for revenues greater than $1,000, $50; and

B. for revenues no more than $1,000, $20.

Subp. 3. **Fees for class E.** The amount of the fee for class E providers is $500.

Subp. 4. **Fees for medical equipment vendors.** Regardless of the class under which it is licensed, a provider whose principal business is medical supplies and equipment shall pay an annual fee of $500.